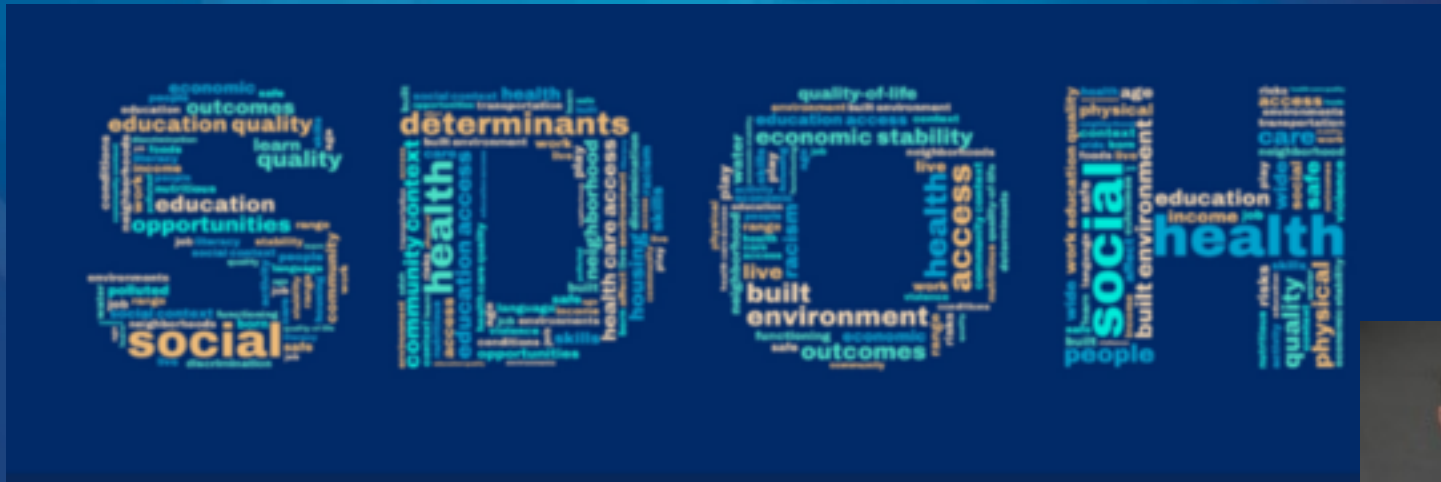


Nursing Informatics Role in Health Equity



Charla B. Johnson, DNP, RN-BC, ONC, FNAON

Charting a Path to Health Equity

❖ The Future of Nursing Report

Distinguished the nurses' role

Challenges nurses to take action

❖ Key Focus Areas

- 1) Need to work to **reduce health disparities and promote equity**
- 2) Rising costs through more care delivery
- 3) Use of **technology** to reach vulnerable populations
- 4) Priority on patient and family focused care

❖ **Recommendation VI**

Nursing Informaticist Role in HE

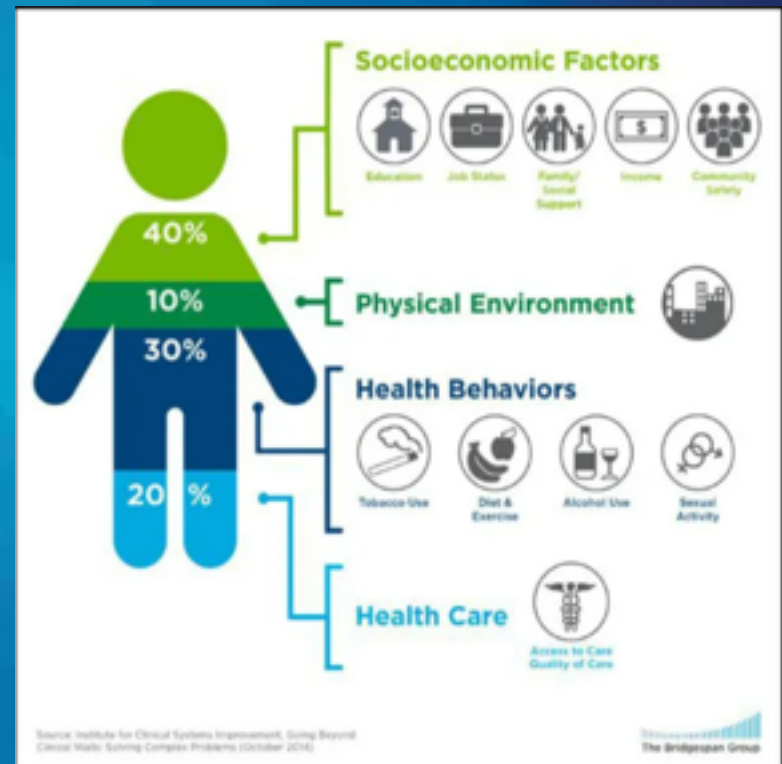
❖ ANA (1992)

- ❖ Specialty to support nurses
- ❖ Manage data to support practice
- ❖ Technology and Innovation

❖ Health Equity

- ❖ Significance of SDOH
- ❖ Drivers of Regulatory Compliance
- ❖ Identify Clinical and Data Collection Workflows-
Optimize Screening

- Tobacco use
- Alcohol and substance use
- Housing stability
- Depression/Stress
- Intimate partner violence (IPV)
- Sexual activity
- Social support/isolation
- Physical activity
- Community safety
- Transportation
- Food insecurity
- Access to care/Quality of care
- Financial strain
- Education



Drivers of Regulatory Compliance

- ❖ TJC
- ❖ Leadership (LD) Chapter -6 elements Eps
 - ❖ **LD.04.03.08**
 - ❖ Reducing health care disparities is a quality and safety priority.
 - ❖ EP 1: The [organization] designates an individual(s) to lead activities to reduce health care disparities for the
 - ❖ EP 2: The [organization] **assesses the [patient's] HRSN and provides information about community resources** and support services.
 - ❖ 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]. ** Age, Gender, Preferred Language, Race/Ethnicity
 - ❖ EP 4: 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
- ❖ Record of Care (RC)
 - ❖ **RC.02.01.01**, EP 25
 - ❖ Collect patient race and ethnicity data



Drivers of Regulatory Compliance

- ❖ Centers of Medicaid and Medicare (CMS)
 - ❖ Published a framework for Health Equity
 - ❖ Five Priorities
 - #1 Expand the collection, reporting, and analysis of standardized data
 - ❖ Data is comprehensive, interoperable, and standardized
- ❖ 2023 IPPS Final Rule
 - ❖ Hospitals -Inpatient Quality Reporting
 - ❖ Voluntary 2023 & Mandatory 2024 SDOH
 - ❖ Attestation of Commitment to HE
 - ❖ Annually during April 1-May 15 '25



Drivers of Regulatory Compliance

- ❖ HE- Strategic Priority
- ❖ HE-Hospitals Collects Data
 - ❖ Demographic information
 - ❖ SDOH
 - ❖ Train Staff in Culturally Sensitive collection of data
 - ❖ Hospitals inputs demographic/SDOH data
 - ❖ Structured
 - ❖ Interoperable data elements
 - ❖ Certified EHR
- ❖ HE- Data Analysis
 - ❖ Hospital stratifies KPI's to address equity gaps/dashboard
- ❖ HE- QI



Drivers of Regulatory Compliance

- ❖ SDOH Structural Measures

- ❖ SDOH-1 Screening for Social Drivers of Health

- # of patients screened*

- ❖ SDOH-2 Screen Positive Rate for Social Drivers of Health (numerator/denominator)

- of those screened/+*

- ❖ Population

- ❖ Inpatient, 18 years or older



Drivers of Regulatory Compliance

Health Related Social Needs (HRSN)

Five Specific HRSN

1. Food Insecurity
2. Housing Instability
3. Transportation Needs
4. Utility Difficulties
5. Interpersonal Safety



Nursing Navigator

OVERVIEW

- Outside Records
- Travel/Exposure
- TB Risk
- Vital Signs
- Allergies
- Home Meds
- Medical Alerts
- OB/Gyn Status
- Lactation Status
- History
- Immunizations
- Vaccinations
- Directives
- Health Care Agents
- Implants
- Belongings
- Psychosocial Scr...
- SDoH Screen**

SDOH Screening Exclusion

SDOH Screening Exclusion

Transportation Needs

In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?

In the past 12 months, has lack of transportation kept you from meetings, work, or from getting things needed for daily living?

Food Insecurity

Within the past 12 months, you worried that your food would run out before you got the money to buy more.

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

Housing Stability

In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?

In the last 12 months, how many places have you lived?

In the last 12 months, was there a time when you did not have a steady place to sleep or slept in a shelter (including now)?

Utilities

In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

Intimate Partner Violence

Within the last year, have yo

Within the last year, have yo

Within the last year, have yo

Within the last year, have yo

Brain Sidebar Summary

Shift PRN A S D

Admission Quality Measures

Last Updated: 1249

Refresh

Quality Measures

Overdue (1)

SDOH Screening

Flowsheets



Reviewing for HRSN's

Patient Class: Inpatient
Financial Class: Self-Pay
Next Review: Not scheduled
Last Payer Comm: None sent

CONTINUED CARE AND SERVICES
 Destination

SOCIAL DETERMINANTS
⚠ Concerns present







Pathway: Community Resources

Ht: —
Last Wt: —
BMI: —

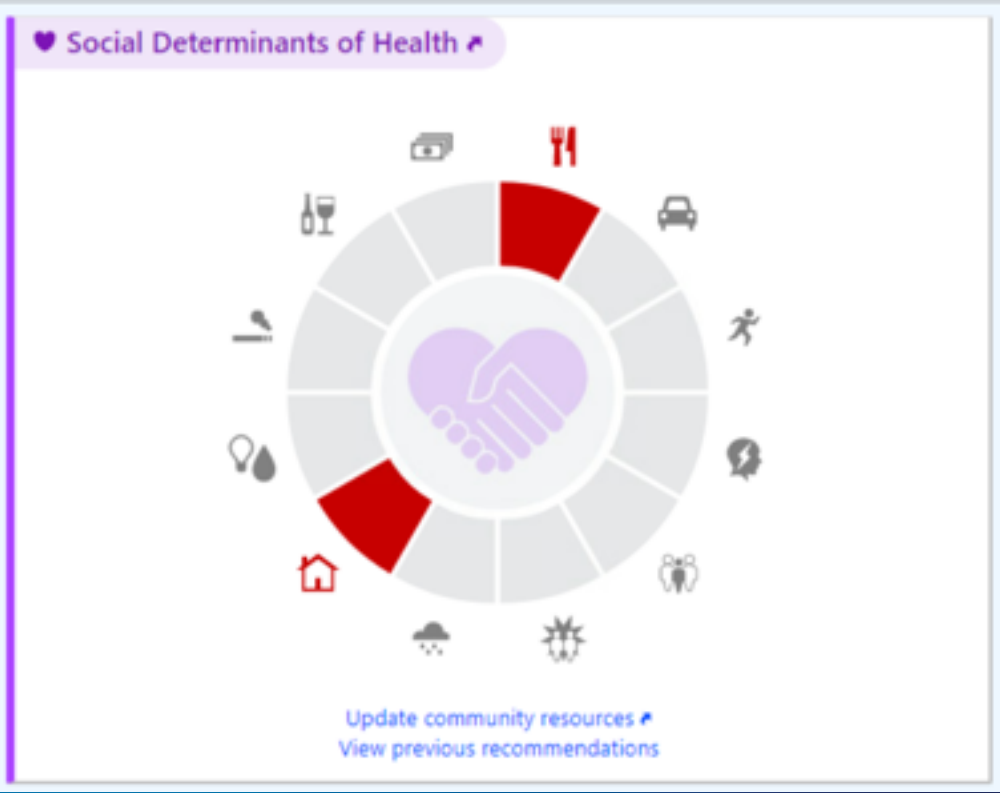
Cvg 1 Approved Days: None
Cvg 2 Approved Days: None
Primary Auth: None

Signed-In Providers

♥ Social Determinants of Health

-  **Tobacco Use** [↗](#)
Not on file
-  **Financial Resource Strain** [↗](#)
Oct 5, 2023: High Risk
-  **Transportation Needs** [↗](#)
Not on file
-  **Stress** [↗](#)
Not on file
-  **Intimate Partner Violence** [↗](#)
Not on file
-  **Housing Stability** [↗](#)
Oct 5, 2023: High Risk

-  **Alcohol Use** [↗](#)
Not on file
-  **Food Insecurity** [↗](#)



MyChart Bedside Feature

Back M Questionnaires

This is a non-production environment. If you are a patient, contact the system administrator immediately. [X]

For your hospital stay in **ST FRANCIS MEDICAL CENTER - LABOR AND DELIVERY**

[Admission Questionnaire](#) →

Admission Questionnaire

For your hospital stay in **ST FRANCIS MEDICAL CENTER - LABOR AND DELIVERY**

In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?

In the past 12 months, has lack of transportation kept you from meetings, work, or from getting things needed for daily living?

Best Practices for Screening and Referral

1. Appropriate Screening Tools
2. Integrate screening into existing workflows
3. Universal screening
4. Referral base
5. Technology Integration
6. Data tracking/reporting
7. Optimal staffing for referral

Berry, C. et al (2020)

References

1. National Academies of Sciences, Engineering, and Medicine (NASEM). (2021). The future of nursing 2020-2030: Charting a path to achieve health equity. The National Academies Press. <https://doi.org/10.17226/25982>
2. Healthy People 2030. (2021). Social Determinants of Health. <https://health.gov/healthypeople/objectives-and-data/social-determinants-health>
3. Berry, C., Paul, M., Massar, R., Marcello, R., Krauskopf, M. (2020). Social needs screening and referral program at a large US public hospital system, 2017. American Journal of Public Health, 10(52), 5211-5214.
4. Centers for Medicare and Medicaid Services [CMS] (2021a). Fiscal year (FY) 2022 Medicare hospital inpatient prospective payment systems (IPPS) and long term care hospital (LTCH) rates final rule (CMS-175-F). Retrieved from: <https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2022-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-0>
5. Cantor, M. & Thorpe, L. (2018). Integrating data on social determinants of health into electronic health records. Health Affairs, 37(4). <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.1252>