



Lawrence  
General  
Hospital

# Addressing Health Equity in Primary Care

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So good. So caring. So close.

## Objectives

1. Describe projects to initiate SDOH screening and identify health disparities in primary care, done in partnership with commercial payers
2. Share lessons learned and best practices
3. Make the connection between SDOH and patient outcomes
4. Showcase the importance of data analytics in identifying and improving health equity

# Project Support & Partners



Point32Health





# Lawrence General Impact



Lawrence  
General  
Hospital

Highest  
COVID Rate  
Of 351 cities and towns

Very high  
Community Social Vulnerability

## Community



2,200  
Total employees

## Jobs



400  
Physicians on staff



20%  
Living in poverty

Lawrence, Massachusetts  
Largest community  
of color

89% of 90,000  
City residents



350,000  
Patient encounters



65,000  
ER visits



1,000+  
Trauma calls

## Services & Volume



1,500  
Deliveries



Ambulance &  
Regional Paramedic  
Service Provider

Major, High  
Volume Acute  
Care Hospital



186 Beds plus  
41 Bassinets

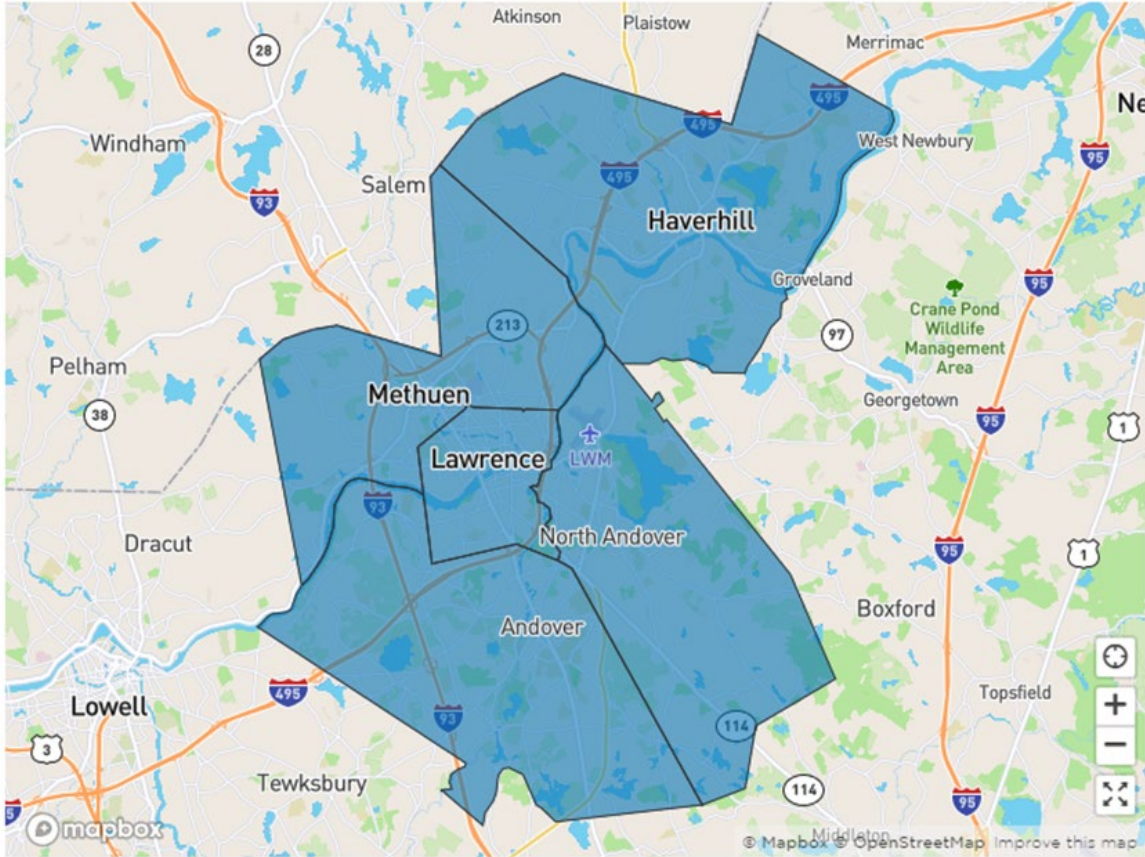


12,000  
Inpatient discharges



# LGH Service Area

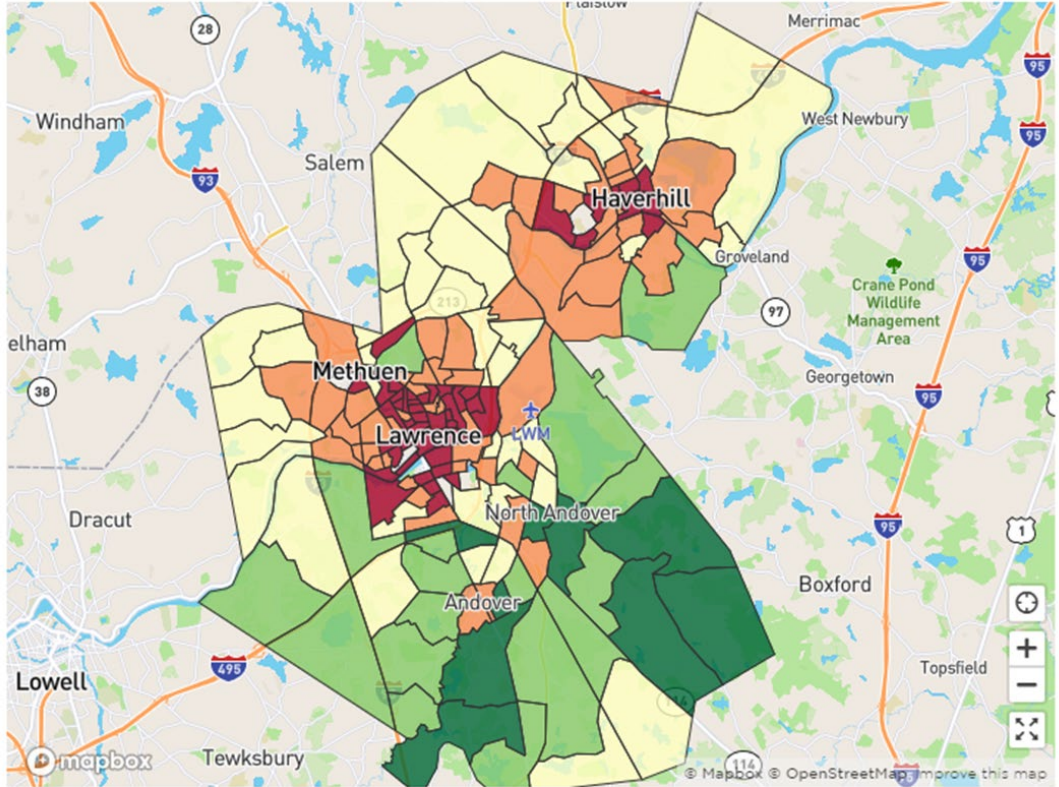
Greater Lawrence



County Subdivisions inside Greater Lawrence

<https://reports.mysidewalk.com/fce4aec136>

Median Household Income

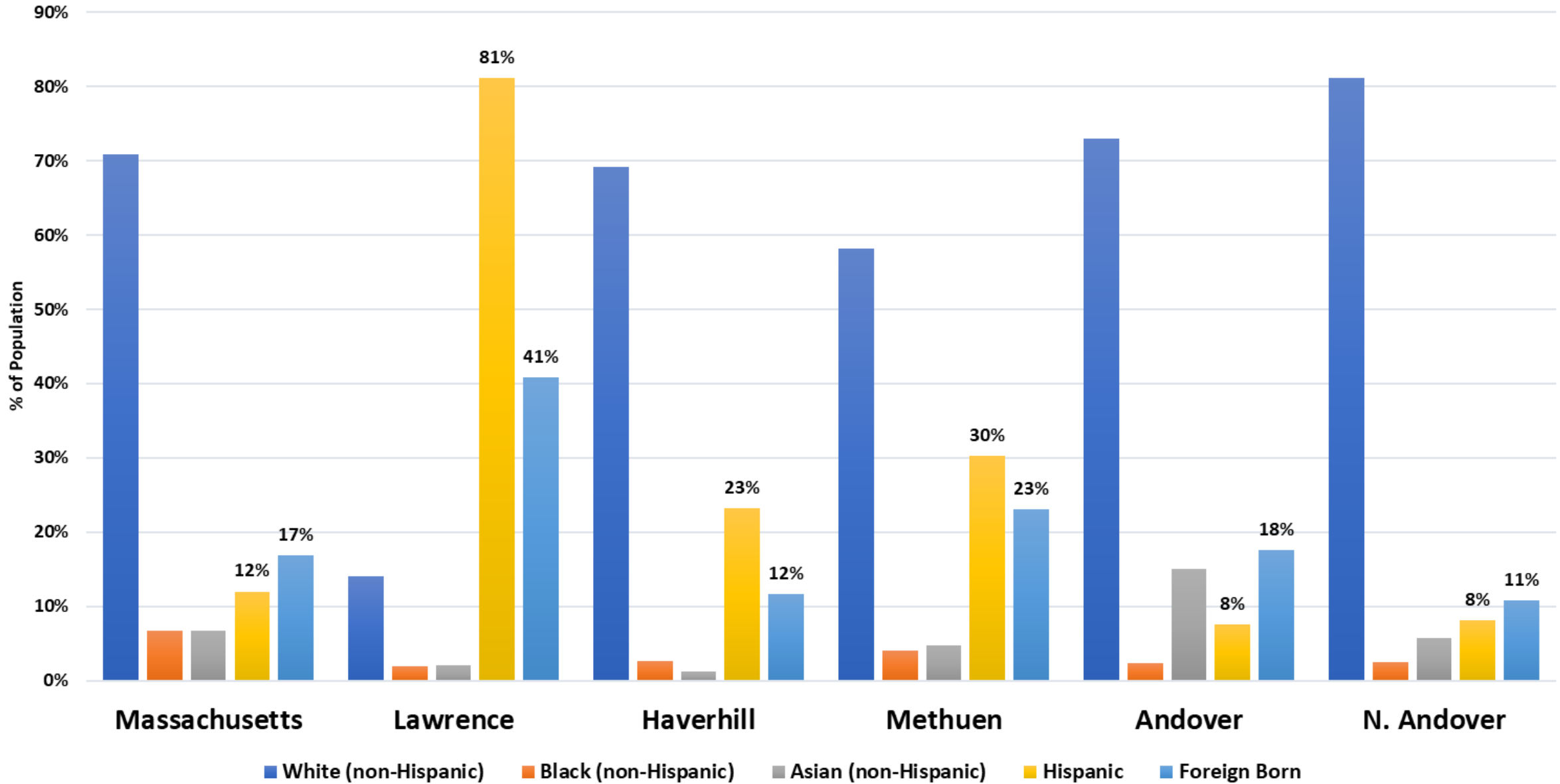


- \$12,156 - \$55,943
- \$55,944 - \$89,999
- \$90,000 - \$133,597
- \$133,598 - \$200,965
- \$200,966 - \$239,375

Data from the LGH 2022 CHNA  
<https://reports.mysidewalk.com/fce4aec136>

Sources: US Census Bureau ACS 5-year 2016-2020

# Race and Hispanic Ethnicity by City/Town



# Lawrence General Hospital's Strategic Pillars

## OUR 5 Es OF EXCELLENCE:

- **Enhance** Community & Patient Perceptions
- **Elevate** Health Equity & DEI
- **Emerge** as Regional Provider & Employer of Choice
- **Establish** Financial Sustainability
- **Enable** Innovation

## OUR VISION:

Become the region's destination community-focused hospital and health system





# DEI/Health Equity Timeline of Accomplishments

## 2020

- Chartered DEI Steering Committee
- **Hired DEI Program Officer**
- Administered employee DEI survey with > 700 responses
- Updated RELD data collection practices at registration
- **Established regional COVID testing site and mobile unit**
- **Embedded DEI/Health Equity in hospital Strategic Plan**
- Initiated organizational DEI assessment
- Established the LGH/GLFHC DEI Advisory Council

## 2021

- **Developed EMR-based Health Equity Dashboard to stratify patient outcomes by RELD**
- **Chartered Board DEI Subcommittee**
- **Offered DEI/HE education to staff** including e-learning and in-person learning opportunities
- DEI added to Daily Safety Huddles
- Partnered with El Mundo to promote COVID vaccines, recruit diverse candidates
- **Developed Multi-Year DEI/Health Equity Plan with annual goals**
- **LGH Joins the Health Equity Compact**

## 2022

- **Achieved > 90% Year 1 DEI/Health Equity goals**
- Approved new DEI policy
- Launched free Community Health Screenings with focus on most vulnerable residents
- **Received ACHE Honorable Mention as leader in DEI/Health Equity**
- Introduced Pocketalk devices to increase linguistic support
- Added option for preferred pronouns to employee badges
- **Completed analysis of MCH Health Equity**
- Awarded Point32Health funding to support SDOH screening in primary care

## 2023

- **Engaged Board in DEI/Health Equity education via MHA and Chartis**
- Elevated Health Equity in new Strategic Plan
- Awarded BCBSMA funding to identify and address disparities in preventative care (e.g. breast cancer screening, disease management)
- **Partnered with DCFI to address disparities in colorectal cancer screening**
- Welcomed 25 local student interns from Top Notch Scholars
- **Increased supplier diversity by contracting with Casabe**, a local woman and minority-owned restaurant, to operate a second location at LGH

### Ongoing staff education and awareness

- E-learning modules in English and Spanish
- DEI/Health Equity at Nursing skills days
- Healthcare Leadership Course
- Medical Grand Rounds
- Conference attendance
- New Hire Orientation
- Power to Heal video showings
- Celebration of a growing list of diverse holidays with staff education and awareness raising activities



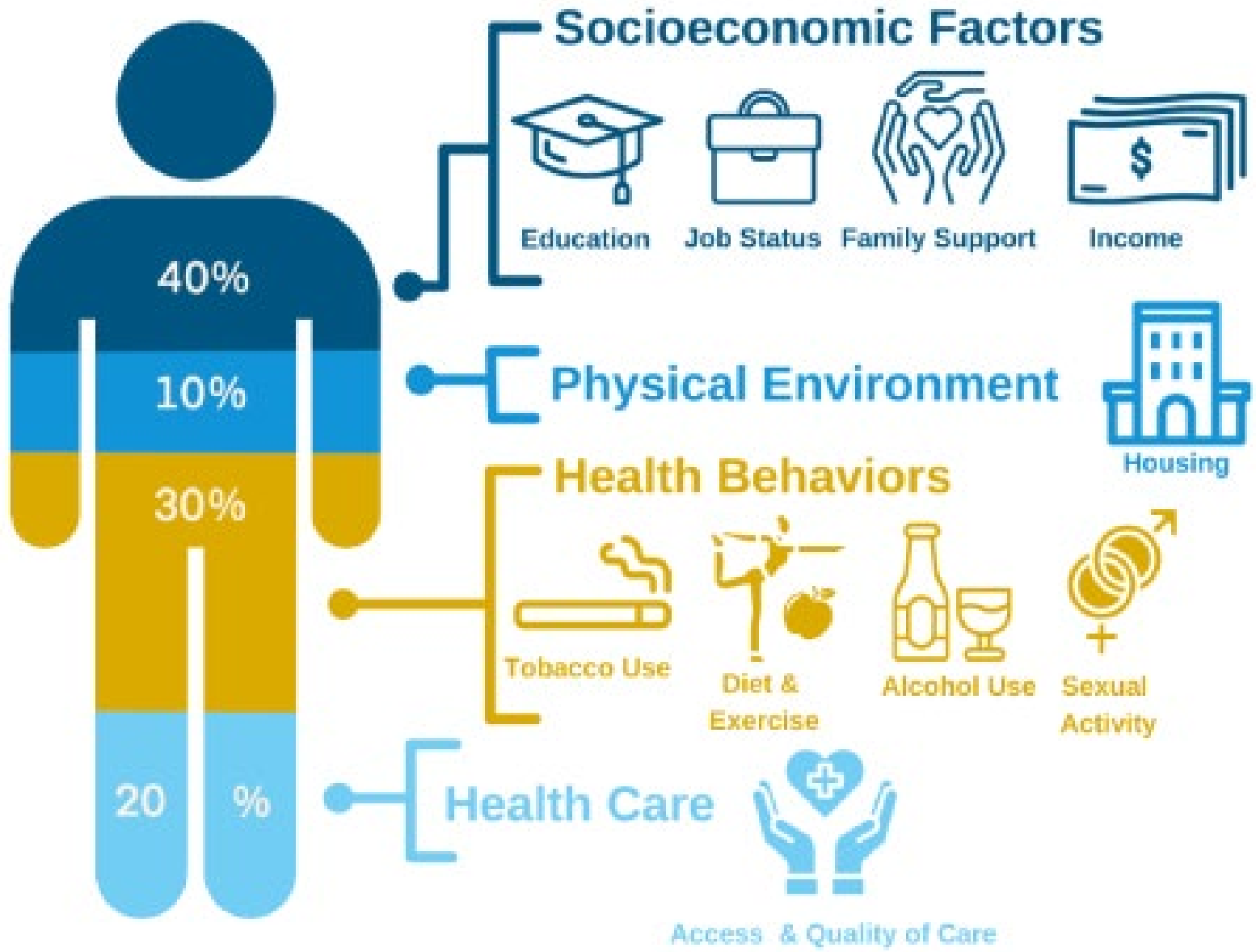
# Community Medical Associates

Welcome To Our  
Primary Care Team!



- Established by LGH in 2011
- 3 MDs, 1 NP
- 3300+ patients
- 6800+ annual visits
- Multilingual staff, providers
- 2 Sites
  - Lawrence MA
  - N. Andover MA

# SDOH Screening in Primary Care



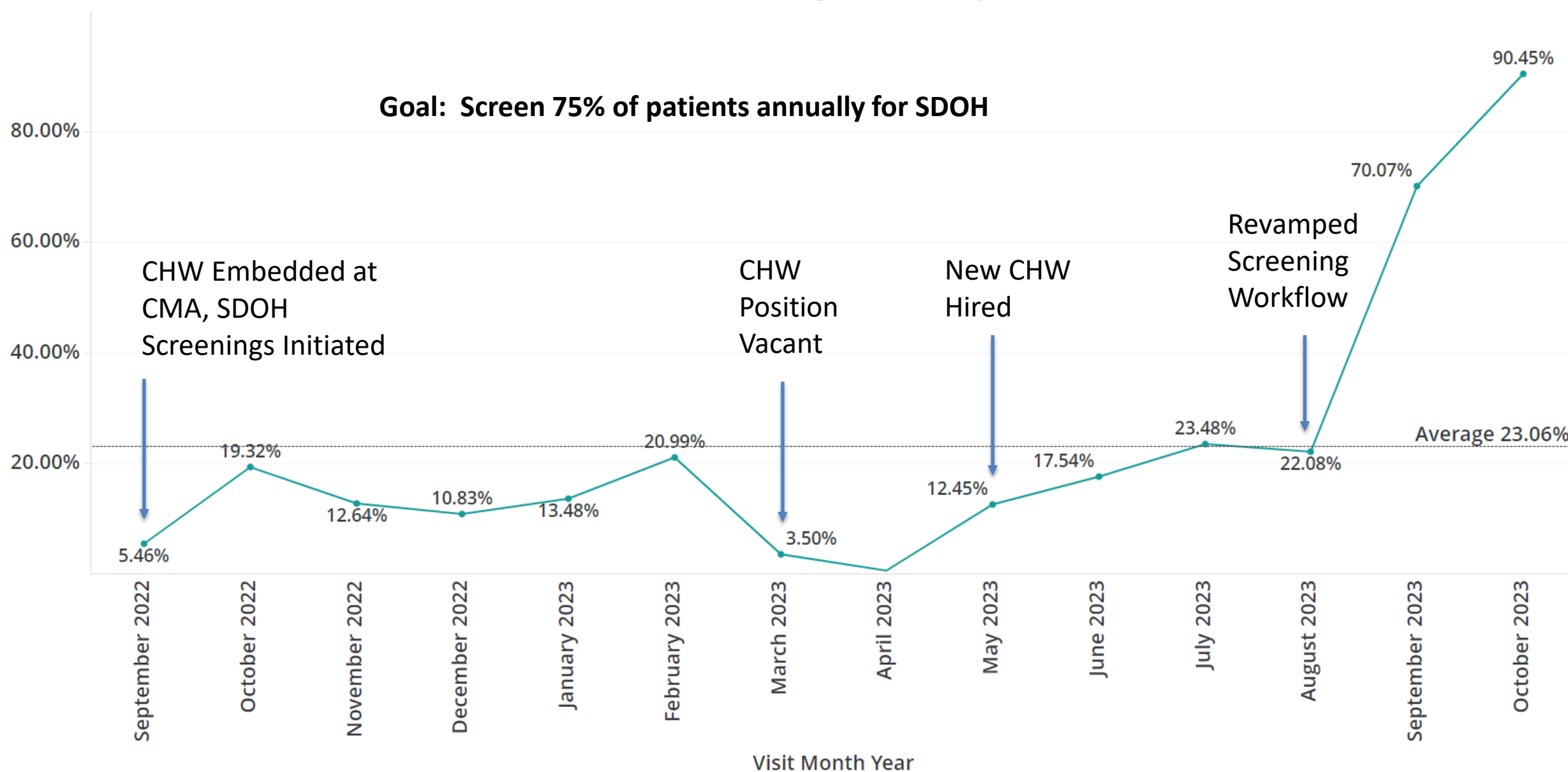
## Project Objectives

- Initiate annual SDOH screening
- Embed CHW to connect patients to services
- Establish SDOH screening as standard care
- Measure impact on health outcomes

# % of New/Annual Visits with SDOH Screening at Community Medical Associates

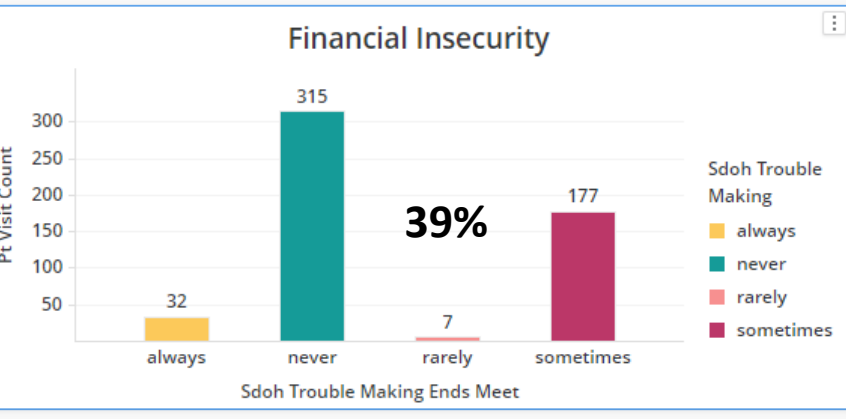
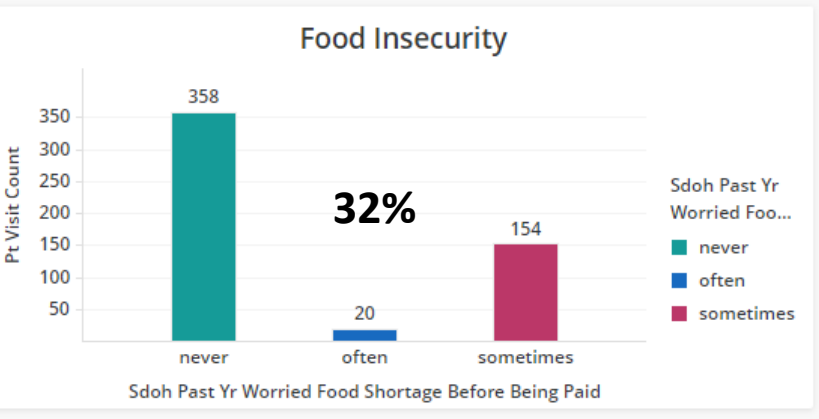
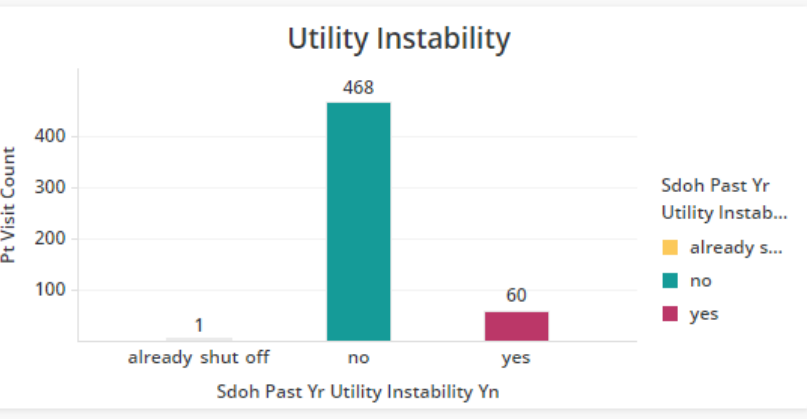
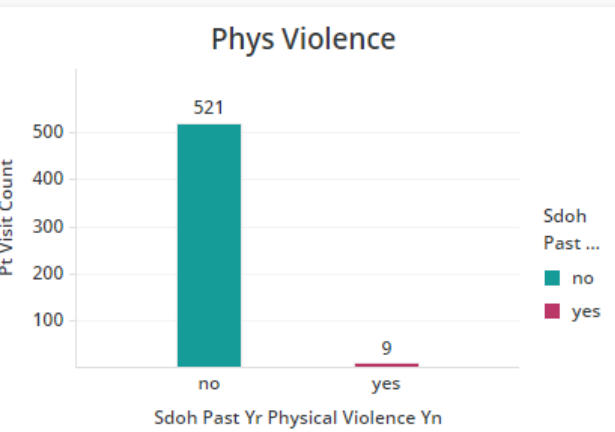
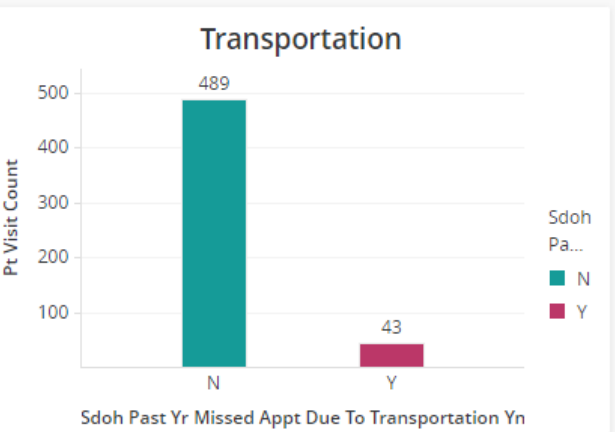
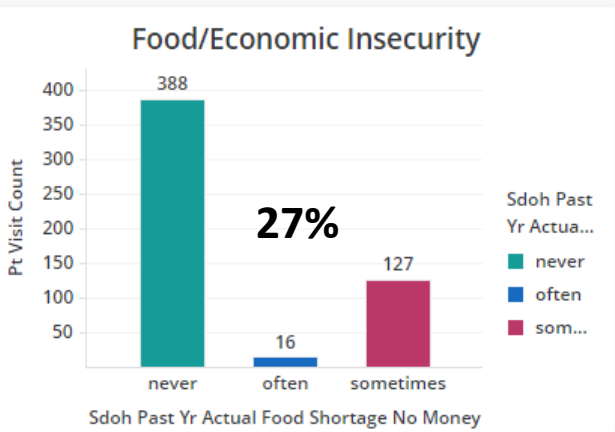
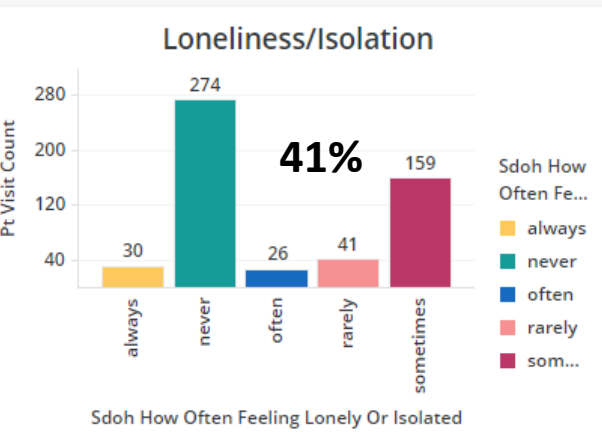
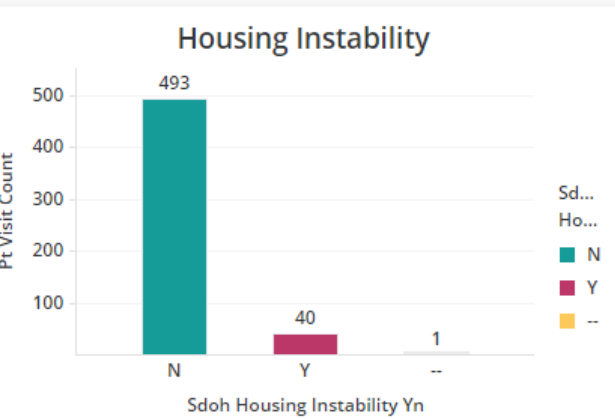
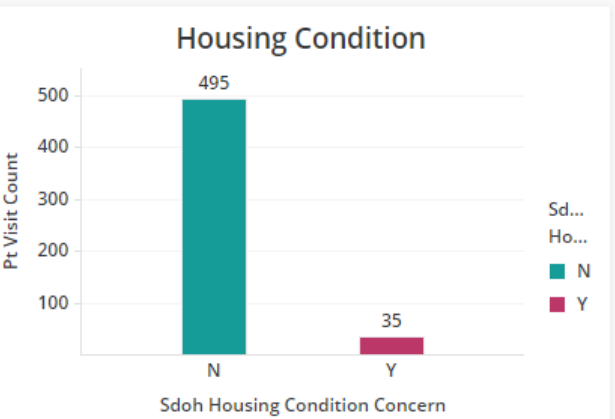
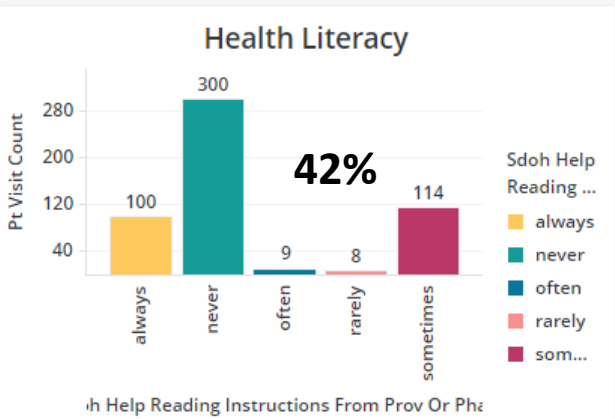
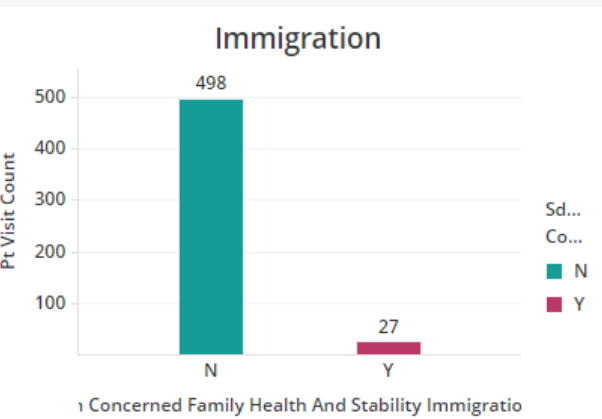
**Goal: Screen 75% of patients annually for SDOH**

% of Visits Screened for SDOH



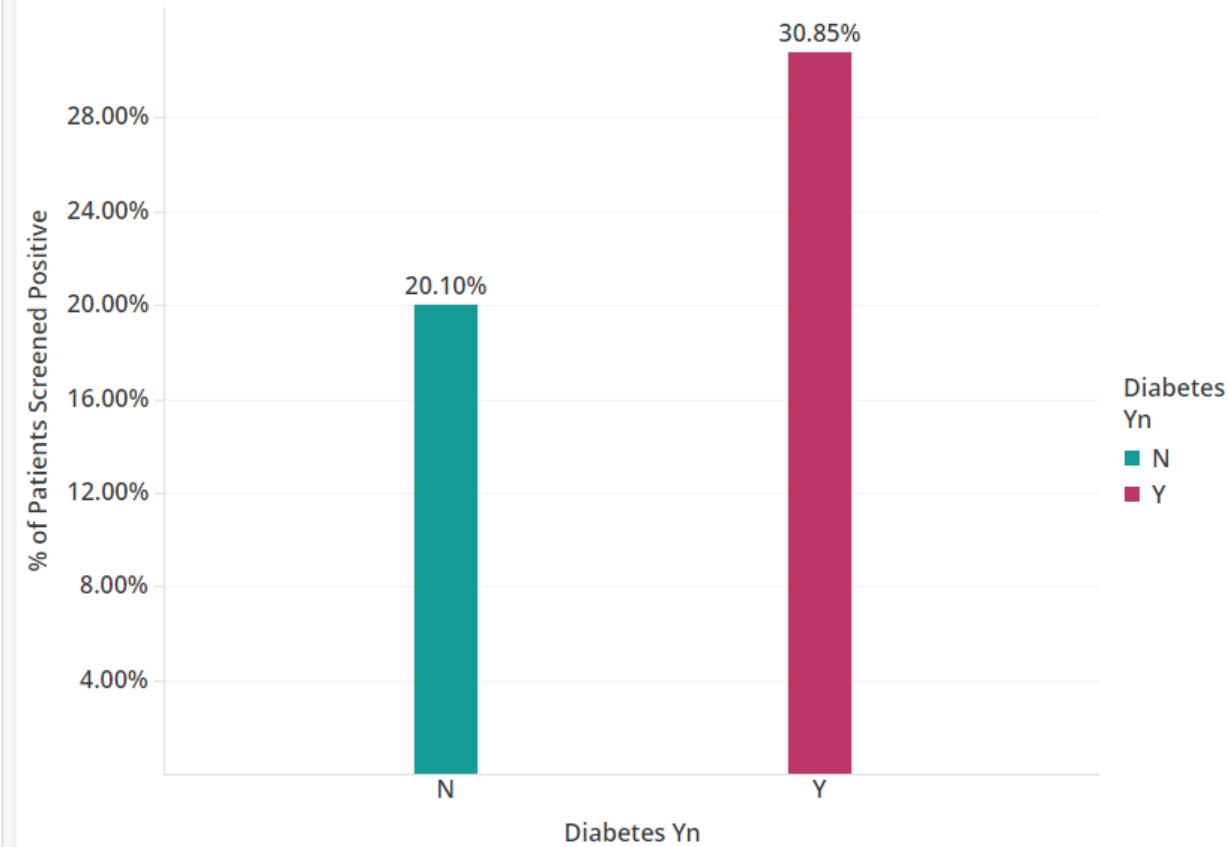


# Top Needs Among Patients Screening Positive for SDOH

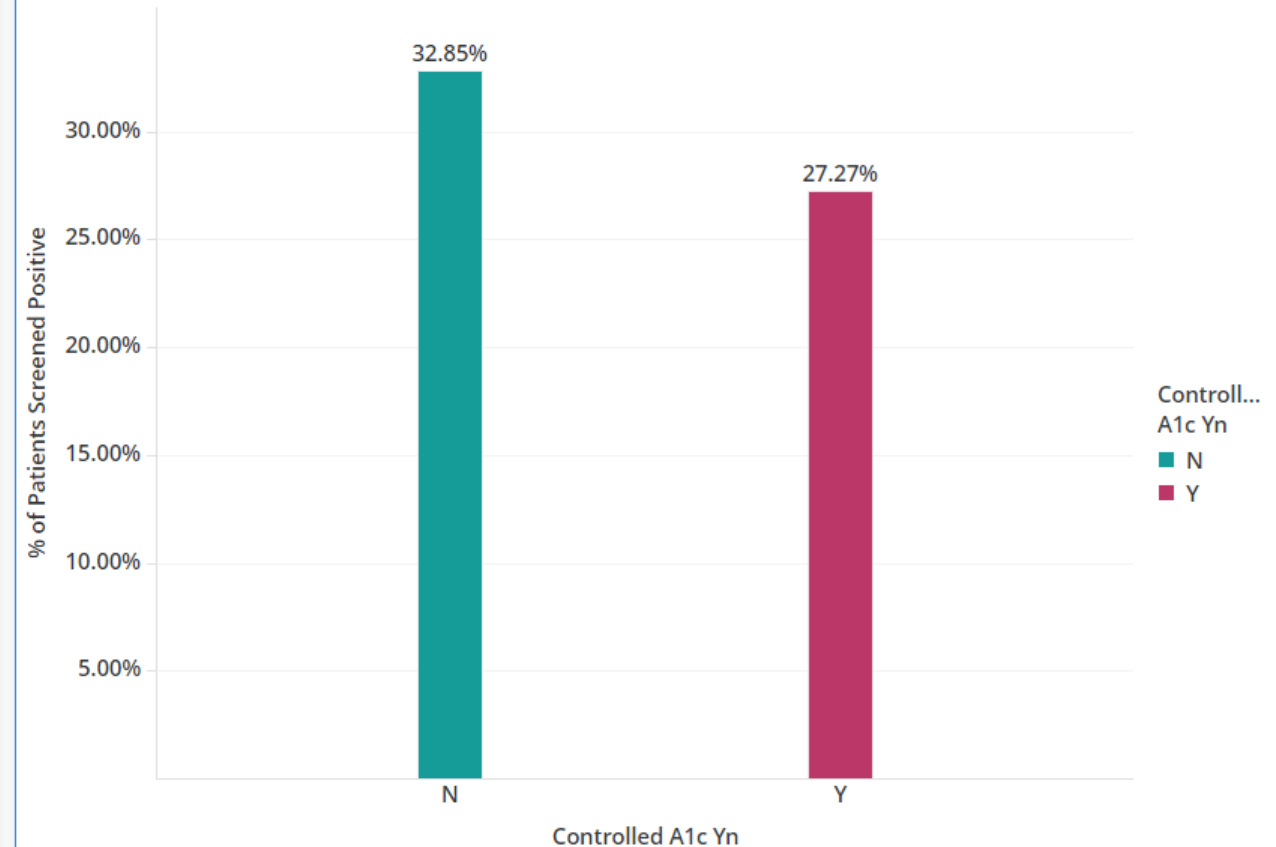


# Relationship Between Health Outcomes and SDOH

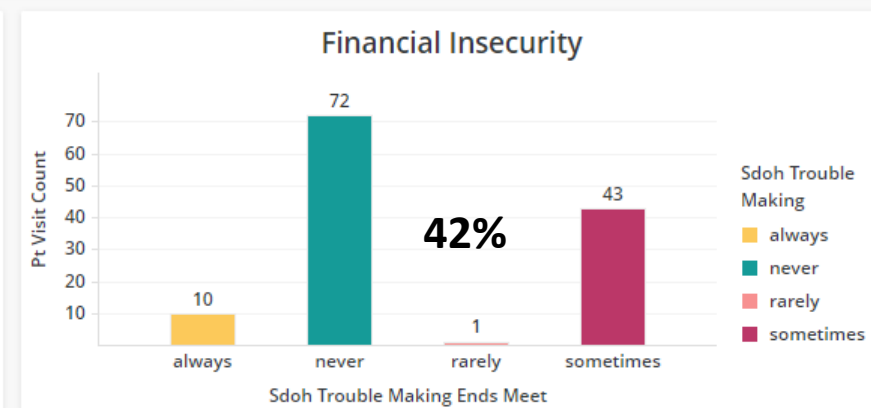
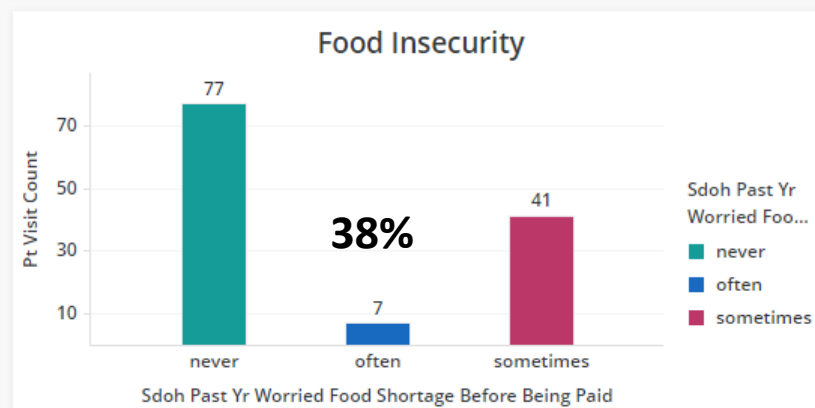
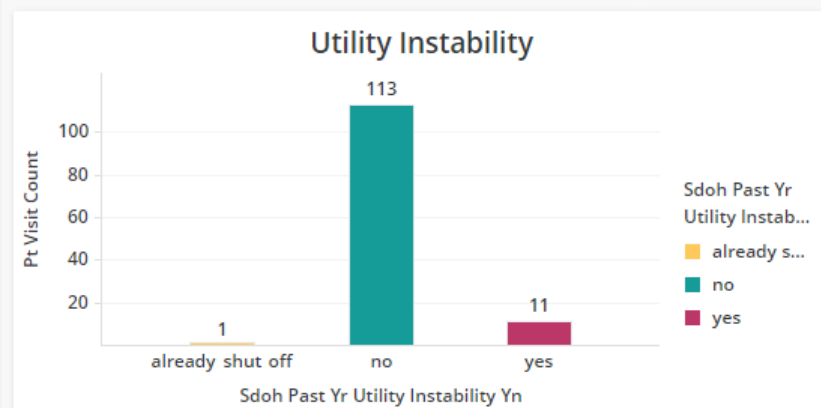
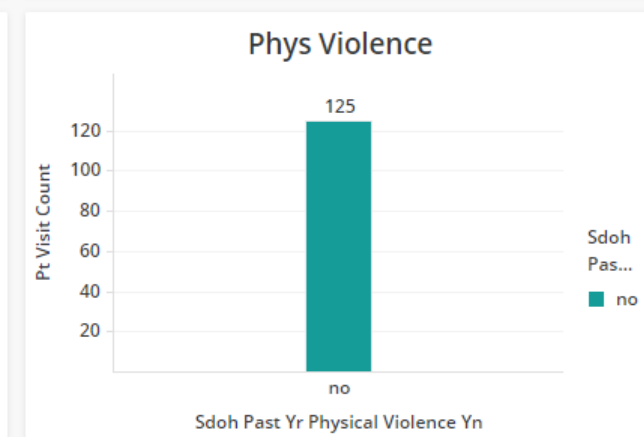
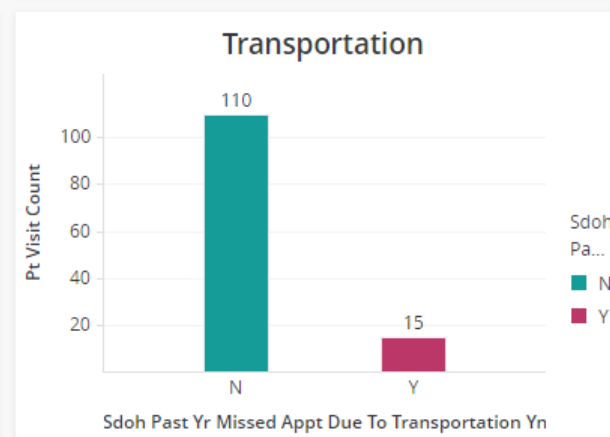
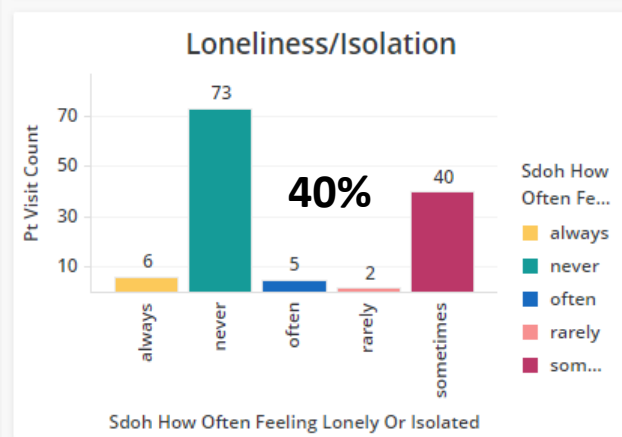
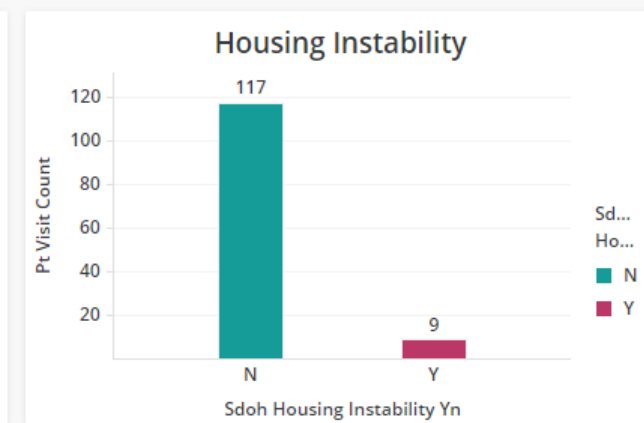
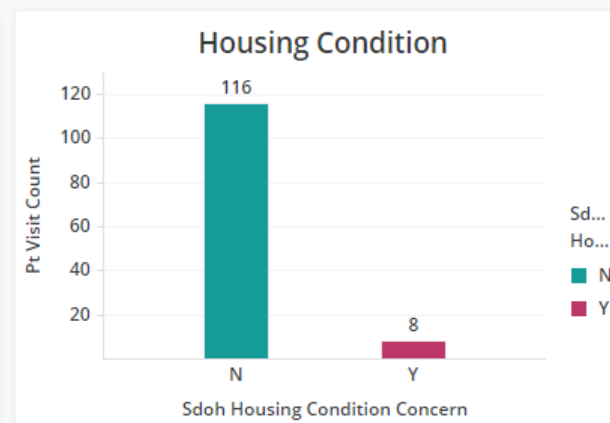
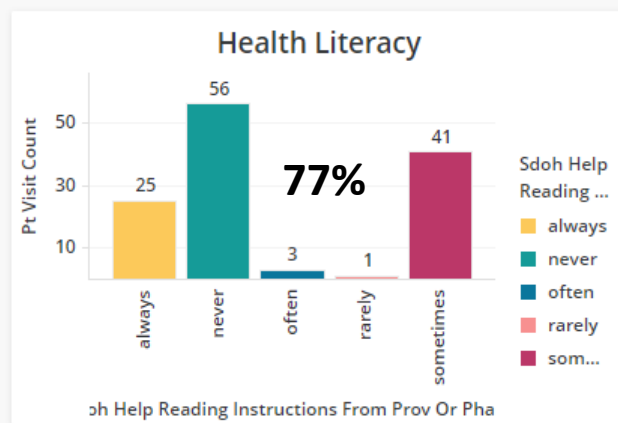
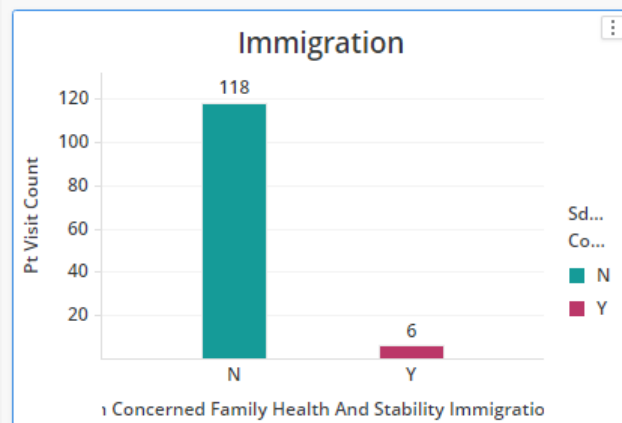
## SDOH Screening Positivity Rates between Diabetic and Non-Diabetic Patients



## A1c Control Among Patients Screening Positive for SDOH Needs



# Top Needs Among Diabetic Patients Screening Positive for SDOH





# Social Determinants of Health Technology, Powered by the Community

Request Demo



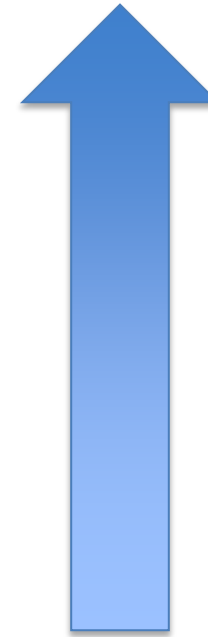
Report

Integrating Social Care Services to Improve Quality Performance

Blog

Medicaid's Next Generation Strategy

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## Lessons Learned

- **Medical Assistant bandwidth is limited**
- **Bias and perception play a role in who is/isn't screened**
- **Paper vs. EMR**
- **Yes/No answers**
- **CHW services critical, but not reimbursable**

## Next Steps

- **SDOH screenings at N. Andover site initiated**
- **Expand to inpatients in 2024**
- **Unite Us engaged through 2025**
- **Emmi Educate – videos in multiple language to simplify/standardize education**
- **Continue studying impact on outcomes, developing ROI**



# Ambulatory Health Equity



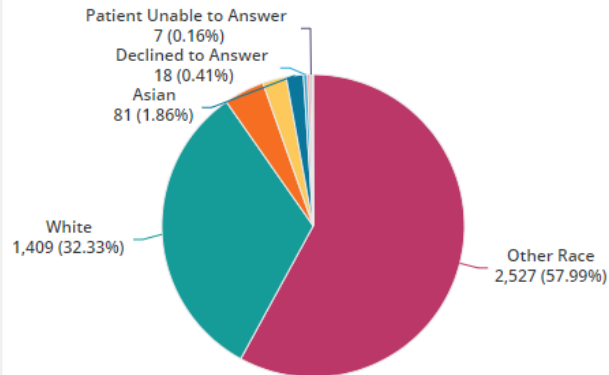
## Project Objectives

- Identify groups experiencing health disparities in primary care
- Identify drivers of disparities
- Develop and implement interventions

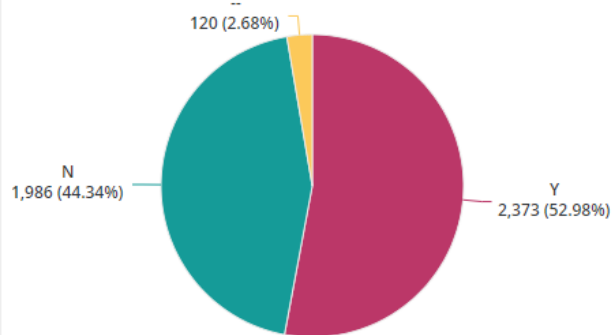
# CMA Lawrence Site Patient Demographics

(All)
  CMA Marston PCP
  CMA North Andover P...

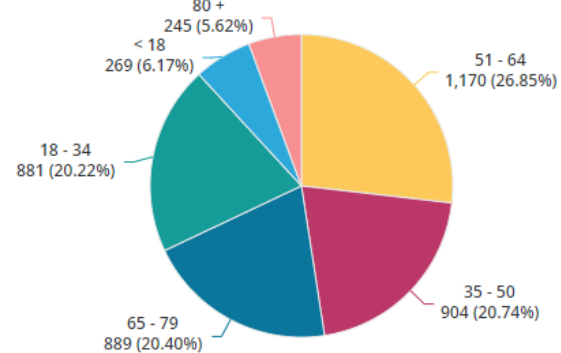
### Race



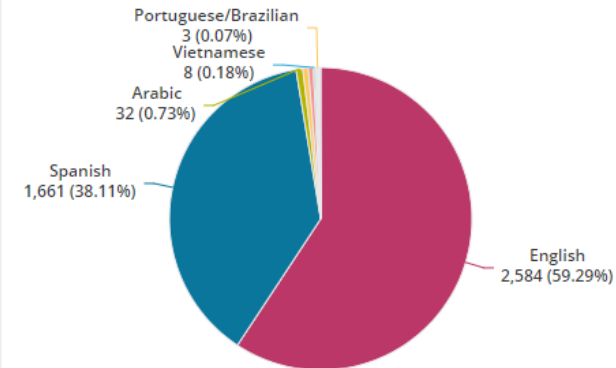
### Hispanic Y/N



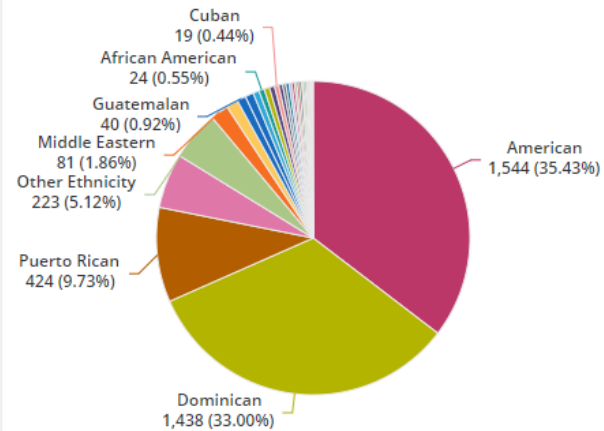
### Age Group



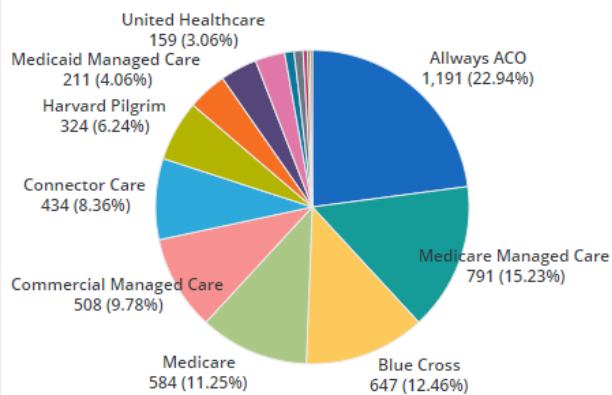
### Preferred Spoken Language



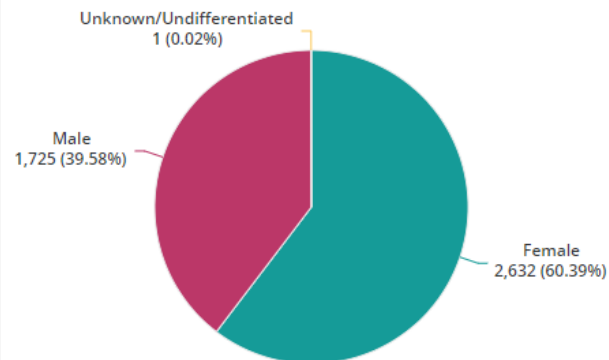
### Ethnicity



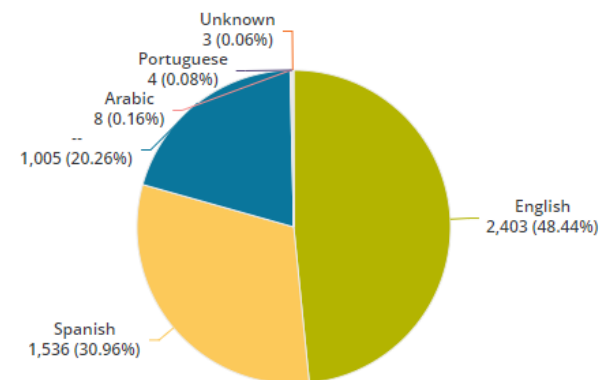
### Payer Mix



### Gender



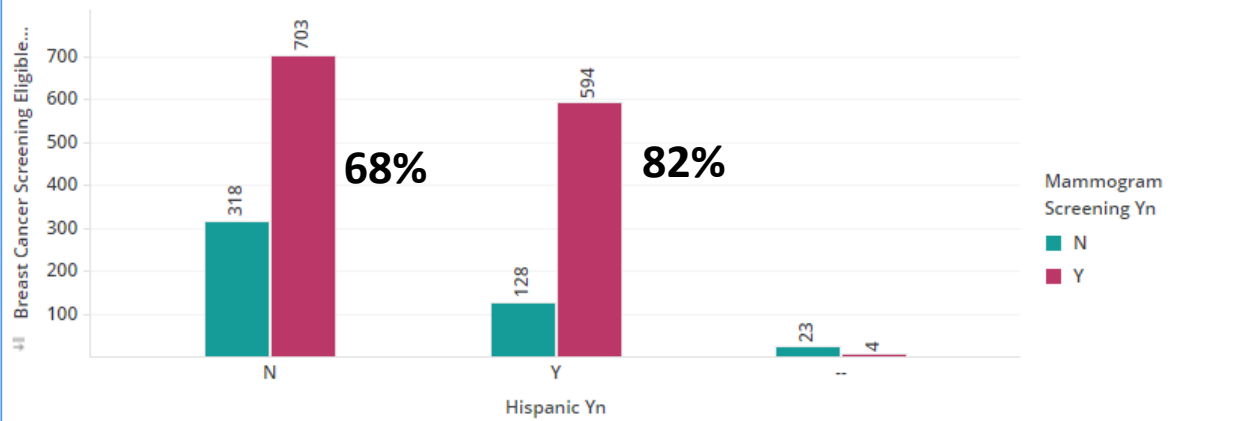
### Preferred Written Language



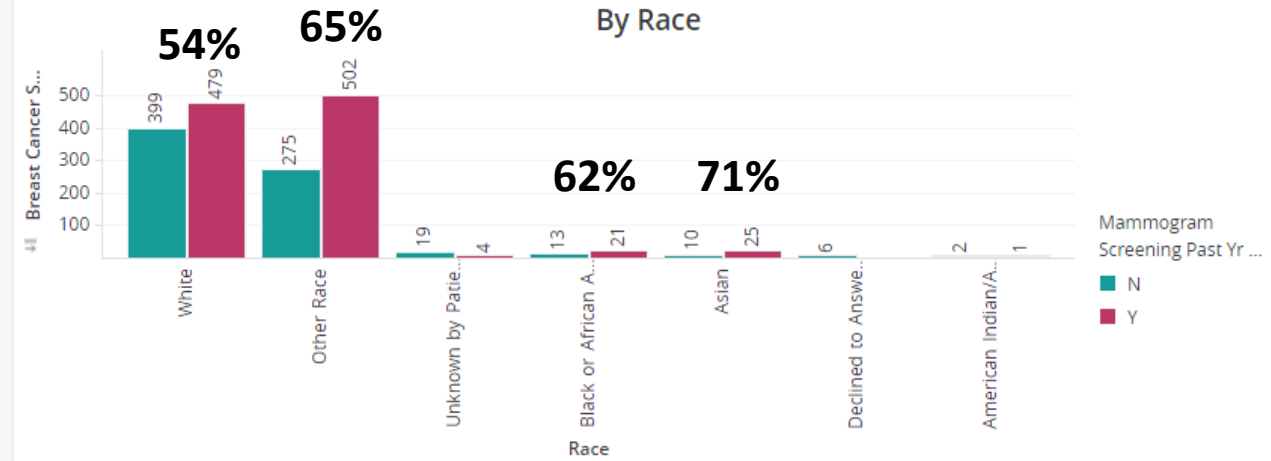
# Breast Cancer Screening

## Breast Cancer Compliance w/REaL Data Analysis

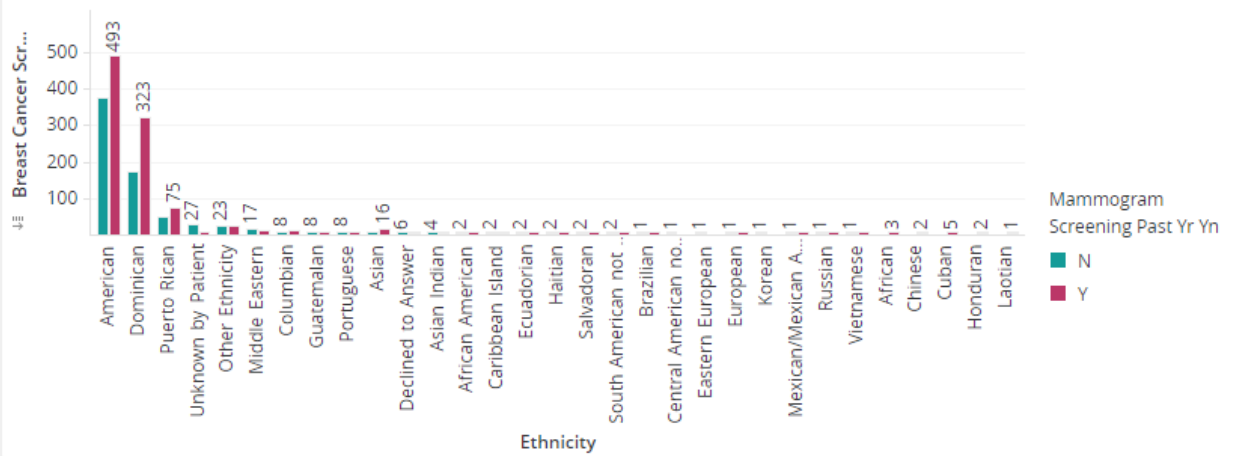
### By Hispanic Yes/No Flag



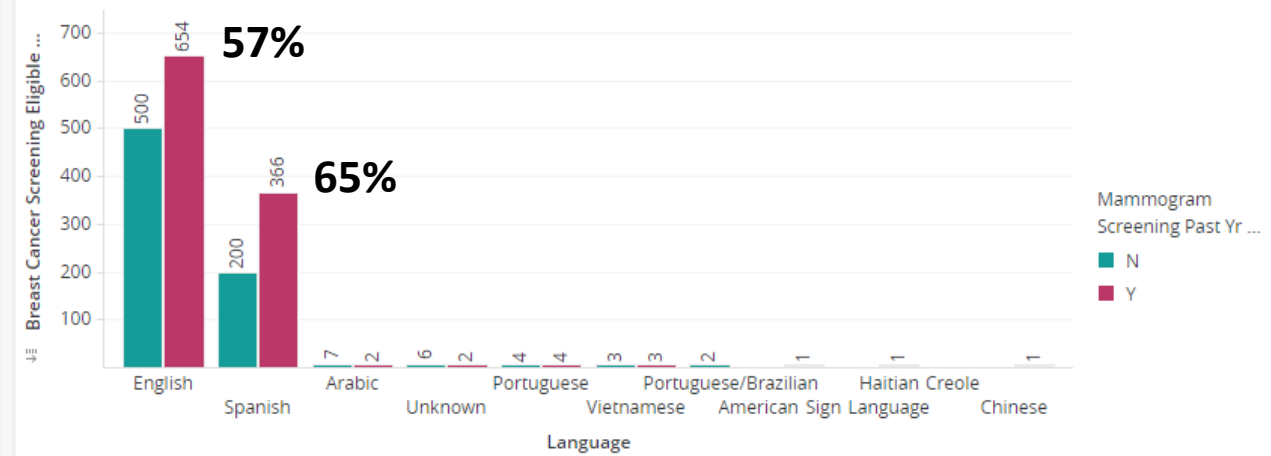
### By Race



### By Ethnicity



### By Language



## Lessons Learned

- **Data is crucial – cannot assume we know what disparities are being experienced**
- **Validates staffing and care delivery – culturally and linguistically competent staff, office on free bus route**
- **Race and ethnicity are not straightforward**

## Next Steps

- **Gain a deeper understanding of what the data is telling us**
- **Qualitative data collection to incorporate the patient's voice**
- **Activate a provider-led health equity team**
- **Develop and implement interventions**



## Contact Information

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# Questions?