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Navigating the Pathway Forward: A Journey Toward Health Equity in Rehab

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Disclosure

No relevant financial relationships to disclose

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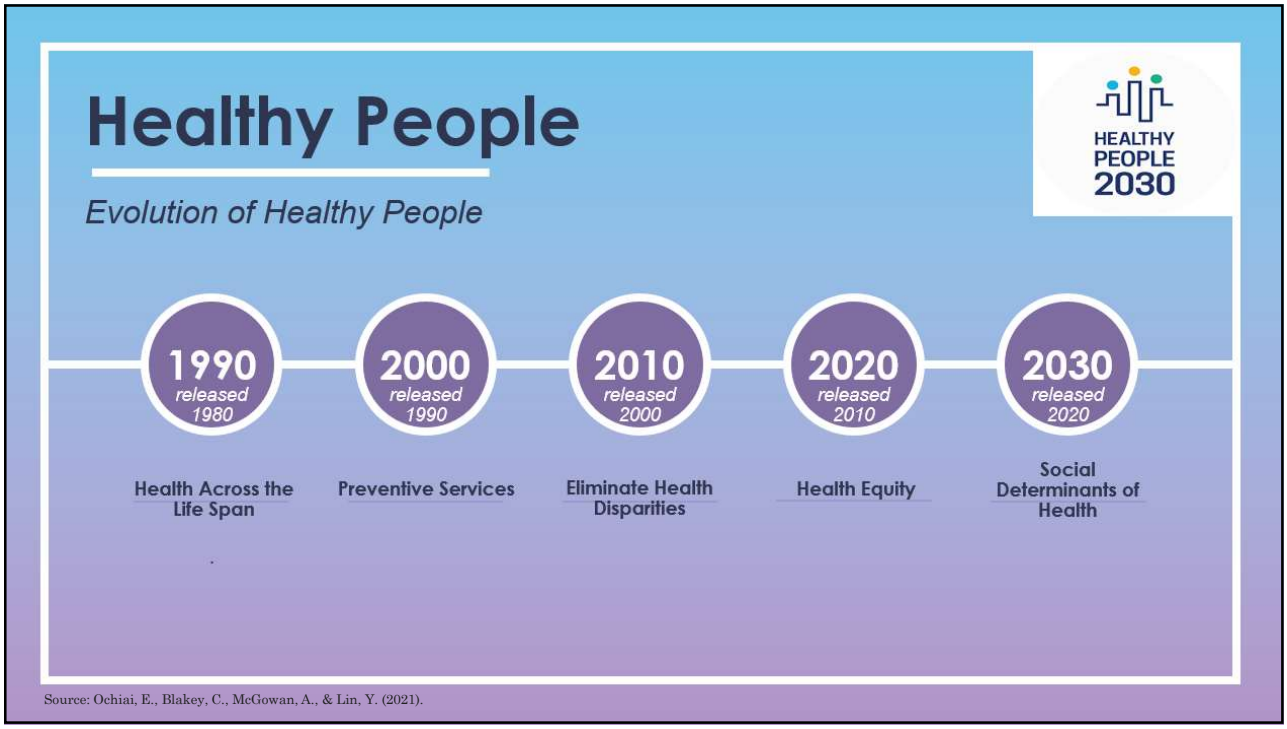
Objectives:

Define Social Determinants of Health and the impact it has on
health equity and health outcomes

Describe ways for nurses to engage in Social Determinants of Health

Discuss ways to position nurses and nurse leaders to lead with a compass of equity, inclusion, and diversity

Describe activities that support nurse preparedness in addressing unmet health needs in rehabilitation settings



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How does *Healthy People* 2030 address SDOH?

- Attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.
- Eliminate **health disparities**, achieve health equity, and attain health literacy to improve the health and well-being of all.
- **Create social, physical, and economic environments** that promote attaining the full potential for health and well-being for all.
- Promote healthy development, healthy behaviors, and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

Source: https://health.gov/healthypeople/objectives-and-data/social-determinants-health

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What are Social Determinants of Health (SDoH):

- Nonmedical factors influencing health (Braveman et at 2011)
- Health starts long before illness (Robert Wood Johnson Foundation n.d.)
- Health starts in our homes, schools, workplaces, neighborhoods, and communities (Healthy People 2020)
- Conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks (Healthy People 2030)
- The conditions in which people are born, grow, live, work, and age, and which are shaped by distribution of money, power and resources at global, national and local levels (WHO, n.d.)

Source: https://health.gov/healthypeople/objectives-and-data/social-determinants-health

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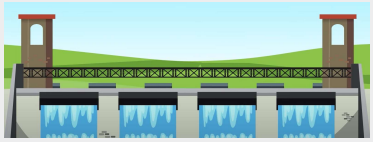
Examples of Social Determinants of Health (SDoH)

Upstream

- Institutional Discrimination
- Accessibility of Resources
- Employment
- Housing
- Healthy Foods
- Quality Healthcare

Downstream

- Employment Status
- Level of Education
- Aspects of Identity:
  - Gender
  - Race
  - Disability Status



Source: https://www.youtube.com/watch?v=17jeXGbKlTQ

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Examples of Social Determinants of Health (SDoH) in Post-Acute Healthcare

- Caregiver Resources Evaluation
- Community Resources
- Education Management
- Financial Status and Benefits
- Health Literacy
- Safety
- Screening for Health-Related Social Needs
- Social Support
- Transportation

Source: https://www.youtube.com/watch?v=17jeXGbKlTQ

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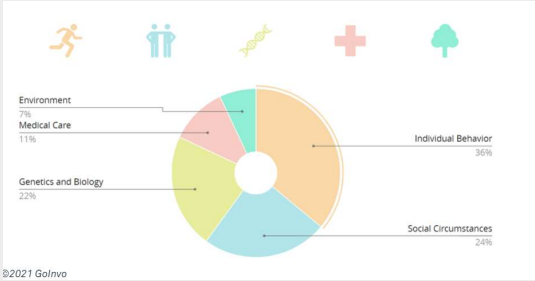
Ways to Engage in Addressing SDoH

1. Understand and Engage Your Community
2. Engage Key Leadership
3. Assess Your Readiness
4. Select and Define Your Plan
5. Assess SDOH at the Patient Level
6. Link Patients to SDOH Resources
7. Evaluate and Refine
8. Celebrate Your Success



Source: https://edhub.ama-assn.org/steps-forward/module/2702762

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Understand and Engage Your Community

Begin by understanding the health needs of the communities you serve.

Review your patient's health needs via Community Health Needs Assessment (CHNA).

The CHNA serves, identifies disparities, and prioritizes health issues of concern.

If you are in a community practice with patients seeking care across multiple hospitals, we recommend sampling a few CHNA reports to further define your patient population's needs.

The assessment can be easily accessed online by typing your organization's name and "Community Health Needs Assessment" into a search engine.

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Engage Key Leadership

Addressing SDOH is an essential strategy to maintain or improve the health of a population.

Receive support from key leadership, such as a Chief Executive Officer (CEO), Chief Operating Officer (COO), Chief Medical Officer (CMO), and Chief Medical Information Officer (CMIO), is recommended.

Ensure Executive leadership provides the necessary financial and staffing resources to implement programs and initiatives, as well as assist in removing any administrative or logistical barriers.

For a smaller scope of intervention, such as an individual department within a larger institution, secure the support of the department chair; for an individual practice, seek the practice manager's buy-in.

Source: https://edhub.ama-assn.org/steps-forward/module/2702762

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Assess Your Readiness

- **Perceived value of moving upstream**—Identify the perceived value of change to assess and address social determinants of health
- **Executive sponsorship**—Assess the quality and degree of executive sponsorship to advance social determinants interventions
- **Non-clinical and clinical team roles**—Identify if non-clinical and clinical team roles have been clearly defined and integrated into upstream work
- **Scope of work of upstream interventions**—Consider if the scope of the proposed or current upstream intervention has been defined
- **Project management of upstream interventions**—Assess the maturity and style of project management for social determinants interventions
- **Workflow integration**—Assess the degree to which your social determinant intervention is integrated in care delivery workflows
- **Quality improvement**—Assess your organization's quality improvement culture and processes as they relate to social determinants interventions
- **Organizational infrastructure**—Consider the organizational infrastructure and supports for your social determinants intervention
- **Financial readiness**—Identify the

Source: https://edhub.ama-assn.org/steps-forward/module/2702762

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Select and Define Your Plan

1. Select a social need
2. Choose a health outcome to track
3. Define your target patient population
4. Consider what type of practice setting best describes your clinical practice:
   a. Physician practice
   b. Federally qualified health center (FQHC)
   c. Hospital/health system

Source: https://edhub.ama-assn.org/steps-forward/module/2702762

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Assess SDOH at the Patient Level

PRAPARE—Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences Implementation and Action Toolkit

SIREN—Social Interventions Research and Evaluation Network

The EveryONE Project™

AHCM—Accountable Health Communities Health-Related Social Needs Screening Tool

OCHIN—Oregon Community Health Information Network

Source: https://edhub.ama-assn.org/steps-forward/module/2702762

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Link Patients to SDOH Resources

Examples of resource connections might include:

- Referrals to local food banks and food pharmacies
- Vouchers for bus, share-ride transportation
- Providing a mobile food pantry at a clinic location
- Referrals to loan closets (medical equipment)
- Caregiver respite grants

Source: https://edhub.ama-assn.org/steps-forward/module/2702762

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Evaluate and Refine

Refine and enhance your workflows.

Discuss with your team and patients to learn what is working and what needs to change.

Re-examine the process to see if you can identify a better way to screen more patients.

The solution may be as simple as training one extra staff member on administering the questionnaire during rooming.

Source: https://edhub.ama-assn.org/steps-forward/module/2702762

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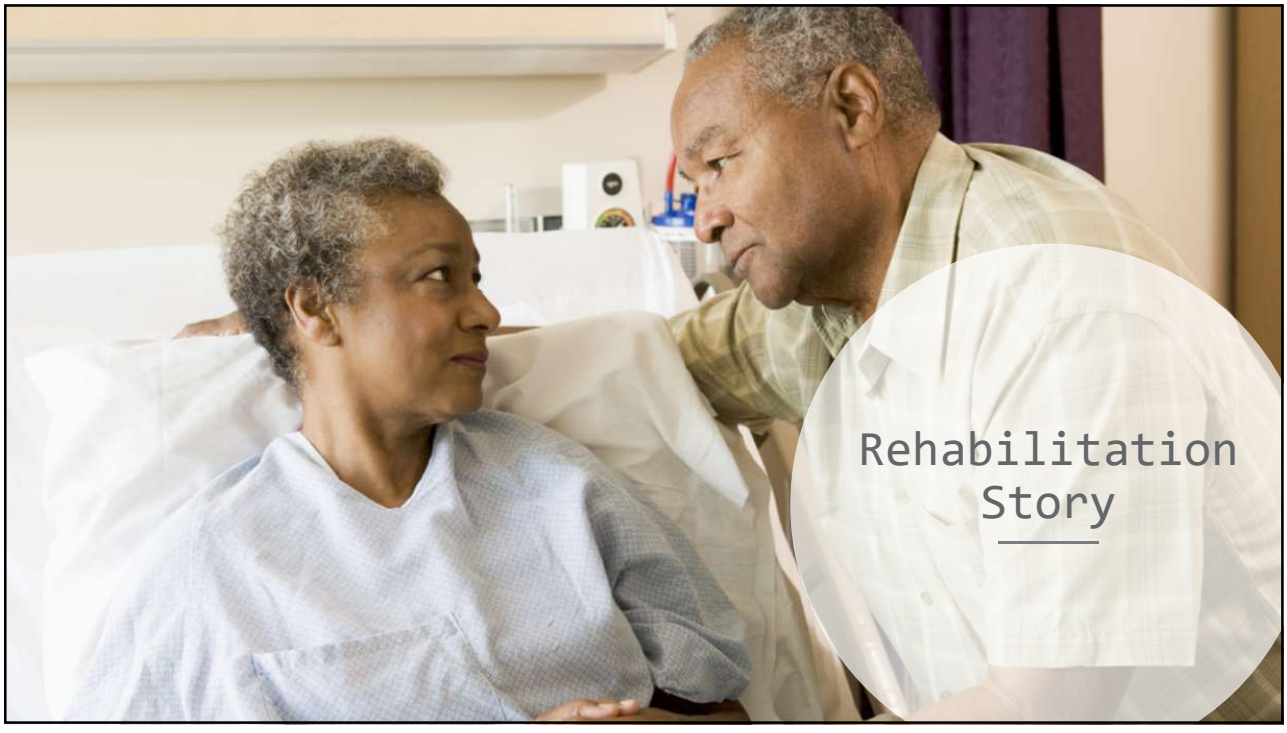
Celebrate Your Success

As you continue to refine your workflow, celebrate your successes.

Share patient stories and best practices with colleagues across your organization and community.

By sharing your stories, you may inspire other practices to implement your model, which will help to scale and sustain the initiative and improve the health outcomes of many more patients across the community.

Source: https://edhub.ama-assn.org/steps-forward/module/2702762



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Improving Population in Health is critical to research outcomes

Over 80% of a person's health is determined by the social and economic conditions of their homes and communities, their Social Determinants of Health (SDOH).

Healthcare organizations pursuing value-based care must go beyond standard claims and medical data and integrate data sources that measure SDOH to effectively treat the whole person.

Establishing interventions for high-risk populations starts with identifying the most critical needs.

Leveraging demographic and economic data is the foundation for addressing social determinants, but most organizations are working with an incomplete picture at best.

Source: https://www.himss.org/resources/social-determinants-health

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Health inequities and the social determinants of health are not a footnote to the determinants of health. They are the main issue.

~ Michael Marmot

Source: https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00691

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Racial and Health Equity

- **Racial Equity** is a process of eliminating racial disparities and improving outcomes for everyone. It is the intentional and continual practice of changing policies, practices, systems, and structures by prioritizing measurable change in the lives of people of color.
- **Health Equity** means that **everyone has a fair and just opportunity to be healthy**. Include removing obstacles of health, such as food security, socioeconomic status, access to care, reliable transportation, safe housing, neighborhood characteristics and social support.

https://www.cdc.gov/healthequity/racism-disparities/index.html

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Health Inequities and their causes

According to the WHO:

- Health inequities are systematic differences in the health status of different population groups.
- Health inequities are differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age.
- Children from rural and poorer households remain disproportionately affected.
- In low-resource settings, health-care costs for noncommunicable diseases (NCDs) can quickly drain household resources, driving families into poverty.
- In the United States of America, African Americans represent only about 13% of the population but account for almost half of all new HIV infections.

Source: World Health Organization (2022)

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Addressing Health Inequities

- Health inequity issues are well documented, so there is no need for further needs assessment.
- Health inequity is a complex issue based on years of discrimination and racism in clinical care and research, so it requires a complex solution.
- Solutions must be action oriented and address the entire health and research continuum.

Source: https://www.ncbi.nlm.nih.gov/books/NBK425845/; Williams, D. R., & Rucker, T. D. (2000).

Image: https://region2phtc.org/category/health/page/4/

Improving health equity requires a holistic approach. **Change is needed everywhere – from the bedside to the board room to how payers pay for care to health policy changes.**

nam.edu/Perspectives

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"When we work to find out what diverse populations need in order to be successful and devote our work towards meeting those needs, then diverse populations will begin to perform to their potential, and we will one day see equality"

~ Lisa Bass, Ph.D.

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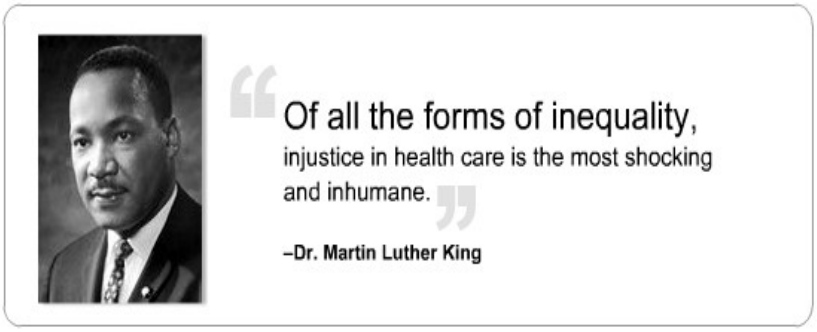

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Thank you

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