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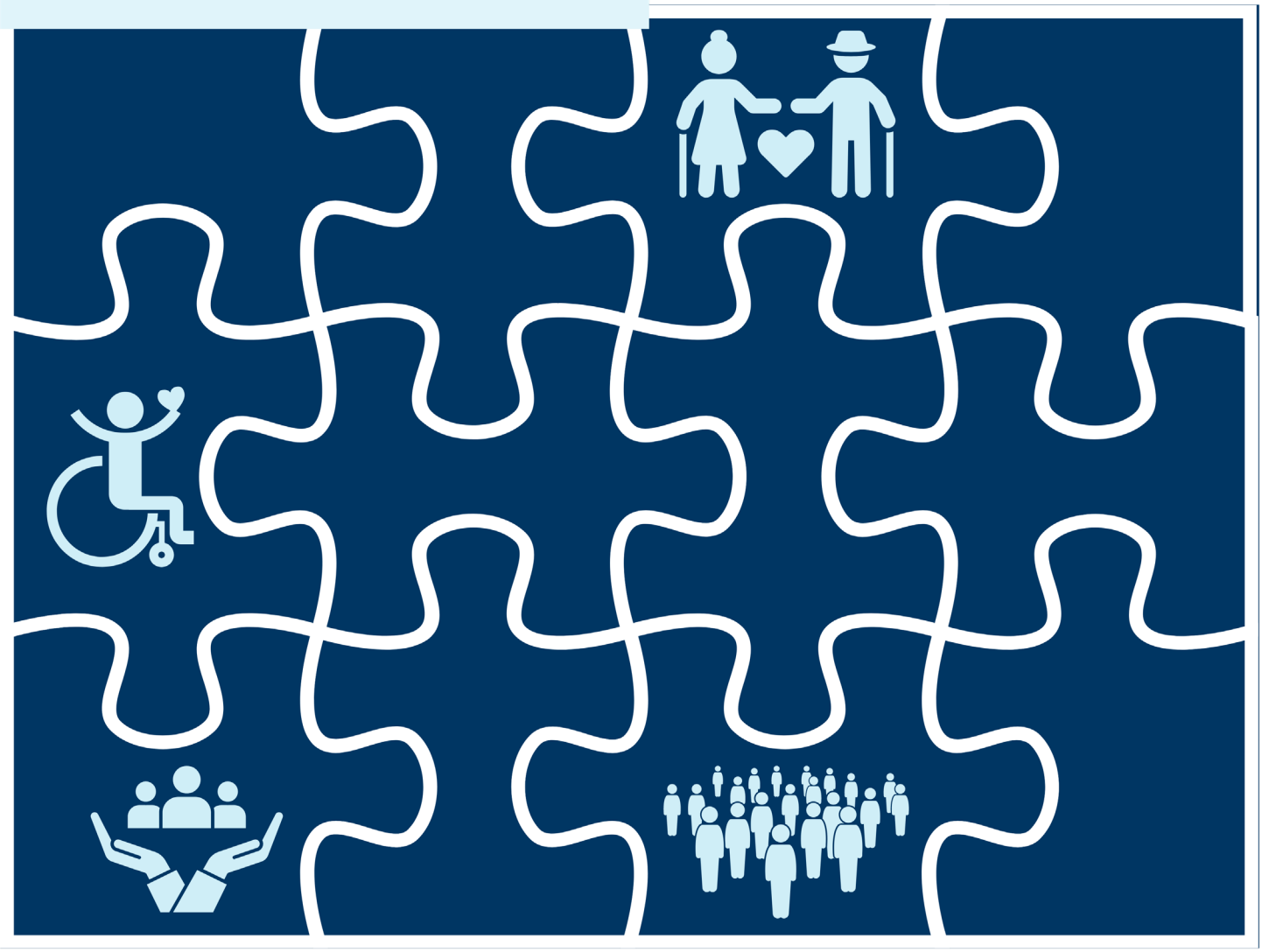
HEALTH EQUITY TOOLKIT

Driving Equitable Care in Nebraska Hospitals



The trusted voice and influential advocate of health care in Nebraska

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NHA EQUITY SUPPORT

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WHY?

The NHA Quality Team created this Equity Toolkit to assist Nebraska hospitals to drive equitable care across the state while also meeting regulatory requirements related to health equity.

"It is our goal to help health care leaders understand health equity and create actionable work to drive equitable care."

Leaders must note when the inequities are:

- ☐ Measurable at the individual level
- ☐ Proximate to health care outcomes
- ☐ Actionable

If these three are met, then disparities clearly fall within the work of health care organizations.

How Can We Help?

TEAM EDUCATION

The NHA Quality Team and collaborating partners can offer education to organizational leaders and staff to help understand the importance of equity work.

PROJECT IMPLEMENTATION

The NHA Quality Team will come onsite to work alongside staff in equity project planning and implementation.

TEAM TRAINING

The NHA Quality Team and collaborating partners can offer specific training to teams to better equip them to be part of successful roll-out.

DATA REPORTS AND ANALYSIS

The NHA Data and Quality Team can run reports based on specific demographic elements to best stratify work. This includes but is not limited to REaL data and Z-Codes.

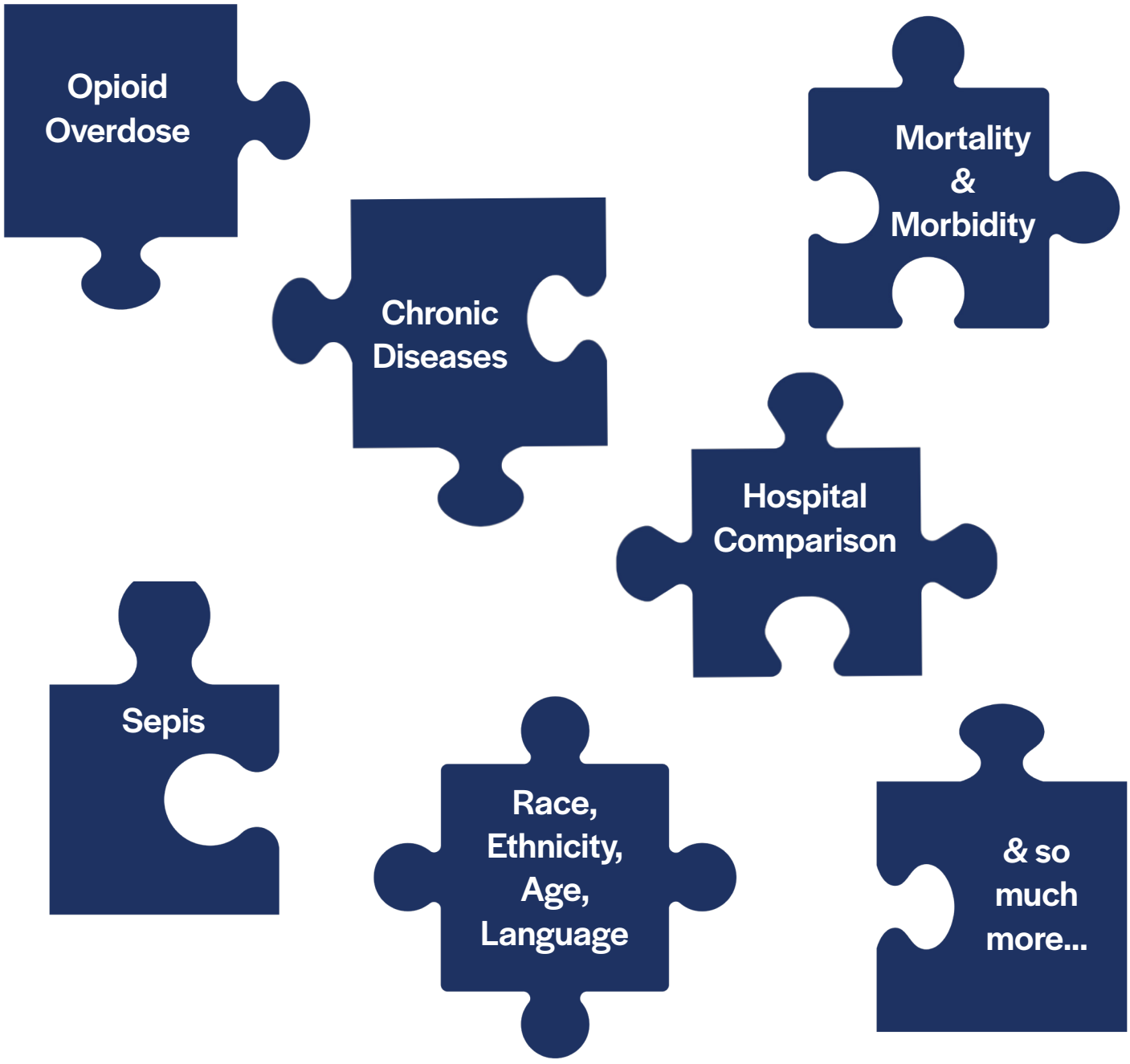
Health equity and screening for social determinants of health are new and complex processes for health care entities. The NHA Team is here to be your partner on this journey to high-quality, equitable care.

THE NHA TEAM IS HERE TO HELP YOU REACH YOUR ORGANIZATIONS HEALTH EQUITY GOALS

Drive Quality Improvement Using Data

Quality improvement and data analysis are essential components for projects in the health care setting. Using data at every phase of a quality initiative helps inform the progress and outcomes of the work. Using data allows organizations to identify opportunities for improvement, benchmark against their peers, test new strategies, and learn more about their communities by reviewing meaningful data. Stratifying data within your organization will drive equitable work and make effective change for your patient populations.

TELL A STORY WITH YOUR DATA TO MAKE EFFECTIVE CHANGE...



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IMPROVING EQUITABLE CARE BY IMPLEMENTATION OF

AGE FRIENDLY HEALTH SYSTEMS

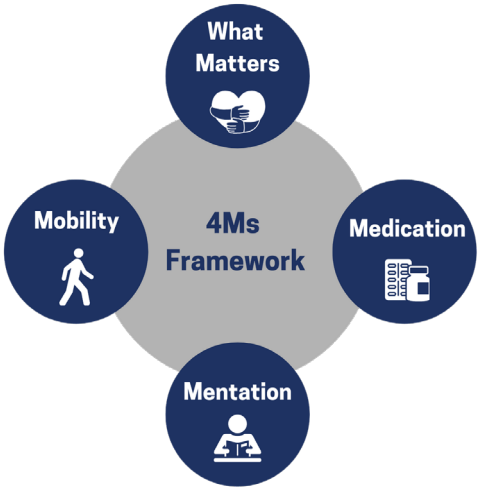
What is Age-Friendly?

Age-Friendly Health Systems is an initiative of The John A. Hartford Foundation and the Institute for Health care Improvement (IHI), in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA), designed to meet the challenge of the aging population in the US.

Age-Friendly Health Systems aim to:

- Follow an essential set of evidence-based practices;
- Cause no harm; and
- Align with What Matters to the older adult and their family caregivers.

4 M's Framework



What Matters
Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

Medication
If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mentation
Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility
Ensure that older adults move safely every day in order to maintain function and do What Matters.

Benefits of Age-Friendly Care

Elderly patients in Nebraska account on averagee:

16% of Nebraska's population

30% of ED admissions

55% of inpatient admissions

Lowers Inpatient Utilization	⬇ 54%
Lowers ICU Stays	⬇ 80%
Increases Hospice Use	⬆ 47%
Increases Patient Satisfaction	

EQUITY PROJECT PLANNING

NEED TO KNOW

DEFINITIONS

Health Equity

Everyone has a fair and just opportunity to be as healthy as possible which requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

Health Inequity

Unjust and avoidable differences in the distribution or allocation of resources between marginalized and dominant groups that lead to disparities. These can be inequities stemming from external factors such as SDOH or from inequities due to bias and structural issues in health care.

Disparities

Differences in health status and mortality rates across population groups, which can sometimes be expected, such as cancer rates in the elderly versus children. Disparities are distinct from health inequities.

Social Drivers of Health (SDOH)

SDOH (sometimes referred to as Social Determinants of Health) are the nonmedical factors that influence health outcomes; the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life, including economic policies and systems, development agendas, social norms, social policies, and political systems.

Intersectionality

The way in which systems of inequality based on gender, race, ethnicity, sexual orientation, gender identity, disability, class and other forms of discrimination intersect to create unique dynamics and effects.

IDENTIFYING IMPROVEMENT OPPORTUNITIES USING A

GAP ANALYSIS

Strategy	Yes	No	Partial	Ref. Page
Is health equity addressed in your strategic plan?				16
Are your board and c-suite engaged in health equity work?				
Do you have an equity champion or formal equity team that addresses health equity in your organization?				
Processes	**Yes**	**No**	**Partial**	**Ref. Page**
Does your organization have a process for screening patients regarding Social Determinants of Health in:				23-36
Emergency Department				
Acute Care				
Clinic				
If you screen for SDOH, do you use a standardized tool to screen? (Note which SDOH pillars you screen for)				
Documentation	**Yes**	**No**	**Partial**	**Ref. Page**
Is your screening tool included in your Electronic Health Record (EHR)?				17, 23-36
Do you have a standardized process for documenting screenings?				
Coding and Analysis	**Yes**	**No**	**Partial**	**Ref. Page**
Does your organization code Z-codes for positive SDOH screenings?				16
Does your organization run a report regarding Z-codes used?				
Does your organization stratify quality data based on equity data (REaL or SDOH)?				
Strategy	**Yes**	**No**	**Partial**	**Ref. Page**
Is health equity addressed in your strategic plan?				38-41
Are your board and c-suite engaged in health equity work?				
Do you have an equity champion or formal equity team that addresses health equity in your organization?				16
Actionable Work	**Yes**	**No**	**Partial**	**Ref. Page**
Does your organization have a formal resource list to connect patients in need?				23-36
Does your organization assess changes in quality metrics related to disparity or equity?				
Education	**Yes**	**No**	**Partial**	**Ref. Page**
Has your organization completed organization-wide education/training on health equity?				15-16
Does your organization offer annual education regarding health equity?				

PROJECT CHARTER

General Project Information		
Project Name	**Project Manager**	**Project Sponsor**
Project Overview		
Problem or Issue		
Purpose of Project		
Business Case		
Goals / Metrics		
Expected Deliverables		
Project Scope		
Within Scope		
Outside of Scope		
Tentative Schedule		
Key Milestones	**Start**	**Finish**
Form Project Team and Conduct Preliminary Review		
Finalize Project Plan and Project Charter		
Conduct Definition Phase		
Conduct Measurement Phase		
Conduct Analysis Phase		
Conduct Improvement Phase		
Conduct Control Phase		
Close Out Project and Write Summary Report		

Costs				
Cost Type	**Vendor/ Labor Names**	**Rate**	**City**	**Amount**

Benefits		
Process Owner		
Key Stakeholders		
Expected Benefits		
Type of Benefit	**Basis of Estimate**	**Estimated Benefit Amount**
Specific Cost Savings		
Enhanced Revenues		
Higher Productivity		
Improved Compliance		
Better Decision Making		
Lower Maintenance Costs		
Few Miscellaneous Costs		
Risks, Constraints, and Assumptions		
Risks		
Constraints		
Assumptions		

SMART GOALS

S **SPECIFIC**	▪ Who: Who is involved? ▪ What: What do you want to accomplish? ▪ Where: Where will you complete the goal? ▪ When: When do you want to do it? ▪ Which: Which requirements and constraints might get in your way? ▪ Why: Why are you doing it?	
M **MEASURABLE**	▪ These goals are defined with precise times, amounts, or other units - especially anything that measures progress toward a goal. ▪ A measurable goal statement answers questions starting with “how,” such as “how much,” “how many,” and “how fast.”	
A **ATTAINABLE**	▪ Attainable goals stretch the limits of what you think is possible. While they’re not impossible to complete, they’re often challenging and full of obstacles.	
R **RELEVANT**	▪ Relevant goals focus on what you truly desire. ▪ They are the exact opposite of insconsistent or scattered goals.	
T **TIME-BOUND**	▪ Time-bound goals have specific deadlines. You are expected to achieve your desired outcome before a target date.	
SMART Goal Statement		

EQUITY OVERVIEW & CMS FRAMEWORK

CMS COMMITMENT TO HEALTH EQUITY

UNDERSTANDING THE FRAMEWORK

Strategic Pillars

Advance Equity	Expand Access	Engage Partners	Advance Equity	Protect Programs	Foster Excellence
Advance health equity by addressing the health disparities that underlie our health system	Build on the Affordable Care Act and expand access to quality, affordable health coverage and care	Engage our partners and the communities we serve throughout the policymaking implementation process	Drive innovation to tack our health system challenges and promote value-based, person-centered care	Protect our programs' sustainability for future generations by serving as a responsible steward of public funds	Foster a positive and inclusive workplace, workforce, and promote excellence in aspects of CMS' operations

Priorities

Priority 1: Expand the Collection, Reporting, and Analysis of Standardized Data

Priority 2: Assess Causes of Disparities Within CMS Programs and Address Inequities in Policies and Operations to Close Gaps

Priority 3: Build Capacity of Health Care Organizations and the Workforce to Reduce Health and Health Care Disparities

Priority 4: Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services

Priority 5: Increase All Forms of Accessibility to Health Care Services and Coverage

Hospital Commitment to Health Equity

Hospitals must attest to activities in five domains:

- Strategic Planning
- Data Collection
- Data Analysis
- Quality Improvement
- Leadership Engagement

*Hospitals must include all elements and activities for successful implementation

DOMAIN 1:

STRATEGIC PLANNING

Strategic Plan Elements:

1. Priority populations
2. Health care equity goals and action plans
3. Dedicated resources
4. Engagement approach

- **Prepare by identifying needs to improve equity**
- **Tie equity into your organization's strategic plan and department level goals**
- **Sustain the plan by demonstrating senior leader ownership and commitment to improving health equity**

DOMAIN 2 & 3:

DATA COLLECTION & ANALYSIS

Data Collection Activities:

1. Data collection itself
2. Staff training
3. Leveraging EHR
4. Stratify key performance indicators by demographic and/or SDOH variables to identify equity gaps and create a performance dashboard

- **Engage senior leadership**
- **Build data collection into quality improvement initiatives**
- **Review, revise and refine processes over time**
- **Communicate to staff and patients why and how the data will be used**

DOMAIN 4:

QUALITY IMPROVEMENT

Partnership Opportunities:

1. Nursing Homes
2. Clinicians
3. Communities
4. Public Health / State Leaders

- **Participate in local, regional, or national quality improvement activities focused on reducing health disparities**

DOMAIN 5:

LEADERSHIP ENGAGEMENT

Engagement Activities:

1. Annual review of strategic plan by senior leadership including hospital board

- **Annual review of key performance indicators stratified by demographic and/or social factors by senior leadership**

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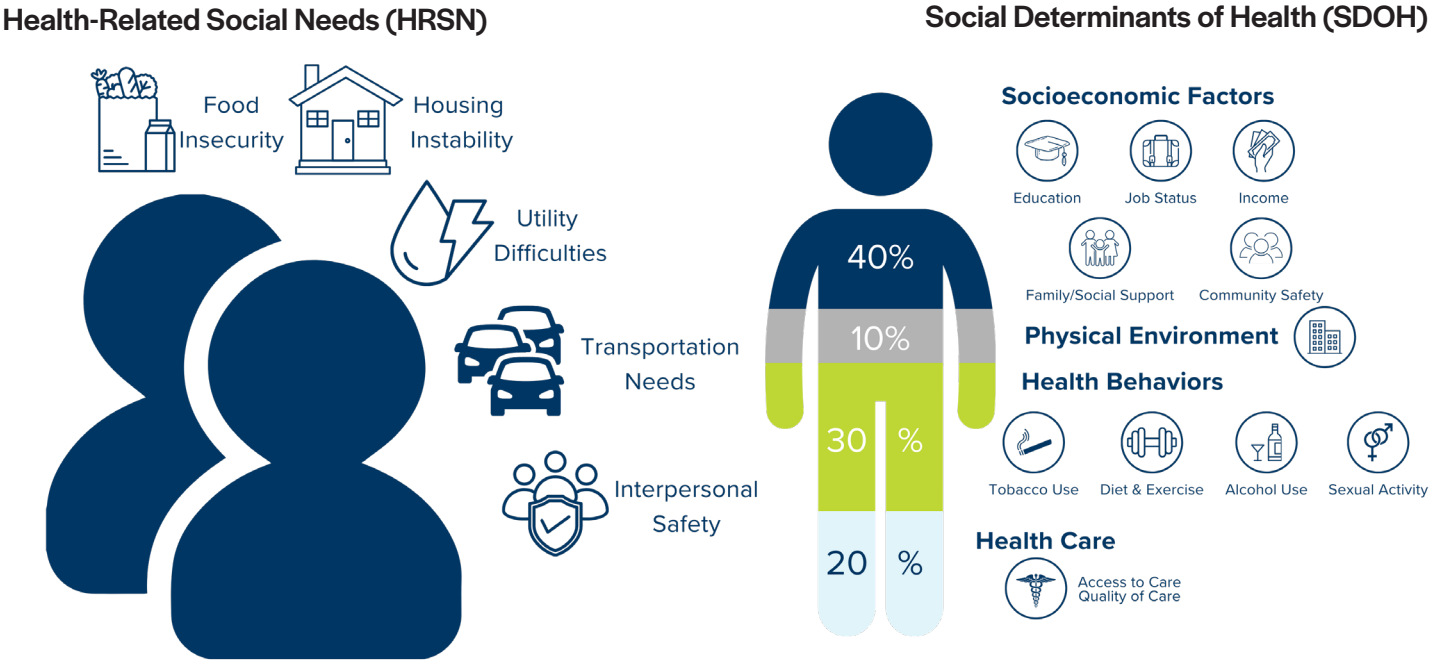
Screening for

SOCIAL DRIVERS OF HEALTH



Inpatient Quality Reporting Program

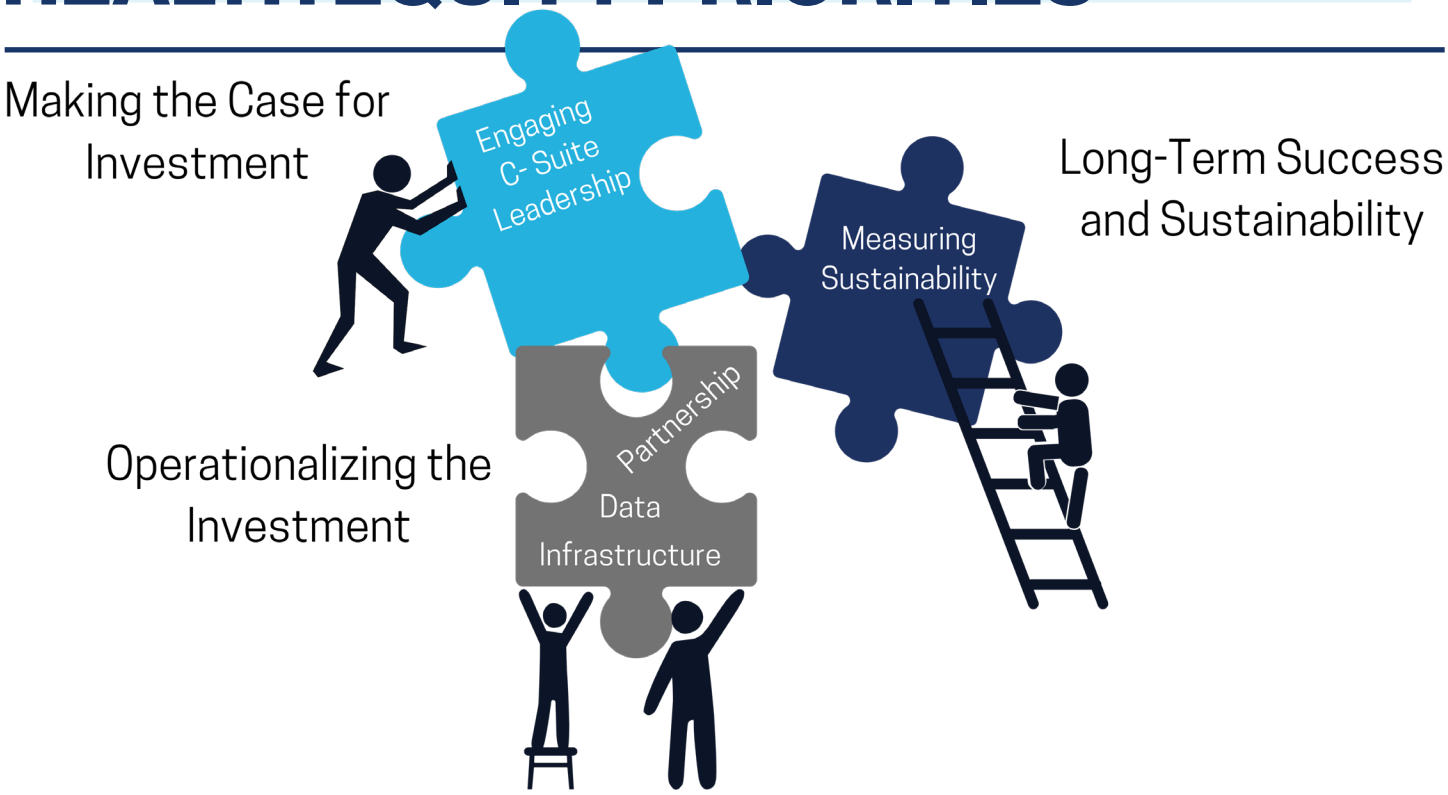
Requirement	Method of Measurement	Timeline
Hospital Commitment to Health Equity (HCHE)	Five Domains (Yes/No)	CY 2023 Reporting Period
Screening for Social Drivers of Health (SDOH-1)	# of screens for HRSNs / # of inpatients	Voluntary CY 2023 Reporting Mandatory CY 2024 Reporing
Screen Positive for Social Drivers (SDOH-2)	# of positive screens for HRSNs / # of screens	

- Report Annually
- Data will be publicly reported
- Exclusions include: patient declines or unable to answer

BUILDING YOUR EQUITY BUSINESS CASE

BUILDING A BUSINESS CASE FOR

HEALTH EQUITY PRIORITIES



1.	**Making the Case for Investment:** What rationale and/or messages resonate with C-Suite leadership and governing bodies who are integral to approving the operational commitment and investments in long-term efforts? What internal culture change investments are necessary to make health equity efforts succeed?
2.	**Operationalizing the Investment:** **Fostering a Culture of Partnership:** What strategies can organizations employ to establish a culture that prioritizes building trust with patients and family/caregivers, and fostering partnerships both within an institution and with the community? How can organizations ensure patients are respected, included, and valued? **Building Data Capabilities:** What are the operational challenges to collecting patient-level data? How can data best be collected, used, reported, and shared? How do data collection requirements for Joint Commission, NCQA, and other accrediting bodies affect the need for data exchange capabilities? **Creating the Infrastructure:** What are the operational steps necessary to design and implement programs and models that address health equity gaps both within the health system and in the broader community? What structures – staffing, training, engagement with the community, data infrastructure etc. – are necessary to make these efforts succeed?
3.	**Long-Term Success and Sustainability:** How can support – both via a dedicated team, and consistent funding - be established in a sustainable way, given the long-time horizon that health equity efforts require to create noticeable improvements? What role does progress measurement play in sustainability, and what are tools for assessing progress?

7 REASONS WHY YOU SHOULD PRIORITIZE EQUITY

1 | Move Beyond the Moral Imperative

Taking steps to make health care more equitable is the right thing to do, but it also makes good business sense. As organizations see that their mission and quality care commitment are synonymous with health equity goals, they will realize that health equity is essential to long-term business success.

2 | Direct and Indirect Cost Savings

Taking steps to make health care more equitable is the right thing to do, but it also makes good business sense. As organizations see that their mission and quality care commitment are synonymous with health equity goals, they will realize that health equity is essential to long-term business success.

3 | Avoiding Future and Opportunity Costs

For health care organizations, the future missed revenue and increased costs due to poor health in the communities they serve are measurable and devastating. These costs go beyond charity care and lost revenue from collection - they speak to the value of a healthier person to the local economy, tax base, philanthropy, and workforce.

4 | Future Value of More Diverse Consumers

When people are supported through health equity and SDOH programs, and they reap the many benefits of improved health, their income can increase, as well as their buying power. Using health equity initiatives to build more positive and trusting relationships with historically marginalized groups is a sound investment in future consumers.

5 | Future Value of Healthier Workforce

Lost productivity and workforce shortages will continue to impact health care organizations. And since health care relies heavily on employees across various populations, economic backgrounds, and education levels, investing in health equity makes sense. Improving health and engagement, as well as preventing diseases, creates a broader and more capable talent pool. For current employees, demonstrated efforts to enhance health equity make a more loyal and productive workforce with less absenteeism and less presenteeism.

6 | Government and Organizational Grants/Funding

Health equity investments also help health care organizations meet quality goals, comply with regulatory requirements, and achieve eligibility for federal and state grants and funding

7 | Market Value and Mindshare in the Community

Health equity efforts can build or rebuild trust with historically marginalized people who have undergone harmful and racist treatment and experienced poor health outcomes from health care systems. Acknowledging, engaging, and addressing key health issues prioritized by people in the community can create measurable value in goodwill, positive sentiment, and loyalty. Data gathered from CAHPS and other satisfaction and engagement surveys provide movement in beliefs and attitudes over time. Results indicate greater trust translates into patient and member retention and growth.

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COSTS RELATED TO HEALTH INEQUITIES

Health disparities caused by health inequities cost the US billions each year. The National Vital Statistics Report estimates that disparity-related direct medical care expenses cost **$230 billion** annually. Actuarial analysis of high-cost diseases puts that estimate at **$320 billion** a year. Providing equitable care—or ensuring that all individuals receive the tools and resources they need to achieve health and well-being, regardless of gender, ethnicity, geography, or socioeconomic status—could save the nation upwards of **$1 trillion** per year.

MEASURING SUCCESS

STRATEGY	MEASURE	REPORTING
Mitigate Bias	Readmission for Diabetes	Acute Care
Mitigate Bias	Rates of corticosteroid prescriptions for asthma patients	Specialty
Mitigate Bias	Readmissions for mental health disorders	Specialty
Mitigate Bias	Severe maternal morbidity	Specialty
Mitigate Bias	Attendance for outpatient appointments	Specialty
Mitigate Bias	Staff perception survey	All
Mitigate Bias	Diversity of staff	All
Mitigate Bias	Community perception survey	All
Address Social Needs	Use of standardized tool to assess SDOH	All
Address Social Needs	Increasing use of Z-codes	All
Ensure Accountability	Hospital progress toward implementation	All
Ensure Accountability	Hospitals reporting framework	All

SDOH IMPLEMENTATION WORKBOOK

- FOOD INSECURITY
- TRANSPORTATION
- HOUSING INSTABILITY
- INTERPERSONAL SAFETY
- UTILITY NEEDS

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DRIVING EQUITABLE WORK IN NEBRASKA RELATED TO

FOOD INSECURITY

Screening

- ☐ The food that we bought just didn't last, and we didn't have money to get more. We couldn't afford to eat balanced meals.
- ☐ In the last 12 months, did you or other adults in your household ever cut the size of your meals or skip meals because there wasn't enough money for food?
- ☐ In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?
- ☐ In the last 12 months, were you ever hungry but didn't eat because there wasn't enough money for food?
- ☐ Within the past 12 months, we worried whether our food would run out before we got money to buy more.
- ☐ Within the past 12 months, the food we bought just didn't last and we didn't have money to get more.

Documentation

- Documentation can be completed by any licensed professinal:
  - Nursing
  - Social Services
  - Provider
- Ensure that documentation occurs in a consistent manner. Same questions documented in the same place.
- Any positive answer to pre-determined questions allow for Z-Code to be dropped.

Z-Codes to Consider

Z59.4: Lack of Adequate Food
Z59.41: Food Insecurity
Z59.5: Extreme Poverty
Z59.6: Low Income

Potential Action Steps

SHORT TERM

- Invest in food systems such as food banks, local emergency food services, food shelters and food pantries
- Partner with local farmers markets and grocery stores
- Partner with schools and community organizations
- Develop strategic and financial plans to include food insecurity

LONG TERM

- Advocate to inform public policy on the health effects of food insecurity

Why is this Important?

Food insecurity limits people from consuming a balanced diet, increasing their risk for chronic conditions and mental illness. This may lead to obesity, diabetes, malnutrition and can increase the risk of hypertension, asthma, tooth decay, anemia, infection, depression, anxiety, stress, and starvation. Many people with food insecurity suffer from health care issues that increase their expenses for medical care.

DETERMINANTS	ISSUE	EXAMPLES
Socio-Economic Factors	▪ Inability to afford healthy foods due to poverty, lack of education and employment	▪ Maximized calorie consumption due to purchasing high-calorie, often lower cost food items ▪ Malnutrition
Physical Environment	▪ Lack of access to grocery stores and farmers markets with fresh, healthy, and shelf-stable foods ▪ Difficulty getting to grocery stores due to lack of transportation or unsafe neighborhoods	▪ Limited consumption of fresh, healthy foods ▪ Unhealthy diet that can lead to chronic diseases
Clinical Care	▪ Inability to access health insurance ▪ High costs of health care leading to financial trade-offs ▪ High cost of healthy foods ▪ Lack of adherence to provider recommendations ▪ Irregular eating habits and limited intake of food	▪ High risk of chronic diseases like diabetes, and obesity in some age groups ▪ Difficulty self-managing chronic diseases such as diabetes, obesity, HIV, etc. ▪ Increase in health care costs due to hospital readmissions and medical treatments ▪ Developmental delays in children ▪ Inability to learn and focus, whether in school or at work ▪ Increased stress levels and behavioral health issues

Source HRET 2017

Mapping it Out

SCREENING TOOL	SCREENING QUESTIONS	LOINC CODES
US Household Food Security Survey	The food we bought just didn't last and we didn't have money to get more. We couldn't afford to eat balanced meals. In the last 12 months, did you ever cut the size of your meals or skip meals because there wasn't enough money for food? In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food? In the last 12 months, were you ever hungry but didn't eat because there wasn't enough money for food?	**95361-2** 88123-5 95248-1 95249-9 95251-5 95252-3
Hunger Vital Sign	We worried whether food would run out before we got money to buy more. The food we bought just didn't last, and we didn't have money to get more.	**88121-9** 88122-7 88123-5
Safe Environment for Every Kid Parent Questionnaire	In the past 12 months, did you worry that your food would run out before you could buy more? In the past 12 months, did the food you bought just not last and you didn't have money to get more?	**95403-2** 95400-8 95399-2

DRIVING EQUITABLE WORK IN NEBRASKA RELATED TO

TRANSPORTATION

Screening

- In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?
- Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?
- Do you put off or neglect going to the doctor because of distance or transportation?
- In the last 12 months, have you ever had to go without health care because you didn't have a way to get there?
- Do you have trouble finding or paying for a ride?
- Tell us about your transportation/mobility.

Documentation

- Documentation can be completed by any licensed professinal:
  - Nursing
  - Social Services
  - Provider
- Ensure that documentation occurs in a consistent manner. Same questions documented in the same place.
- Any positive answer to pre-determined questions allow for Z-Code to be dropped.

Z-Codes to Consider

Z59.64: Unable to Pay for Transportation
Z59.82: Transportation Insecurity
Z59.5: Extreme Poverty
Z59.6: Low Income

Potential Action Steps

SHORT TERM

- Provide transportation services through community partnerships
- Establish volunteer driver programs
- Provide travel vouchers for patients
- Provide telehealth services
- Offer onsite pharmacy and other services to reduce needs for travel

LONG TERM

- Invest in transit systems to improve health
- Establish mobile health clinics

Why is this Important?

Transportation and other social determinants of health are interrelated and play a major role in a person's health and well-being. For example, lack of transportation to grocery stores is one of many causes of food insecurity. Physical environmental attributes such as limited transportation options or food deserts can contribute to limited consumption of fresh, healthy foods. Transportation to and from work, school, recreation and other activities can have an impact on an individual's social support, education, employment, housing and health behaviors. Barriers to transportation and lack of transportation options can interfere with people enjoying a healthier, higher quality of life. People depend on safe and easy transportation to travel to health care services as well as places of employment, childcare, places of worship, parks and recreation, social gatherings and more.

Building a Business Case

ISSUE	EXAMPLES
Missed Appointments	Patients frequently identify transportation barriers as a major reason for missing health care appointments. Missed appointments are associated with increased medical care costs for the patient, disruption of patient care and provider-patient relationships, delayed care and increased ED visits. Missed appointments and the resulting delays in care cost the health system $150 billion each year in the US. When a patient is unable to find or afford a ride, costs accrue for patients, caregivers, providers, insurers and taxpayers. health care systems lose revenue from missed appointments because of the effects on delivery, cost of care, and resource planning.
Decreased Pharmacy Access and Prescription Fills	Patients are less likely to fill prescriptions if they experience transportation issues. According to one study, 65% of patients said transportation assistance would help with prescription fills after discharge. Studies have shown that restriction of Medicaid payments for transportation resulted in decreased prescription refills.
Economic Barriers	Transportation is linked to economic mobility. Approximately 80% of workers drive or ride in a car to work. Research has shown that disruption or barriers to transportation negatively affects productivity and employment and causes health inequities. Multimodal transportation systems offering a combination of affordable, high-quality vehicular, public, or alternative transportation options support community economic development, health care utilization, and promote health behaviors such as exercise.

Source HRET 2017

Mapping it Out

SCREENING TOOL	SCREENING QUESTIONS	LOINC CODES
Accountable Health Communities (AHC) Health-Related Social Needs Screening (HRSN) Tool	In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?	**96777-8** 93030-5
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)	Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?	**93025-5** 93030-5
American Academy of Family Physicians Social Needs Screening Tool- Short Form	Do you put off or neglect going to the doctor because of distance or transportation?	**99595-1** 99594-4
Health Leads Screening Panel	In the last 12 months, have you ever had to go without health care because you didn't have a way to get there?	**99549-8** 99553-0
WellRx Questionnaire	Do you have trouble finding or paying for a ride?	**93667-4** 93671-6
Outcome and Assessment Information Set (OASIS) Form	Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?	**99160-4** 101351-5
Comprehensive Universal Behavior Health Screen (CUBS)	Tell us about your transportation/mobility.	**89556-5** 89569-8

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DRIVING EQUITABLE WORK IN NEBRASKA RELATED TO

HOUSING INSTABILITY

Screening

What is your living situation today?

- I have a steady place to live
- I have a place to live today, but I am worried about losing it in the future
- I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, in a car, abandoned building, bus or train station, or in a park)

Think about the place you live. Do you have problems with any of the following?

- Pests such as bugs, ants, or mice
- Mold
- Lead paint or pipes
- Lack of heat
- Oven or stove not working
- Smoke detectors missing or not working
- Water leaks
- None of the above

Documentation

- Documentation can be completed by any licensed professinal:
  - Nursing
  - Social Services
  - Provider
- Ensure that documentation occurs in a consistent manner. Same questions documented in the same place.
- Any positive answer to pre-determined questions allow for Z-Code to be dropped.

Z-Codes to Consider

Z59.0: Homelessness
Z59.1: Inadequate Housing
Z59.5: Extreme Poverty
Z60.2: Problems Related to Living Alone

Potential Action Steps

SHORT TERM

- Know shelters in your area (for rural entities – look regionally)
- Have a transportation plan to get the patient to the shelter as needed
- Build relationships with churches and other community resources to assist in an emergent situation

LONG TERM

- Housing Projects
- Grant Funds

Why is this Important?

Housing instability is an umbrella term for the continuum between homelessness and a totally stable, secure housing situation. Housing instability takes many forms: physical conditions like poor sanitation, heating and cooling; compromised structural integrity; exposure to allergens or pests; homelessness; and unstable access to housing or severe rent burden. Studies show that individuals experiencing housing instability have limited access to preventive health care compared to stably housed people, are more likely to delay filling prescriptions and are less likely to adhere to treatment plans. These trends may be a matter of competing priorities.

About 44 percent of Nebraskan households are "housing insecure". This means that over 30 percent of these households incomes are being spent on housing-related expenses. Lincoln alone is facing a looming shortage of 17,000 housing units by 2030.

HOUSING ISSUE	EXAMPLES	RELATED HEALTH CONDITIONS
Homelessness	▪ Total lack of shelter ▪ Residence in transitional or emergency shelters	▪ Increased rates of chronic and infectious conditions (e.g., diabetes, asthma, COPD and tuberculosis) ▪ Mental health issues, including depression and elevated stress ▪ Developmental delays in children
Lack of Affordable Housing	▪ Severe rent burden ▪ Overcrowding ▪ Eviction or foreclosure ▪ Frequent moves	▪ Stress, depression and anxiety disorders ▪ Poor self-reported health ▪ Delayed or diminished access to medications and medical care
Poor Housing Conditions	▪ Structural issues ▪ Allergens like mold, asbestos or pests ▪ Chemical exposures ▪ Leaks or problems with insulation, heating and cooling	▪ Asthma or other respiratory issues ▪ Allergic reactions ▪ Lead poisoning, harm to brain development ▪ Other chemical or carcinogenic exposures ▪ Falls and other injuries due to structural issues

Source HRET 2017

Mapping it Out

SCREENING TOOL	SCREENING QUESTIONS	LOINC CODES
Accountable Health Communities (AHC) Health-Related Social Needs Screening (HRSN) Tool	What is your living situation today? Think about the place you live. Do you have problems with any of the following? Pests, mold, lead paint or pipes, lack of heat, oven or stove not working, smoke detectors missing or not working, water leaks, or none of the above.	**96777-8** 71802-3 96778-6
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)	How many family members, including yourself, do you currently live with? What is your housing situation today? Are you worried about losing your housing?	**93025-5** 63512-8 71802-3 93033-9
American Academy of Family Physicians Social Needs Screening Tool- Short Form	What is your housing situation today? Think about the place you live. Do you have problems with any of the following? Pests such as bugs, ants, or mice, mold, lead paint or pipes, lack of heat, oven or stove not working, smoke detectors missing or not working, water leaks or none of the above.	**99595-1** 71802-3 96778-6
American Academy of Family Physicians Social Needs Screening Tool- Long Form	Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as part of a household? Think about the place you live. Do you have problems with any of the following? Pests such as bugs, ants, or mice, mold, lead paint or pipes, lack of heat, oven or stove not working, smoke detectors missing or not working, water leaks or none of the above.	**99593-6** 99550-6 96778-6
Children's Health Watch Housing Stability Vital Signs	In the past 12 months, was there a time when you were not able to pay the mortgage or rent on time? In the past 12 months, how many times have you moved where you were living? At any time in the past 12 months, were you homeless or living in a shelter?	**98975-6** 98976-4 98977-2 98978-0
WellRx Questionnaire	Are you homeless or worried that you might be in the future?	**93667-4** 93669-0
Healthy Leads Screening Panel	Are you worried that in the next 2 months, you may not have stable housing?	**99549-8** 99550-6

DRIVING EQUITABLE WORK IN NEBRASKA RELATED TO

INTERPERSONAL SAFETY

Screening

Because violence and abuse happens to a lot of people and affects their health we are asking you the following questions.

- How often does anyone, including family and friends, physically hurt you?
- How often does anyone, including family and friends, insult or talk down to you?
- How often does anyone, including family and fiends, threaten you with harm?
- How often does anyone, including family and friends, scream or curse at you?

Never (1) Rarely (2) Sometimes (3) Fairly Often (4) Frequently (5)

A score of 11 or more when the numerical values for answers above are added shows that the person might not be safe.

Documentation

- Documentation can be completed by any licensed professinal:
  - Nursing
  - Social Services
  - Provider
- Ensure that documentation occurs in a consistent manner. Same questions documented in the same place.
- Any positive answer to pre-determined questions allow for Z-Code to be dropped.

Z-Codes to Consider

Z60.2: Problems Related to Living Alone
Z60.4: Social Exclusion and Rejection
Z63.0: Problems in Relationship with Spouse or other Family Member
Z63.4: Disappearance and Death of a Family Member
Z63.72: Alcoholism or Drug Addiction in the Family

Potential Action Steps

SHORT TERM

- Partner with local domestic violence providers
- Provide training to all employees who interact with patients on the basics for how to identify safety issues
- Explore different professional organizations that can provide support to your community

LONG TERM

- Create an interdisciplinary medical-law partnership to allow health care providers immediate referrals

NHA | NEBRASKA HOSPITALS

Why is this Important?

Interpersonal, domestic, and family violence is a pervasive issue that affects people across many socioeconomic, cultural, and community demographics. Medical practitioners play an important role in identifying and addressing domestic and family violence, often treating patients who are hesitant or afraid to disclose incidents for fear of escalation, legal involvement, or financial distress.

Building a Business Case

Prioritizing Safety and Support	
Safety	Ensuring the safety of patients experiencing abuse and violence should be the primary focus for health care professionals
Comprehensive Systems	Health practitioners should establish systems that encompass the entire practice, providing referral pathways to guide patients toward recovery and safety
Addressing Attitudes and Assumptions	Training programs should encompass health care professionals' attitudes and assumptions about abuse and violence, as these factors can significantly impact the response to patients
Determining Appropriate Levels of Involvement and Intervention	
Identification and Validation	Health care professionals should proactively ask patients displaying clinical indicators of the mental and physical effects of abuse about their experiences. Patients disclosing abuse should be provided with first-line support, including active listening, validation of their experiences, and enhancing their safety
Safety and Risk Assessment	While expressing concern for a patient's safety and likelihood of risk is crucial, it is equally important to respect patient autonomy in deciding the most suitable pathway to safety
Mandatory Reporting	Health care practitioners are considered mandatory reporters and are required by law to report suspected child abuse and neglect to government authorities
Counseling and Support	Intimate partner abuse often coexists with mental health issues. Health care professionals should ensure a comprehensive understanding of interpersonal violence and employ counseling approaches tailored to meet each patient's specific needs. Careful planning is necessary during separation to ensure the safety of women and their children
Collaborative Intervention	Health care practitioners should view themselves as part of a wider support network, collaborating with domestic violence services, legal professionals, police, and housing agencies to effectively assist survivors

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Mapping it Out

SCREENING TOOL	SCREENING QUESTIONS	LOINC CODES
Accountable Health Communities (AHC) Health-Related Social Needs Screening (HRSN) Tool	How often does anyone, including family and friends, physically hurt you? How often does anyone, including family and friends, insult or talk down to you? How often does anyone, including family and friends, threaten you with harm? How often does anyone, including family and friends, scream or curse at you? Safety total score	**96777-8** 95617-7 95616-9 95615-1 95614-4
American Academy of Family Physicians Social Needs Screening Tool	Hurts, insults, threatens, and screams (HITS) How often does anyone, including family, physically hurt you? How often does anyone, including family, insult or talk down do you? How often does anyone, including family, threaten you with harm? How often does anyone, including family, scream or curse at you? Total score (HITS)	**99595-1** 95618-5 95617-7 95616-9 95615-1 95614-4
WellRx Questionnaire	Are you concerned about someone in your home using drugs or alcohol? Do you feel unsafe in your daily life? Is anyone in your home threatening or abusing you?	**93667-4** 93676-5 93682-3 93683-1

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DRIVING EQUITABLE WORK IN NEBRASKA RELATED TO

UTILITY NEEDS

Screening

- In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
- Do you have trouble paying for your gas or electricity bills?
- Do you have any concerns about your current living situation, like housing conditions, safety, and costs?

Documentation

- Documentation can be completed by any licensed professinal:
  - Nursing
  - Social Services
  - Provider
- Ensure that documentation occurs in a consistent manner. Same questions documented in the same place.
- Any positive answer to pre-determined questions allow for Z-Code to be dropped.

Z-Codes to Consider

Z59.5: Extreme Poverty
Z59.6: Low Income
Z59.86: Financial Insecurity
Z59.11: Inadequate Housing Environmental Temperature
Z59.12: Inadequate Housing Utilities
Z59.89: Other Problems Related to Housing and Economic Circumstances
Z59.9: Problems Related to Housing and Economic Circumstances

Potential Action Steps

SHORT TERM

- Connect patients with local support systems such as:
  - Low Income Home Energy Assistance Program (LIHEAP)
  - Low Income Household Water Assistance Program (LIHWAP)
  - Catholic Social Services
  - Community Action Partnership

LONG TERM

- Partner with your local Benefits Enrollment Center

Why is this Important?

M any Americans are struggling to afford the cost of heating and cooling their home. Now, with inflation at a 40-year high, budgets are squeezed even tighter. This burden is especially painful in the peak winter and summer months, when energy costs can eat up nearly 30% of a low-income household's monthly income. These soaring costs have resulted in roughly 20% of US households being late on a utility bill in the last month—or missing a payment altogether. Multiple studies have established the links between energy insecurity and adverse outcomes in mental health, respiratory health, thermal stress, sleep quality, and child health. Families suffering from energy insecurity have significant risks related to developmental concerns for children living in those homes.

Mapping it Out

SCREENING TOOL	SCREENING QUESTIONS	LOINC CODES
Accountable Health Communities (AHC) Health-Related Social Needs Screening (HRSN) Tool	In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home?	**96777-8** 96779-4
WellRx Questionnaire	Do you have trouble paying for your gas or electricity bills?	**93667-4** 93670-8

SDOH Z-CODE LIST

SOCIAL DETERMINANTS OF HEALTH

Z-CODE LIST

*Bold indicates Nebraska priority Z-code

Z55 - Problems Related to Education and Literacy

Z55.0 Illiteracy and low-level literacy
Z55.1 Schooling unavailable and unattainable
Z55.2 Failed school examinations
Z55.3 Underachievement in school
Z55.4 Educational maladjustment and discord with teachers and classmates
Z55.5 Less than a high school diploma
Z55.6 Problems related to health literacy
Z55.8 Other problems related to education and literacy
Z55.9 Problems related to education and literacy, unspecifiedZ60.9 Problems related to social environment, unspecified

Z56 - Problems Related to Employment/Unemployment

Z56.0 Unemployment, unspecified
Z56.1 Change of job
Z56.2 Threat of job loss
Z56.3 Stressful work schedule
Z56.4 Discord with boss and workmates
Z56.5 Uncongenial work environment
Z56.6 Other physical and mental strain related to work
Z56.81 Sexual harassment on the job
Z56.82 Military deployment status
Z56.89 Other problems related to employment
Z56.9 Unspecified problems related to employment

Z57 - Occupational Exposure to Risk Factors

Z57.0 Occupational exposure to noise
Z57.1 Occupational exposure to radiation
Z57.2 Occupational exposure to dust
Z57.31 Occupational exposure to environmental tobacco smoke
Z57.39 Occupational exposure to other air contaminants
Z57.4 Occupational exposure to toxic agents in agriculture
Z57.5 Occupational exposure to toxic agents in other industries
Z57.6 Occupational exposure to extreme temperature
Z57.7 Occupational exposure to vibration
Z57.8 Occupational exposure to other risk factors
Z57.9 Occupational exposure to unspecified risk factors

SOCIAL DETERMINANTS OF HEALTH

Z-CODE LIST

*Bold indicates Nebraska priority Z-code

Z58 - Problems Related to Physical Environment

Z60.0 Problems of adjustment to life-cycle transitions
Z60.2 Problems related to living alone
Z60.3 Acculturation difficulty
Z60.4 Social exclusion and rejection
Z60.5 Target of (perceived) adverse discrimination and persecution
Z60.8 Other problems related to social environment

Z59 - Problems Related to Housing, Transportation, and Economic Circumstances

Z59.00 Homelessness, unspecified
Z59.01 Sheltered homelessness
Z59.02 Unsheltered homelessness
Z59.1 Inadequate housing
Z59.10 Inadequate housing, unspecified
Z59.11 Inadequate housing environmental temperature
Z59.12 Inadequate housing utilities
Z59.19 Other inadequate housing
Z59.2 Discord with neighbors, lodgers, and landlord
Z59.3 Problems related to living in residential institution
Z59.4 Lack of adequate food
Z59.41 Food insecurity
Z59.48 Other specified lack of adequate food
Z59.5 Extreme poverty
Z59.6 Low income
Z59.61 Unable to pay for prescriptions
Z59.63 Unable to pay for medical care
Z59.64 Unable to pay for transportation
Z59.7 Insufficient social insurance and welfare support
Z59.8 Other problems related to housing and economic circumstances
Z59.81 Housing instability, housed
Z59.811 Housing instability, housed, with risk of homelessness
Z59.812 Housing instability, housing, homelessness in past 12 months
Z59.819 Housing instability, housed unspecified
Z59.82 Transportation insecurity
Z59.86 Financial insecurity
Z59.87 Material hardship due to limited financial resources, not elsewhere classified
Z59.89 Other problems related to housing and economic circumstances
Z59.9 Problems related to housing and economic circumstances

SOCIAL DETERMINANTS OF HEALTH

Z-CODE LIST

*Bold indicates Nebraska priority Z-code

Z60 - Problems Related to Social Environment

Z60.0 Problems of adjustment to life-cycle transitions
Z60.2 Problems related to living alone
Z60.3 Acculturation difficulty
Z60.4 Social exclusion and rejection
Z60.5 Target of (perceived) adverse discrimination and persecution
Z60.8 Other problems related to social environment

Z62 - Problems Related to Upbringing

Z62.0 Inadequate parental supervision and control
Z62.1 Parental overprotection
Z62.2 Upbringing away from parents
Z62.21 Child in welfare custody
Z62.23 Child in custody of non-parental relative
Z62.24 Child in custody of non-relative guardian
Z62.29 Other upbringing away from parents
Z62.3 Hostility towards and scapegoating of child
Z62.6 Inappropriate (excessive) parental pressure
Z62.8 Other specified problems related to upbringing
Z62.81 Personal history of abuse in childhood
Z62.810 Personal history of physical and sexual abuse in childhood
Z62.811 Personal history of psychological abuse in childhood
Z62.812 Personal history of neglect in childhood
Z62.813 Personal history of forced labor or sexual exploitation in childhood
Z62.814 Personal history of child financial abuse
Z62.815 Personal history of intimate partner abuse in childhood
Z62.819 Personal history of unspecified abuse in childhood
Z62.82 Parent-child conflict
Z62.820 Parent-biological child conflict
Z62.821 Parent-adopted child conflict
Z62.822 Parent-foster child conflict
Z62.823 Parent-step child conflict
Z62.83 Non-parental relative or guardian-child conflict
Z62.831 Non-parental relative-child conflict
Z62.832 Non-relative guardian-child conflict
Z62.822 Group home staff-child conflict

SOCIAL DETERMINANTS OF HEALTH

Z-CODE LIST

*Bold indicates Nebraska priority Z-code

Z62 - Problems Related to Upbringing (cont.)

Z62.89 Other specified problems related to upbringing
Z62.890 Parent-child estrangement NEC (not elsewhere classifiable)
Z62.891 Sibling rivalry
Z62.892 Runaway (from current living environment)
Z62.898 Other specified problems related to upbringing
Z62.9 Problem related to upbringing, unspecified

Z63 - Other Problems Related to Primary Support Group, Including Family Circumstances

Z63.0 Problems in relationship with spouse or partner
Z63.1 Problems in relationship with in-laws
Z63.31 Absence of family member due to military deployment
Z63.32 Other absence of family member
Z63.4 Disappearance and death of family member
Z63.5 Disruption of family by separation and divorce
Z63.6 Dependent relative needing care at home
Z63.71 Stress on family due to return of family member from military
Z63.72 Alcoholism and drug addiction in family
Z63.79 Other stressful life events affecting family and household
Z63.8 Other specified problems related to primary support group
Z63.9 Problem related to primary support group, unspecified

Z64 - Problems Related to Certain Psychosocial Circumstances

Z64.0 Problems related to unwanted pregnancy
Z64.1 Problems related to multiparity
Z64.4 Discord with counselors

Z91 - Personal Risk Factors, Not Elsewhere Classified

Z91.1 Patient's noncompliance with medical treatment and regimen
Z91.4 Personal history of psychological trauma, not elsewhere classified
Z91.5 Personal history of self-harm
Z91.8 Other specified personal risk factors, not elsewhere classified
Z91.A Caregiver's noncompliance with patient's medical treatment and regimen

REAL/AGE DATA & SOCIAL DETERMINANTS OF HEALTH

REaL/Age Data & Social Determinants of Health

EQUITY DATA GAP ANALYSIS

To best address and identify areas of health care disparity, Social Determinants of Health (SDOH) Screening Information, REaL (Race, Ethnicity, and Language), and Age Data have proven to be increasingly important for all hospitals. Health care leaders have noted significant barriers to collecting this data such as Electronic Health Records systems, data collection process, and staff training, which can lead to the information being inaccurately reported or not collected at all.

Complete the gap analysis to assess SDOH and REaL/Age Data Collection in your organization. The tool focuses on three identified areas of potential concern within the data collection process:

Metric	Assess	Interventions
Electronic Health Record (EHR)	☐ Do we currently collect SDOH/REaL/Age data within the EHR? ☐ Where do we document SDOH/REaL/Age data within the system? ☐ What is the complexity of finding the SDOH/REaL/Age data assessment? ☐ Are any aspects of SDOH/REaL/Age data a hard stop (required) data point? ☐ Does our EHR allow for adequate data collection (ex. Are we missing applicable ethnicities that we serve?)?	☐ Require hard stops on all SDOH/REaL/Age Data requirements ☐ Have SDOH/REaL/Age Data requirements easily found and documentable within the system

Staff Training / Education	☐ Does our staff understand why we collect SDOH/REaL/Age data?
	☐ Does our staff understand the definitions of ethnicity, race, and nationality?
	☐ What concerns do our staff have with asking these questions? How do we fix these concerns?
	☐ Does our staff understand which SDOH measures are screened, and why?
		☐ Provide education and training to all staff.
		☐ Examples include:
		  ☐ Social Determinants of Health Virtual Expedition Modules by American Hospital Association at: https://www.aha.org/physicians/SDOH
		  ☐ Foundations of Health Equity Training Plan by CDC at: https://www.cdc.gov/healthequity/training/index.html
		☐ Consider Scripting (see examples below)
		☐ Role play and script training
		☐ Provide follow-up education (quarterly and as needed). Consider education at pre-set facility meetings (Nursing, Managers, Quality, etc.)

Data Collect Process	☐ Who is collecting this data from the patients? ☐ What do we do after hours?	☐ Set standard person(s) to collect data ☐ Consider Scripting (see examples below)

Metric	Assess	Interventions
Data Review Process	☐ Are we reviewing our data? Who and how often? ☐ What is our follow up process with individual staff who are not collecting data or asking the patients these questions?	☐ Use NHA generated quarterly scorecards ☐ Use EHR generated SDOH/REaL/Age data reports ☐ Make data review a standing agenda item in applicable meetings (quality)

REaL/Age Data Sample Scripting

Metric	Question Suggestion
Conversation Starters	▪ "I'm going to ask you some questions about your background. We ask these questions so we can provide the best care to every patient."
Language	▪ "In what language would you prefer to communicate with the medical team?"
Race	▪ "Is there a racial group you identify with?"
Ethnicity	▪ "What ethnic background do you identify with?" ▪ If they don't understand ask, "Where is your family from?"
Hispanic	▪ "Do you identify as Hispanic or Latino?"

SDOH Data Sample Scripting

- "Many times, our patients come to us with needs beyond just medical, for example, housing, food, and transportation. While we don't help with those directly, we do have partners in the community who can help, and we would like to link you with them. Would you mind if I ask you a few questions to see if there are resources I can share?"

OR

- "At [insert name], we believe that basic needs influence a patient's overall health. We would like to begin to screen patients for different types of basic needs so that we can help connect them with resources to assist them with these needs. For some needs, we may not be able to connect patients with resources to assist them, but we would like to identify community needs that we need to create resources for as well."

OR

- "As part of your visit today we'd like to help with other resources to help you/your family maintain your health. Some examples of these include food, housing, utility assistance, and transportation. Could we ask you a few questions to see if you have any needs in these areas?"

Example screening questions are from the Michigan Department of Health and Human Services.

Putting It All Together, Next Steps:

Each facility offers unique services, has differing staffing models, and manages differing patient volumes. Each has an individual way of delivering the best care to our patients. When working through the SDOH/REaL/Age Data and process steps to consider, whether implementing for the first time or re-evaluating the current process(es) include:

- Create a team.
- Some team members to consider include:
  - Nursing
  - Admissions
  - Billing/Coding
  - Social Services/Care Management
  - Informatics/IT
- Some processes and areas to consider:
  - Patient Care
  - EHR (documentation process)
  - Follow Up Process
  - Data Analysis
- Complete the NHA Gap Analysis and identify areas of opportunity
- Assemble your team to discuss priority areas, create an action plan, and assign responsibility
- Use the PDSA model to create and implement process improvement plans
- Use the resources included within the document along with others to drive actionable work
- Follow up with data review of EHR-generated reports and the quarterly NHA scorecard

REaL/AGE Data & Social Determinats of Health Resources

- **Z-Codes Associated with Social Determinants of Health**

Completing the SDOH screening is the first step to creating more equitable care. It is important to use the data to drive change. This comes from ensuring complete and accurate documentation of the social determinants followed by data analysis and resource referrals. Data can best be tracked across the state, region and nation using Z-Codes. Many SDOH needs can be attached to a Z-Code that will allow for better data analysis.

Below are links from the Center Medicare and Medicaid Services, the Nebraska Hospital Association, and the American Hospital Association that discuss coding social determinant codes and give the z codes specific for documentation.

- https://www.cms.gov/files/document/cms-2023-omh-z-code-resource.pdf
- https://www.cms.gov/files/document/zcodes-infographic.pdf
- https://www.aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf
- https://www.nebraskahospitals.org/file_download/inline/f49871dc-29ed-4970-90a7-7a1afc094475

Other Resources for SDOH/ REaL/Age Data

- There are several resources available online when looking for best practices, evidence-based practices, and interventions for SDOH/ REaL/Age Data. Below are just a few of the many sites that discuss these topics:
- **SDOH**
  - https://www.nebraskahospitals.org/file_download/inline/f49871dc-29ed-4970-90a7-7a1afc094475
  - https://www.cdc.gov/about/priorities/why-is-addressing-sdoh-important.html
  - https://health.gov/healthypeople/priority-areas/social-determinants-health
- **REaL Data/Age Data**
  - https://www.aha.org/topics/race-ethnicity-and-language-REaL-data
  - https://www.cms.gov/about-cms/agency-information/omh/downloads/data-collection-resources.pdf

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American Hospital Association (2024). Social determinants of health virtual expedition modules. Retrieved from: https://www.aha.org/physicians/SDOH

Center for Disease Control and Prevention. (2024). Foundations of health equity training plan. Retrieved from: https://www.cdc.gov/healthequity/training/index.html

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Center Medicare and Medicaid Services.(2024). Using Z codes. Retrieved from: https://www.cms.gov/files/document/zcodes-infographic.pdf

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CONNECTING WITH NEBRASKA MEDICAID MANAGED CARE ORGANIZATIONS

Key Contacts at Molina

Main Nebraska Office | 1471 W Center Road Suite 104, Omaha, NE 68144
Member One Stop Resource Center | 3301 Harney Street, Omaha, NE 68131
Member Services | 844-781-2018 (TTY: 711)
Behavioral Health Crisis Line | 844-782-2721 (TTY: 711)
24-Hour Nurse Line | 844-782-2721 (TTY: 711)
Care and Case Management Referrals | ne_cm@molinahealthcare.com

Molina Member Website

Contents of the website allow members to access:

- Important phone numbers
- Member handbook
- Finding a provider
- Value added benefits
- Requesting an ID card
- Pharmacy information
- Resources
- Information on member rights and responsibilities, grievance and appeals, fraud prevention, and quality improvement programs

Molina Provider Website

Contents of the website allow providers to access:

- Code look-up tool
- Peer-to-Peer scheduling tool
- Important updates/communications
- How to join the network | Welcome to Molina Healthcare, Inc - ePortal
- Provider materials
- Claims and authorization information
- Health resources

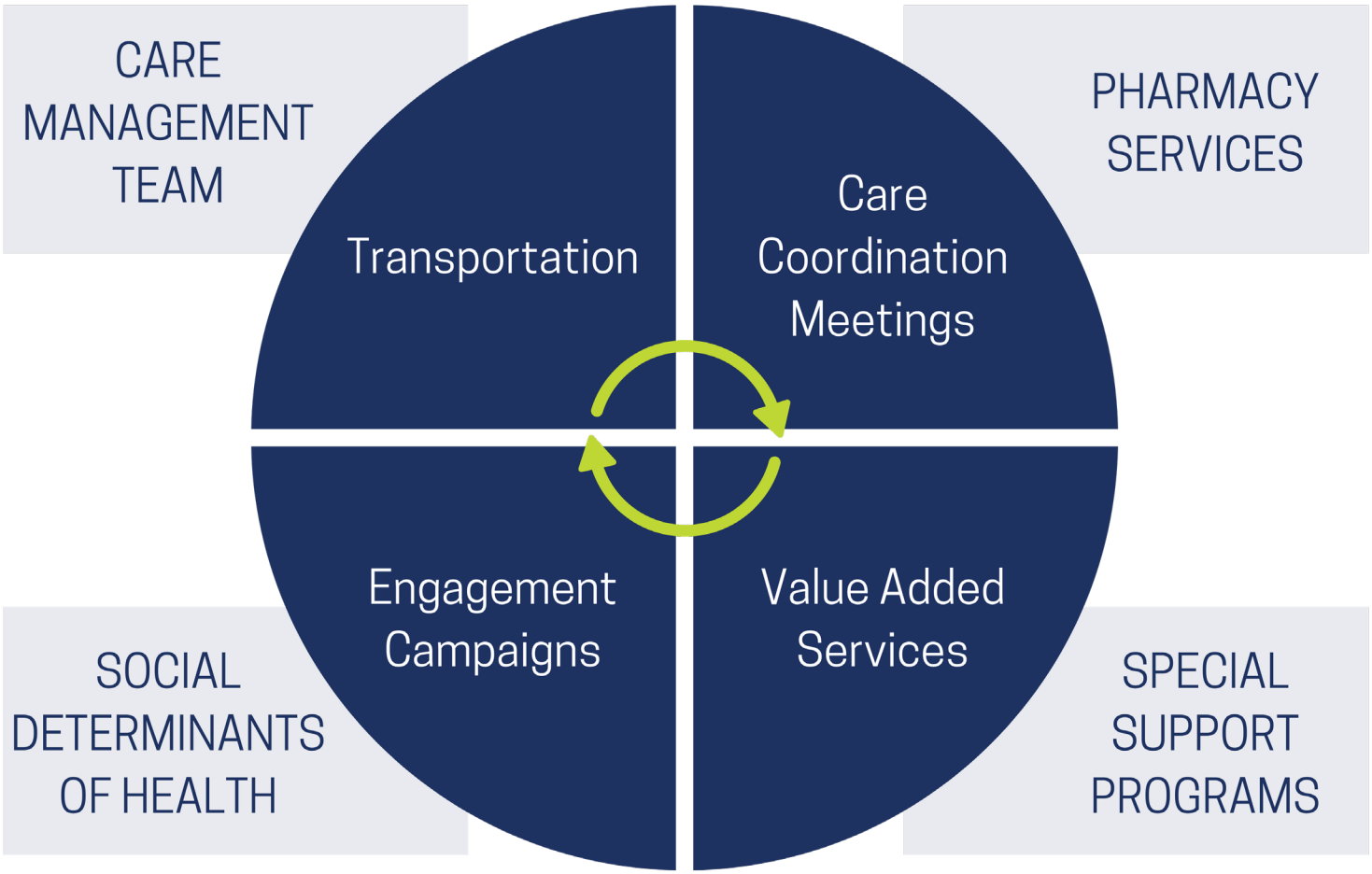
Post-Acute Support

Care Management	For members with lower health care needs, especially those with Social Determinant of Health (SDOH) needs.
Case Management	For members with complex health care and SDOH needs Specialty Support Personnel Offered: ▪ Substance Use Disorder (SUD) Navigator ▪ Child Behavioral Health Specialist ▪ Home and Community Based Service (HCBS) Waiver Liaison ▪ Community Health Workers located across the state ▪ Omaha, Lincoln, Lexington, Inman, Belgrade, Gering, and Hasting ▪ Employment Specialist ▪ Housing Specialist ▪ Justice Liaison ▪ Rural Health Specialist ▪ Dental Coordinator
Care Connections	Team of Molina Nurse Practitioners and Social Workers to provide wellness and preventive services to members ▪ Review documentation and diagnoses - focus on closing gaps in care, including SDOH needs ▪ Offer POC testing with education ▪ Coordinates care with member and PCP ▪ Considered an additional access point for health care needs

Transitions of Care Model	Targets patients with complex care needs
	▪ Implemented when a member moves from one health care setting to another
	▪ Follows patients for 4 weeks
	▪ Interventions conducted by a clinician include:
	  ▪ Hospital/SNF pre-discharge intervention
	  ▪ One home contact two days after discharge
	  ▪ Two (at minimum) additional follow-up home contacts

How to Connect	
Website	www.nebraskatotalcare.com
Website Information for Members	▪ Find a doctor, hospital, pharmacy or specialist ▪ Access secure member portal ▪ Access your Member Handbook ▪ Discover value-added benefits ▪ Education and resources
Website Information for Providers	▪ Provider Portal to verify member eligibility, manage authorizations and claims and view your patient list ▪ Code check/Prior authorization check ▪ Provider news and events ▪ Information on contracting and credentialing ▪ Links to pharmacy, quality assessments and performance ▪ improvement, practice guidelines for medical and behavioral and more
Phone	844-386-2192 (TYY 711)
E-Mail for Members	Secure Member Portal allows members to email Nebraska Total Care https://www.nebraskatotalcare.com/login.html
Contracting & Credentialing	Email: providerrelations@nebraskatotalcare.com Website: https://www.nebraskatotalcare.com/providers/provider-relations.html
Provider Relations	Email: providerrelations@nebraskatotalcare.com Website: https://www.nebraskatotalcare.com/providers/provider-relations.html
Make a Referral	Make a referral to Care Management by phone: 844-386-2192 (TTY 711) or in the provider portal https://www.nebraskatotalcare.com/login.html
Care Management Services and Supports	
Care Management Team	RNs, Social Workers, Mental Health Therapists, PT/OT/ST, Pharmacy, Program Specialists, Community Health Workers, and Doctors.
Care Plans	Individualized to support members in achieving health goals and assist with care coordination. Care plans are provided to the Primary Care Provider for collaboration.
Care Conferences	Care Conferences available with Care Management Team to facilitate member and provider needs.
Transitions of Care Program	Support members transitioning to lower levels of care (Behavioral Health and Physical Health).
Face to Face Visits	Routine, in-person rounding on members and providers in the hospital, NICUs, Homeless Shelters and in the members home to facilitate care coordination and SDoH needs.
Care Manage-ment Delivery	Care Management supports members physical health, behavioral health, social needs, dental, vision and hearing health needs. It is offered in person, telephonically and digitally.
SDoH Support	Care Management team assesses individual member needs. We also use predicive modeling to understand who may be at risk for adverse health outcomes as it relates to SDoH needs. NTC supports members by connecting them to resources and education.
Specialized Teams	Care Management has specialized teams with expertise in: Transition of Care, Foster Care, Housing, Transplants, Pregnancy, Alcohol and Substance Use Disorder, Non-Medical Drivers of Health (SDoH), Sickle Cell, Behavioral Health (including suicide prevention) and Physical Health.

Care Management Services and Supports	
Transportation	Non-Emergency Medical Transportation Company MTM Phone: 844-261-7834 Nebraska Total Care Member Services 1-844-385-2192 (TTY 711)
Comprehensive Pharmacy Services	90-day prescription fill on maintenance medications for chronic, long-term conditions or illnesses, medication reviews, vaccination program
Value-Added Benefits	NTC offers many value added benefits to members. A complete list can be found here: https://www.nebraskatotalcare.com/members/medicaid/benefits-services/value-add-services.html



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UnitedHealthcare Community Plan

United Healthcare Community Plan - Member Services	
UHCCommunityPlan.com/NE	Current member plan information: ▪ Sample Member ID Cards ▪ Dental Plans ▪ Provider Directories ▪ Vision Plans
Member Services	Assists members with social needs by calling **800-641-1902 (TTY 711)**: ▪ Food, Transportation, Housing ▪ DME ▪ Medical Services ▪ Dental Care ▪ Behavioral Services ▪ Vision Needs ▪ Pharmacy /Medication Assistance
Available 7 a.m. - 7 p.m. CT, Monday - Friday **Members can request to connect with a case manager through Member Services**	

Connect Providers with UHC Support Services for Patients

Clinicians can connect with UHC's support services when a patient is in need via e-mail, NE_CM@uhc.com.

- Mailbox is checked twice a day
- Needs are immediately assigned and addressed
- Please include member information:
  - Name
  - D.O.B.
  - Description of Need(s)
  - Medicaid ID
  - Contact Number

Provider Services Model	
Self-Serices	▪ Access the self-service options available 24 hours a day at the Provider Portal, UHCprovider.com. ▪ Use Integrated Voice Response (IVR) telephone system for self-service information at **866-331-2243**.
Provider Services Represenatives	Call Customer Care at **866-331-2243** to speak with a Provider Representative.
Access Click to Chat	Chat Now: Support is just a click away at UHCprovider.com/chat.

Additional Behavioral Health Resources

United Group Partner for Individual Behavioral Health Self-Care tool: AbleTo App

- On-Demand help for stress and emotional well-being

Key Contacts at UHC

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