the most valuable partners in outbreak control, the people they are trying to help. This disconnect has undermined control of nearly every outbreak to date.

The Ugandan authorities recently decided to send a single multidisciplinary team to provide an integrated response to SVD hotspots, rather than sending multiple separate teams to operate in silos. This approach provides an opportunity to present the community with a single point of contact from which a relationship may be built between the people responding to the outbreak and those affected by it that would allow for mutual understanding and building of trust, enabling responders and community members to work together as partners — and would perhaps prevent another small outbreak from becoming large.

An audio interview with Dr. Sprecher is available at NEJM.org

Disclosure forms provided by the author are available at NEJM.org.

From Médecins Sans Frontières, Brussels.

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Hospitals and Health Equity — Translating Measurement into Action

Sahil Sandhu, M.Sc., Michael Liu, M.Phil., and Rishi K. Wadhera, M.D., M.P.P.

The U.S. health care system ranks last on measures of equity among similar high-income countries.[1] Although policymakers and payers have increasingly looked to hospitals to help reduce inequities, there's been less focus on their role in addressing health-related social needs (HRSNs). Such needs are related to food insecurity, housing instability, a lack of access to transportation, an inability to afford utility bills, and exposure to interpersonal violence, among other concerns. Despite the strong links between HRSNs and health outcomes, recent evidence suggests that only one quarter of U.S. hospitals screen for these five needs.[2]

To address this issue, the Centers for Medicare and Medicaid Services (CMS) recently announced the adoption of three health-equity measures in the Hospital Inpatient Quality Reporting program. The first measure, which will be implemented for the 2023 reporting period, evaluates hospitals on five domains: commitment to health equity as a strategic priority, collection of sociodemographic and HRSN data, analysis of these data, adoption of quality-improvement activities focused on health disparities, and leadership engagement with equity efforts. The second and third measures will require that hospitals report the percentage of adult patients who are screened for the five HRSNs described above at the time of admission and the proportion who screen positive for these needs.

Hospitals will probably require new capabilities and planning to successfully screen for HRSNs, but there's limited evidence to inform approaches to inpatient screening. Research on the acceptability of screening among patients and providers and the validity and reliability of specific tools has been primarily conducted in outpatient settings. A recent report found that only 2 of 42 implementation studies related to multidomain HRSN screening were conducted in inpatient settings.[3] Nonetheless, there are several steps that hospitals could take to support the adoption of these measures.

First, hospitals must decide which screening tool to use. The federal Accountable Health Communities Model features a 10-item tool that encompasses the five HRSNs included in CMS's new measures. This tool is applicable to various patient populations and has been used to screen more than 1.1 million Medicare and Medicaid beneficiaries. Other

tools capture different aspects of the same five HRSNs or assess different problems, such as social isolation and immigration-related concerns. Hospitals must grapple with the trade-off between collecting more comprehensive data on HRSNs and prioritizing the needs that they have the most capacity to screen for and meaningfully address. The Social Interventions Research and Evaluation Network provides detailed comparisons of widely used screening tools. Eventually, movement toward the adoption of a single standardized tool for all hospitals could support more accurate benchmarking and comparisons in national quality and reporting programs.

Second, hospitals will have to consider how to collect data and who will collect them. Implementing HRSN screening will probably require substantial financial and human-resource investment to develop workflows, train employees to be attuned to patient privacy and comfort, and consistently administer the screening tool. As hospitals deal with the financial aftermath of the Covid-19 pandemic, leaders should consider how best to leverage existing resources and minimize workflow disruptions. Options include incorporating the HRSN screening tool into routine surveys, such as those that are currently used to collect self-reported sociodemographic information; the intake process completed by the bedside nurse; or discharge workflows. Tablet-based screening approaches could reduce staff burden and potentially elicit higher rates of disclosure than face-to-face approaches.

Third, hospitals could integrate screening results into electronic health records (EHRs) to increase data access for clinicians and health care system leaders and inform population-level quality-improvement efforts. Leaders should consider linking responses to codes from the *International Classification of Diseases*, 10th revision (ICD-10), Systematized Nomenclature of Medicine (SNOMED), and Logical Observation Identifiers Names and Codes (LOINC) that have been recommended by the Gravity Project, a national collaborative dedicated to developing standards for the use and exchange of data regarding social determinants of health. Payers and accreditation organizations could adopt a common set of health-equity measures in their quality-reporting programs to reduce administrative burdens for hospitals. For example, the National Committee for Quality Assurance recently created a Healthcare Effectiveness Data and Information Set measure focused on screening for food-, housing-, and transportation-related needs.

We believe establishing measures related to structural commitments to health equity and HRSN screening is a necessary step. Routine screening might help clinicians tailor care, strengthen patient–provider relationships, and destigmatize discussion of social needs and seeking of services.[4] But these measures risk becoming checkboxes that increase administrative burden and waste resources if hospitals don't use sociodemographic and HRSN data to take meaningful action at the bedside and in their surrounding communities.

At the patient level, hospitals could design workflows to address identified social needs. Less intensive interventions could involve providing patients with curated lists of community resources, using either community-resource platforms (e.g., Unite Us or WellSky) or populated templates in EHRs. More intensive interventions could involve employing case managers, social workers, or community health workers to streamline community-services navigation for patients with unmet social needs during and after hospitalization. A recent trial showed that pairing community health workers with hospitalized patients to help patients connect with clinical and social services for 1 month after discharge significantly reduced 30-day readmissions and missed outpatient visits.[5] Expanding the social care workforce to lead these efforts and streamlining interprofessional collaboration could help avoid further burdening physicians and nurses.

At the community level, hospitals could partner with and invest in community-based organizations equipped to address HRSNs. This approach could involve hospitals organizing cross-sector coalitions or nonprofit hospitals building on existing partnerships as part of mandated assessments of community health needs. Hospitals and community-based organizations could then develop standardized workflows and direct referral pathways to connect hospitalized patients with local social services. Engaging affiliated primary care practices in these partnerships may reduce duplication of efforts and enable longitudinal patient support. State governments can also establish infrastructure and provide tech-

nical assistance for facilitating such linkages. In North Carolina, the Department of Health and Human Services developed a statewide shared-data platform (NCCARE360) to enable cross-sector referrals. For a patient who was recently evicted from their home, for example, a hospital social worker can use the platform to search for tailored housing resources, send a secure referral to an agency for emergency housing assistance, and track whether the patient received appropriate services. Data could also guide more tailored use of community-benefit spending, most of which has traditionally been allocated for providing uncompensated or subsidized health care services. For example, some hospitals serving a disproportionate number of patients experiencing homelessness have invested in affordable housing units in the surrounding community.

The three new measures may not provide sufficient incentives for hospitals to address HRSNs and reduce health inequities. In future years, CMS could create follow-on measures that evaluate the number of patients who received interventions focused on their HRSNs, stratified by characteristics such as race and ethnicity, or evaluate a hospital's overall progress toward reducing health inequities affecting marginalized populations, such as inequities driven by structural racism. Unlike larger integrated health care systems, however, safety-net hospitals that disproportionately serve disadvantaged communities may lack the resources to invest in nonreimbursed social interventions. Adoption of equity-centered value-based payment models may increase financial flexibility and stability for hospitals and enable them to provide both health and social care services. CMS could increase prospective payments for hospitals that participate in alternative payment models and care for patient populations with higher-than-average HRSNs or could earmark a portion of shared savings for reinvestment in local HRSN initiatives. Massachusetts Medicaid, for example, has granted accountable care organizations additional funding to develop programs and pay community-based organizations to provide nutrition- and housing-related services for patients with high levels of medical and social needs.

Although the implementation of equity-focused measures is an important step, it's unclear whether HRSN screening alone will reduce health disparities. Such efforts will need to be paired with the cessation of detrimental practices by some hospitals — including aggressive debt collection targeting patients who cannot afford their medical bills and inadequate spending on community benefits — that exacerbate inequities. Translating measurement into meaningful action will require thoughtful leadership from hospitals in close collaboration with primary care practices, community-based organizations, and payers. Ultimately, hospital actions shouldn't be viewed as a panacea for achieving health equity, but rather as adjuvants to broader state and federal policies that improve the social conditions that drive health outcomes.

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From Harvard Medical School (S.S., M.L.), and the Section of Health Policy and Equity, Richard A. and Susan F. Smith Center for Outcomes Research, Beth Israel Deaconess Medical Center (M.L., R.K.W.) — both in Boston.

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