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, MPH
Health Equity Lead
Alliant Health Solutions
Rosa.Abraha@allianthealth.org

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 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.
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
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.

### Health Equity Gap Analysis

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

<table>
<thead>
<tr>
<th>Hospital name:</th>
<th>Date:</th>
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<table>
<thead>
<tr>
<th>ELEMENT</th>
<th>BEST PRACTICE RECOMMENDATION</th>
<th>IMPLEMENTATION STATUS</th>
<th>ACTION PLAN/ NEXT STEPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORGANIZATIONAL LEADERSHIP</td>
<td></td>
<td>FULLY</td>
<td>PARTIALLY</td>
</tr>
<tr>
<td>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.</td>
<td>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.</td>
<td></td>
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</tr>
<tr>
<td>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.</td>
<td>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.</td>
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</tbody>
</table>

(Source: Eastern US Quality Improvement Collaborative)
Tift Regional Medical Center: Health Equity Organizational Assessment

October 28, 2022

Data Collection
- Self-Reported data
  - Verification points beyond registration
  - Additional demographic data (SOGI)

Data Collection Training
- Training includes role playing, scripts, didactic, manuals, on-line modules, or other aids.
- Evaluate effectiveness

Data Validation
- Standardized process in place to both evaluate the accuracy and completeness (percent of fields completed) for REaL data
- Standardized process for REaL, SDOH, and SOGI

Data Stratification
- At least one patient safety, quality and/or outcome measure by REaL
- More than one REaL, SOGI, SDOH
- Standardized process in place to evaluate the accuracy and completeness (percent of fields completed) for REaL data

Communicate Findings
- Reporting Mechanism (equity dashboard) to communicate findings to:
  1. Senior executive leaders & Board
  2. Widely within the organization
  3. Patients and families, PFAC, other community partners & stakeholders

Address & Resolve Gaps in Care
- Multidisciplinary team(s) to develop and test pilot interventions to address identified disparities in patient outcomes.
- Implements interventions (redesigns processes, system PI projects, develops new services)
- Process in place for ongoing review, monitoring, recalibrating interventions, ensure sustainable change

October 28, 2022

Reai, sogi, sdoh

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Reai, sogi, sdoh
Six Steps for Health Equity

Step 1: Identify team including leadership

Step 2: Data collection REaL & SDOH embed in EHR

Step 3: REaL & SDOH stratification and analysis

Step 4: Identify priority population

Step 5: Health equity goals and action steps

Step 6: Develop community partnerships
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

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

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

<table>
<thead>
<tr>
<th>CMS HCHE</th>
<th>MUC 2021-106</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 2A</td>
<td>Our hospital collects demographic information, including self-reported race and ethnicity and/or social determinant of health information on the majority of our patients.</td>
</tr>
<tr>
<td>Domain 2B</td>
<td>Our hospital has training for staff in culturally sensitive collection of demographic and/or social determinant of health information.</td>
</tr>
<tr>
<td>Domain 2C</td>
<td>Our hospital inputs demographic and/or social determinant of health information collected from patients into structured, interoperable data elements using a certified EHR technology.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TJC</th>
<th>Standard RC.02.01.01</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The [medical] record contains information that reflects the [patient’s] care, treatment, and services.</td>
</tr>
<tr>
<td></td>
<td>EP 28</td>
</tr>
<tr>
<td></td>
<td>The medical record contains the patient’s race and ethnicity.</td>
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</tbody>
</table>

Mandatory CY23

Mandatory 1/1/24
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 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).

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

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 | 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      | 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]. |

Mandatory CY23

Mandatory 1/1/24
1. Stratify admissions data by race/ethnicity
2. Disaggregate readmission data by race/ethnicity and compare to admissions data, i.e., Black/African American
3. Stratify priority population by top DRGs or CMS conditions for admissions and readmissions
4. Stratify top DRG/CMS condition for priority population by DOH domains
5. Display identified equity gaps on performance dashboard
Tift Regional Medical Center – Process for Health Care Equity Data Analysis by Quality Measures

1. All Admissions by Race/Ethnicity

2. All Readmissions by Race/Ethnicity

3. Black/African American Males Readmissions, Heart Failure

4. All Readmissions SDOH Food Insecurity and Transportation Needs
## Steps 1, 2, and 3 Discussion

<table>
<thead>
<tr>
<th>Step 1: Identify Health Equity Team</th>
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<tbody>
<tr>
<td>Team leader, title</td>
</tr>
<tr>
<td>Team members, titles</td>
</tr>
</tbody>
</table>

| Step 2: Data Collection (REaL and SDOH) and embedded in EMR |

| Step 3: REaL and SDOH stratification and analysis |

---
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.
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/their
She/her/hers
He/him/his
Ze/hir/hirs
Just my name please!
Not listed but wish to share:_________________

**HOSPITAL STAFF:**
“What do you refer to yourself as?” 

**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?” 

**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

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

Source: [https://qualitynet.cms.gov/inpatient/iqr/measures#tab2](https://qualitynet.cms.gov/inpatient/iqr/measures#tab2)
Alliant Health Solutions Health Equity Coaching Package

Additional Resources

1. AHA Institute for Diversity and Health Equity [https://ifdhe.aha.org/](https://ifdhe.aha.org/)


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

Step 1 Identify team including leadership

Step 2 Data collection REal & SDOH embed in EHR

Step 3 REal & SDOH stratification and analysis

Step 4 Identify priority population

Step 5 Health equity goals and action steps

Step 6 Develop community partnerships

Health Equity Action Steps

ALLIANT HQC 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 know how to meet CMS and The Joint Commission’s (TJC) health equity requirements and improve patient outcomes for your community? Join Alliant Health Solutions and TJC Regional Medical Center 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 data, and health-related social needs data, implement interventions, and establish community partnerships.
3. Discuss how a TJC-accredited hospital started on its health equity journey, overcame challenges and made it work for its patients and community.

REGISTER HERE:

FEATURING:

Rosa Ariuna, MPH
Health Equity Lead
Alliant Health Solutions

LeAnn Pertict, MSN, RN, CNHQ
System Director of Quality and Safety
TJC 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/7WN_b9348hFoRXWVZIMdNe_swv#/?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!