Alliant HQIC LAN – Health Equity Strategy Session #1

Presented by:
Rosa Abraha, MPH, Alliant Health Solutions
LeAnn Pritchett, Tift Regional Medical Center

August 29, 2023

ALLIANT HEALTH SOLUTIONS | HQIC Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES iQUALITY IMPROVEMENT & INNOVATION GROUP

Agenda

- Welcome
- Pre-work to complete and keep at desk:
  - Gap analysis – assess areas for improvement
  - Participant worksheet (PPT) – can be used to document hospital's work
- Discuss six steps for health equity strategy
- Review steps 1- 3 and provide practical examples
  1. Identify health equity team
  2. Describe data collection
  3. Discuss how REaL/SDOH data are stratified
- Steps 1, 2, and 3 discussion
- Resources
- Discuss session #2
- Q&A/Wrap Up

Rosa Abraha, Alliant Health Solutions

Rosa Abraha, MPH
Health Equity Lead
Alliant Health Solutions
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Rosa joined Alliant in December 2021 to lead the company's first health equity strategic portfolio and embed health equity in the core of Alliant's work. Rosa has 10 years of experience in public health advisory for premier agencies, including the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH) and the Food and Drug Administration (FDA). She holds a Master of Public Health in health policy and management from Emory University.

LeAnn Pritchett, Tift Regional Medical Center (GA)

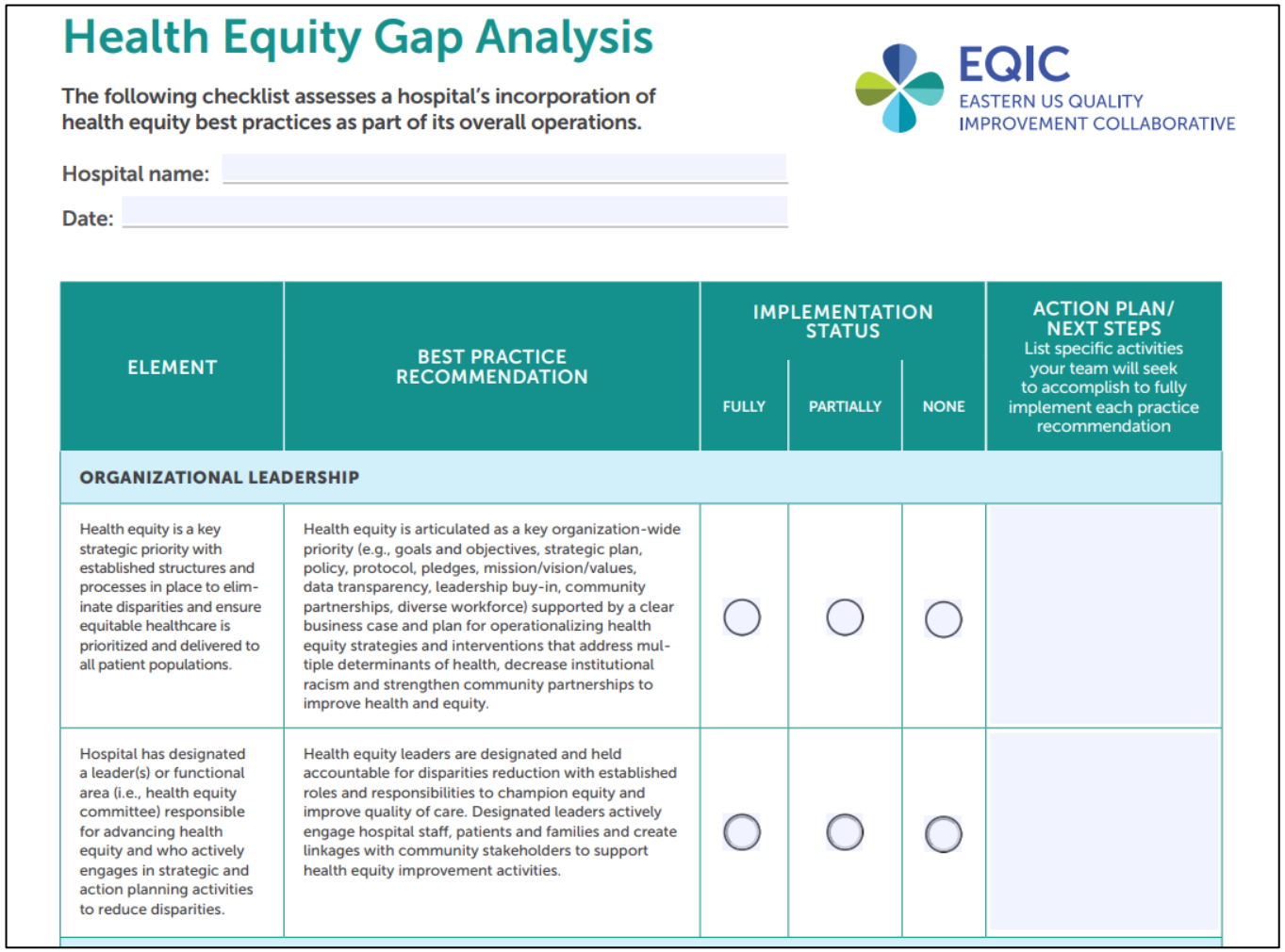
LeAnn started her nursing career at TRHS in 1986 as a registered nurse, providing bedside care in the medical-surgical and orthopedic units. She has served in various leadership roles, including director of nursing for a skilled nursing facility, assistant nurse manager of an orthopedic unit, nurse manager of a surgical unit, and director of patient safety. LeAnn has served as the system director of quality and patient safety role since 2020.

LeAnn Pritchett, MSN, RN, CPHQ
System Director of Quality & Safety
Tift Regional Medical Center Southwell

Tift Regional Medical Center - Southwell

- Nonprofit health system serving 12 counties in south-central Georgia
- The main campus is Tift Regional Medical Center, a 181-bed regional referral hospital in Tifton, Ga.
- Tifton West Campus houses various diagnostic services and the region's largest multi-specialty clinic
- Cook County campus is anchored by Southwell Medical, an acute care facility, and includes a 12-bed geriatric psychiatric unit and a 95-bed skilled rehabilitation facility

Pre-Work: Health Equity Gap Analysis



Health Equity Gap Analysis

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

The following checklist assesses a hospital's incorporation of health equity best practices as part of its overall operations.

Hospital name: _____

Date: _____

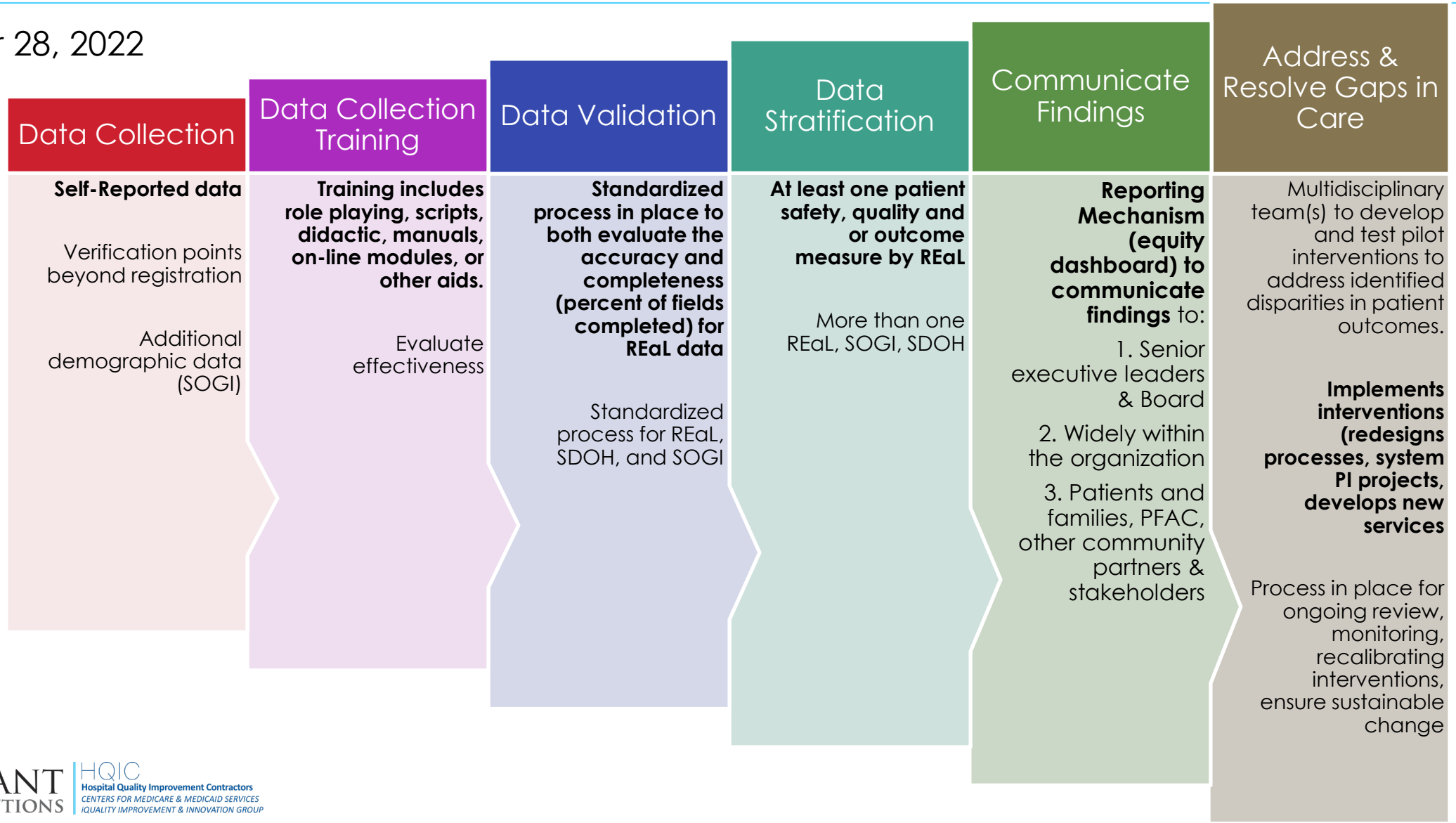
ELEMENT	BEST PRACTICE RECOMMENDATION	IMPLEMENTATION STATUS			ACTION PLAN/ NEXT STEPS List specific activities your team will seek to accomplish to fully implement each practice recommendation
		FULLY	PARTIALLY	NONE	
ORGANIZATIONAL LEADERSHIP					
Health equity is a key strategic priority with established structures and processes in place to eliminate disparities and ensure equitable healthcare is prioritized and delivered to all patient populations.	Health equity is articulated as a key organization-wide priority (e.g., goals and objectives, strategic plan, policy, protocol, pledges, mission/vision/values, data transparency, leadership buy-in, community partnerships, diverse workforce) supported by a clear business case and plan for operationalizing health equity strategies and interventions that address multiple determinants of health, decrease institutional racism and strengthen community partnerships to improve health and equity.	○	○	○	
Hospital has designated a leader(s) or functional area (i.e., health equity committee) responsible for advancing health equity and who actively engages in strategic and action planning activities to reduce disparities.	Health equity leaders are designated and held accountable for disparities reduction with established roles and responsibilities to champion equity and improve quality of care. Designated leaders actively engage hospital staff, patients and families and create linkages with community stakeholders to support health equity improvement activities.	○	○	○	

- This **template** helps organizations assess the extent to which they have incorporated health equity best practices as part of their overall operations.
- There are seven major *categories* for evaluation in this analysis: organizational leadership, workforce training, data collection, data validation, data stratification, health literacy/cultural competence, and community partnerships.

(Source: Eastern US Quality Improvement Collaborative)

Tift Regional Medical Center: Health Equity Organizational Assessment

October 28, 2022



Six Steps for Health Equity

Polling Question 1

Health Equity Gap Analysis

The following checklist assesses a hospital's incorporation of health equity best practices as part of its overall operations.

ORGANIZATIONAL LEADERSHIP	IMPLEMENTATION STATUS		
	FULLY	PARTIALLY	NONE
1. Hospital has designated a leader(s) or functional area (i.e., health equity committee) responsible for advancing health equity and actively engages in strategic and action planning activities to reduce disparities.	○	○	○

Step #1: Hospital Leadership Engagement and Health Equity Team

CMS HCHE *Mandatory CY23*	**MUC 2021-106 | Domain 5A** Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews our strategic plan for achieving health equity.
TJC *Mandatory 1/1/24*	**Standard LD.04.03.08** Reducing healthcare disparities for the [organization's] [patients] is a quality and safety priority. **EP 1** The [organization] designates an individual(s) to lead activities to reduce healthcare disparities for the [organization's] [patients].

Tift Regional Medical Center: Leadership Engagement and Health Equity Team

- Dr. Jessica Beier, Chief Quality Officer
- Dr. Cameron Nixon, Chief Transformation Officer
- LeAnn Pritchett, System Director of Quality and Safety
- Jill McIntyre, Director of Diversity, Inclusion, and Wellness

Committee Structure

Board of Directors	• Quality Council • Administration Quality Committee
Medical Executive Committee	• Annual and Semi-Annual Medical Staff Meeting • Medical Staff Department Meetings
High Impact Team: Readmissions & Heart Failure	• Multidisciplinary Teams
High Impact Team: Health Equity/SDOH	• Stakeholders • Subject Matter Experts
Equity and Inclusion Steering Committee	• Leaders • Frontline Team Members • Board Members
Patient and Family Advisory Council –	• Community Members

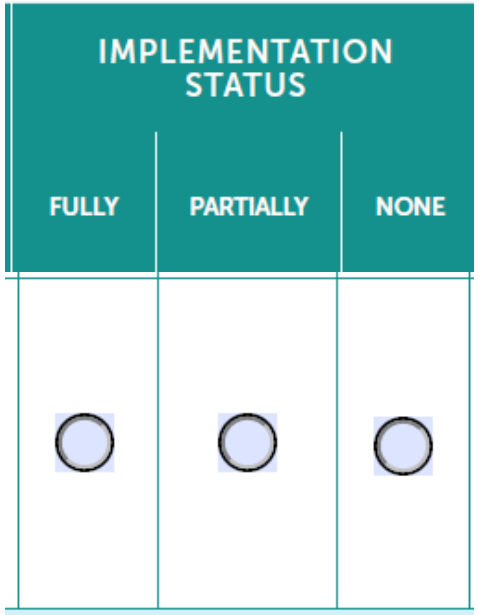
Polling Question 2

Health Equity Gap Analysis

The following checklist assesses a hospital's incorporation of health equity best practices as part of its overall operations.

DATA COLLECTION AND UTILIZATION

2. Hospital uses a self-reporting methodology to collect **SDOH data** (i.e., transportation, food insecurity, housing, etc.) from the patient, family member or care partner



Step #2: Data Collection - REaL and SDOH Patient Demographic Data

CMS HCHE *Mandatory CY23*	**MUC 2021-106** **Domain 2A** Our hospital collects demographic information, including self-reported race and ethnicity and/or social determinant of health information on the majority of our patients. **Domain 2B** Our hospital has training for staff in culturally sensitive collection of demographic and/or social determinant of health information. **Domain 2C** Our hospital inputs demographic and/or social determinant of health information collected from patients into structured, interoperable data elements using a certified EHR technology.
TJC *Mandatory 1/1/24*	**Standard RC.02.01.01** The [medical] record contains information that reflects the [patient's] care, treatment, and services. **EP 28** The medical record contains the patient's race and ethnicity.

Data Collection: 5 CMS Domains of SDOH Screening

1. **Food Insecurity**
   Food insecurity is defined as limited or uncertain access to adequate quality and quantity of food at the household level.

2. **Housing Instability**
   Housing instability encompasses multiple conditions ranging from the inability to pay rent or mortgage, frequent changes in residence including temporary stays with friends and relatives, living in crowded conditions, and actual lack of sheltered housing in which an individual does not have a personal residence.

3. **Transportation Needs**
   Unmet transportation needs include limitations that impede transportation to destinations required for all aspects of daily living.

4. **Utility Difficulties**
   Inconsistent availability of electricity, water, oil, and gas services is directly associated with housing instability and food insecurity.

5. **Interpersonal Safety**
   Assessment for this domain includes screening for exposure to intimate partner violence, child abuse, and elder abuse.

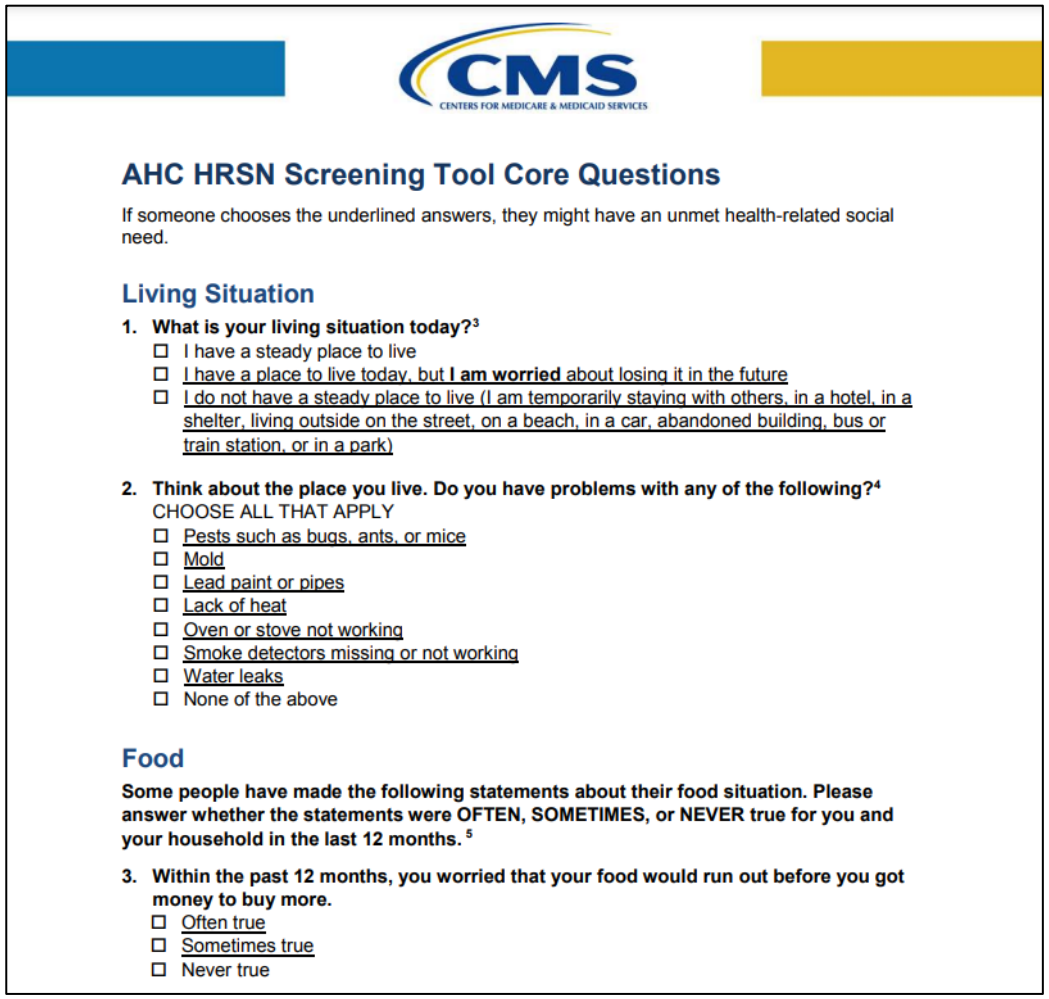
Data Collection: Screening Patients for SDOH

● CMS SDH *Voluntary CY23* *Mandatory CY24*	**Screening for Social Drivers of Health MUC2021–136** Numerator: Number of beneficiaries 18 and older screened for food insecurity, housing instability, transportation needs, utility assistance, and interpersonal violence. Denominator: Number of beneficiaries 18 and older in practice (or population). **Screen Positive Rate for Social Drivers of Health MUC2021–134** Numerator: Number of beneficiaries 18 and older that screen positive for food insecurity, housing instability, transportation needs, utility assistance or interpersonal violence. Denominator: Total number of beneficiaries 18 and older screened for food insecurity, housing instability, transportation needs, utility assistance or interpersonal violence.

NOTES:

- *These are both structural measures and the data can come from multiple sources (administrative claims data, electronic clinical data, standardized patient assessments, or patient-reported data and surveys).*
- *Exclusion criteria exist for patients who opt out of screening and/or patients who are unable to complete the screening during their stay and have no legal guardian or caregiver who can do so on their behalf.*
- *The screen-positive rate will result in five unique rates for each of the five categories of social drivers of health.*

CMS AHC HRSN - SDOH Screening Tool



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

AHC HRSN Screening Tool Core Questions

If someone chooses the underlined answers, they might have an unmet health-related social need.

Living Situation

1. **What is your living situation today?**[3]
   - ☐ 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, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. **Think about the place you live. Do you have problems with any of the following?**[4]
   CHOOSE ALL THAT APPLY
   - ☐ 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

Food

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months. [5]

3. **Within the past 12 months, you worried that your food would run out before you got money to buy more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

- CMS and CMMI developed the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool.
- It is recommended to use this form and integrate the questions into your HER. It contains two questions in each of the five core domains that CMS will be evaluating for both structural measures (SDOH-1 and SDOH-2).

https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

Tift Regional Medical Center - REaL Data Collection

What we collect:

- Race, Ethnicity and Language (REaL) Data
- Self-reported
- At registration (Developing a validation point)
  - Training (https://ifdhe.aha.org/hretdisparities/collecting-data-nuts-bolts)

Focus Considerations:

- Existing improvement focus measures – Readmissions, Excess Days in Acute Care, CMS Conditions
- Active Improvement Teams
- Strategic Priorities
- Existing Data / Dashboards

Information Systems:

- Cerner EMR
- Optum Data Hub Analytics – New information system search

Focus: % 30-Day All-Cause Readmissions

Tift Regional Medical Center - SDOH Data Collection

- SDOH screen implemented in April 2023
  - CMS Accountable Health Communities Health-Related Social Needs Screening Tool
  - Patient screen completed by admitting nurse
  - Case Management consult triggered with four of five positive screen elements and/or the safety question.
  - Use custom Cerner reports and Optum Data Hub Analytics for Analysis

- Major themes
  - Transportation
  - Food Insecurity
  - Homelessness

- Training – Nursing Staff (Acute and Ambulatory Care)

Polling Question 3

Health Equity Gap Analysis

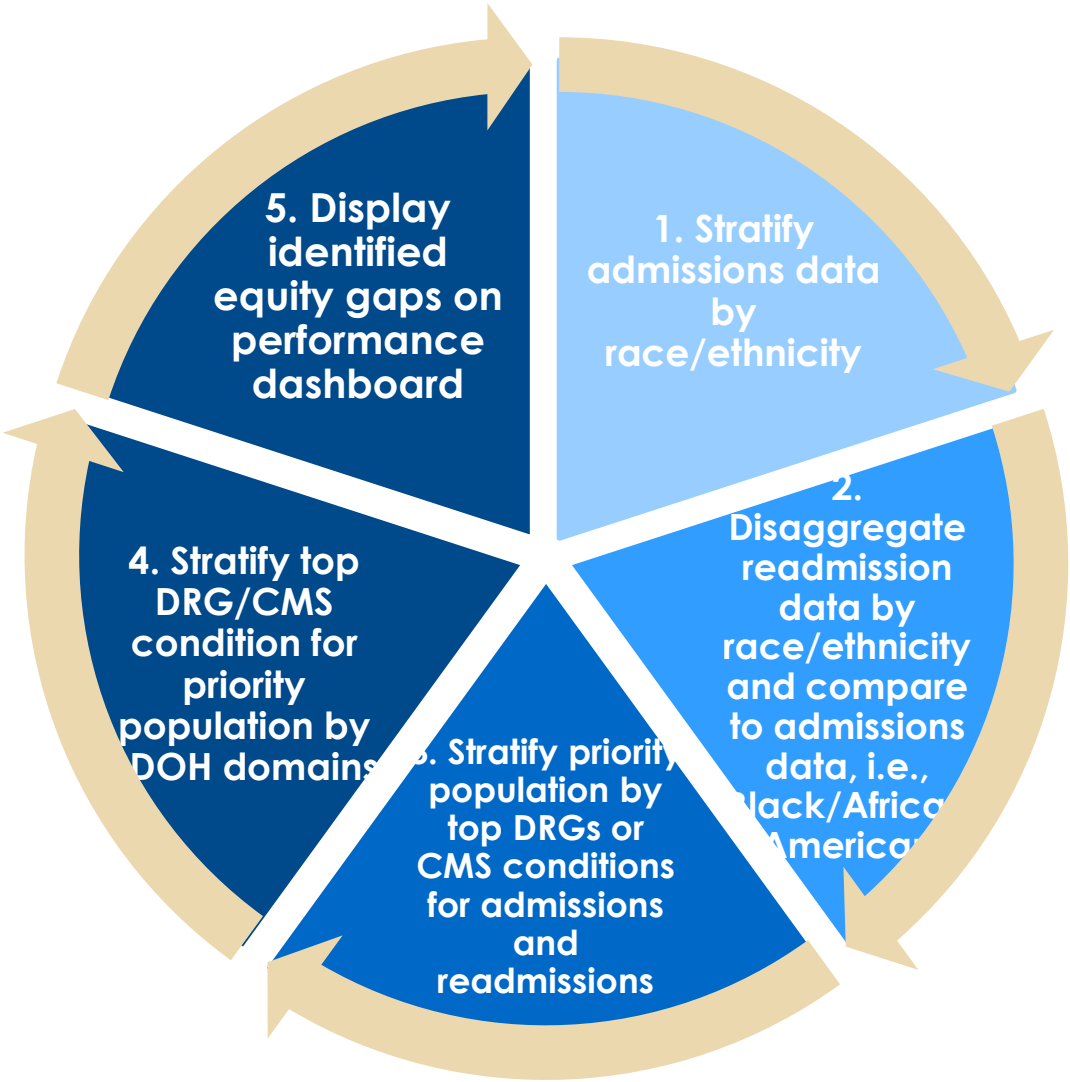
The following checklist assesses a hospital's incorporation of health equity best practices as part of its overall operations.

DATA STRATIFICATION	IMPLEMENTATION STATUS		
	FULLY	PARTIALLY	NONE
3. Hospital stratifies patient safety, quality/and or outcome measures (e.g., 30-day readmission rates) by race, ethnicity and language to examine differences and equity of care provided.	○	○	○

Step #3: Data Analysis and Stratification by Hospital Quality Measures

CMS HCHE *Mandatory CY23*	**MUC 2021-106** **Domain 3A** Our hospital stratifies key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and includes this information on hospital performance dashboards. **Domain 1B** Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews key performance indicators stratified by demographic and/or social factors.
TJC *Mandatory 1/1/24*	**Standard LD.04.03.08** Reducing healthcare disparities for the [organization's] [patients] is a quality and safety priority. **EP 3** The [organization] identifies healthcare disparities in its [patient] population by stratifying quality and safety data using the sociodemographic characteristics of the [organization's] [patients].

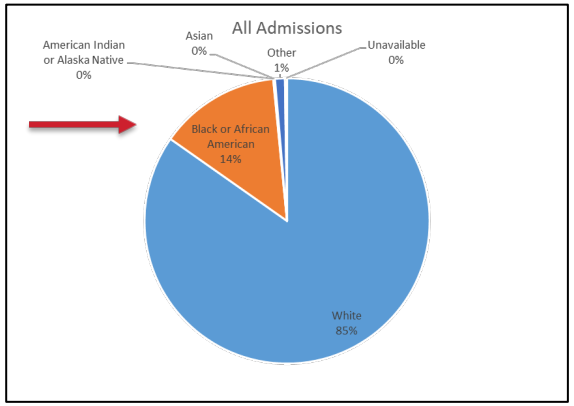
Tift Regional Medical Center: Process for Health Care Equity Data Analysis Through Stratification for Readmissions



Tift Regional Medical Center – Process for Health Care Equity Data Analysis by Quality Measures

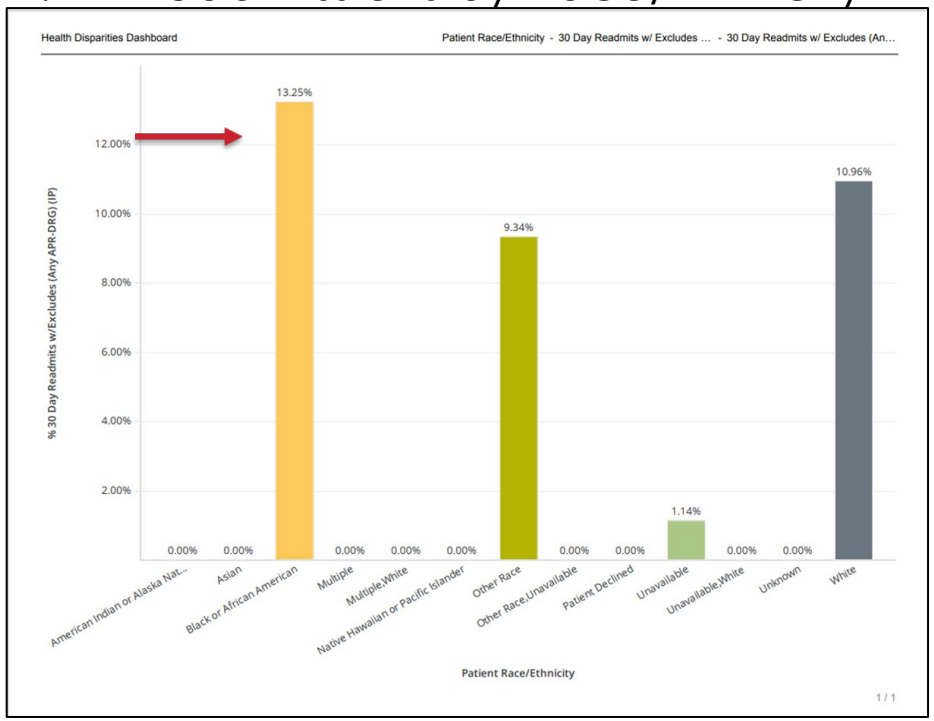
1. All Admissions by Race/Ethnicity

Black/African American



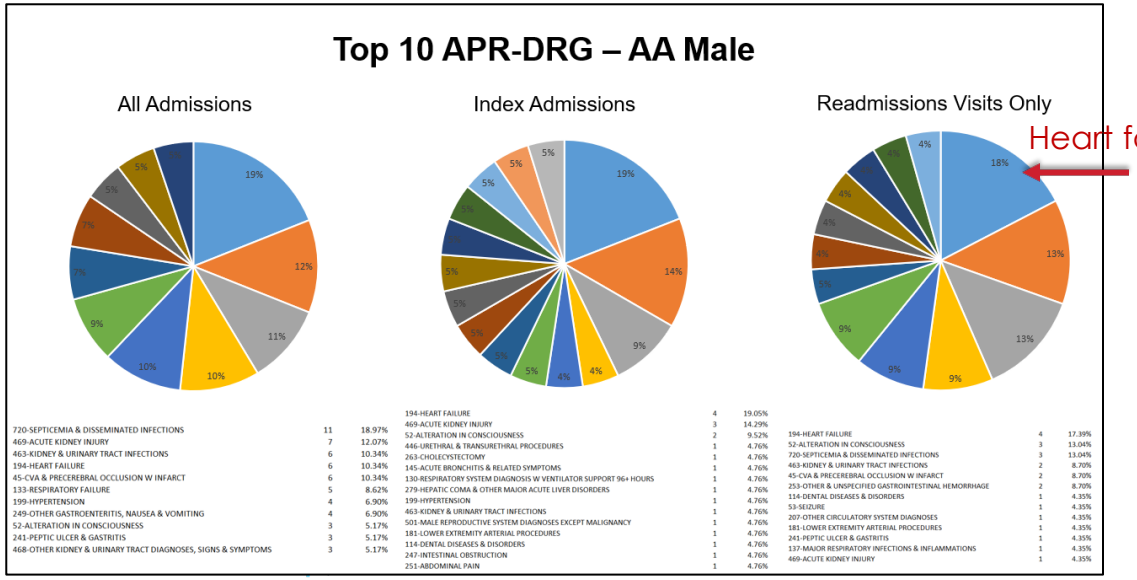
2. All Readmissions by Race/Ethnicity

Black/African American

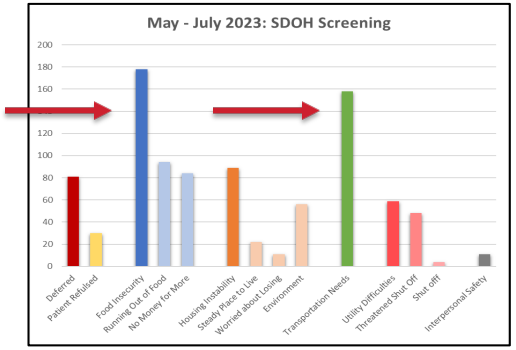


3. Black/African American Males Readmissions, Heart Failure

Heart failure



4. All Readmissions SDOH Food Insecurity and Transportation Needs



Steps 1, 2, and 3 Discussion

Step 1: Identify Health Equity Team	Step 2: Data Collection (REaL and SDOH)and embedded in EMR	Step 3: REaL and SDOH stratification and analysis
Team leader, title Team members, titles		

Asked and Answered

1. Please address different or not required reporting for Critical Access Hospitals CAHs do not fall under the CMS IQR purview, but requirements for the next Flex funding cycle will include the five CMS SDOH domains.
2. First steps in implementing the program? Identify the team, including leadership; don't forget gap analysis
3. Are any hospitals getting hostile patient responses to staff when gathering this information? Scripting includes "why" collect information; patients can decline or defer.
4. Does your registration or nursing staff collect the data? Tift Regional Medical Center example of REaL data collection in Registration and SDOH data collection (in EMR) with Nursing
5. Overcoming data collection issues is real - what suggestions do you have to address? See slide 18 for focus considerations

Asked and Answered

6. What is included in staff education for staff that collect social determinants of health (SDOH) information? Learning objectives could include:
   - Define SDOH and describe how factors impact patient outcomes
   - Describe the purpose of the SDOH Screening Tool and understand its importance
   - Identify the SDOH Screening Tool within the Power Chart
7. Do inpatient behavioral health patients need to be screened for SDOH? Yes
8. When do the requirements have to be reported, and on what platform? CMS CY23 mandatory requirements due via Hospital IQR web-based tool; See reference for dates https://qualitynet.cms.gov/inpatient/iqr/resources

   Note: Screening patients for SDOH is voluntary for CMS CY23 and mandatory in CY24
9. Scripting for asking the sex element questions? See the SOGI Collection Conversation Example on slide 27. SOGI is not required by states; however, building functionality in EMR is recommended.

SOGI Collection Conversation Example

- **Stay tuned for SOGI data collection clarification from CMS**
- Suggest asking SOGI questions first to ensure you are referring to the person by the correct pronoun

HOSPITAL STAFF:
"Thank you for all the information you have provided so far. We have a few more questions that are important for our hospital to ask. Learning more about the people we care for helps us to measure how well we are meeting the needs of each culture we serve.

"Information about your sexual orientation and gender identity will help our health care providers communicate with you effectively. This information will help our hospital understand the populations we serve, and which populations are receiving unequal care. Your information will be a part of your medical record.

"I want to make sure you feel comfortable and that we are being inclusive. Can you tell me your pronouns so that I refer to you correctly? "

PATIENT:
"They/them/theirs
She/her/hers
He/him/his
Ze/hir/hir
Just my name please!
Not listed but wish to share:_____"

HOSPITAL STAFF:
"What do you refer to yourself as?" *(list options)*

PATIENT:
"Male
Female
Transgender Male/ Female-to-Male
Transgender Female/ Male-to-Female
Gender Queer
Not listed but wish to share:_____"

HOSPITAL STAFF:
"Thank you. And what sex were you assigned at birth? You can decline to answer this question if you are uncomfortable."

PATIENT:
"Male
Female
Decline to Answer"

HOSPITAL STAFF:
"Thank you. And finally, how do you describe yourself?" *(list options)*

PATIENT:
"Lesbian or gay
Straight (not lesbian or gay)
Bi-sexual
Not listed but wish to share:_____"

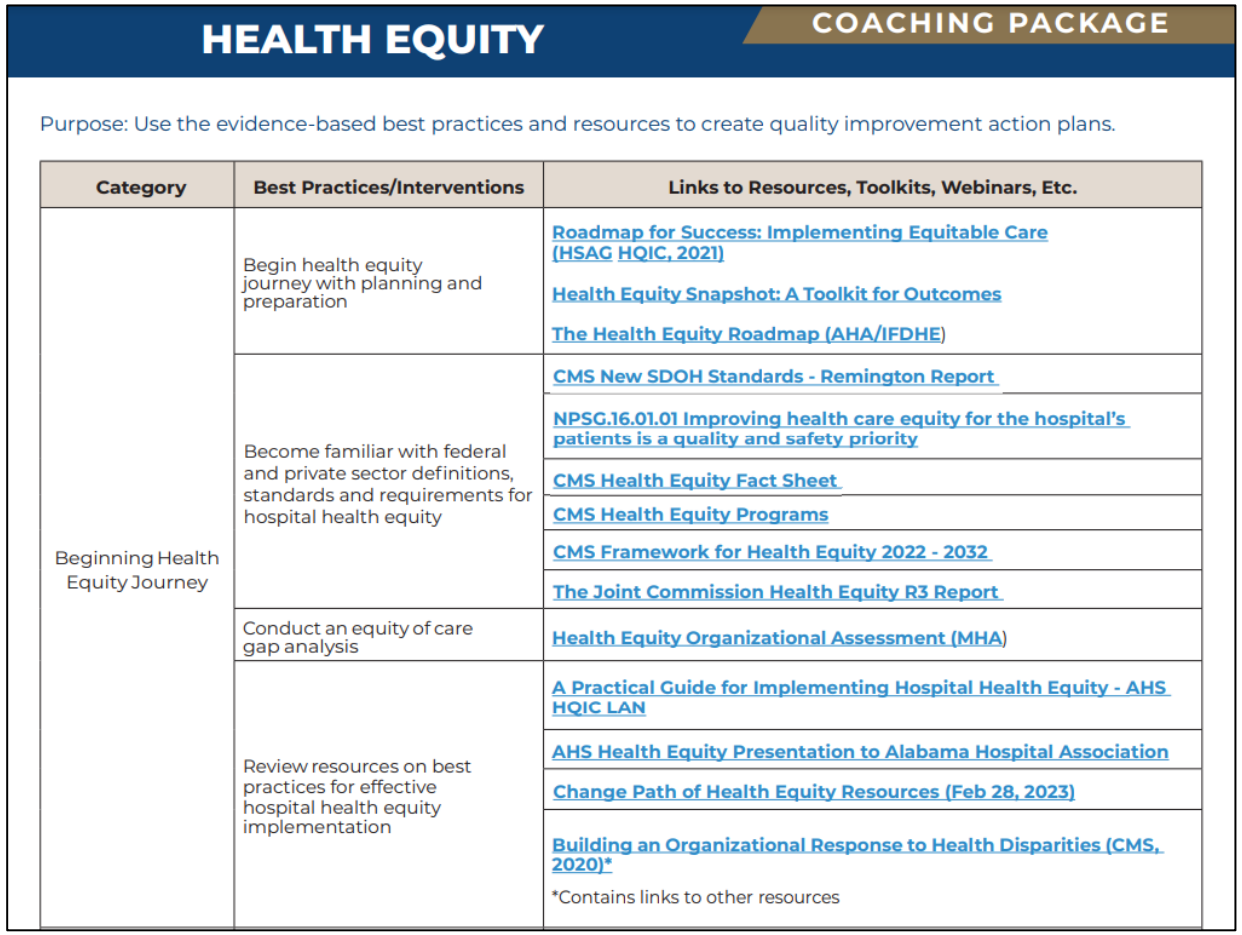
Source: Cynosure/PFCC Partners, 2022

Resource Links to Download for Full CMS Guidance on Health Equity

File Name	File Type	File Size	
Attestation Guidance for the Hospital Commitment to Health Equity Measure (12/2022)	PDF	481 KB	Download
Hospital Commitment to Health Equity Structural Measure Specifications (12/2022)	PDF	251 KB	Download
Screening for Social Drivers of Health Measure and the Screen Positive Rate for Social Drivers of Health Measure (December 2022)	PDF	122 KB	Download
Frequently Asked Questions: Social Drivers of Health (SDOH) Measures	PDF	281 KB	Download

Source: https://qualitynet.cms.gov/inpatient/iqr/measures#tab2

Alliant Health Solutions Health Equity Coaching Package



HEALTH EQUITY COACHING PACKAGE

Purpose: Use the evidence-based best practices and resources to create quality improvement action plans.

Category	Best Practices/Interventions	Links to Resources, Toolkits, Webinars, Etc.
Beginning Health Equity Journey	Begin health equity journey with planning and preparation	Roadmap for Success: Implementing Equitable Care (HSAG HQIC, 2021) Health Equity Snapshot: A Toolkit for Outcomes The Health Equity Roadmap (AHA/IFDHE)
	Become familiar with federal and private sector definitions, standards and requirements for hospital health equity	CMS New SDOH Standards - Remington Report
		NPSG.16.01.01 Improving health care equity for the hospital's patients is a quality and safety priority
		CMS Health Equity Fact Sheet
		CMS Health Equity Programs
		CMS Framework for Health Equity 2022 - 2032
		The Joint Commission Health Equity R3 Report
	Conduct an equity of care gap analysis	Health Equity Organizational Assessment (MHA)
	Review resources on best practices for effective hospital health equity implementation	A Practical Guide for Implementing Hospital Health Equity - AHS HQIC LAN
		AHS Health Equity Presentation to Alabama Hospital Association
		Change Path of Health Equity Resources (Feb 28, 2023)
		Building an Organizational Response to Health Disparities (CMS, 2020)* *Contains links to other resources

https://quality.allianthealth.org/wp-content/uploads/2023/04/2023-Coaching-Package-Health-Equity_508.pdf

Additional Resources

1. AHA Institute for Diversity and Health Equity https://ifdhe.aha.org/

2. Heath Equity Snapshot: A Toolkit for Action (AHA and IDHE, 2020)
https://www.aha.org/system/files/media/file/2020/12/ifdhe_snapshot_survey_FINAL.pdf

3. Health Equity Certification (Joint Commission)
https://www.jointcommission.org/what-we-offer/certification/certifications-by-setting/hospital-certifications/health-care-equity-certification/

4. Vizient Grants Public Access to the Vizient Vulnerability Index™ for Healthcare Providers to Assess Health Equity in their Communities
https://newsroom.vizientinc.com/en-US/releases/releases-vizient-grants-public-access-to-the-vizient-vulnerability-index-for-healthcare-providers-to-assess-health-equity-in-their-communities

Session #2 of Health Equity Strategy Series - Sept. 27 from 2-3 p.m. ET

ALLIANT HEALTH SOLUTIONS | HQIC Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES iQUALITY IMPROVEMENT & INNOVATION GROUP

JOIN OUR UPCOMING WEBINAR EVENT

ALLIANT HQIC HEALTH EQUITY LAN 2-PART SERIES

HEALTH EQUITY STRATEGY SERIES: How to Make it Work for Your Hospital - Part 2

Wednesday, September 27, 2023
2-3 p.m. ET

OVERVIEW:
Join us for Part 2 of the Health Equity Strategy Series.
Do you want to learn how to meet CMS and The Joint Commission (TJC) health equity requirements and improve patient outcomes for your community? Join Alliant Health Solutions and Tift Regional Medical Center (GA) for an interactive two-part series in which we break down exactly what your health equity action plans and next steps should include. To prepare for the series, please complete the gap analysis received after registration.

LEARNING OBJECTIVES:
1. Explain CMS and TJC mandatory health equity requirements.
2. Illustrate a framework and best practice examples to identify health disparities, collect and analyze REaL and health-related social needs data, implement interventions, and establish community partnerships.
3. Discuss how a 181-bed hospital started on its health equity journey, overcame challenges and made it work for its patients and community.

REGISTER HERE:
https://bit.ly/HealthEquityStrategySeriesPt2_Sept27

This material was prepared by Alliant Health Solutions, a Hospital Quality Improvement Contractor (HQIC) under

FEATURED SPEAKERS:

ROSA ABRAHA, MPH
Health Equity Lead
Alliant Health Solutions

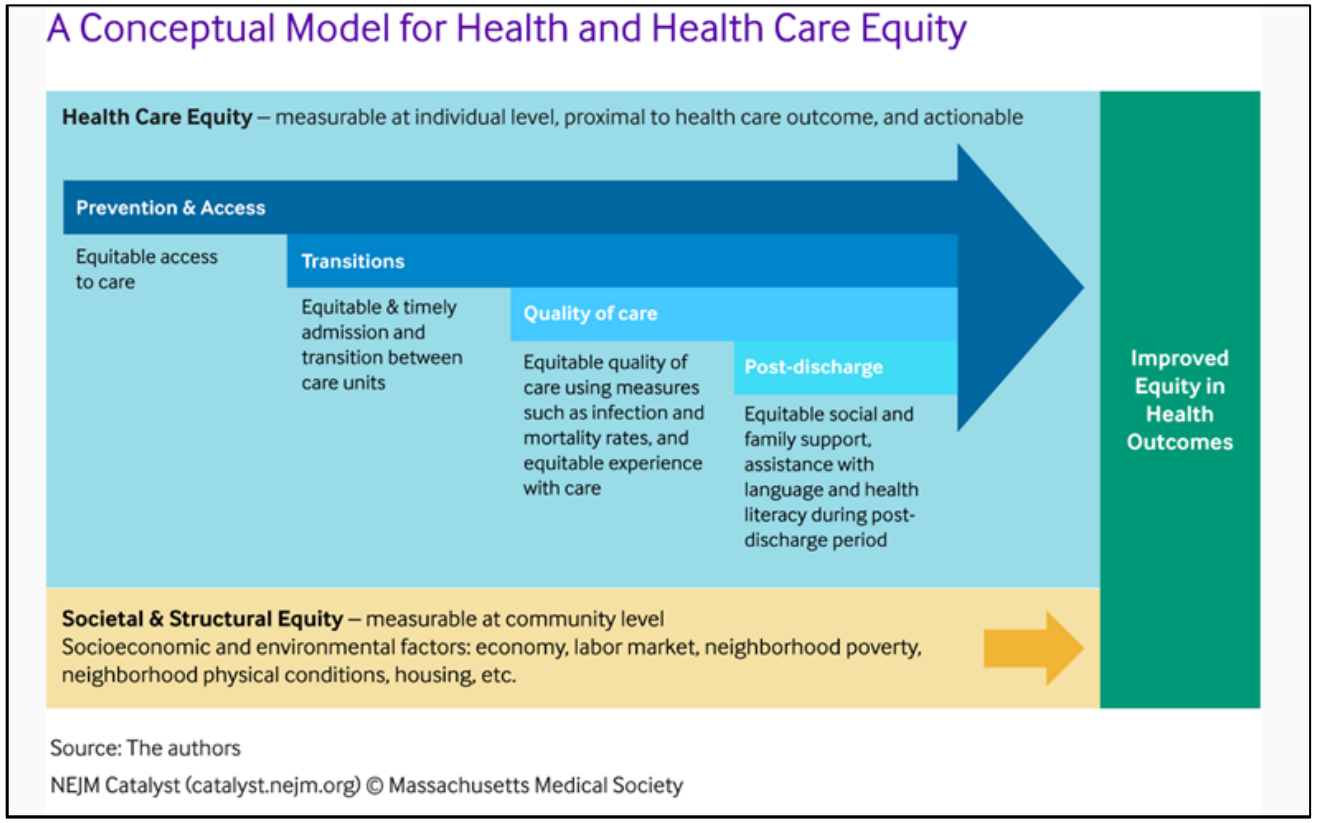
LEANN PRITCHETT, MSN, RN, CPHQ
System Director of Quality and Safety
Tift Regional Medical Center

AUDIENCE:
Health equity and diversity leaders, quality and patient safety professionals, clinical social workers, service excellence professionals, clinical team members, leadership

https://allianthealth-org.zoom.us/webinar/register/WN_b9348hFoRXWVZIMdNe_svw#/registration

Session #2 of Health Equity Strategy Series

- Discuss the conceptual model for health equity and health care equity



Q&A/Wrap Up

Please type questions and comments in the Chat

Please complete evaluation polling questions upon exit

Thank you for attending!

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