Social Drivers of Health & How They Impact Society

New York American College of Physicians
Annual Scientific Meeting

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Cayuga Health System
Cayuga Health Partners

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Agenda

1. Set the Stage
2. Review & Reflection
3. Unpacking the Social Drivers of Health (SDOH)
4. Strategies to Address the SDOH
5. Recap / Questions & Answers

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Workshop Understandings

- Delivery model is width vs depth
- Time is always a barrier
- Commitment to create space outside of the workshop
- Engagement is requested
- We are at different starting points
- Expect discomfort
- Purposefully listen

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Learning Takeaways

- Ability to describe the social drivers of health and/or health related social needs
- Understand the connection between health equity and the social drivers of health
- Understand best practice strategies on how we can positively impact the social drivers of health
- Cultivate a proactive mindset in addressing the social drivers of health

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Section I

Reflecting on What We Already Know :

Social Drivers of Health & How They Impact Society

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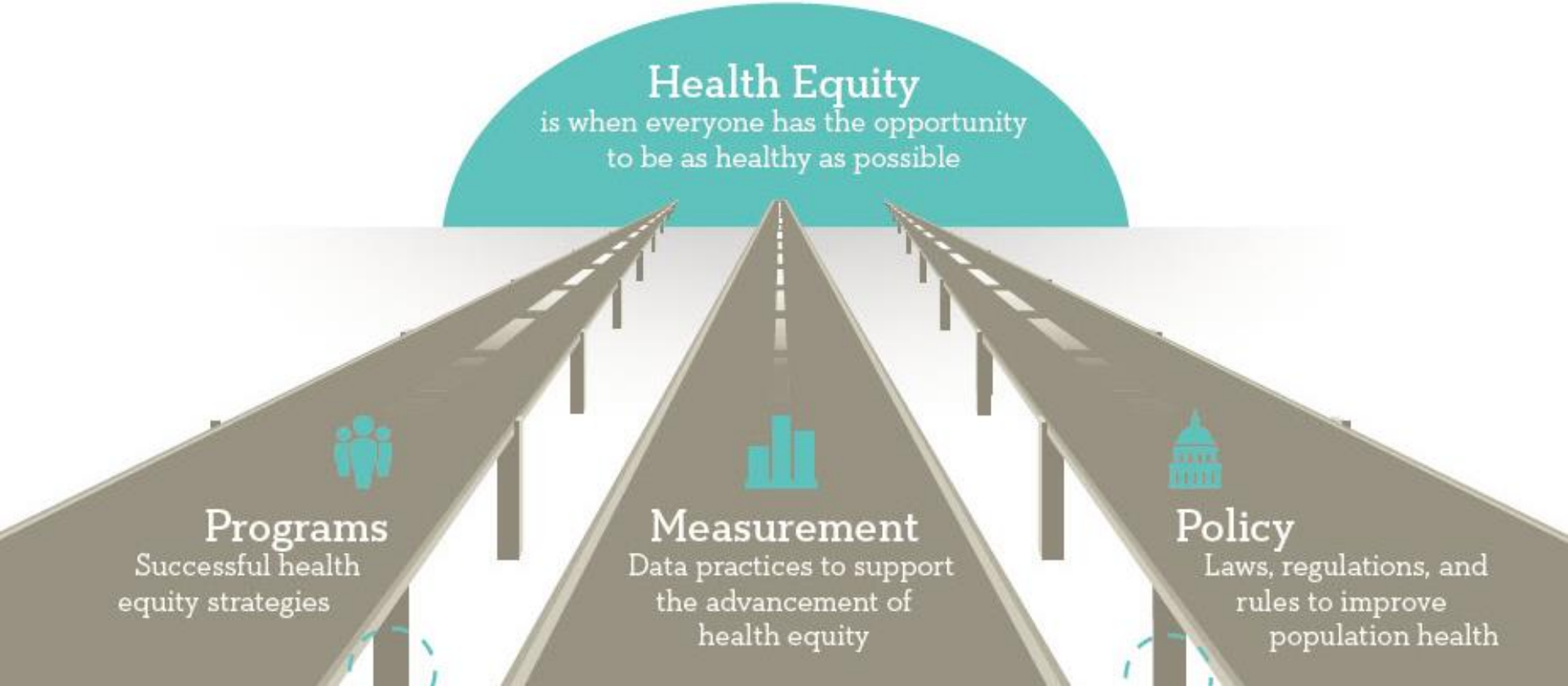
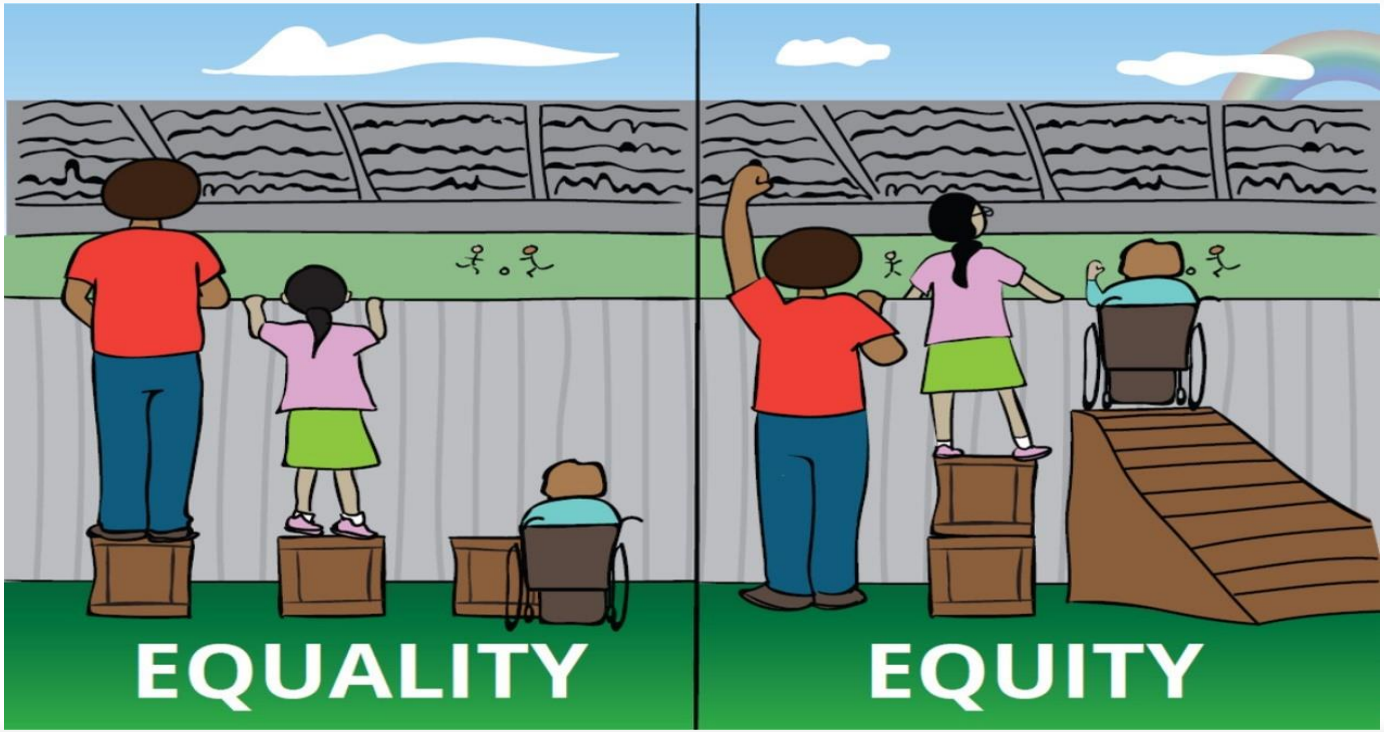
PAVING THE ROAD TO HEALTH EQUITY



Equity Simplified



Where Health Happens

What percentage of health happens or occurs outside of health care facilities?

A. 25%

B. 40%

C. 60%

D. 75%

E) None of the above

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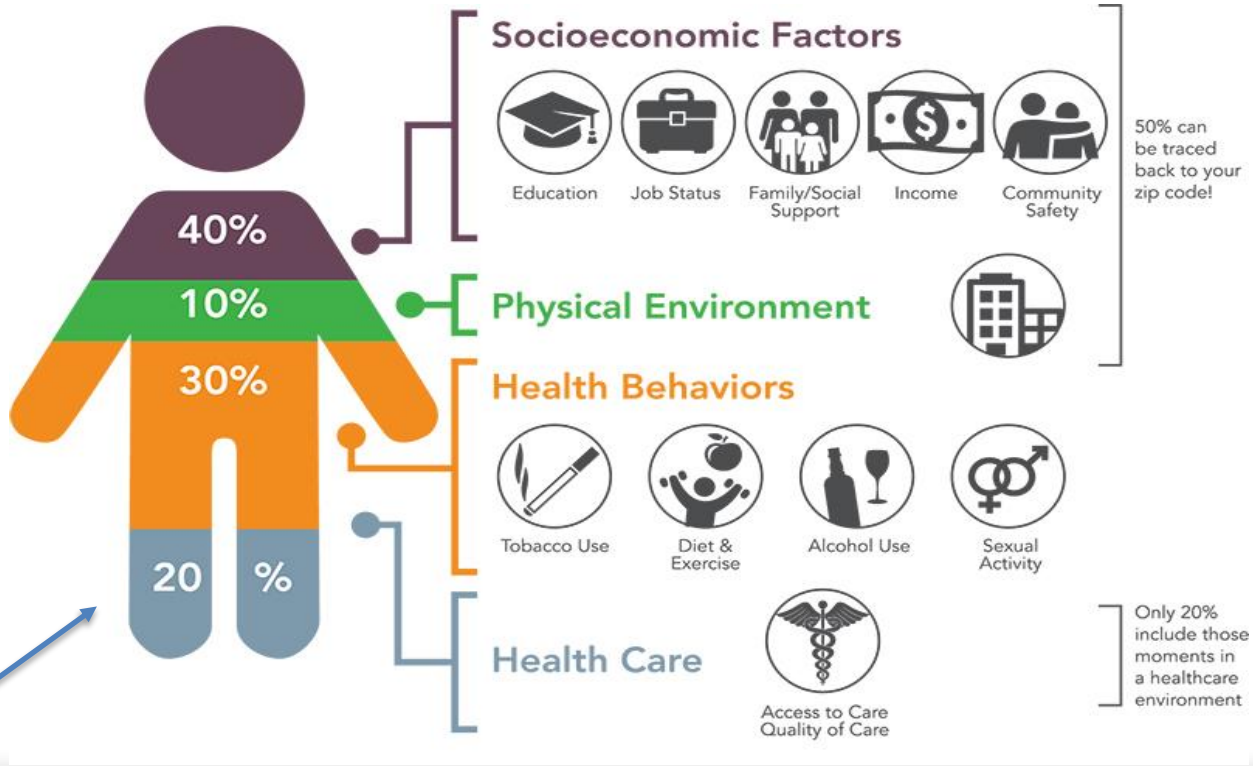
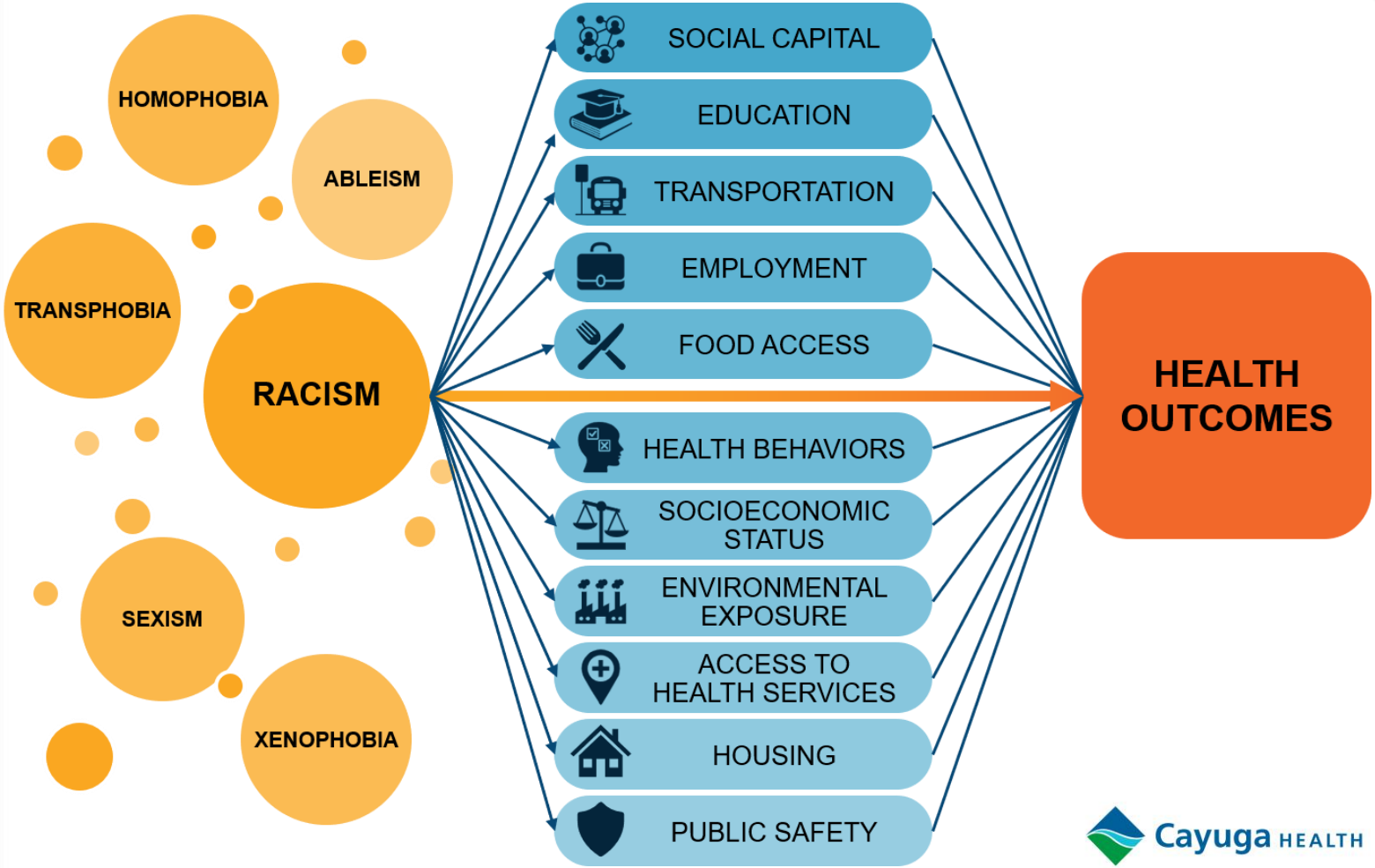


Health Inequities

Health Inequities:

- Are structural forces that influence health and are not only unfair - but also unjust
- Ultimately result in health disparities
- Identifies the root causes of the disparities
- Describes what shapes the quality of the conditions experienced by people
- Addresses resource distribution and barriers to opportunities

Social Drivers and How They Impact Society



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Health Equity in a Local Community

Tompkins County is ranked #5 in health outcomes in NYS

But in measures of health equity, we are significantly lower

County Health Rankings, Robert Wood Johnson Foundation, 2022

Tompkins County Health Data (2018-2020)

	Non-Hispanic / Latino				
Health / Social Indicator	**White**	**Black / African American**	**Asian / Pacific Islander**	**Hispanic / Latino**	**Total**
Socio-Demographic Indicators					
Population	80,851 (79%)	4,943 (5%)	10,777 (11%)	5,405 (5%)	**102,382**
Percentage of Families Below the Poverty Rate	4%	18%	8%	20%	**5%**
Health Indicators					
Premature Deaths (< 75 Years)	37%	61%	46%	50%	**38%**
Percentage of Premature Births (<37 Weeks)	7%	14%	2%	5%	**7%**
Diseases of the Heart Hospitalizations (Age Adjusted / Per 100,000)	48	87	12	16	**51**
Diabetes Hospitalizations (Age Adjusted / Per 10,000)	106	269	27	47	**116**

Source: NYS DOH County Health Indicators by Race/Ethnicity (CHIRE)

Reflection Question

If the data presented is applicable or comparable to your own county or region, what proactive measures could you take within your sphere of influence to drive meaningful change?

Section II

Unpacking the Social Drivers of Health:

Social Drivers of Health & How They Impact Society

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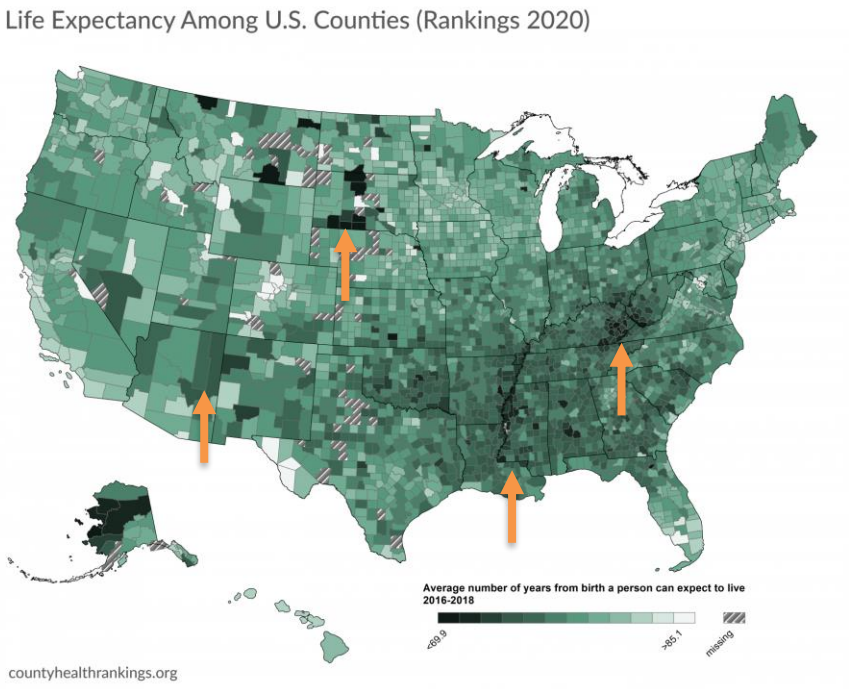
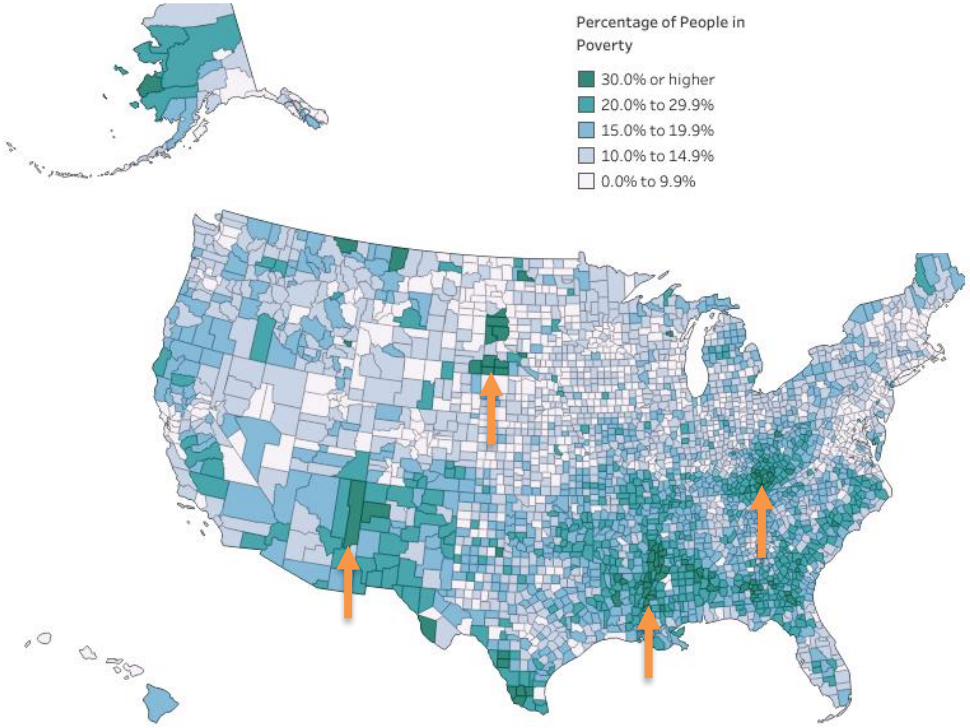
The Drivers


Neighborhood and Built Environment
Health Care and Quality
Social and Community Context
Education Access and Quality
Economic Stability

Life Expectancy | Poverty Rate





Source: Countyhealthrankings.org | U.S. Census Bureau

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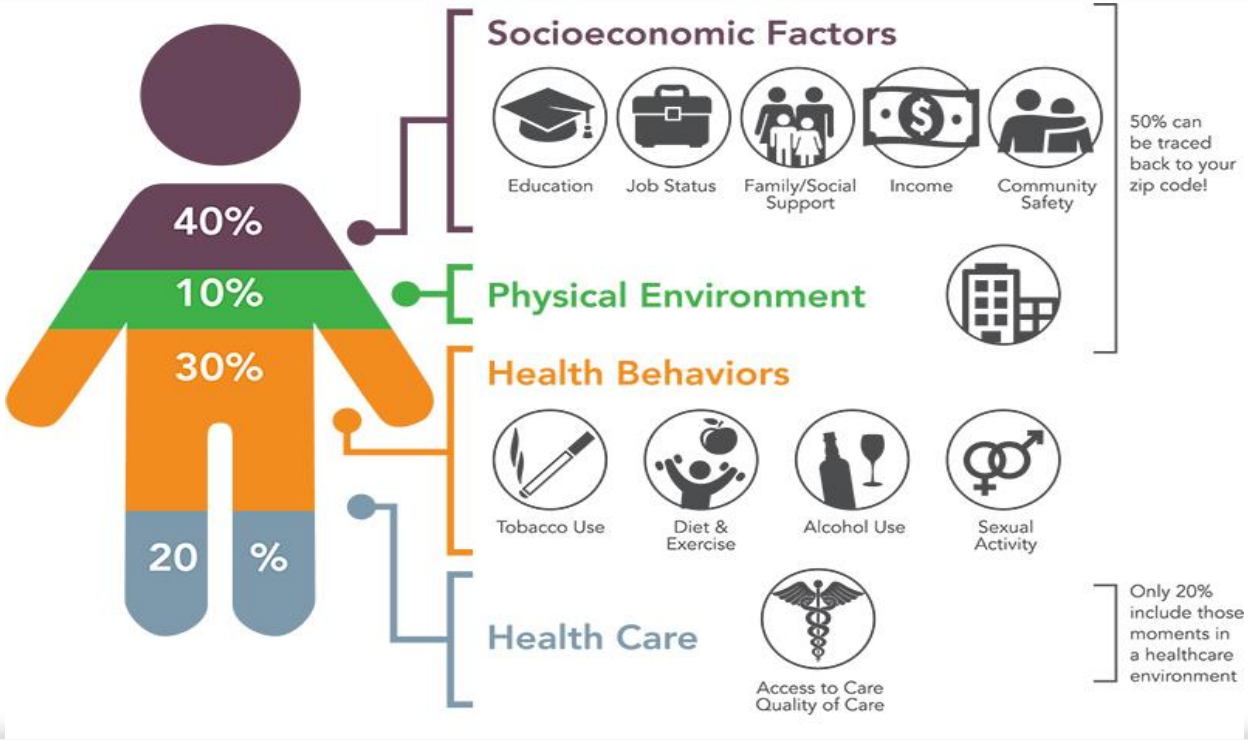
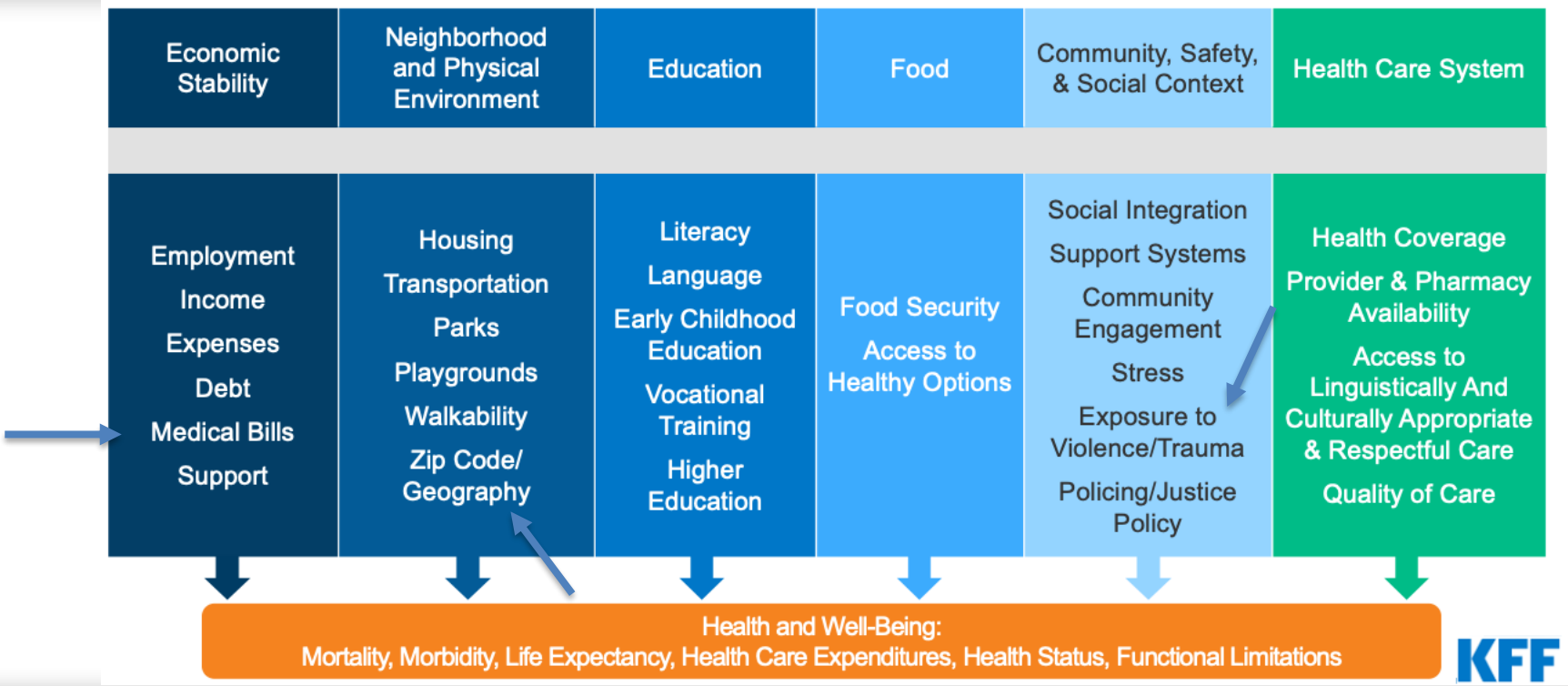
Where Health Happens



The Drivers in Detail



Section III

Addressing the Social Drivers of Health :

Social Drivers of Health & How They Impact Society

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Improved Data Practices

1. Improving data collection practices for intake and registration for REAL & SOGI information
2. Updating or adjusting EMR systems to better capture patients' full identity
3. Stratifying data to identify health disparities
4. Utilizing data to support and advocate for resources to address needs of identified populations

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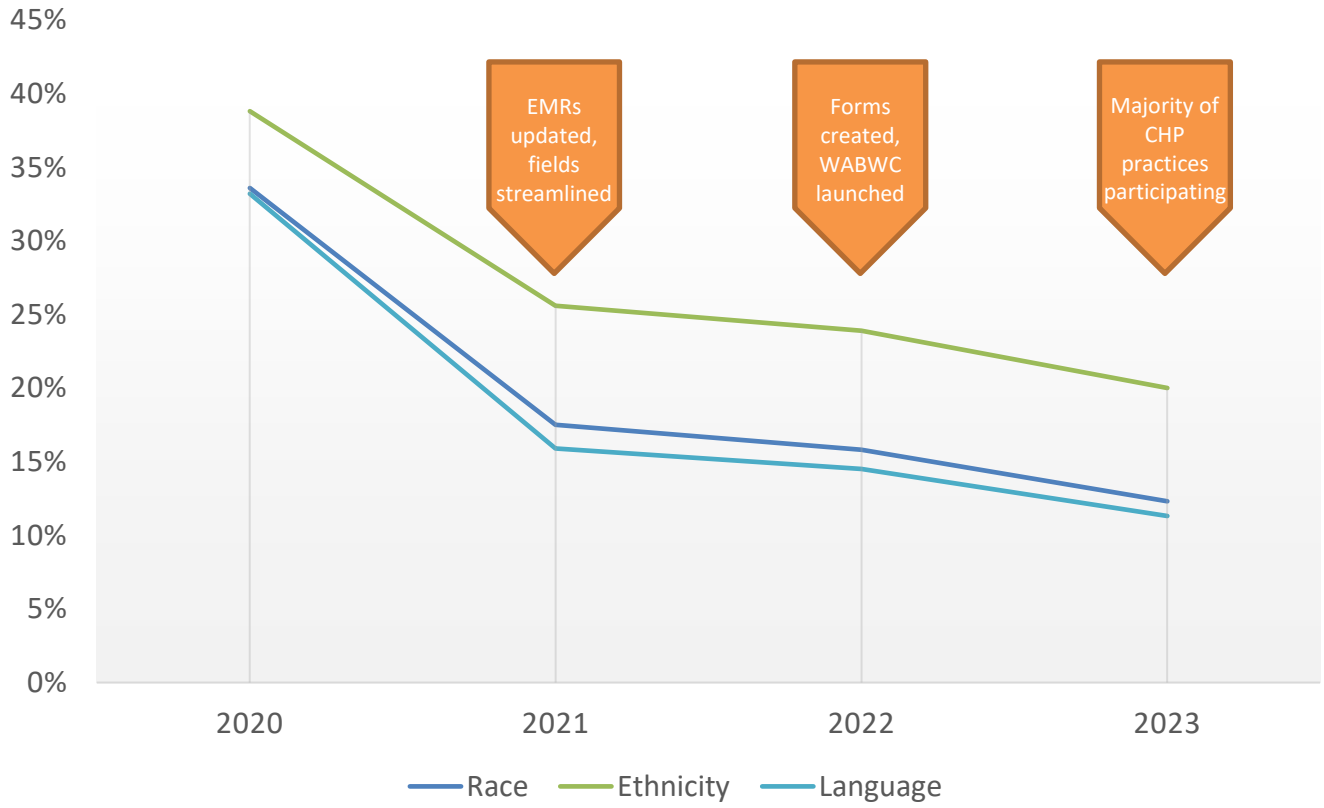
Rate of Unknown REAL Data, 2020-2023



48% ↓

63% ↓

66% ↓

Health Equity Dashboards with Real-Time Visualization

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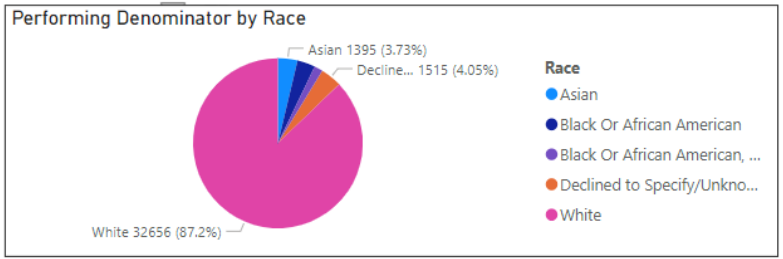
2023.08.11, 5:00 AM
Last Update

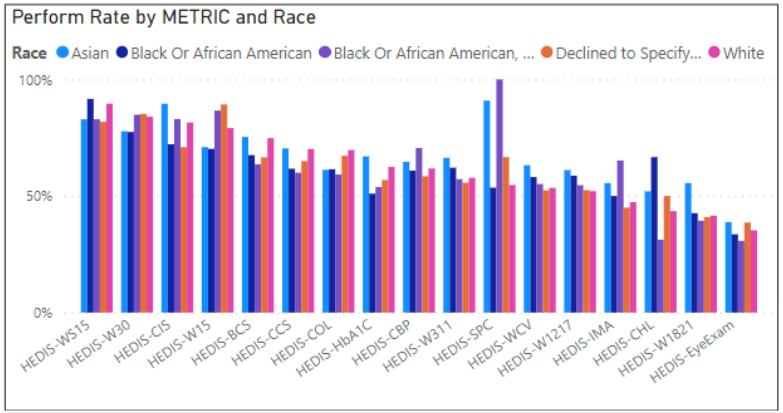
Payer
- Select all
- Aetna
- Excellus
- Excellus-CMA
- Excellus-CMC
- Excellus-Schuyler

ASSIGNED_PRV_FLG
- 0
- 1

PRV_TITLE
- Select all
- DO
- MBBS
- MC
- MD
- NP

Metrics Name	Performing Denominator	Performing Numerator	Perform Rate
HEDIS-COL: Colorectal Cancer Screening	**17709**	**12244**	**69.14%**
White	15978	11139	69.71%
Declined to Specify/Unknown	739	497	67.25%
Asian	508	311	61.22%
Black Or African American	457	281	61.49%
Black Or African American, White	27	16	59.26%
HEDIS-CCS: Cervical Cancer Screening	**10691**	**7446**	**69.65%**
White	9332	6547	70.16%
Asian	538	379	70.45%
Declined to Specify/Unknown	434	282	64.98%
Black Or African American	337	208	61.72%
Black Or African American, White	50	30	60.00%
HEDIS-WCV: Child and Adolescent Well Care Visits	**10280**	**5566**	**54.14%**
White	8561	4579	53.49%
Asian	451	285	63.19%
Black Or African American	449	261	58.13%
Black Or African American, White	428	236	55.14%
Declined to Specify/Unknown	391	205	52.43%
HEDIS-BCS: Breast Cancer Screening	**8298**	**6171**	**74.37%**
White	7563	5661	74.85%
Declined to Specify/Unknown	314	209	66.56%
Asian	219	165	75.34%
Black Or African American	191	129	67.54%
Total	**37449**	**27511**	**73.46%**





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SDOH Screenings & Referrals

1. Unmet social needs are major drivers of health outcomes, health disparities, and healthcare utilization
2. Patients find it acceptable and an important element of patient centered-care
3. Better understanding of the need for community resources
4. Public and private payers are investing in social interventions
5. Healthcare stakeholders are paying closer attention to wellbeing and equity in the communities they serve

Partnering with Community Based Organizations (CBO's)

1. Partnerships allow for greater collective impact on community
2. Difficult for healthcare facilities to wholistically support the needs of their patients
3. CBO's often have more knowledge about appropriate messaging and partnership with specific populations
4. CBO's often have established trust with folx that are historically mistrustful

Additional Strategies to Address SDOH

1) **Economic Stability & Development**: Programs that provide stable housing, living wages, and food security can significantly improve
2) **Policy Change:** Advocacy for policies that address social determinants at a systemic level can be highly effective. This could include policies that reduce income inequality, improve working conditions, or address systemic
3) **Debiased Utilization of Artificial Intelligence:** AI can analyze vast amounts of data to predict which communities are most at risk due to various social determinants. This can help in the targeted allocation of resources

Recap & Key Takeaways

- Social drivers of health are upstream health factors that impact individual and community health
- To achieve health equity and eliminate health disparities, we must prioritize and address the social drivers of health
- One of (if not the most) key drivers that impact health outcomes is economic stability
- Intentional strategies & interventions such as improved data practices, partnerships and proactive screenings are the best way to address the upstream drivers of health

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Social Drivers of Health & How They Impact Society

Please connect with me after the workshop for additional conversation & questions.

Herb Alexander, M.S.L
Cayuga Health System
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Section IIII

Annex:

Social Drivers of Health & How They Impact Society

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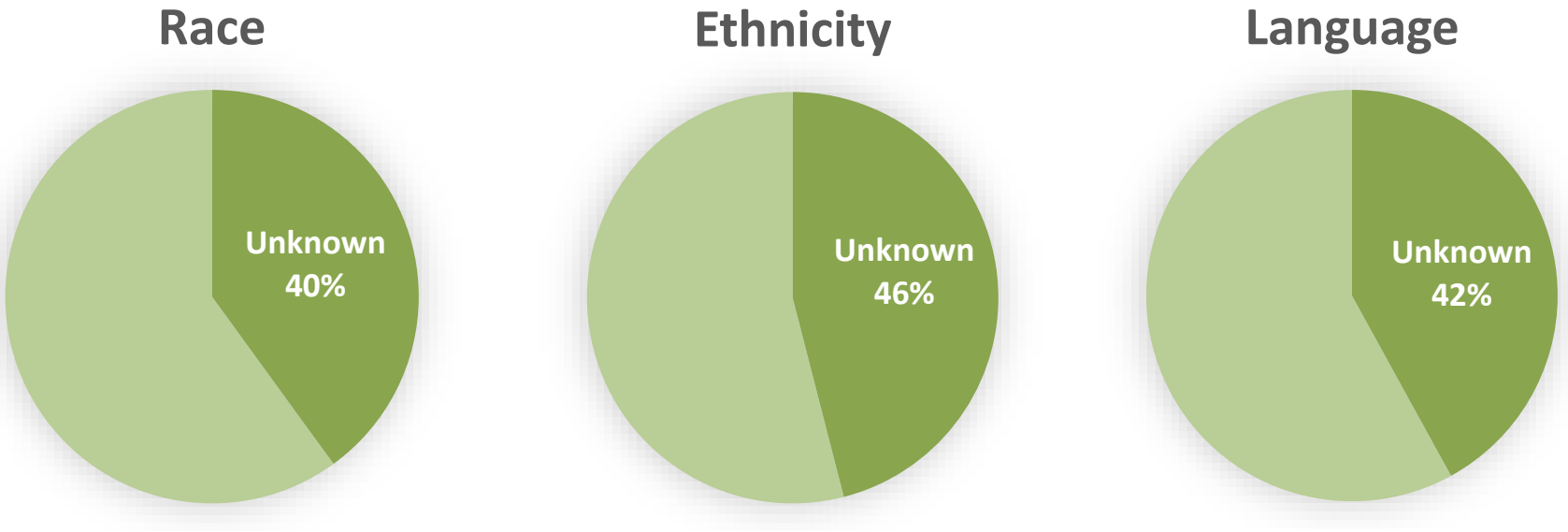
Defining Our Goals

- **Goal: Improve patient demographic data collection (2022-2023 focus: CMC & CMA)**
  - Decrease the rate of unknown race, ethnicity, and language by 5% in 2022 and 2023 at CMC and CHP practices
  - Establish capability to collect and determine baseline for sexual orientation and gender identity data by July 2023
  - Begin the use of standardized patient demographic forms at CMC Main Admissions and 100% of CMA practices by July 2023
  - Provide education to 100% of CMA practices by July 2023
- Tompkins County Community Health Improvement Plan 2022-2024 includes:
  - Increase patient demographic data collection at Cayuga Health, including 42 outpatient practices, via the *We Ask Because We Care* campaign to identify and address disparities

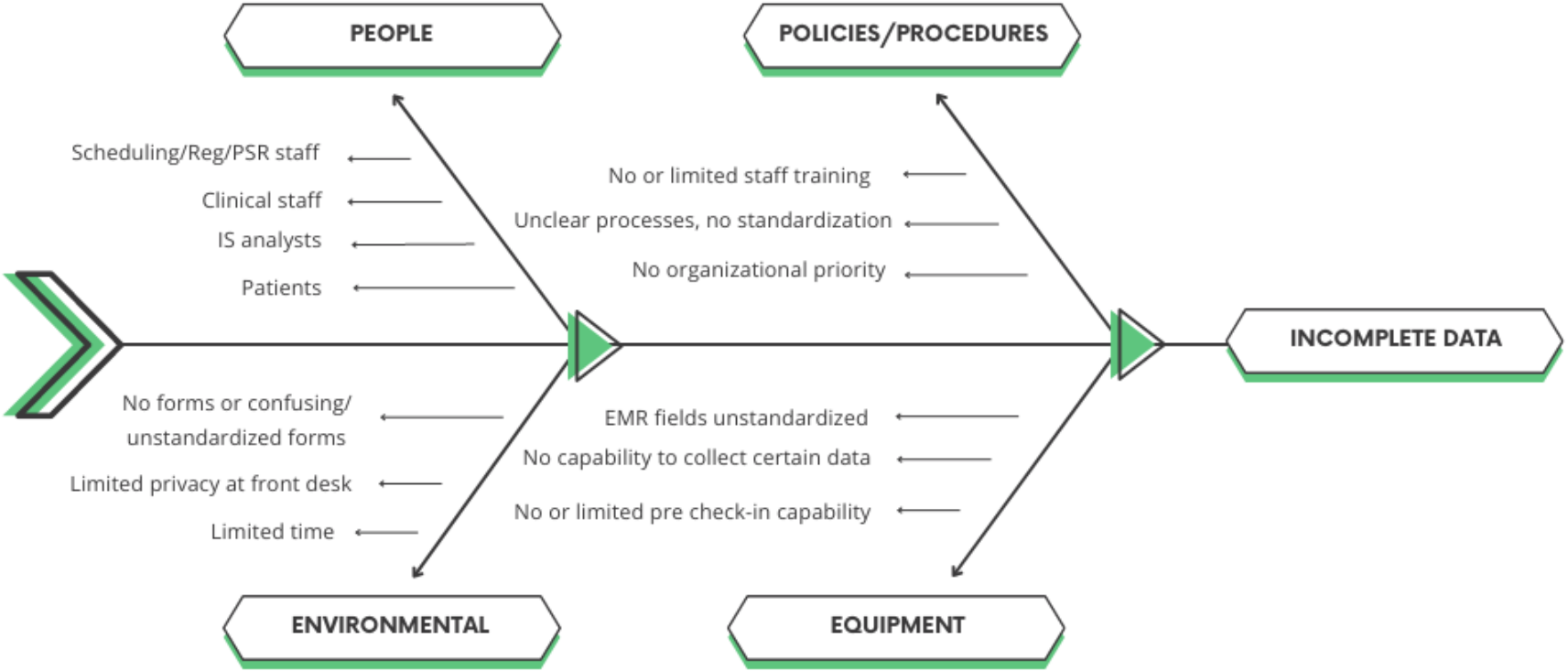
Measure



2020 Baseline Rate of Unknown/Null

Data Source: CHP (includes CHP practices with MEDENT and CMC)

Analyze


PEOPLE
POLICIES/PROCEDURES
Scheduling/Reg/PSR staff
Clinical staff
IS analysts
Patients
No or limited staff training
Unclear processes, no standardization
No organizational priority
INCOMPLETE DATA
No forms or confusing/ unstandardized forms
Limited privacy at front desk
Limited time
EMR fields unstandardized
No capability to collect certain data
No or limited pre check-in capability
ENVIRONMENTAL
EQUIPMENT

Analyze

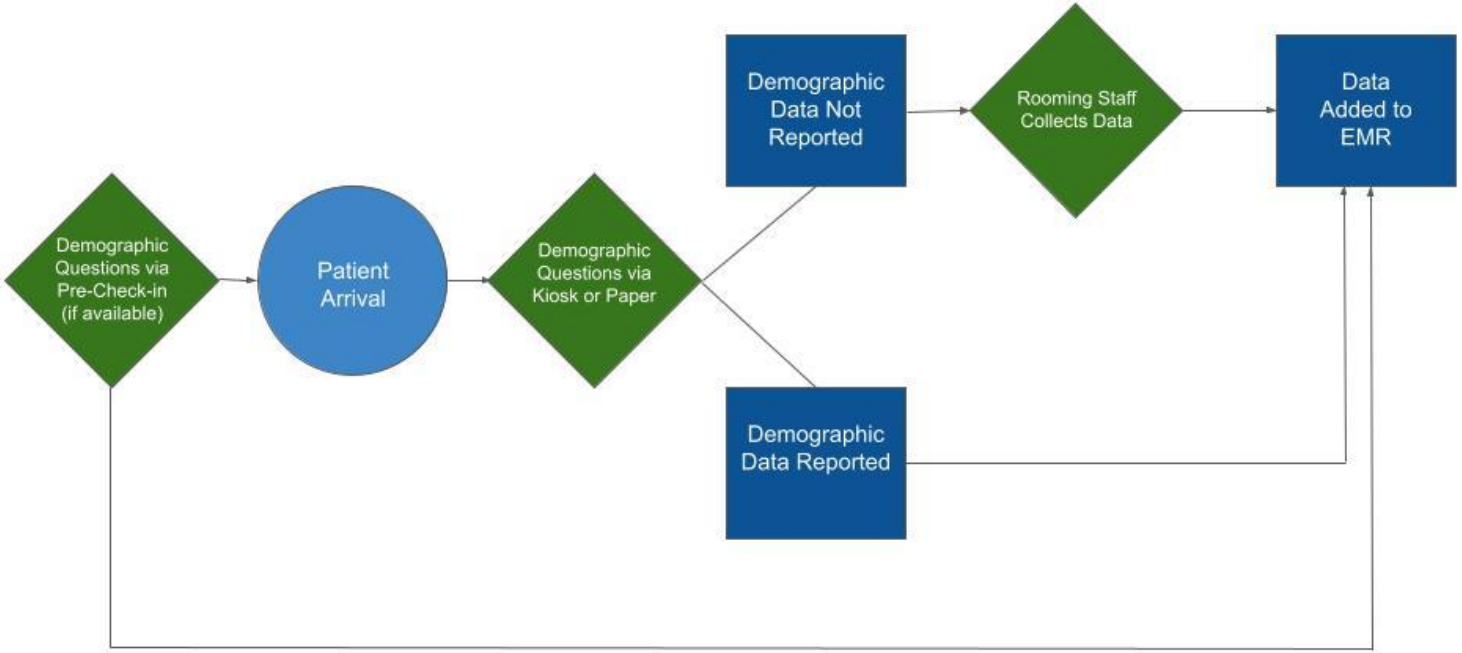
High rate of unknown patient demographic data (race, ethnicity, language) and several known instances of inaccurate data due to:

- Lack of standardization in demographic data fields and data collection processes across locations and EMR systems
- Limited or no capabilities to capture pronouns, gender identity, legal sex, or sexual orientation
- Limited or no staff training about best practices for demographic data collection
- Limited tools to support best practice demographic data collection

Improve

- ✓ Optimized EMR systems to gather best practice demographic information, as standardized as possible
- ✓ Developed standardized process based on best practices, stakeholder discussions, and feedback from patients and staff
- ✓ Launched Cayuga Health Data Governance Committee for Health & Organizational Equity for oversight and monitoring
- ✓ Launched *We Ask Because We Care* campaign (recommended by HANYS):
  - Staff education about best practices and technical assistance for practices
  - Communications campaign to share information with patients and community
- ✓ Developed dashboards for tracking

Standardized Process

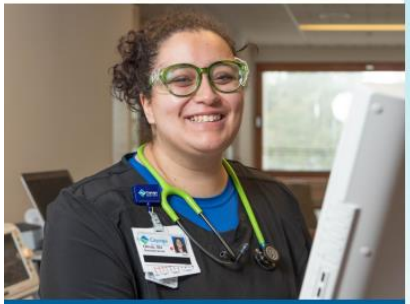


Communications

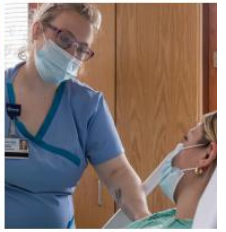
Our goal is to provide the best health care with compassion and respect to everyone, including **you.**

Why is collecting demographic data important?

Learning about our patients helps us to give care that meets your needs in a kind and respectful way. This information also helps us better support you as a person. If we don't ask these questions, we might disrespect patients by mistake. The data will also be used to find and address unequal health outcomes in our community. When we know what disparities exist we are able to develop programs that work to remove them.



We ask because we care about **you** and **our community.**



Why are you asking me these questions?

We are asking you questions about race, ethnicity, preferred language, sexual orientation, and gender identity to provide the best person-centered care we can.

How will this information be used?

Your provider will use this information to give care that meets your needs in a kind and respectful way. This information also helps your provider better support you as a person. The data will also be used to create programs that address health disparities.

How does this help the practice help patients?

This information helps us provide better care for our patients by allowing us to understand your needs and provide you with the best care.

What If I don't want to share this information?

You can always choose to not answer these questions, we ask because we care, you decide what to share. If you change your mind later, this information can always be added.

What if I only want to answer some of the questions?

You only have to answer the questions that you want to.

We ask
because we care.

Financial Impact

- Improving patient experience, access, and trust, especially among minoritized populations
  - More than 1 in 5 LGBQ+ and more than 1 in 3 transgender people delay or avoid the medical care they need due to disrespect or discrimination
    - In Tompkins County, at least 3% of the population, over 31,500 people are LGBTQ+ (over 6,300 people may be delaying or avoiding care)
  - Across all populations, about 60% of people would switch to another provider for more trust and respect, even when they are satisfied with their care (AHA)
  - Tracking and reporting our progress to advance health equity are crucial to demonstrate accountability and build trust

Control & Next Steps

- Data Governance Committee to continue to monitor:
  - Collection of patient demographic data (key indicator: rate of unknown)
  - Staff education (key indicators: % of practices/locations/staff trained)
  - Utilization of patient demographic data to measure health equity (key indicators: quality metrics)
- Next steps include:
  - Continue to provide *We Ask Because We Care* education to additional CHP practices, CMC, and SH
  - Continue to gather patient and staff feedback for continuous improvement
  - Develop on-demand virtual education session, available for all Cayuga Health staff
  - Determine capabilities and limitations for external data sharing and dashboard visibility
  - Launch internal *We Ask Because We Care* campaign to gather staff demographic data

Lessons Learned

- Start with the end in mind, lead with the “why,” and clarify purpose of data
- Data is important to inform what we do, but we don’t always need all the data to get started (and we might never have all the data)
- Quantitative data without qualitative data leaves an incomplete picture
- Learn from and adapt best practices
- Value of local campaigns with familiar faces
- Never enough input

Questions?

Contact us:
diversity@cayugamed.org

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Addendum

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Cayuga Health

Our Mission:

Cayuga Health System will remain the region's leading healthcare system, and most trusted driver of integrated health services, together with valued partners. We empower our people and employ our capabilities to ***equitably improve the well-being of the communities we serve***.

Our Vision:

To be an essential organization that inclusively and cooperatively ***drives superior health outcomes and demonstrable community benefit***.

Cayuga HEALTH

BUILDING A HOUSE

FOR

DIVERSITY, EQUITY & INCLUSION

CULTIVATING A MORE EFFECTIVE, INCLUSIVE WORKPLACE

&

CREATING A HEALTHIER, MORE EQUITABLE COMMUNITY

THE BLUEPRINT

Health Equity Starts with Data

- Health disparities, or preventable differences in health outcomes and healthcare access and experiences, exist across populations
- Accurate data helps us identify and address barriers so all members of our community can live their healthiest lives

Regulations & Requirements

- Collecting demographic data is required by:
  - Joint Commission
  - New York State Department of Health
  - Patient Centered Medical Home (PCMH)
  - U.S. Department of Health & Human Services, Culturally and Linguistically Appropriate Services (CLAS) Standards

Regulations & Requirements

From the Joint Commission's R3 Report, Issue 36, Requirements to Reduce Health Care Disparities, effective January 1, 2023:

Requirement EP3: The [organization] identifies health care disparities in its [patient] population by **stratifying quality and safety data using the sociodemographic characteristics** of the [organization's] [patients].

Requirement EP4: The [organization] develops a written action plan that describes how it will **address at least one of the health care disparities identified** in its [patient] population

Standard RC.02.01.01. Requirement: **The [medical] record contains the [patient's] race and ethnicity**.

Data Governance

Building upon the work started by the DEI Data Governance Committee in 2020, the Cayuga Health Data Governance Committee for Health & Organizational Equity launched in September 2022 to:

- Implement institutional data management **best practices, standards, and policies** to support equity throughout CHS
- Develop and manage a comprehensive demographic data strategy for **collecting, managing, sharing, and using** institutional demographic data to support health and organizational equity
- Ensure the accuracy, consistency, trustworthiness, usability, security, and accessibility of CHS data assets


What are we asking?
RACE
Race is often self-identified. Examples include American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, and white, with additional subcategories available.
SEXUAL ORIENTATION
Common terms for sexual orientation include "gay/lesbian," "bisexual," "straight/heterosexual,"and "queer." Some people use other terms to identify their sexual orientation.
ETHNICITY
Ethnicity is often used to identify people of Hispanic, Latinx, and/or Spanish Origin and sometimes includes more granular options to identify specific countries.
GENDER IDENTITY
Gender identity refers to a person's internal sense of being male, female, both, or another gender, and impacts the pronouns by which a person prefers to use. Examples include she/her, he/him, and they/them.
PREFERRED LANGUAGE
Preferred languages identifies the non-English language needs of the patient to determine whether an interpreter is required at the patient level or whether language access services need to be modified at the organization level.
DISABILITY STATUS
Disability status assesses hearing; vision; difficulty concentrating, remembering, or making decisions; mobility; difficulty dressing, bathing, and doing errands alone.