ADVANCING HEALTH EQUITY:
A moral and business imperative

HANYS Health Equity Task Force priorities: Quick guide

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Healthcare leaders have long recognized the need to address health disparities. But eliminating these disparities is difficult because of their complexity, the array of individuals and organizations involved, and deep-rooted direct and contributory factors.

While health systems and individual providers recognize the moral imperative of addressing health equity, they face significant competing priorities with limited time, resources and talent available. In addition, it is difficult to quantify the return on investment for addressing health equity.

Often healthcare leaders are left asking, **"Why should I prioritize health equity at my organization?"**

Better patient health outcomes, regulatory compliance, improved financial outlook and recognition as a reliable partner in the community are compelling reasons to make health equity a priority.

HEALTH EQUITY: The HANYS' Health Equity Task Force defines health equity as the attainment of the highest level of health for all people, 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.

The benefits of health equity

Better patient health outcomes

Health equity has a direct impact on patient outcomes. Experts agree that medical services have a limited impact on health and well-being. Medical care accounts for only 10% to 20% of health outcomes for a population, according to studies that consider modifiable determinants (not genetics). Social determinants of health such as safe housing, transportation, racism, discrimination, violence, education, job opportunities and income drive the other 80% to 90%.[1]

The moral imperative to address health equity gains more traction every day as data continue to show that millions of Americans suffer and die unnecessarily due to health inequities. The U.S. has ranked last on health equity measures in every edition of the Commonwealth Fund's periodic studies since 2004.

To meet patient needs and improve outcomes, providers must identify social needs and work to mitigate health disparities.

[1] Hood, C. M., K. P. Gennuso, G. R. Swain, and B. B. Catlin. (2016) County health rankings: Relationships between determinant factors and health outcomes. *American Journal of Preventive Medicine*, 50(2):129-135. https://doi.org/10.1016/j.amepre.2015.08.024

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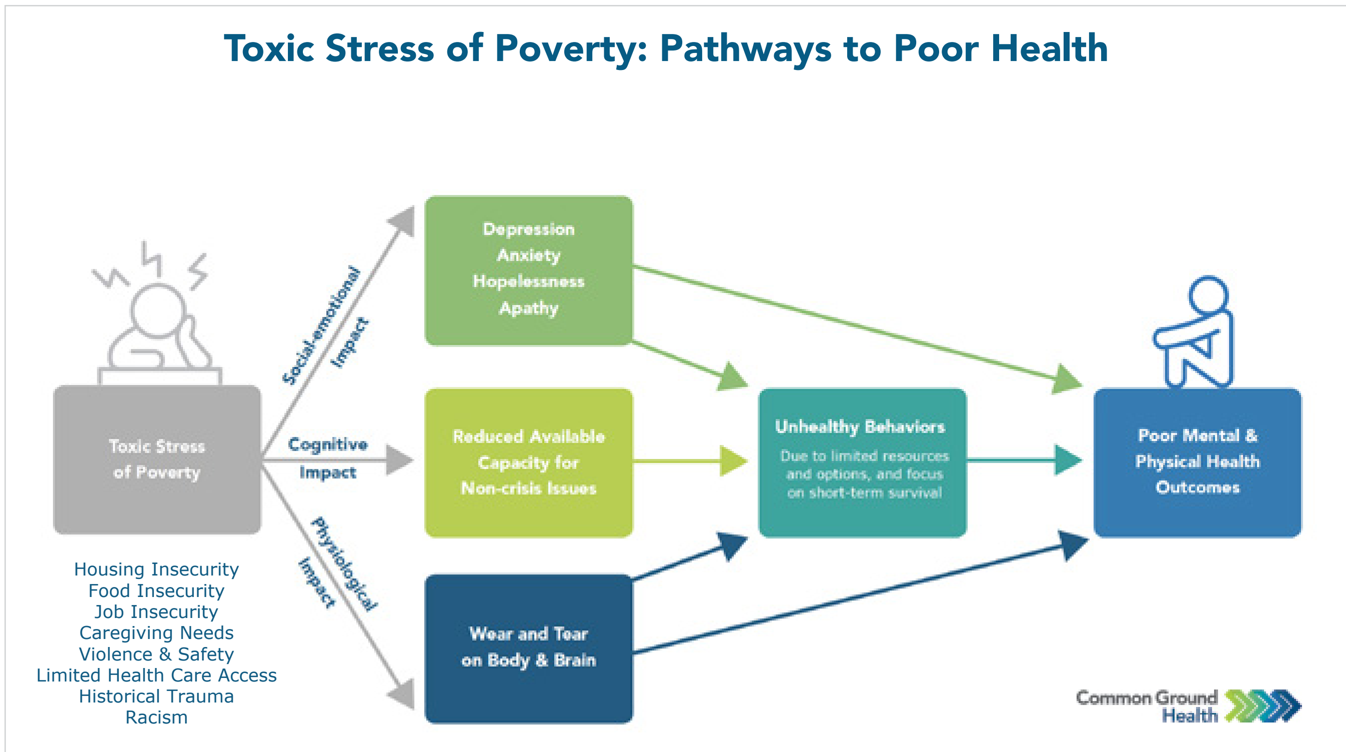

Source: https://media.cmsmax.com/ravk3pgz5ktlujs1r08ci/overloaded-the-heavy-toll-of-poverty-on-our-regions-health.pdf

Regulatory compliance

Many regulatory and accrediting bodies are working to address health disparities. At the federal level, the U.S. Department of Health and Human Services incorporated equity as a goal in its most recent strategic plan update; published an HHS Equity Action plan; and is assessing and modifying its policies, programs and processes.

Using the rulemaking process, CMS recently updated its quality reporting programs to include health equity metrics and proposes incentivizing hospitals to provide care for underserved populations, such as the homeless, when they report SDoH codes on claims. The Joint Commission has added and revised standards to reduce health disparities and added health equity to its 2023 patient safety goals.

Changes are also being made at the state level. New York state requires Medicaid managed care plans to mandate state-approved cultural competency trainings for all providers and now requires health equity assessments as part of the Certificate of Need application process.

Many states, including New York, have mandated insurers to incorporate health equity in proposals to become Medicaid managed care organizations. New York's 1115 Medicaid waiver application is focused on health-related social needs (formerly SDoH) and advances value-based payments.

The momentum is growing. Policymakers and payers are no longer asking for voluntary action; new mandates mean that facilities need to address health equity in a meaningful and impactful way now. HANYS' Hospital Equity Measures and Standards interactive crosswalk illustrates the breadth of emerging requirements that healthcare organizations must meet.

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Improved financial outlook

Equity metrics are starting to be reflected in reimbursement. Both public and commercial payers are increasingly implementing VBP reforms to incentivize providers to reduce health disparities and improve outcomes. Quantitative indicators such as avoidable emergency department utilization, decreased readmissions and less harm (maternal/infant mortality rates) are being monitored to determine cost drivers and cost savers. Health systems should consider using the Commonwealth Fund ROI calculator to explore, structure and plan financial arrangements that support the delivery of social services to high-need, high-cost patients.

Healthcare disparities cost health systems billions of dollars each year. A recent study by the W.K. Kellogg Foundation and Altarum estimated that disparities cost one system approximately $93 billion in excess medical costs and $42 billion in lost productivity per year.[2] A study by Wyatt, et al. projected the economic burden of health disparities in the U.S. to be $353 billion in 2050 if disparities remain unchanged.[3] Addressing disparities can reduce these costs and offer financial benefits for healthcare organizations, while leading to utilization of healthcare services by community members and a healthier, empowered community.

Recognition as a reliable partner in the community

Healthcare organizations are committed to providing equitable health services to all individuals who need care, especially the most vulnerable populations. However, if community members do not view a healthcare organization as a trusted and reliable partner, they will not use that organization's services.

Showing a commitment to health equity through community partnership builds trust between community members and healthcare organizations, and increases the likelihood that the most vulnerable populations will look to those organizations when health issues arise. This results in improved patient and staff experience, higher public ratings and more successful workforce recruitment and retention.

KEY TAKEAWAY

Leadership's commitment to health equity and engagement with health equity initiatives can make or break an organization's ability to transform its culture and ingrain health equity as a strategic priority.

[2] Turner, A. (2018) The Business Case for Racial Equity: A Strategy for Growth, Altarum. https://altarum.org/RacialEquity2018

[3] Wyatt R, et al. (2016) Achieving Health Equity: A Guide for Health Care Organizations. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement. https://www.ihi.org/resources/Pages/IHIWhitePapers/Achieving-Health-Equity.aspx

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Three foundational focus areas to address health equity

In 2022, HANYS launched a statewide Health Equity Task Force to bring together members to provide recommendations, develop initiatives and share strategies to help New York's healthcare providers deliver high-quality care across diverse populations in their communities. Given the complexity of addressing health disparities, the Task Force identified three priority focus areas — data collection, culturally appropriate care and community engagement — and created this guide to provide leaders with foundational information about how to get started in these areas.

Collecting and using data to improve health equity: Z codes

To address the social needs that impact their patients, providers need to effectively screen for, collect, document and code the social needs of their patient populations. It is important to collect information appropriately and capture it discretely so that it can be shared with others to effectively allocate resources and better understand disparities.

To do this, providers should document Z codes in each patient's electronic health record. Z codes are a subset of International Classification of Disease encounter reason codes used to capture factors that influence health status and contact with health services.

Z codes are currently underutilized. A study published by the CMS Office of Minority Health in 2021 showed that only 1.4% of the 33.7 million Medicare fee-for-service claims submitted in 2017 included Z codes. The most

HANYS RECOMMENDATIONS

- Develop and implement a plan to educate key stakeholders, including physicians, non-physician healthcare providers and coding professionals, on the importance of screening, documenting and coding patients' social needs.
- Train staff on how to collect SDoH, race, ethnicity and language, and sexual orientation and gender identity data to identify healthcare disparities, stratify data and improve care for diverse populations.
- Educate coding professionals on the ICD-10-CM codes included in categories Z55-Z65 so they may begin using them when reviewing patient medical records.
- Create a screening strategy (select the domains of interest, identify the screening tool, identify the resources and workflow and identify the technical tools to facilitate).
- Determine how Z codes Z55-Z65 will be identified, used and monitored after the screening.

MEMBER STORY: MediSys Health Network

Steeped in a longstanding tradition of high-quality care for underserved patients in Queens, the MediSys Health Network is keenly aware of the impact of health-related social needs on its diverse communities. Addressing the SDoH our patients face is clinically and fiscally responsible and essential to whole-person integrated health, the cornerstone of our value-based care commitment.

Seeking to better capture and address social determinants, leadership convened a multidisciplinary taskforce to explore stakeholders' needs. Clinical and informatics champions reviewed best practices and developed a standardized screening tool and interdisciplinary clinical workflow. The workflow leverages our EHR to optimize flow to identify at-risk patients and integrate their HRSNs into care and discharge planning. The workflow optimizes usability, employing a best practice alert triggered by identified at-risk areas, within which the physician seamlessly converts social risks into diagnoses and refers to community-based resources or social services directly. CMS ICD-10 Z codes, linked to the identified HRSNs, are dropped in the background, keeping the patient the focus of the clinical team while still documenting risk-based complexity.

Launched with adult ambulatory and acute care patients, early data demonstrates high screening rates. Ongoing IDT listening sessions to address barriers are underway with widespread network dissemination planned.

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used Z code was homelessness (Z590). Significant disparities were observed showing increased rates of homelessness claims for black, Hispanic and American Indian/Alaska Native patients. CMS also noted that low utilization of Z codes resulted from a general lack of awareness and confusion as to who could document social needs.[4]

It is becoming clearer that using Z codes to standardize and improve patient SDoH data collection is associated with higher Medicare reimbursement for high-risk patients. In its federal fiscal year 2024 Medicare inpatient proposed rule, CMS proposes changing the severity level of three ICD-10 Z codes for homelessness to complication or comorbidity, resulting in higher payment when hospitals report these codes on claims.

HANYS' Health Equity Task Force recommends using Z codes as an important step to transform healthcare, support value-based payment and identify both health- and non-health-focused strategies to improve patient outcomes.

Culturally appropriate care

Efforts to address racial and ethnic disparities will be effective only when the healthcare system develops cultural humility to deliver services that meet the social, cultural and linguistic needs of patients while improving health outcomes and care quality.

A detailed culturally appropriate care compendium provides additional categorized strategies, guidance and resources beyond what is listed here.

[4] CMS (January 2020) Z Codes Utilization among Medicare Fee-for-Service (FFS) Beneficiaries in 2017. https://www.cms.gov/files/document/cms-omh-january2020-zcode-data-highlightpdf.pdf

HANYS RECOMMENDATIONS

- Prioritize equity at the leadership level.
- Complete community assessments.
- Recruit and support a culturally diverse workforce.
- Develop and implement policies that support culturally appropriate care.
- Integrate health equity into the organization's strategic plan.
- Invest in a complaint/grievance process that supports cultural diversity.
- Ensure your EMR captures HRSNs to better track and identify solutions to improve patient and community health.
- Ensure patients are able to receive and convey information in their native languages.

MEMBER STORY: Rochester Regional Health

During the height of the pandemic, Rochester Regional Health led community conversations about COVID-19. Our team presented accurate, up-to-date information about the virus and the vaccine options. We successfully connected with multiple communities through our coverage area to include: people of color (Black and Latinx communities), rural migrant farmers, faith communities, deaf and hard of hearing, LGBTQ+, veterans, people living with disabilities, elders and caregivers, and adolescents and parents. Our purpose was to help individuals make the best decisions for themselves, their families and their communities.

We understood the importance of providing this crucial information in different languages. So we provided these conversations in Spanish and secured sign language interpreters at each event. However, after we participated in a Spanish session, we realized that, although we knew the content, it was still hard to follow.

This experience helped RRH further understand the need for all healthcare information to be delivered in a patient's preferred/native language. As a result, DEI and Communications collaborated to add translation to our health system's website. Currently, the RRH website has the capability to translate from English to 100 different languages to support language access.

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Community engagement

Whether community engagement involves helping community members experiencing health inequities or engaging with community-based organizations, it starts by establishing trust. To do this, hospitals and health systems must understand their communities, strengthen community partnerships and foster a mutually beneficial exchange of knowledge with their community partners.

People, and their communities, are deeply impacted by the systems that drive and influence their health; however, they were historically not included in the process to create or restructure programs and policies designed to benefit them.[5] When these programs and policies are not driven by community interests, concerns, assets and needs, these efforts remain disconnected from the people they intend to serve. This disconnect ultimately limits their effectiveness.

Community engagement is critical to advancing health equity because it fosters mutual respect, identifies barriers, elevates community voices and supports appropriate healthcare services utilization.

In addition, community partnerships are required through the Community Health Needs Assessment and The New York State *Prevention Agenda*. Collaboration can better align resources with needs, reduce competition, increase effectiveness and make results more sustainable.

HANYS RECOMMENDATIONS

- Define "the community."
- Identify community-based (external) and internal stakeholders.
- Align the healthcare organization and its community stakeholders by developing shared agendas, goals and metrics.
- Create a steering or advisory committee to determine internal needs that align with community needs and promote patient and family representation on existing boards to ensure cross fertilization of community and hospital boards.
- Build bi-directional relationships that foster the mutually beneficial exchange of knowledge and resources in a context of partnership and reciprocity.
- Employ the CHNA and Health Improvement Plan as tools to engage with external stakeholders to understand community needs and evaluate gaps in care.
- Dedicate internal resources such as funding, staff and/or technology to build infrastructure with community partners.

[5] Centers for Disease Control and Prevention (Oct. 15, 2021) Principles of Community Engagement. 2011. https://www.atsdr.cdc.gov/communityengagement/index.html

MEMBER STORY: University of Rochester Medical Center

The University of Rochester Medical Center believes that community engagement is a collaboration between the institution and the larger community for the mutually beneficial exchange of knowledge and resources in a context of partnership and reciprocity.

When we began screening for SDoH, it was with the intent to link patients who have social needs to the community resources that would be helpful. We worked with our local 2-1-1 system to link their extensive resources to our EMR.

To address emergency needs in food insecurity, URMC partnered with Foodlink, the outstanding Rochester-based nonprofit dedicated to ending hunger and building healthier communities.

Together we created an emergency food pantry where patients can access healthy food after their time with the provider. In the first year of the initiative, the food pantry served over 700 patients (with more than 1500 visits from the most poverty-stricken areas in our community).

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ADDITIONAL RESOURCES

Collecting and using data to improve health equity: Z codes

CMS: Z code Infographic — Outlines key steps for implementing Z code documentation.

CMS: Data Highlight on Utilization of Z-codes for Social Determinants of Health — A deep dive into the use of Z codes for 2019 Medicare FFS beneficiaries.

American Hospital Association: Societal Factors that Influence Health Framework — Designed to guide hospitals' strategies to address SDoH and their impact on health outcomes.

AHA: ICD-10-CM Coding for Social Determinants of Health — Describes coding of SDoH through ICD-10-CM codes; includes code categories, risk factors and links to issue briefs.

The Gravity Project — A public collaborative advancing health and social data standardization for health equity.

Fenway Institute: Helping Your Organization Collect Sexual Orientation and Gender Identity Data — Explains benefits and motivating factors to convince stakeholders that SOGI data collection is necessary.

HANYS: Staff FAQs on collecting race, ethnicity and language data — A resource designed to train staff on gathering REaL data from patients through FAQs for hospital staff.

HANYS: SOGI Patient FAQs — "We Ask Because We Care" patient education sheet on SOGI data.

Culturally appropriate care

AHA: Building a Culturally Competent Healthcare Organization — A guide to support hospitals and care systems to reduce healthcare disparities and promote diversity.

Hospital Cultural Competency Leadership and Training is Associated with Better Financial Performance — This research article from the *Journal of Healthcare Management* offers a business case for cultural competency leadership and training practices.

AHRQ Health Literacy Universal Precautions Toolkit — Supports practices to reduce healthcare complexity, increase patient understanding of health information and enhance support for patients of all literacy levels.

AHRQ: Address Language Differences: Tool #9 I Agency for Healthcare Research and Quality — Health literacy improvement tools on language differences.

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care — Action steps and blueprint for individuals and healthcare organizations to implement culturally and linguistically appropriate services.

Community engagement

Robert Wood Johnson Foundation: Transformational Community Engagement to Advance Health Equity — A report, strategies and case studies providing real world examples of how states can invest in community engagement.

HANYS: Advancing Healthcare Excellence and Inclusion Coalition Building Toolkit — A step-by-step guide to coalition building, coalition building activities and advocacy.

AHA: Equity Roadmap Community Collaboration for Solutions — Includes information on understanding your community, strengthening community partnerships and investing in your community.

Healthy People 2030 — The nation's 10-year plan for addressing critical public health priorities and challenges, including tools for action to assist individuals, organizations and communities.

NYSDOH: Community Health Planning Guidance — Describes the goals for collaborative planning, required elements for a local Community Health Assessment, Community Health Improvement Plan and Community Service Plan for local health departments and hospitals.

CDC: Principles of Community Engagement — This CDC primer provides tools for those leading efforts to improve population health through community engagement.

DataGen: CHNA Advantage Multi-sector Collaborative — Tip sheet on strategies and rationales for forming multi-sector collaboratives.

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HANYS is your committed partner

With guidance from HANYS' Health Equity Task Force, we are advocating on our members' behalf before DOH and CMS for payment adequacy, delivery system transformation support, workforce investments and reasonable approaches to measurement and public reporting.

HANYS is committed to partnering with our members on their health equity journey. We encourage you to review the following HANYS programs and resources:

- HANYS' health equity learning collaborative, Advancing Healthcare Excellence and Inclusion, provides virtual education, staff and patient education tools, and project management support.
- HANYS offers free member education. Visit our Health Equity Educational Programming page to see upcoming and recorded events.
- Healthcare Trustees of New York State, a division of HANYS, offers ongoing education, tools and resources on community health, board diversity and other relevant issues.
- HANYS' affiliate, DataGen, offers consulting services and data analytics to support your CHNA and broader market analysis.

This quick guide reflects the work of three subgroups of HANYS' Health Equity Task Force. HANYS thanks the following subgroup members for their time, expertise and invaluable contributions to this publication:

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