Indiana Hospital Association

Indiana Healthy Opportunities for People Everywhere

Roadmap

Patient Safety is Personal

What is "Indiana Healthy Opportunities for People Everywhere (I-HOPE)"?

I-HOPE is a grant offered by the CDC and awarded to the State Office of Rural Health through the Indiana Department of Health (IDOH) and is designed to work with hospitals to address COVID-19 related health disparities and advance health equity by expanding resources and services offered to rural communities with underserved populations. The Indiana Hospital Association (IHA) was chosen to lead this work with 60 hospitals who meet the category requirements set by the CDC. The grant period runs from June 1, 2021 – May 31, 2024.

What will IHA provide in this grant?

IHA will provide:

- targeted training and education based on state and regional dashboards.
- address the Healthy People 2030 focus areas of vaccination, respiratory disease, infectious disease, and social determinants of health.
- provide your hospital with data collection and reporting required by the CDC and IDOH throughout the term of the grant.
- collaboration with other partners working on this grant across the state.

What is Healthy People 2030?

Since 1980, the Healthy People initiative has set measurable objectives to improve the health and well-being of people nationwide. At the beginning of every decade, a new iteration of the initiative that addresses the latest public health priorities and challenges is launched. Healthy People 2030 is the initiative's fifth iteration.

How does Healthy People 2030 Address Social Drivers of Health (SDOH)?

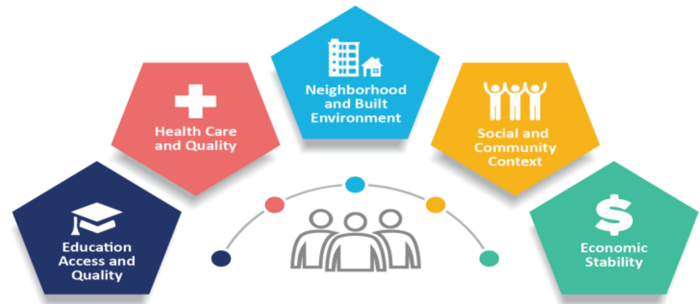
One of Healthy People's 2030s overarching goals is specifically related to SDOH: "Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all". In line with this goal, Healthy People 2030 features many objectives related to SDOH. These objectives highlight the importance of "upstream" factors — usually unrelated to health care delivery — in improving health and reducing health disparities.

What are social drivers of health?

SDOH are the conditions in the environments where people are born, live, work, play, worship, and age that affect a wide range of health and quality of life outcomes and the risks associated with them.

SDOH can be broken down into 5 domains:

- •Economic stability
- •Education access and quality
- •Health care access and quality
- •Neighborhood and environment
- •Social and community context



How do we use Healthy People 2030 in our work?

One of the action tools that Healthy People 2030 offers and a tool that we at IHA use for other projects, is a roadmap that outlines how we can target and improve on a health outcome and the disparities that impact that population. The steps that we will use to do this work are:

1. Identify needs and priority populations

- » Browse objectives to learn about national goals to improve health
- » See how national goals align with your priorities
- » Consider focusing on groups affected by health disparities

Use this information to make the case for your program, secure resources, and build partnerships.

2. Set your own targets

- » Find data related to your work
- » Use national data to set goals for your program

Healthy People 2030 establishes objectives and targets for the entire United States, but setting local targets contributes to national success.

3. Find inspiration and practical tools

- » Explore critical public health topics relevant to your work
- » Learn about successful programs, policies, and interventions
- » Look for evidence-based resources and tools your community, state, or organization can use

4. Monitor national progress — and use our data as a benchmark

- » Check for updates on progress toward achieving national objectives
- » Use our data to inform your policy and program planning
- » See how your progress compares to national data

What are our strategies areas for I-HOPE?

Our strategy is to increase/improve data collection and reporting for populations experiencing a disproportionate burden of COVID-19 infection, severe illness, and death to guide the response to the COVID-19 pandemic. Our chosen priority populations are those experiencing Chronic Obstructive Pulmonary disease, or COPD. We chose this population because not only is there a need to improve upon readmissions for COPD in Indiana, but there is also a link between people who had COVID-19 who also suffer from COPD and experienced hospitalization or even death.

What does Healthy People 2030 say about COPD?

More than 16 million people in the United States have COPD, which is a major cause of death. Strategies to prevent diseases-like reducing air pollution and helping people quit smoking-are key to reducing deaths from COPD. This is the 4th highest disease in Indiana! Our goal is to uncover reasons for this, then build strategies to prevent disease such as educating both ourselves and our patients about COPD, encouraging smoking cessation, reducing the exposure to secondhand smoke, and pulmonary rehabilitation.

What are the goals for I-HOPE and how will we support them?

Goal #1:

- Identify the chosen priorities with the select Healthy People 2030 strategy areas working with existing partnerships.
- Develop data visualizations with baseline data.
- Track performance quarterly of each measure.

By creating statewide and regional data visualizations which reflect our chosen priority of COPD readmissions, we will be able to connect SDOH to mortality and morbidity and will include increasing the number of hospitals that include *Z codes*, which are the social drivers of health, within their coding practices. We have already developed data visualization through our data platform, DataLink, that shows baseline data for COPD, COPD readmissions, COPD with COVID-19, and COPD mortality. We have also included race and ethnicity data. This dashboard will serve as our performance tracker as you progress in your work. If you are the lead for your hospital and need to obtain access to DataLink, please email Ryan Prentice at Rprentice@ihaconnect.org and request access as an I-HOPE lead.

Goal#2:

- Analyze current data structure of Z codes.
- Recommend improvement strategies.
- Increase the collection of Z codes.

With the development of these dashboards, we have been able to review all the data to identify those hospitals that will benefit from this grant. By focusing on those groups that are disproportionately impacted by SDOH, we can help to provide resources and build capacity to support programs to reduce negative health outcomes. We will assist you with building your program to increase your collection of Z codes and recommend improvement strategies. Learn more about the work being done by hospitals and health systems with Z codes here.

What is a Z code?

Z codes are a subset of ICD-10-CM diagnosis codes used to report social, economic, and environmental determinants known to affect health and health-related outcomes. They comprehensively identify non-medical factors affecting health and track progress toward addressing them. These codes are found in the Z55-Z65 group to identify social drivers of health.

Here are the categories:

Z55 – Problems related to education and literacy
Z56 – Problems related to employment and unemployment
Z57 – Occupational exposure to risk factors
Z58-- Problems related to employment and unemployment
Z59 – Problems related to housing and economic circumstances
Z60 – Problems related to social environment
Z62 – Problems related to upbringing
Z63 – Other problems related to primary support group, including family circumstances
Z64 – Problems related to certain psychosocial circumstances
Z65 – Problems related to other psychosocial circumstances

In these main categories are many additional codes. Go Here to see some examples of what other codes are found in the ICD-10-CM manual.

Screening for social drivers of health and capturing Z codes is supported by CMS and many other regulatory bodies. They have outlined a process that shares the steps in the journey for better health outcomes:

Goal #3:

- Identify the complementary partnerships.

Goal 3 includes leveraging existing collaborative partnerships to advance community connections and outcomes. With Purdue University being selected by the IDOH to facilitate these connections, the three-year I-HOPE initiative will deploy teams across the state to facilitate community-level conversations, resulting in strategies to address the factors that prevent people from living their healthiest lives. The work will examine longstanding risk factors, as well as the impact of the COVID-19 pandemic on Hoosiers' health. During the grant cycle, you will be introduced to partners that will help with your efforts to be educated and be educators to your patients, and assist patients with getting the care they need to prevent them from achieving optimal health outcomes or being readmitted to the hospital. We will be providing you with resources to share with your patients who may be experiencing a social driver, which prevents them from maintaining stability in their chronic disease. We will also offer educational opportunities to help increase capacity in your hospital and outpatient programs such as cardiopulmonary rehabilitation. We are partnering with the American Lung Association to offer programming for respiratory health and diseases. Visit here to learn more about what is offered.

Goal #4:

- Offer the AHRQ Culture of Patient Safety Survey.
- Each hospital will receive their results.
- A meeting to review the results will be offered.
- Aid in providing necessary tools for performance improvement for identified opportunities.
- Tracking of year-over-year performance in results if a hospital completes a second or third survey during the contract period.

Patient safety culture is the shared values, beliefs, and attitudes that influence the collective behavior of healthcare professionals and other staff in relation to patient safety. A solid patient safety culture is vital for providing high-quality healthcare and protecting patients from harm. Hospitals with a strong patient's safety culture are more likely to have fewer medical errors and better patient outcomes. I-HOPE hospitals are being offered facilitation of the AHRQ Culture of Patient Safety Survey. Learn more about how IHA can assist you with conducting the survey here.

Goal #5:

- Develop the content of the roadmap to include such things as:
- Evidence based practices.
- Systems of Change.
- Environmental inequities related to COVID-19 and other public health threats.

This document serves as a roadmap to help with your journey to provide better care for your patients. Below are additional resources to be used to support your work. Please also visit the IHA website for recorded webinars here.

AHRQ COPS Tools

Hospital Action Planning Tool
Hospital Survey
Hospital Users Guide
Workplace Safety Survey
Hospital Database Report
Workplace Safety Database Report
Performance Improvement Resource List

COPD

Intervention to address SDOH and COPD
COPD National Action Plan
Defining and targeting health disparities in COPD
GOLD Report 2023

COPD & COVID-19

COVID-19 & pulse oximeters
Homelessness and COPD
Homelessness and COVID-19
Therapeutic modalities for Asthma, COPD, COVID-19

Oral Health
Dental health correlations with COPD
Respiratory infections and oral health
Resources American Thoracic Society
Dental Lifeline Network
The relationship between periodontal diseases and respiratory diseases
Healthy Gums Healthy Lungs
Oral health and pneumonia
Dental health and lung disease

Electronic Medical Record SDOH Screening
Cerner
EPIC
Cerner PRAPARE

Screening Tools
CMS AHC Tool
Health Leads
PRAPARE
AAFP

Readmissions
Benefits of pulmonary rehabilitation
Readmission after COPD exacerbation
Reducing COPD hospital readmissions
Transitions from hospital to community to reduce readmissions

Health Equity Resources
10 Questions Boards Can Answer to Advance Equity | AHA Trustee Services
Mapping US Medicare Disparities | CMS
Social Determinants of Health in Rural Communities Toolkit
Hospitals and food insecurity
Understanding the Social Determinants of Health for Rural Healthcare Teams
CMS study on top 5 Z codes
2022 AHRQ National Health Care Quality & Disparities Report
Find out how your county fares with social determinants of health
CDC resource to help communities address social determinants of health
Health Leads Resource Library
ICD-10-CM Coding for Social Determinants of Health

Systems of Change

What are systems of change?
Purdue HealthTAP
Health Care/System redesign
IHA changes for improvement

For any questions, please contact Madeline Wilson, MSN, RN, CLSSBB-Quality & Patient Safety Advisor and Health Equity Lead-Indiana Hospital Association at Mwilson@ihaconnect.org