ACOs Advancing Health Equity: Wake Forest Baptist Health

September 2021

Defining Equity and Disparity

Healthy People 2030 defines ***health equity*** as "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities." A ***health disparity*** is "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage."

Social determinants of health (SDOH) are the conditions where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples of SDOH include:

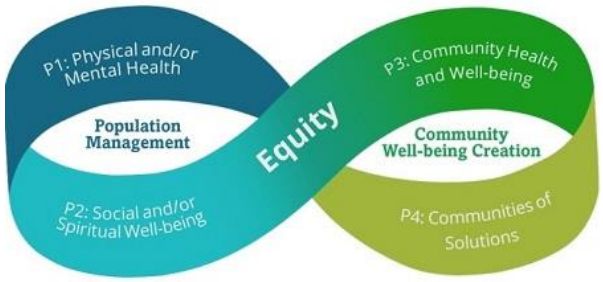
- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

— Adapted from Healthy People 2030

Equity in Social Needs

Health equity begins at home for Wake Forest Baptist Health (WFBH) when employees face food or housing insecurity or other social needs. "There's three main buckets in how we're thinking about our equity work–the first is equity in social needs, and we're doing a lot of that work with our ACO patients, our uninsured, our community members but also our own employees and teammates," said Jennifer Houlihan, vice president for value-based care and population health at WFBH Medical Center. A partner in a Medicare ACO, the Winston-Salem, NC-based system has prioritized investing ACO savings in community-based initiatives to address social needs. WFBH, now part of Atrium Health, also participates in an Institute for Healthcare Improvement collaborative piloting the Pathways to Population Health Framework. "The framework really helps connect the dots in the work we're doing…from on-the-ground what we're doing in population health management with our RN care managers to how that connects all the way to community partners and solutions where we're thinking about bigger issues like housing and food security," Houlihan said. Key strategies include using place-based indicators and mapping to identify neighborhoods where need is concentrated, screening for social needs, and partnering with community-based organizations to connect people to needed services and "closing the loop on referrals."

Pathways to Population Health Framework



Source: Institute for Healthcare Improvement

Equity in Quality and Outcomes

Improving equity by focusing on quality and outcomes is part of the health system's annual performance goals, and collecting better patient demographic data was an important first step. "We're really digging into our demographics in a different way," she said. To improve the accuracy of demographic information, patients have more options to describe their ethnicity, race, gender identity, and other characteristics. In response, the system has increased interpreter services and used improved demographic information to identify and addresses gaps in clinical quality and outcomes across populations, with a special emphasis on high prevalence conditions like diabetes and high blood pressure.

Wake Forest Baptist Health invests almost $15 million a year to address SDOH in local communities.

Equity in Access

Improving access to care is a key element of WFBH's population and community health work to advance equity and eliminate health disparities. A key tenet is identifying a primary care medical home relationship for all patients, both insured and uninsured. To provide a medical home for people who are uninsured or covered by Medicaid, WFBH, in partnership with its affiliated medical school, provides clinicians to staff free community clinics and federally qualified health centers. For high-risk patients, including ACO patients, the system has designed the Care plus program to provide comprehensive screening for food, housing, and transportation needs. These patients also can access longer, more frequent visits and home visits, and care management staff will contact them if they miss appointments to check on them. The system also operates a mobile clinic throughout the Winston-Salem area to bring care to people where they live.

Maya Angelou

Medical School Serves as Resource

The health system also works closely with the medical school, which has developed a health equity curriculum. A recent study found the curriculum was associated with significant improvement in medical students' knowledge and understanding of social determinants and their confidence in working with underserved populations. The medical school also offers a certification program in health equity as part of the internal medicine program. Experts at the medical school's Maya Angelou Center for Health Equity also advise WFBH on community engagement strategies and other community-based initiatives. The center promotes health equity through interdisciplinary community-engaged research, health education and training, health promotion and literacy, and social justice initiatives.

Faith-Based Partnerships

FaithHealthNC is a partnership between faith communities, WFBH Medical Center, and other health care providers focused on improving health. The partnerships combine the strengths of congregations, the clinical expertise of health care providers, and a network of community resources. Across more than 500 congregations and nearly 90,000 members, when illness strikes, volunteers provide support before, during and after hospitalizations. They make home visits, provide emotional and spiritual support, and assess practical needs, including meals, transportation, and help with medications. WFBH provides training for the volunteers on such topics as respecting patients' privacy, hospital visitation, care at the end of life, mental health first aid, and home health care. The partnership focuses on the following principles when supporting people:

- Right Door: Promoting care upstream—reduction in emergency department visits and cost of care by targeted zip code and community health worker caseload.
- Right Time: Encourage people to seek care sooner and do not delay treatment.
- Ready to be Treated/Healed: Ensure people and patients are prepared when arriving to receive health care or community-based services.
- Not Alone: Aligning social networks with patients who are alone in their health care journeys.

Racial Equity Task Force

To ensure health equity work is scaling across the health system, WFBH has formed a racial equity task force and CEO Cabinet of senior leaders tasked with creating and implementing an institutional plan for tangible, sustainable steps for racial equity. Leaders participate in monthly small group learnings about racial equity to help them tailor goals and actions for their departments, teams, or units.