Title: Advancing Health Equity in Clinical Care: Leveraging Data to Secure Organizational Buy-In and Evaluate Outcomes

Abstract:

Background

Social Drivers of Health influence up to 80% of an individual's health outcomes and are a driving force behind the health disparities seen today, imploring health centers to expand their capacity to routinely and systematically obtain and act on this information. While health centers are eager to evolve beyond taking a health-equity "lens" to patient care to integrating it infrastructurally, the path forward is ill-defined. Community Health and Wellness Partners (CHWP) of Logan County, Ohio is a rural FQHC fiercely committed to identifying a path forward and using SDOH data to improve health outcomes within their community.

Objective

Using census and Community Health Needs Assessment data, CHWP created an annual health equity plan that included a PDSA to improve screening rates, community-based referral rates, and utilization of SDOH data across all departments.

Methods

The PDSA aimed to screen all patients annually using the PRAPARE tool. This required standardizing workflows for screening and interventions, adapting the EHR to capture interventions in trackable fields, and implementing huddle facilitation tools to make social care information available at the point-of-care. Using a population health analytics platform, CHWP built dashboards to monitor progress against the health equity plan and integrate SDOH data into all parts of the organization, including point-of-care teams, case management, and school-based health. These dashboards were distributed monthly and highlighted services gaps, barriers to care, and community needs.

Results

From 2022 to 2023, CHWP increased SDOH screening rates among patients 18+ by 22% and among patients 17 and younger by 122%. Warm handoffs to community-based resources expanded in scope and increased by 108%.

Conclusion

Advancing health equity in clinical settings requires 1) expanding capacity to screen patients and provide interventions, 2) access to data to evaluate the impact of efforts on equitable health outcomes, and 3) an organizational commitment to incorporating this data across all departments.