Powering the Climb: Measurement and Evaluation for Health Equity

Thursday, March 9, 3:30-4:45 pm
Building Capacity to Contribute to Health Equity through Evaluation
Nancy Kopf, Director, Success Measures Evaluation Strategies, NeighborWorks America
Chantel Welch, Community Initiatives Specialist, NeighborWorks Alaska
Jaime Lee Brown, Vice President, Community Services, Housing Partnership

A critical shift in the community development and affordable housing fields is moving many community-based organizations to embrace the link between their upstream work addressing the conditions in which low and moderate income people live and improved health outcomes. Much like community benefits programs, the work of these organizations is aimed at improving the health and overall quality of life for individuals and communities. Armed with new evaluation tools that were developed by Success Measures, an evaluation resource group, community development organizations have been able to carefully map the ways in which their programs are affecting health and measure those results. In 2016, 11 community development organizations participated in a national pilot program to build their internal capacity to articulate the connections between their work and health, and to measure the results of those programs and strategies. These organizations are embracing their role in creating healthier communities and understand that they have to evaluate it to make that connection. In this presentation you will hear from two of the 11 participating organizations.

NeighborWorks Alaska is working with formerly homeless people to build both food security and a sense of social cohesion through community gardening efforts. The Housing Partnership in Florida is working as part of a cross-sectoral health initiative evaluating social cohesion and community engagement as it relates to health. Both organizations are expanding this approach to other program areas within their organization and both are using the results of their evaluation work to communicate more effectively with health partners. This presentation will highlight the practical aspects of evaluation as well as the transformative power of using data to not only tell a better story, but to become a more effective partner for improved community health. Session participants will be able to see how these tools and evaluation approaches apply to their community benefit efforts.

Learning Objectives:
• Identify new measures that evaluate health outcomes
• Demonstrate how data can be used in communities to promote health equity through the use of two in-depth examples
• State evaluation methods used in community development to promote health equity
Collaborating for Health in Pre-Natal and Post-Natal Care
Andrew Knighton, PhD, CPA, Health Services Scientist, Intermountain Healthcare
R Neal Davis, MD, Medical Director, Salt Lake Central Region, Intermountain Healthcare
Mikelle Moore, MBA, HSA, Vice President, Community Benefit, Intermountain Healthcare

Combining lecture, interactive discussion, multimedia and an exercise, we will explore how Intermountain Healthcare OB/GYN (IH) is teaming with the Salt Lake County Health Department (SLCH) using a data driven-approach to target first-time expectant mothers most likely to benefit from the Nurse-Family Partnership (NFP) program. The NFP’s maternal health program is an evidence-based solution that introduces vulnerable first-time parents to caring maternal and child health nurses providing home-based patient education and support. Engaging front-line clinical staff to support community-based initiatives is particularly challenging given multiple clinical priorities and time demands. A key component in successfully Elevating Impact Together is using measurement and evaluation methods to improve program efficiency. Robust patient triage to identify eligible candidates can minimize clinician time spent referring patients not likely to benefit from program participation. To better understand this, we combined health data from the health care delivery system and NFP to evaluate historical invitation, acceptance and retention rates for program participation as measures of program efficiency. We supplemented patient payer type with an area deprivation index (ADI) adapted for use at IH to measure patient social determinants at a neighborhood level. We found that patients on Medicaid or commercial insurance who came from more deprived neighborhoods had significantly higher retention rates than similar patients from less deprived neighborhoods. The estimated effect of using this additional criteria would lower referral rates by 66% while doubling program retention rates. We’ve adapted the referral criteria model to include neighborhood material deprivation in the patient evaluation process and are monitoring performance. The workshop session includes a program overview, discussion of program organization and collaboration roles for IH and SLCH, in-depth look at data-driven candidate identification and referral, and impact on clinical workflow and pilot results, including recorded clinician and patient testimonials.

Learning Objectives:
• Identify common program elements for an effective OB-GYN/community-based partnership
• Use data-driven criteria for improving clinician efficiency in referral generation
• Employ common program elements to implement a collaborative program in a local community

Friday, March 10, 8:45-10:00 am
Eight Years of Evaluating the Heart of New Ulm Project
Cindy Winters, Project Manager, Minneapolis Heart Institute Foundation
Gretchen Benson, RD, CDE, Manager, Healthcare Systems Integration, Minneapolis Heart Institute Foundation

In order for health care to extend beyond the clinic walls and into the community to address or improve population health, a coordinated effort among key stakeholder groups is needed. This session will use examples from Hearts Beat Back: The Heart of New Ulm (HONU) Project, a 10-year research demonstration project in a rural Minnesota community. Attendees will be engaged in a discussion about how the HONU Project forms strategic community partnerships to generate collective impact, works across sectors to collect, share and utilize data, and communicates outcomes with the community.

This session will demonstrate how collaborative evaluation is essential for improving community health and creating sustainable impact. Using HONU’s partnerships with local government, health care, public health, and businesses, as examples, we will describe how new and existing data sources are being leveraged to assess the personal, institutional and environmental impact of the project. Electronic health records paired with community screenings, nutrition environment assessments, and active transportation tallies, are just a few of the ways we have evaluated HONU in the short-, medium- and long-term. Attendees will learn how to combine these various types of data to not only assess impact, but to identify aspects of the community most in need of improvement and address those inequities. Lastly, we will discuss strategies for communicating data with key stakeholders and the community at large. Thoughtful sharing of
outcomes is necessary for building community support and in turn, sustainable impact. Attendees will learn about engaging ways to disseminate their evaluation findings in both community and clinical settings.

Learning Objectives:
• Identify how to utilize and adapt existing data sources for longitudinal follow-up
• Outline how to combine evaluation methods to effectively drive program development
• Translate outcomes effectively with different stakeholder groups

Friday, March 10, 10:30-11:45 am

Elevating the Impact of a Health System’s Health Equity Agenda
Camellia Mortezazadeh, MPH, Associate Director, Health Equity and Access, Office of Diversity and Inclusion, NYC Health + Hospitals
Matilde Roman, JD, Senior Director, Office of Diversity and Inclusion, NYC Health + Hospitals

NYC Health + Hospitals is the largest municipal health care delivery system in the country, serving 1.2 million patients from diverse racial, ethnic, socioeconomic and linguistic backgrounds each year. With a workforce of 42,000 and a network of acute care, ambulatory, long-term, and community health facilities, NYC Health + Hospitals impacts community health by serving as the public safety net system for all New Yorkers, regardless of citizenship status or ability to pay. In 2014, NYC Health + Hospitals began strategic planning to integrate health equity goals and the American Hospital Associations’ #123 for Equity Campaign initiatives into existing services. Since our inaugural Health Equity Symposium, the organization developed initiatives within the following domains: Patient Experience and Engagement; Workforce Strategy; Health Literacy; Data Governance; Communications; and Leadership. Informed by our Community Health Needs Assessments, patient satisfaction and employee engagement data, and demographic trends and projections, NYC Health + Hospitals embarked on a system-wide journey to improve health equity for our patients and ensure all New Yorkers live their healthiest life.

The health equity agenda at NYC Health + Hospitals is a multi-pronged framework for addressing health care inequities and community health needs, including: Organizational assessments measuring stakeholder awareness and engagement in health equity initiatives; Training programs on LGBTQ health, unconscious bias, religious diversity and language access; Interactive diversity and inclusion campaigns; Initiatives to improve the collection of race, ethnicity and language data and efforts to collect sexual orientation and gender identity data. In this presentation we will outline NYC Health+ Hospitals’ journey from strategic planning to implementation. We will share a case study on how to incorporate health equity goals into an organization’s strategic priorities, and provide examples of new initiatives and evaluations underway that assess progress on our health equity agenda and impact on organizational transformation and community health.

Learning Objectives:
• Identify strategies for developing and embedding a large-scale health equity agenda and initiatives within current organizational priorities and goals
• Recall new performance measures and indicators to evaluate the progress of health equity goals and sustain their impact
• Compare the experience and lessons learned from a large, urban public health care system serving a diverse and changing patient population to your organization’s efforts

Friday, March 10, 2:45-4:00 pm

Collaborations through Health Impact Assessments: A Tool for Community Benefit
Legislation has moved hospitals and other health care organizations to address community health issues strategically and collaboratively to meet community need and achieve lasting trust. Many tools and approaches have emerged to support this work. Health Impact Assessment (HIA) is a flexible, six-step process that combines stakeholder input, qualitative and quantitative data, to help predict how proposed policies, programs, and projects might impact health outcomes. HIAs provide decision-makers information about the tradeoffs for health, and offer recommendations to maximize health benefits and mitigate unintended negative consequences.

This presentation will begin with defining HIAs, describing the overlap and alignment between HIA and CHNA processes, and discussing how HIAs may serve as powerful tools to strengthen both CHNA processes and selection of implementation strategies. We will follow with a panel discussion with the community benefit strategist for Children’s Hospital Colorado and the senior policy director of Keystone Policy Center, a nonprofit that brings together public, private, and civic sector leaders to overcome policy obstacles. Panelists will provide a case study of how Children’s Hospital Colorado has utilized HIAs as part of their community benefit activities in two ways: to inform their implementation strategy development and to inform legislative change on topics that impact the health of the communities that they serve. Panelists will discuss collaboration and stakeholder engagement - including collaboration with nontraditional partners, potential role of advocacy, and making the case for social determinants of health to hospital/health system leadership. They will offer specific strategies for community engagement to build strong partnerships and effective ways to utilize evidence-informed strategies to elevate the health impact of our state together with the community. Additional discussion will focus on how HIAs may be adjusted and applied to hospital/health system CHNAs, implementation strategy planning, or general community benefit activities to inform policy efforts.

Learning Objectives:
• Define Health Impact Assessments (HIA), including steps, values and areas of overlap between HIAs and Community Health Needs Assessments (CHNA)
• Describe potential opportunities for integration of HIAs into CHNAs, implementation strategies and other community benefit activities
• Recall the Children’s Hospital Colorado case example of HIA integration into hospital community benefit programs, including strategies to identify and engage with potential partners
Tracking social factors in health care data systems represents a key opportunity for influencing care and payment transformation, measuring the needs of patient populations, and evaluating efforts to improve population health. To the extent that “social codes” are available in medical documentation systems, they can offer one powerful tool for capturing, aggregating, and helping the health care system address social and behavioral needs for individuals and populations. “Social codes” were first introduced into the International Classification of Diseases, Ninth Revision (ICD-9) as “V-codes” and were expanded in the ICD-10 as “Z-codes”. Surprisingly little information is publicly available about the historical origins of these social codes or the nature of their clinical use.

We first present the results of archival research into the history of social codes. We then present results from quantitative analyses that describe social code utilization within both pediatric and adult populations from national inpatient and outpatient databases. We examine the patterns of social code utilization across these settings by principal diagnoses as well by key demographic characteristics, including age, gender, and race/ethnicity. Our preliminary findings indicate that despite the historical inclusion of social codes within the ICD-9 and their expansion within the ICD-10, they are seldom utilized in clinical practice. The under-utilization of social codes for diagnostic and billing purposes stands in stark contrast to the high prevalence of social needs (e.g. poverty and food insecurity) in the U.S. We will present two practice-based initiatives incorporating Z-codes into electronic health records and some of the challenges related to this integration.

This session will be valuable to conference attendees who are interested in the opportunities and barriers to using “social codes” in existing medical documentation systems as a potential tool for screening and taking action on patients’ social needs in health care settings.

Learning Objectives:
- Recall the historical origins of the inclusion of “social codes” (i.e., v codes) in the ICD-9 and the expansion of these codes in the ICD-10 (z codes)
- Describe the contemporary landscape of social code utilization across national inpatient and outpatient databases, including patterns of social code utilization by key demographic characteristics (e.g., age, gender, race/ethnicity)
- Discuss the potential for social codes to be utilized as tools for individual- and population-level screening and action on the social determinants of health within the health care setting