We Ask Because We Care

Julia E. Iyasere, MD, MBA

Executive Director, Dalio Center for Health Justice, NewYork-Presbyterian

Senior Vice President, Health Justice and Equity, NewYork-Presbyterian

Assistant Professor, Medicine, Columbia University Irving Medical Center

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Agenda

- **Introductions**
  - HANYS AHEI team
  - AHEI faculty
- **Our partners**
- **Session 2:**
  - We Ask Because We Care
- **Upcoming sessions**

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HANYS AHEI team

Kathleen Rauch, RN, MSHQS, BSN, CPHQ

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Christina Miller-Foster, MPA

Senior Director, Quality Advocacy, Research and Innovation

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Maria Baum, MS, RN, CPHQ

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Project Manager,
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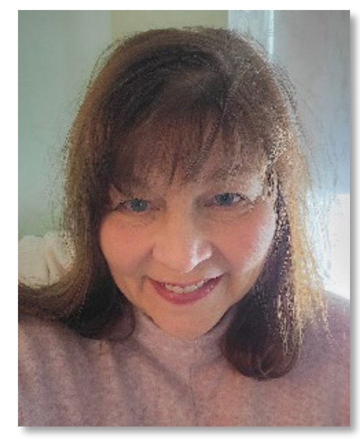
HANYS faculty

Julia E. Iyasere, MD, MBA

Executive Director, *Dalio Center for Health Justice, NewYork-Presbyterian*
Senior Vice President, *Health Justice and Equity, NewYork-Presbyterian*
Assistant Professor, *Medicine, Columbia University Irving Medical Center*



Theresa Green, PhD, MBA

Director, *Community Health Policy and Education, Center for Community Health and Prevention, University of Rochester Medical Center*

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Our funder and partner

Our funder

Funding from the Mother Cabrini Health Foundation allows HANYS to expand its capacity to provide education, direct support, tools and data to our members in a strategic way. With this learning collaborative, we strive to effect lasting change in health equity at the local level by engaging providers and community stakeholders to address health disparities.

Our partner

DataGen develops custom analytics for participants to help them understand how and where communities are affected by health disparities so they can develop tailored interventions.

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Presenter

Julia E. Iyasere, MD, MBA

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STAY AMAZING

NewYork-Presbyterian

WITH WORLD-CLASS DOCTORS FROM

Advancing Health Justice Through Data

A Case Study at NewYork-Presbyterian

Julia Iyasere, MD, MBA
Executive Director, Dalio Center for Health Justice, NewYork-Presbyterian
Senior Vice President, Health Justice and Equity, NewYork-Presbyterian
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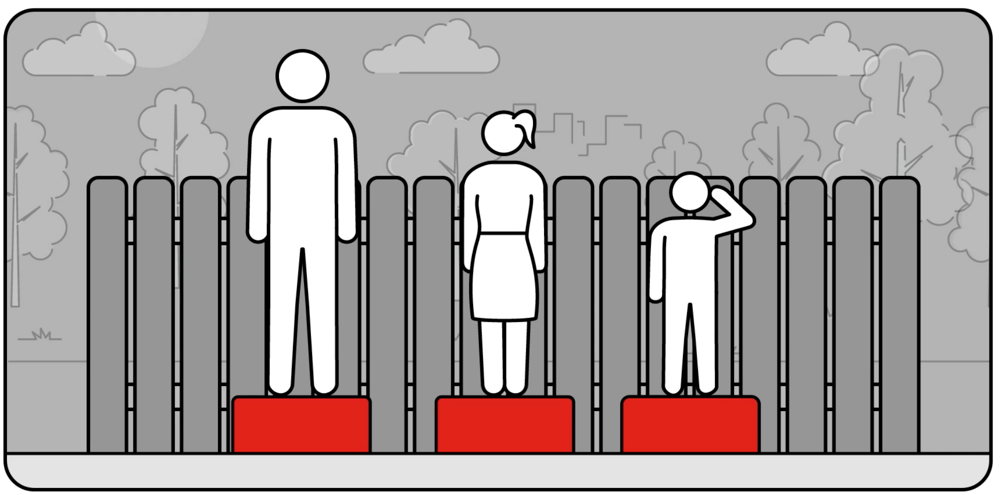
Agenda

1. Introduction
2. Data Collection
    1. Race, Ethnicity, and Language (REaL)
    2. Social Determinants of Health (SDoH)

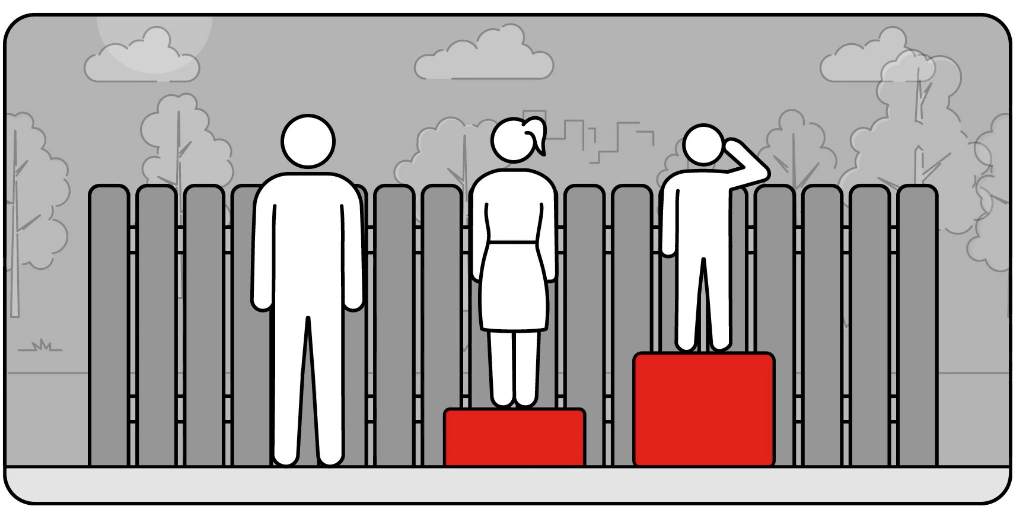
The Dalio Center for Health Justice at NewYork-Presbyterian

Our mission is to be a leader in understanding and improving health equity with a focus on the structural factors that lead to the conditions of poor health.

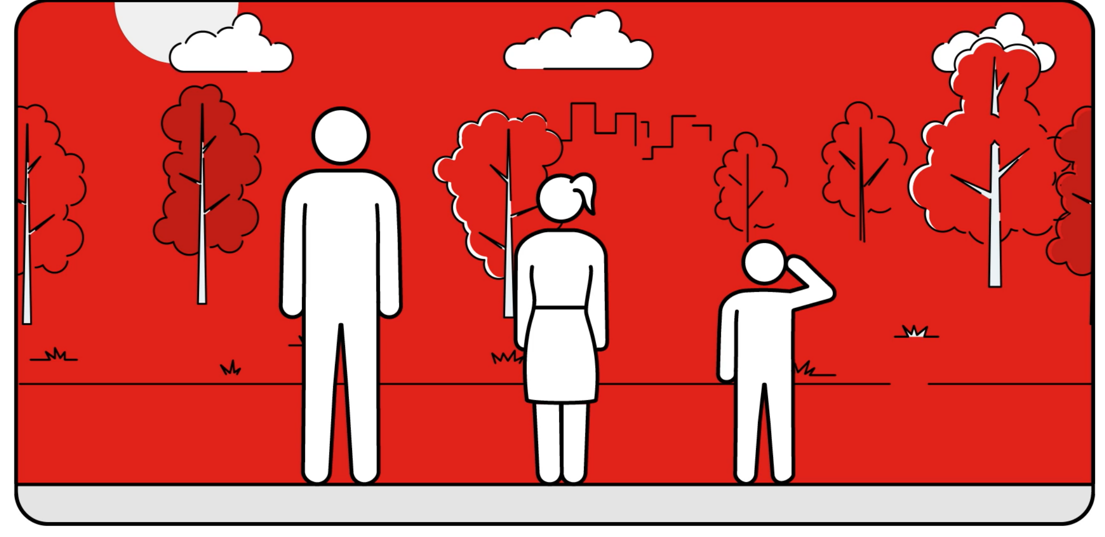
EQUALITY



EQUITY



JUSTICE



“Although the collection of race, ethnicity and language data does not necessarily result in actions that will reduce disparities and improve care, the absence of the data guarantees that none of that will occur.”

Source: IOM (Institute of Medicine). 2009. Race, Ethnicity and Language Data: *Standardization for Health Care Quality Improvement*. Washington, DC.

Patient-Level Health Outcomes Data

Collection

Validation

Disaggregation

Standardization

Race, Ethnicity, and Language

SDOH

Race, Ethnicity and Language Program– Core Elements

Enterprise Commitment

Technical Support

Staff Education

Patient Communication

Monitoring & Intervention

Race, Ethnicity, and Language

SDOH

Race, Ethnicity and Language Program– Core Elements

Enterprise Commitment | Technical Support | Staff Education | Patient Communication Monitoring & Intervention

REaL Workgroup Members

- ✓ Chief Information Officer
- ✓ Chief Transformation Officer
- ✓ Executive Director, Dalio Center for Health Justice
- ✓ VP Finance Revenue Cycle, Access
- ✓ Physician leaders, including Chief of OB, Associate CMIO, Director of Community Pediatrics
- ✓ Representatives from Epic, Data Analytics, Social Work, Dalio Center, & Division of Community and Population Health

Should a health care organization be collecting race and ethnicity data at all, given that race is a *social construct* and not a clinically valuable identifier?

Should we call the electronic medical record field “race” or *“background”* or something else?

Should we purchase data to augment our existing race and ethnicity data?

Should we use algorithms to *infer* patient race and ethnicity?

Should we leverage *natural language processing* to pull race and ethnicity from clinical notes?

"We acknowledge that race is artificial and that differentiating by race is not a valid way to understand human difference.

We also acknowledge that racism continues to shape the lives, opportunities, and health of many. So, even though race is merely a social construct, race and ethnicity data are critical to inform retrospective research and analysis on health equity.

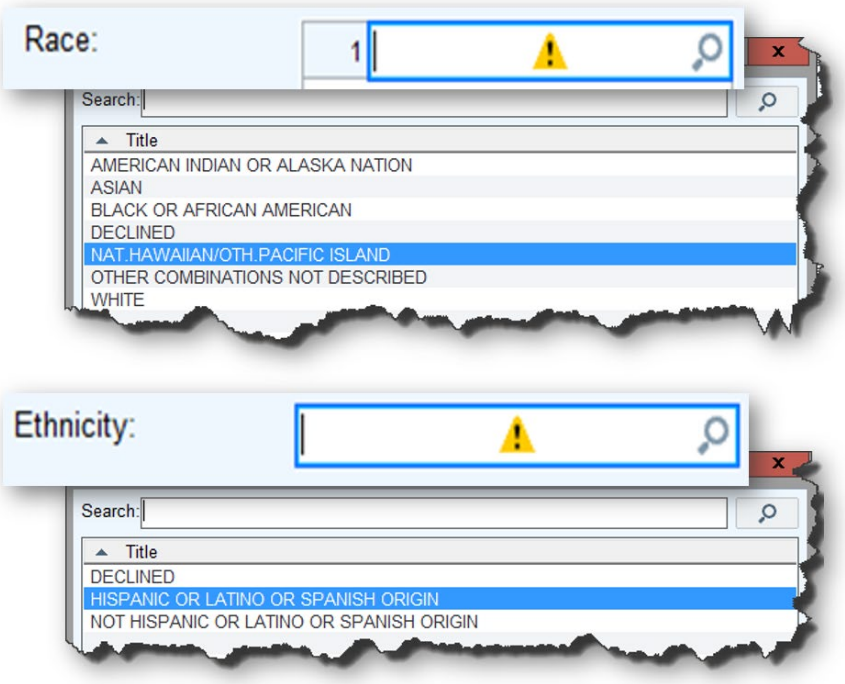
We believe that self-identified race and ethnicity are the gold standard; thus, we did not purchase data or use inferred race and ethnicity to augment self-identified race and ethnicity in the electronic medical record."

Race, Ethnicity, and Language

SDOH

Race, Ethnicity and Language Program– Core Elements

Enterprise Commitment **Technical Support** Staff Education Patient Communication Monitoring & Intervention



Race, Ethnicity, and Language

SDOH

Race, Ethnicity and Language Program– Core Elements

Enterprise Commitment | Technical Support | **Staff Education** | Patient Communication | Monitoring & Intervention

Race, Ethnicity, and Language

SDOH

Race, Ethnicity and Language Program– Core Elements

Enterprise Commitment | Technical Support | Staff Education | **Patient Communication** | Monitoring & Intervention

Overview

A Letter from Ray and Barbara Dalio

Focus Areas & Key Initiatives

Data & Infrastructure

We Ask Because We Care Campaign

Clinical & Community Strategy

Research & Implementation Science

Education & Leadership

External Advisory Board

Meet the Team

We Ask Because We Care

NewYork-Presbyterian, Columbia, and Weill Cornell Medicine celebrate the diverse people and communities we serve. We pledge to give **every** patient the best care possible regardless of race, ethnicity, gender identity, sexual orientation, cultural background, or language.

We will strive to make sure all patients have **equal access** to the highest quality of care. To support this mission, we will ask you questions about your background and preferred language. You can update your information today at **www.myconnectnyc.org**.

Your information is confidential. Sharing it is your choice. But **we ask because we care** about you and the health and wellbeing of all our patients.

At NewYork-Presbyterian, Columbia, and Weill Cornell Medicine, we put patients first.

Race, Ethnicity, and Language

SDOH

Race, Ethnicity and Language Program– Core Elements

Enterprise Commitment | Technical Support | Staff Education | Patient Communication | **Monitoring & Intervention**

NEJM Catalyst

COMMENTARY

Building the Foundations for Equitable Care

Amelia Shapiro, MBA, Dodi Meyer, MD, Laura Riley, MD, Brian Kurz, MPH, Daniel Barchi, MEM

DOI: 10.1056/CAT.21.0256

In 2020, NewYork-Presbyterian, Weill Cornell, and Columbia University launched an enterprise-wide, coordinated campaign to improve collection of race and ethnicity data, which included five key pillars: (1) a steering committee staffed by senior leaders, (2) improvements to streamline data collection process and structure, (3) standardized staff education, (4) direct patient communication, and (5) measurement and monitoring. As large and small health care systems are targeting equity as a key outcome, it is important to share lessons learned so that all can move together toward shared goals.

At NewYork-Presbyterian — an academic health care system affiliated with Columbia University Vagelos College of Physicians and Surgeons and Weill Cornell Medicine — our tripartite mission has long been to be a leader in medical education, groundbreaking research, and innovative, patient-centered clinical care. Our commitment to excellence in these areas includes a profound commitment to health equity.

It is critically important for us to understand and address the root causes of health inequities, including those that fall along racial and ethnic lines, as well as to measure our success in closing health equity gaps. Those efforts require widespread, reliable, and consistent data about our patients' race and ethnicity.[1] We acknowledge that race is a social construct; thus, differentiating by race is not a valid way to understand human difference. However, we also acknowledge that structural racism shapes the lives, opportunities, and health of many, and therefore race data can serve as a proxy for social vulnerability. Therefore, collecting and analyzing race and ethnicity data is critically important for NewYork-Presbyterian, Columbia, and Weill Cornell in our pursuit to achieve equity for all.

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Challenges → Solutions

Challenge:
Ensure that self-reporting by patients is easy and incorporated into a standard work flow

Solution:

Add race/ethnicity questions to patient-facing screens during check-in, in our kiosks, and on the patient online portal

Challenge:
Substantial volume of “NULL” values for Race and Ethnicity

Solution:
Make both questions *required* fields in the electronic medical record

Challenge:
Inconsistent displays and ordering of race and ethnicity questions across our multiple hospital sites

Solution:

Align with published best practice, move questions on ethnicity before race

Challenge:

Listing of options for “granular ethnicity” and “granular race” was very long; patients and staff had difficulty finding the correct values

Solution:

Develop a list of top 10 "granular ethnicity" and "granular race" options to display to end users *(while still providing access to the full list of 44 granular ethnicities and 55 granular races)*

ASIAN

- Asian Indian
- Bangladeshi
- Bhutanese
- Burmese
- Cambodian
- Chinese
- Taiwanese
- Filipino
- Hmong
- Indonesian
- Japanese
- Korean
- Sri lankan
- Thai
- Madagascar
- Singaporean
- Nepalese
- Maldivian
- Iwo Jiman
- Vietnamese
- Okinawan
- Laotian
- Malaysian
- Pakistani

ASIAN

Asian Indian

Bangladeshi

Chinese

Taiwanese

Filipino

Japanese

Korean

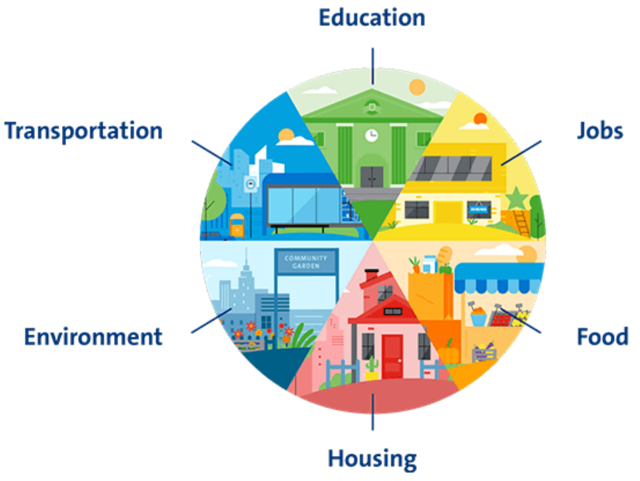
Laotian

Vietnamese

Pakistani

Race, Ethnicity, and Language

SDOH



SDoH Screening and Referral Program – Core Elements

Enterprise Commitment

Technical Support

Staff Education

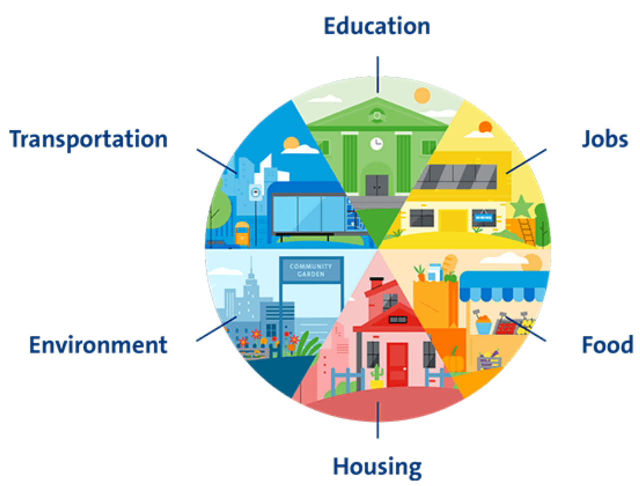
Patient Communication

Monitoring & Intervention

Collection

Race, Ethnicity, and Language

SDOH



SDoH Screening and Referral Program – Core Elements

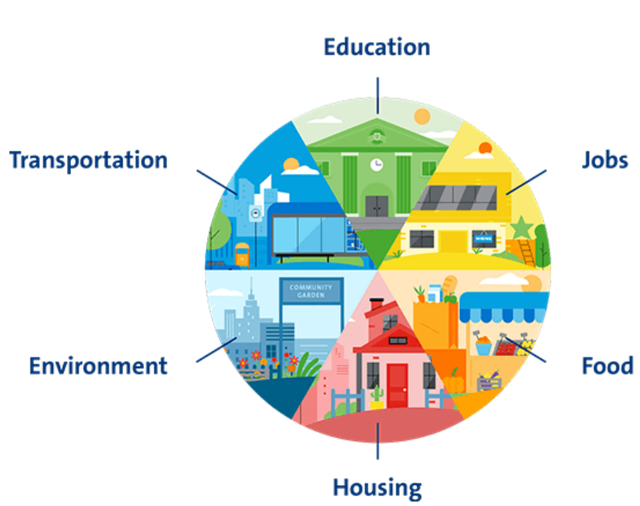
Enterprise Commitment | Technical Support | Staff Education | Patient Communication | Monitoring & Intervention

Social Determinants of Health Workgroup Members

- ✓ SVP & Executive Director, Dalio Center for Health Justice
- ✓ Physician and Nursing leadership
- ✓ Representatives from:
  - ✓ Epic & Data Analytics
  - ✓ Social Work & Care Coordination
  - ✓ Patient Access at Registration
  - ✓ Division of Community & Population Health
  - ✓ Dalio Center for Health Justice

Race, Ethnicity, and Language

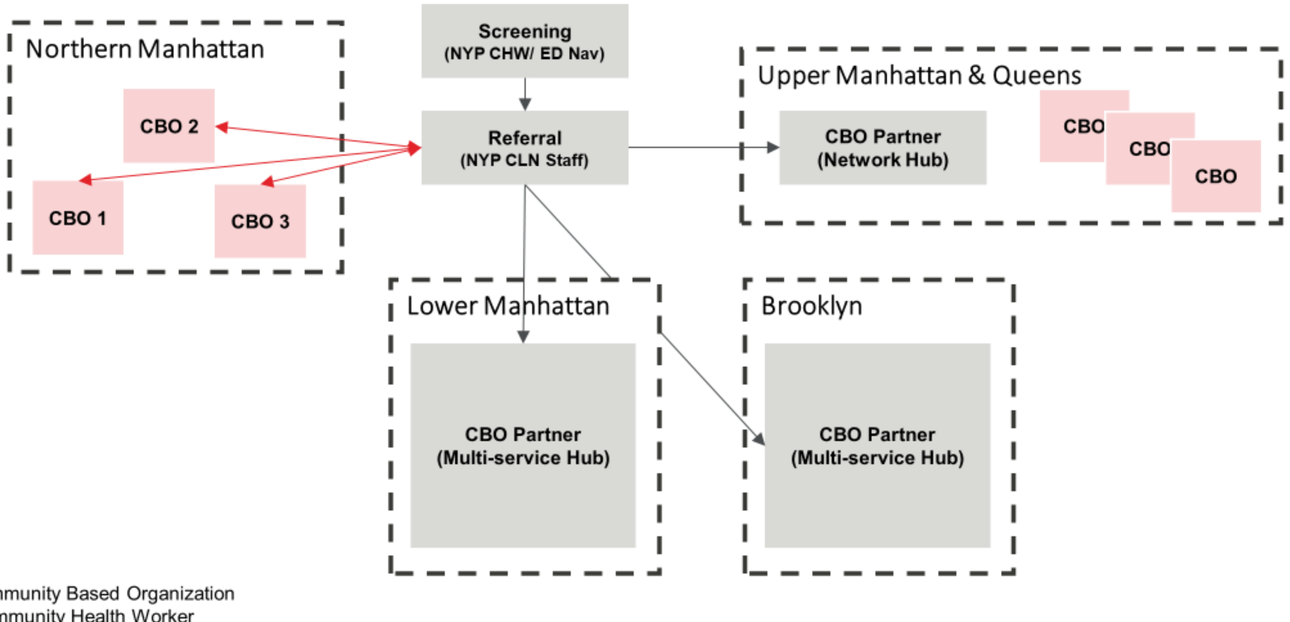
SDOH



SDoH Screening and Referral Program – Core Elements

Enterprise Commitment | **Technical Support** | Staff Education | Patient Communication | Monitoring & Intervention

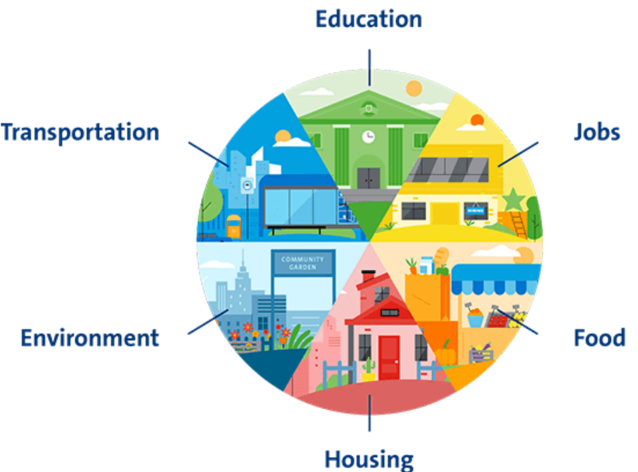
CBO Referral Network



CBO = Community Based Organization
CHW = Community Health Worker

Race, Ethnicity, and Language

SDOH



SDoH Screening and Referral Program – Core Elements

Enterprise Commitment | Technical Support | **Staff Education** | Patient Communication | Monitoring & Intervention

Social Determinants of Health: Sample Scrip

To address the health-related social needs that affect patient health outcomes, NYP is comm implementing Social Determinants of Health (SDoH) screening and navigation in departments and across the enterprise. Below are sample scripts for interacting with patients and requesting that they the SDoH screener, as well as post-screening scripts. We have also provided FAQs for staff completing s

Sample Script for pre-visit, facilitated phone screening

"Hello, may I speak with Patient's Name?"

"Hi Mr./Ms. Patient's Name, my name is Your Name, I am a hospital employee who works with your medical car Clinic's Name. I am calling all patients to remind them of their medical appointment and help them co questionnaire prior to their doctor visit. Before I start to ask you the questions, I need to verify your identity confirm your date of birth?"

"Thank you for verifying your identity Mr./Ms. ______. I will need 5 to 7 minutes of your time to com questionnaire. Your answers **are confidential** and will help us connect you to free resources in your community good time for you?"

If he or she says yes, conduct SDOH questionnaire. If he or she says no, ask the patient when a good time is to call

Sample Script for in waiting-room, patient-led screening

"While you wait for your appointment, we are asking all of our patients to complete a short questionnaire, whicl our team connect you to free resources in the community. It should take around 5-7 minutes and you can a questionnaire by scanning this QR code. Your answers **are confidential**. Do you have any questions?"

Sample Script for in waiting-room, facilitated screening

"Are you a patient at Clinic's Name or are you here with someone else?"
If he or she is a patient, proceed with script. If he or she is not a patient, ask them to direct you to the patient they

"My name is Your Name. I am conducting screening questionnaire prior to your medical appointment. It should tal 5-7 minutes. Your answers **are confidential** and will help us connect you to free resources in the community. W okay if I asked you a few questions right now prior to your appointment?"

Referrals for Social Needs: Tips for New York City

After Social Determinants of Health (SDoH) screening is completed, care teams can take action by referring patients to community-based organizations (CBOs) that fit identified SDoH needs. To find appropriate resources, team members can use this guide or visit HITE (www.hitesite.org) for a list of resources. Starting in October 2023, a CBO directory will be easily available in Epic, via a link under the Epic HealthyPlanet wheel in Snapshot.

Resources for Patients with Transportation Needs

For patients that identify transportation needs, we recommend starting with NYC.gov programs.

Fair Fares NYC	Access-A-Ride
Fair Fares NYC helps low-income New Yorkers save 50% on public transportation including subway fares, eligible bus fares, and Access-A-Ride paratransit trips. https://www.nyc.gov/site/fairfares/index.page	You are eligible for Access-A-Ride if you have a disability that prevents you from using the public buses or subways. https://new.mta.info/accessibility/access-a-ride

Call 311 or visit https://portal.311.nyc.gov/ for more information about these NYC programs.

Resources for Patients with Food Needs

Emergency Food: For patients that identify food needs, we recommend starting with Food Bank for New York City. The Food Bank website allows users to find a soup kitchen, food pantry, or senior center near them. https://www.foodbanknyc.org/get-help/ Below are some superpantries, or high-capacity food pantries, in New York City:

West Side Campaign Against Hunger 263 West 86th Street New York, NY 10024 https://www.wscah.org/ The Campaign Against Hunger 2004 Fulton Street Brooklyn, NY 11233 https://www.tcahnyc.org/	NY Common Pantry 8 East 109th Street New York, NY 10029 1290 Hoe Avenue Bronx, NY 10459 https://nycommonpantry.org/ St. John's Bread and Life 795 Lexington Avenue Brooklyn, NY 11221 https://breadandlife.org/	River Fund 89-11 Lefferts Boulevard Richmond Hill, NY 11418 https://river.fund/ Part of the Solution 2759 Webster Avenue Bronx, New York 10458 https://potsbronx.org/english/

Food Benefit Programs: Additionally, we can direct patients to NYC.gov for food benefit programs.

- SNAP (Food Stamps) helps people with limited income buy food. Benefits are provided on an electronic card (like an ATM card) and accepted at most grocery stores.
- Food for Women, Infants, and Children (WIC) provides pregnant women, mothers, and children with healthy food and support for prenatal care, breastfeeding, and nutrition.

Call 311 or visit https://portal.311.nyc.gov/ for more information about these NYC programs.

NewYork-Presbyterian | Dalio Center for Health Justice | Division of Community & Population Health

Race, Ethnicity, and Language

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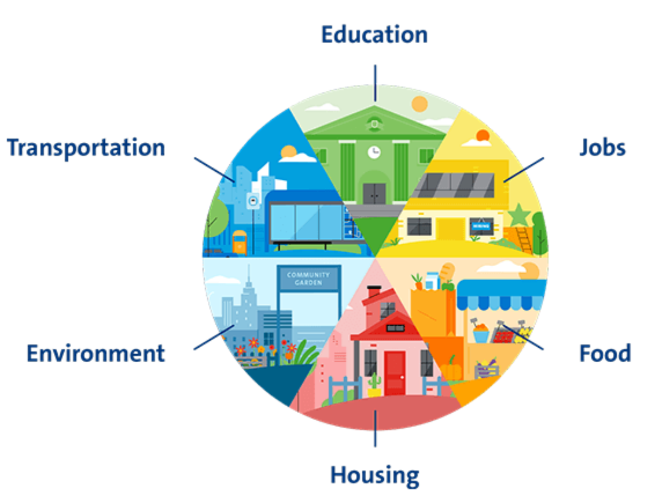

SDoH Screening and Referral Program – Core Elements

Enterprise Commitment | Technical Support | Staff Education | **Patient Communication** | Monitoring & Intervention

Education
Transportation
Jobs
HIRING
Environment
Food
Housing

Overview

RELATED VIDEOS

Now Playing 3:08 Overview

2:58 Education

3:40 Environment

Map: Households Receiving Food Stamps/SNAP

Households Receiving Food Stamps/SNAP per household

- 0% - <9.1%
- 9.1% - <15.9%
- 15.9% - <24.5%
- 24.5% - <37.7%
- 37.7% - 52%

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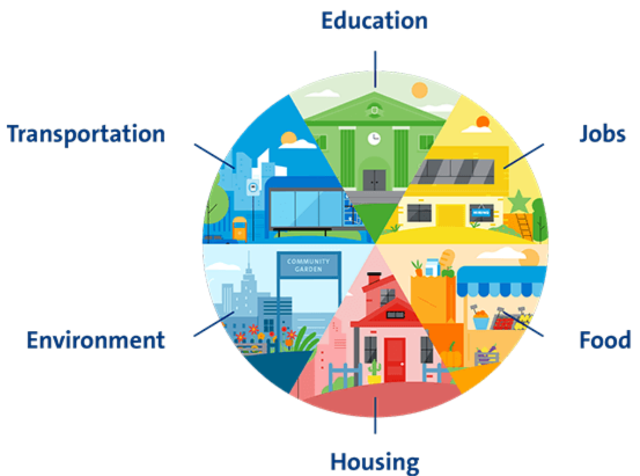
Race, Ethnicity, and Language

SDOH



SDoH Screening and Referral Program – Core Elements

Enterprise Commitment | Technical Support | Staff Education | Patient Communication | **Monitoring & Intervention**

INNOVATION REPORT

Social Determinants of Health Screening and Management: Lessons at a Large, Urban Academic Health System

Patricia Peretz, MPH; Amelia Shapiro, MBA; Luisa Santos; Koma Ogaye, MPH; Emme Deland, MBA; Peter Steel, MA, MBBS; Dodi Meyer, MD; Julia Iyasere, MD, MBA

The Joint Commission Journal on Quality and Patient Safety 2023; 49:328-332

Background: In October 2022 a multisite social determinants of health screening initiative was expanded across seven emergency departments of a large, urban hospital system. The aim of the initiative was to identify and address those underlying social needs that frequently interfere with a patient's health and well-being, often resulting in increased preventable system utilization.

Methods: Building on an established Patient Navigator Program, an existing screening process, and long-standing community-based partnerships, an interdisciplinary workgroup was formed to develop and implement the initiative. Technical and operational workflows were developed and implemented, and new staff members were hired and trained to screen and support patients with identified social needs. In addition, a community-based organization network was formed to explore and test social service referral strategies.

Results: Within the first five months of implementation, more than 8,000 patients were screened across seven emergency departments (EDs), of which 17.3% demonstrated a social need. Patient Navigators see between 5% and 10% of total nonadmitted ED patients. Among the three social needs of focus, housing presented as the greatest need (10.2%), followed by food (9.6%) and transportation (8.0%). Among patients identified as rising/high risk (728), 50.0% accepted support and are actively working with a Patient Navigator.

Conclusion: There is growing evidence to support the link between unmet social needs and poor health outcomes. Health care systems are uniquely positioned to provide whole person care by identifying unresolved social needs and by building capacity within local community-based organizations to support those needs.

CONTEXT: A LARGE ACADEMIC HEALTH SYSTEM WITH EQUITY AND HEALTH JUSTICE AS CORE VALUES

Social determinants of health (SDoH) account for 80% to 90% of modifiable contributors to health outcomes.[1] Unjust differences in SDoH contribute to health disparities[2]; therefore, addressing SDoH is a primary mechanism for achieving health justice and equity.[3]

NewYork-Presbyterian (NYP) is an academic health system based in New York City, with 11 hospital campuses and 4,000-plus beds, providing more than 2.6 million visits annually. NYP is committed to equity and health justice, as well as to community health programs that support disease prevention and education and address clinical, social, and behavioral needs.

NYP's Division of Community and Population Health (DCPH) works alongside clinical leaders and community partners to develop and implement programs that support patients and our surrounding community, including an emergency department (ED)–based Patient Navigator Program, based in seven EDs. Bilingual Navigators provide culturally sensitive education and help connect patients to follow-up appointments and connect postdischarge to support appointment adherence.[4,5]

NYP has launched several initiatives over the past few years to advance equity and health justice, including the Dalio Center for Health Justice (DCHJ), which aims to understand and address the root causes of health inequities, with a special focus on the SDoH and addressing our patients' health-related social needs.

In 2022 DCPH and DCHJ launched a comprehensive SDoH screening initiative across seven EDs. The goal was to uncover and address those social barriers that interfere with patients' health and often perpetuate and exacerbate preventable conditions and then to connect patients to resources to address their needs. The DCPH and DCHJ

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https://doi.org/10.1016/j.jcjq.2023.04.002

AMAZING THINGS ARE HAPPENING HERE

thank you

Upcoming sessions

Tuesday, April 16 | 11 a.m. to noon.

SOGI data best practices

Learn best practices for collecting and using SOGI data to identify disparities and improve care.

Sessions will be held on the following Tuesdays from 11 a.m. to noon:

- April 23 | Collecting and reporting SDoH data
- April 30 | Establishing referral processes with SDoH data
- May 7 | Using data to identify disparities (1/2)
- May 14 | Using data to identify disparities (2/2)
- May 21 | Community partnerships
- May 28 | Patient and family engagement

Register here.

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Questions?

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