

## Health Equity Plan

### Top ten disparities:

1. Housing
2. Food insecurity
3. Utilities instability
4. Transportation challenges
5. Education and literacy
6. Difficulty paying for prescription
7. Difficulty paying for medical bills
8. Health and exercise
9. Wellness and belonging to a social organization
10. Interpersonal safety

Del Amo Hospital promotes health/ behavioral health equity, which is the state in which everyone has a fair and just opportunity to attain their highest level of health/ behavioral health. The hospital identifies health-related social needs of adult patients and information provided about community resources and support services to assist the patients in overcoming those identified barriers to health care/ behavior. Identifying these possible barriers promotes health/ behavioral health equity by our social workers providing information and/or resources to patients and/or their support person(s) to address these possible barriers. Patients are being provided with the correct referrals on discharge based on the identified healthcare disparities.

All patients, including homeless patients, will be provided with discharge planning services to include resources for food, shelter, clothing, psychiatric follow-up, support groups, medical and legal and other community referrals as indicated by their psychosocial assessment. All patients are assessed upon admission and throughout hospitalization for aftercare needs. A written aftercare plan will be provided to all patients upon discharge individualized to meet the patients discharge needs. Upon discharge, all patients will receive a written copy of their aftercare plan. The patient may request that a friend or family member also be given this information. The staff will obtain a release of information prior to disclosing aftercare information.

### Reducing Health Care Disparities

The new 2023 TJC standards related to reducing health care disparities require that we identify areas of disparity in our patients and work to address those issues. Research shows that our patients, particularly those with serious mental illnesses, have a shorter lifespan than the general population. Cardio metabolic factors, including diabetes, hypertension, hyperlipidemia, and cardiovascular disease, are seen as major drivers of this earlier mortality. The illnesses have been identified as both caused and compounded by smoking, lack of physical exercise, poor nutrition, and the many social determinants that negatively impact on the health of our patients.

To address these new standards and work to decrease this healthcare disparity with our patients, a multifocal approach has been identified and developed.

1. **Assessment:** Modification to the psychosocial assessment to include identification of impairments in various areas of social determinants for each patient.
2. **Wellness education:** Wellness groups have been added to each schedule daily provided by a variety of trained staff.
3. **Discharge planning:** An addendum to the psychosocial assessment, a health-related social needs screening assessment, will be completed within 72 hours of admissions for all patients admitted inpatient, 18 and older. If the patient is discharged prior to the 72 hours a note indicating that the health-related social needs screening assessment was not completed due to the brief length of stay. The health-related social needs screening assessment identifies specific referral needs for the patient based on the identified impairments. The social services staff have developed a list of local resources and provide the appropriate referrals to each patient as part of the discharge process.
4. **Monitoring:** The DCS or designee monitors a representative sampling of discharge records each quarter to ensure the patients are being provided with the correct referrals on discharge based on the identified needs at the time of admission.