Alliant HQIC LAN – Health Equity Strategy Session #2

Presented by:
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LeAnn Pritchett, Tift Regional Medical Center

September 27, 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)
- Recap of Session 1
- Review steps 4-6 and provide practical examples
  - Step 4: Identify the priority population
  - Step 5: Write health equity goals and action steps
  - Step 6: Develop community partnerships
- Resources
- Asked and Answered
- Q&A/Wrap Up

Karen Holtz, MT (ASCP), MS, CPHQ
HQIC Education Lead
Alliant Health Solutions

Rosa Abraha, Alliant Health Solutions

Rosa Abraha, MPH
Health Equity Lead
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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.

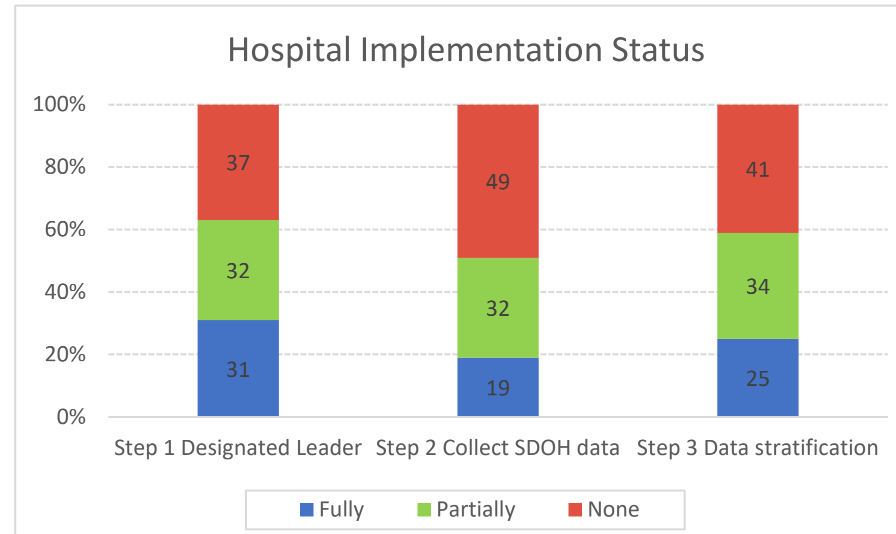
She has served in various leadership roles, including director of nursing for a skilled nursing facility, assistant nurse manager of an orthopedic unit, nurse manager of a surgical unit, and director of patient safety.

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

Recap of Session 1

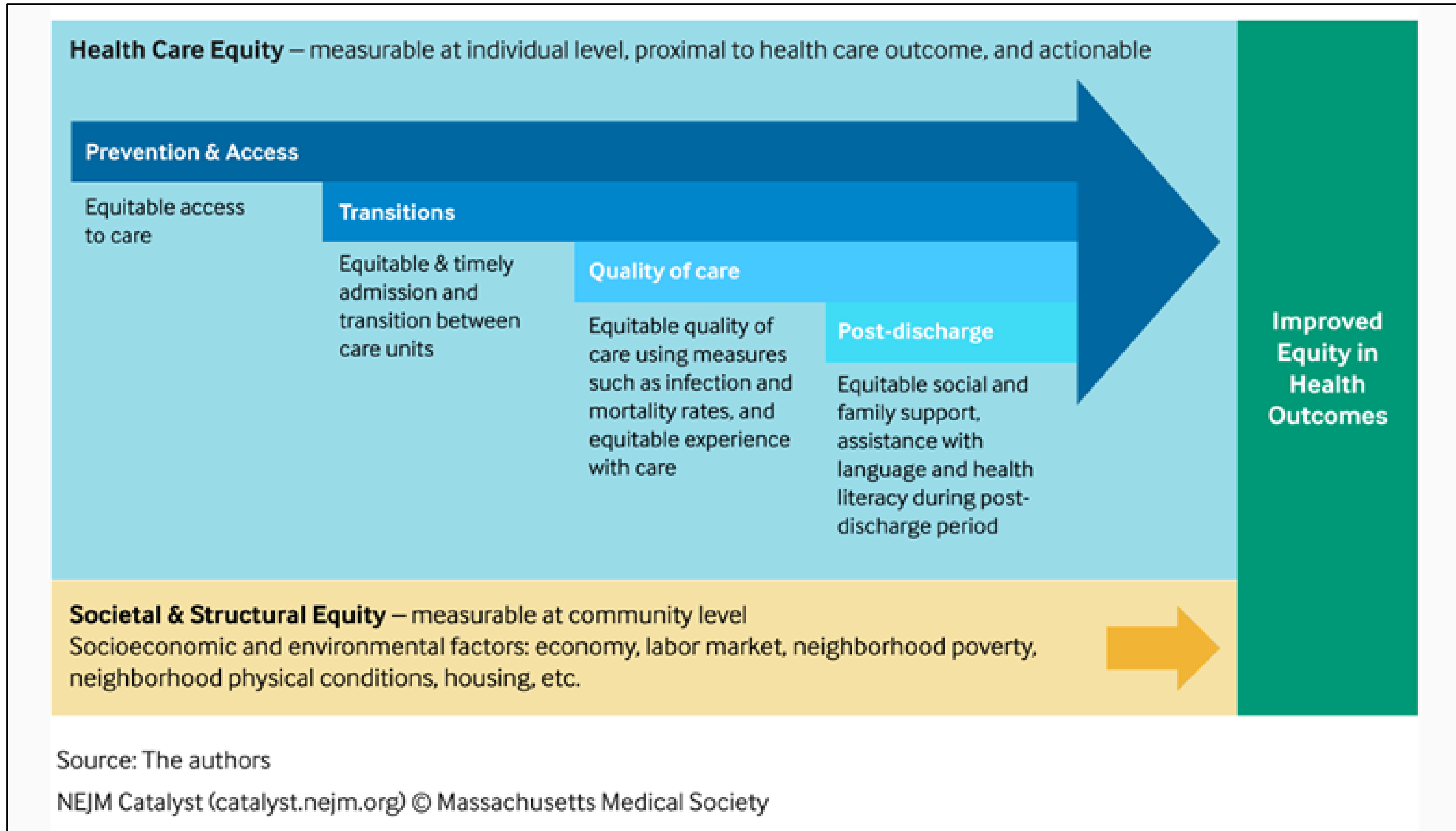
- 67 attendees from 36 hospitals and 11 states
- Polling results for steps 1-2-3



Start doing?

- Conduct gap analysis
- Build a team
- Organize a health equity committee
- Talk with senior leadership to see what is already in place for gathering our team
- Initiate a plan to begin asking these questions and reporting the data, as well as using the data to assist our patients
- Continuing to enhance the collection of SDOH
- Alter collection methods

Conceptual Model for Health and Health Care Equity



https://catalyst.nejm.org/doi/full/10.1056/CAT.22.0442

Six Steps for Health Equity

Polling Question 1

1. What is your hospital's implementation status with identifying a priority population driven by the data and currently experiencing health disparities?

- Fully
- Partially
- None

Step 4: Health Equity Priority Population

CMS HCHE *Mandatory CY23*	**MUC 2021-106** **Domain 1A** Our hospital strategic plan identifies priority populations who currently experience health disparities. **Domain 1B** Our hospital strategic plan identifies healthcare equity goals and discrete action steps to achieving these goals. **Domain 1C** Our hospital strategic plan outlines specific resources which have been dedicated to achieving our equity goals.
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 4** The [organization] develops a written action plan that describes how it will address at least one of the healthcare disparities identified in its [patient] population. **EP 5** The [organization] acts when it does not achieve or sustain the goal(s) in its action plan to reduce healthcare disparities.

Focus on Priority Populations in the Five 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.

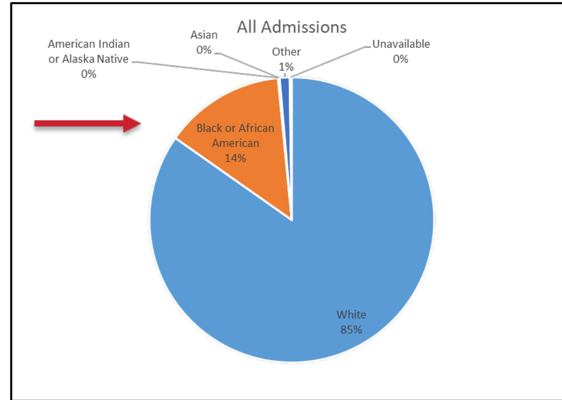
4. **Utility Difficulties**
   Inconsistent availability of electricity, water, oil, and gas services is directly associated with housing instability and food insecurity.

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

Step 4: Tift Regional Medical Center – Identify Health Equity Priority Population

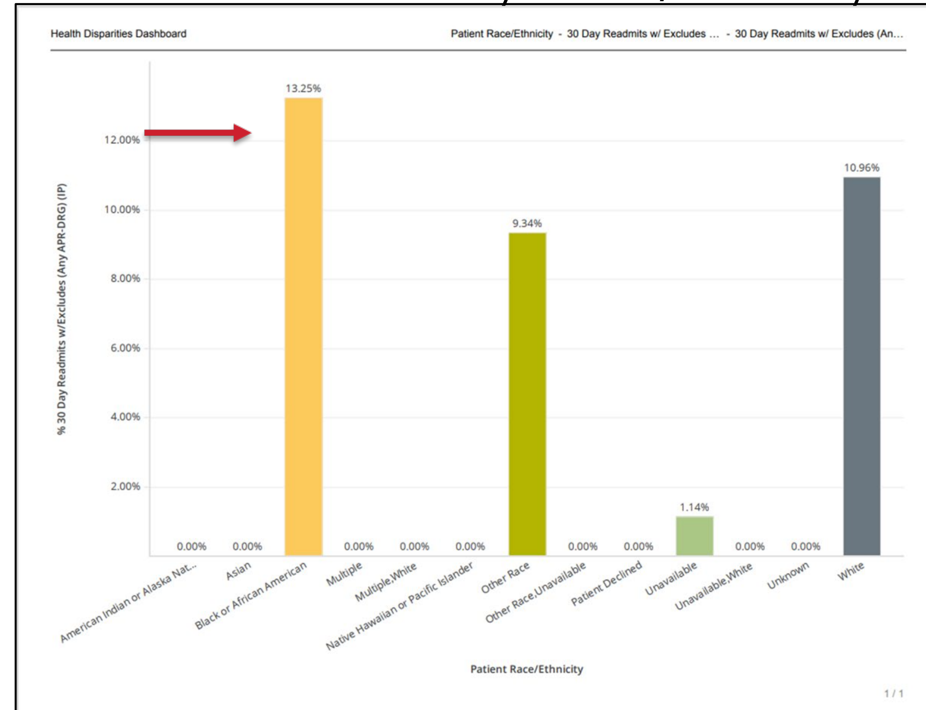
1. All Admissions by Race/Ethnicity

Black/African American

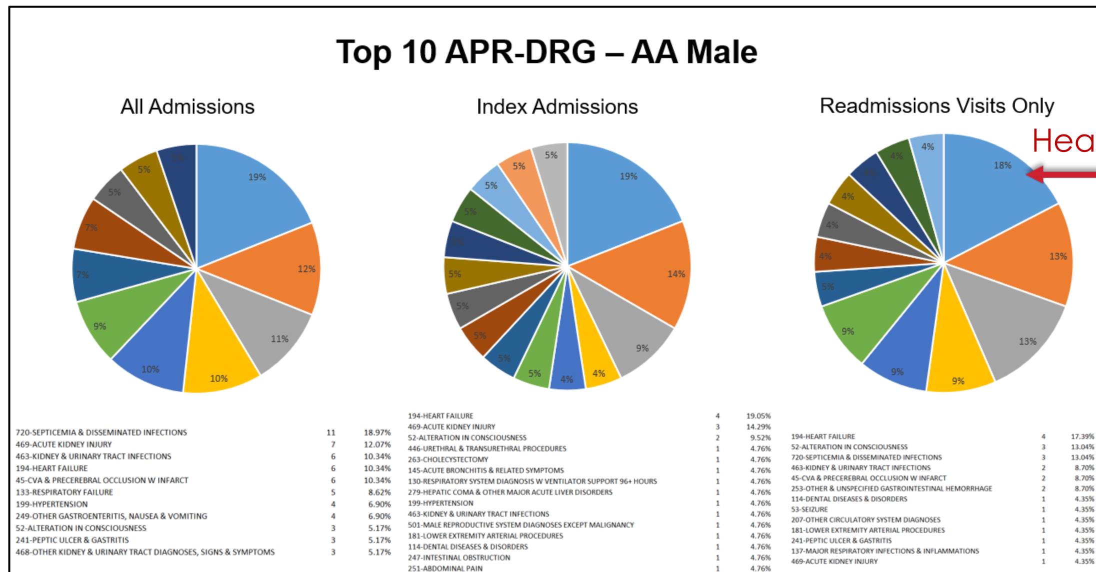


2. All Readmissions by Race/Ethnicity

Black/African American



3. Black/African American Males Readmissions, Heart Failure



All Admissions

APR-DRG	Count	%
720-SEPTICEMIA & DISSEMINATED INFECTIONS	11	18.97%
469-ACUTE KIDNEY INJURY	7	12.07%
463-KIDNEY & URINARY TRACT INFECTIONS	6	10.34%
194-HEART FAILURE	6	10.34%
45-CVA & PRECEREBRAL OCCLUSION W INFARCT	6	10.34%
133-RESPIRATORY FAILURE	5	8.62%
199-HYPERTENSION	4	6.90%
249-OTHER GASTROENTERITIS, NAUSEA & VOMITING	4	6.90%
52-ALTERATION IN CONSCIOUSNESS	3	5.17%
241-PEPTIC ULCER & GASTRITIS	3	5.17%
468-OTHER KIDNEY & URINARY TRACT DIAGNOSES, SIGNS & SYMPTOMS	3	5.17%

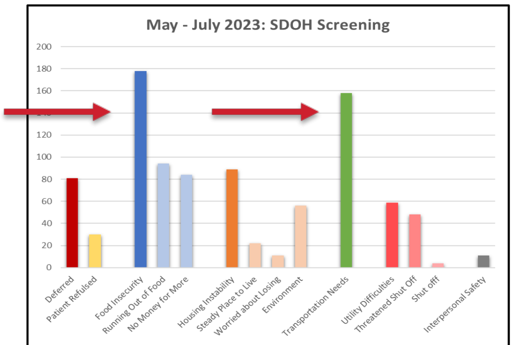
Index Admissions

APR-DRG	Count	%
194-HEART FAILURE	4	19.05%
469-ACUTE KIDNEY INJURY	3	14.29%
52-ALTERATION IN CONSCIOUSNESS	2	9.52%
446-URETHRAL & TRANSURETHRAL PROCEDURES	1	4.76%
263-CHOLECYSTECTOMY	1	4.76%
145-ACUTE BRONCHITIS & RELATED SYMPTOMS	1	4.76%
130-RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	1	4.76%
279-HEPATIC COMA & OTHER MAJOR ACUTE LIVER DISORDERS	1	4.76%
199-HYPERTENSION	1	4.76%
463-KIDNEY & URINARY TRACT INFECTIONS	1	4.76%
501-MALE REPRODUCTIVE SYSTEM DIAGNOSES EXCEPT MALIGNANCY	1	4.76%
181-LOWER EXTREMITY ARTERIAL PROCEDURES	1	4.76%
114-DENTAL DISEASES & DISORDERS	1	4.76%
247-INTESTINAL OBSTRUCTION	1	4.76%
251-ABDOMINAL PAIN	1	4.76%

Readmissions Visits Only

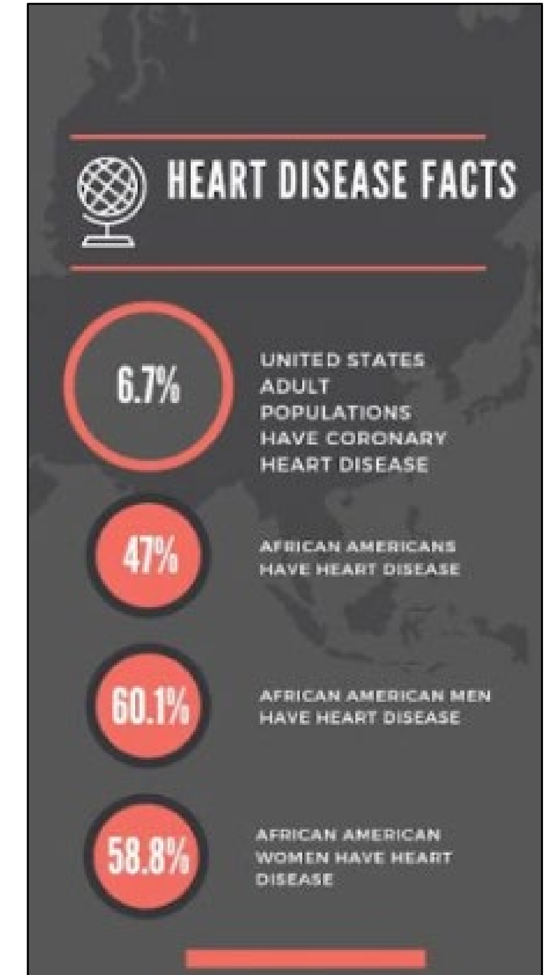
APR-DRG	Count	%
194-HEART FAILURE	4	17.39%
52-ALTERATION IN CONSCIOUSNESS	3	13.04%
720-SEPTICEMIA & DISSEMINATED INFECTIONS	3	13.04%
463-KIDNEY & URINARY TRACT INFECTIONS	2	8.70%
45-CVA & PRECEREBRAL OCCLUSION W INFARCT	2	8.70%
253-OTHER & UNSPECIFIED GASTROINTESTINAL HEMORRHAGE	2	8.70%
114-DENTAL DISEASES & DISORDERS	1	4.35%
53-SEIZURE	1	4.35%
207-OTHER CIRCULATORY SYSTEM DIAGNOSES	1	4.35%
181-LOWER EXTREMITY ARTERIAL PROCEDURES	1	4.35%
241-PEPTIC ULCER & GASTRITIS	1	4.35%
137-MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS	1	4.35%
469-ACUTE KIDNEY INJURY	1	4.35%

4. All Readmissions SDOH Food Insecurity and Transportation Needs



Step 4: Insights

- Data will shift and change
  - Baseline data shifted as a result of mortality in older Black men
  - New finding of younger and sicker Black men with cardiac failure diagnosis
- Know the related national statistics
- Continue to ask why to identify root causes
  - SDOH needs exist for some of the focus population; others may incur issues of medical mistrust and/or implicit bias
  - Cultural and linguistic barriers that impact community reach
  - What can we learn from our HCAPHS analysis?
- Go to the source (patients in the priority population)
- Develop a plan, goals, and interventions that target real improvement – It will take time to identify root causes!
- Building trust as an action item – See the link below
  - Improving communication
  - Increasing transparency
  - Creating welcoming environments
  - Attending to access barriers



https://www.commonwealthfund.org/publications/newsletter-article/2021/jan/medical-mistrust-among-black-americans

Polling Question 2

2. What is your hospital's implementation status with having a strategic plan or quality improvement plan with health equity goals and action steps tied to the priority population?

- Fully
- Partially
- None

Step 5: Health Equity Goals and Action Steps

CMS HCHE *Mandatory CY23*	**MUC 2021-106** **Domain 1A** Our hospital strategic plan identifies priority populations who currently experience health disparities. **Domain 1B** Our hospital strategic plan identifies healthcare equity goals and discrete action steps to achieving these goals. **Domain 1C** Our hospital strategic plan outlines specific resources which have been dedicated to achieving our equity goals.
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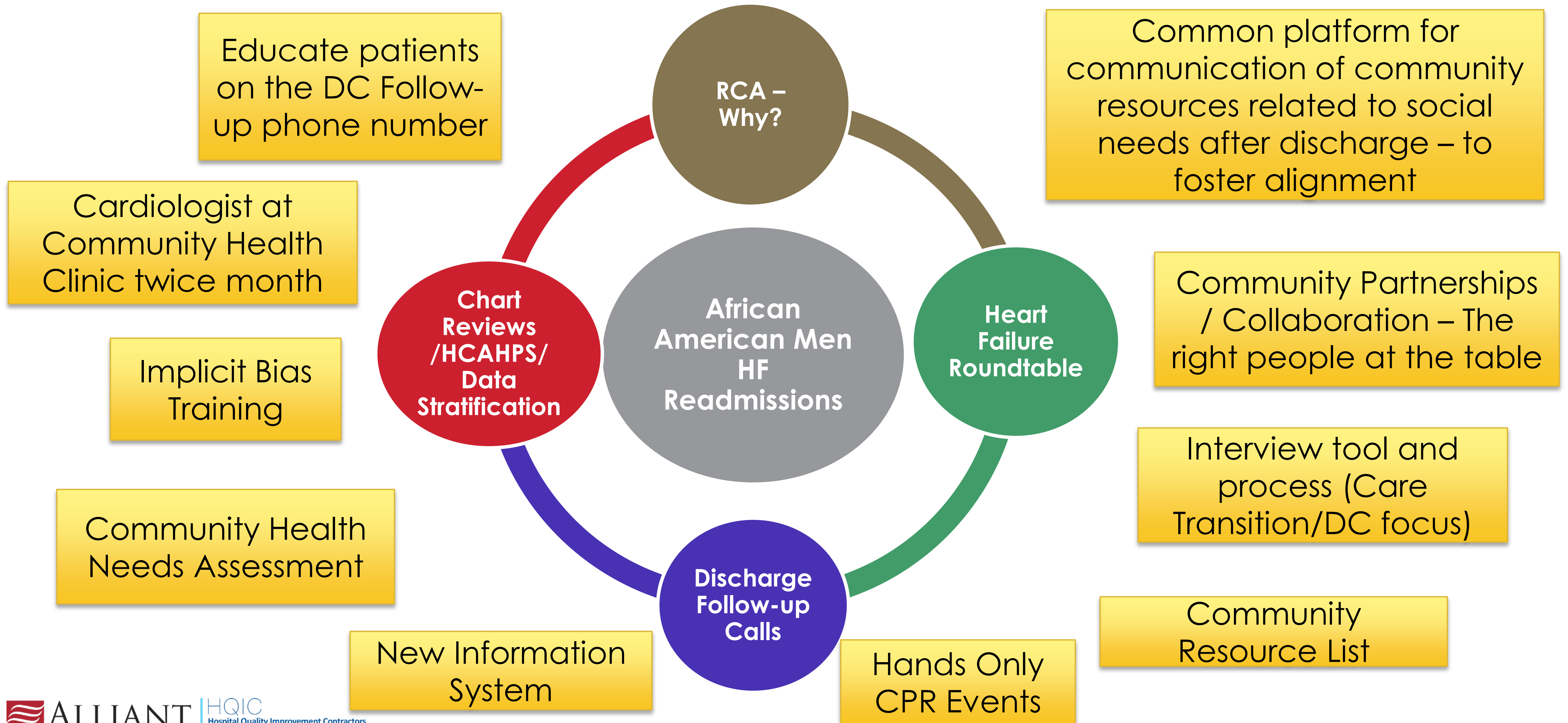
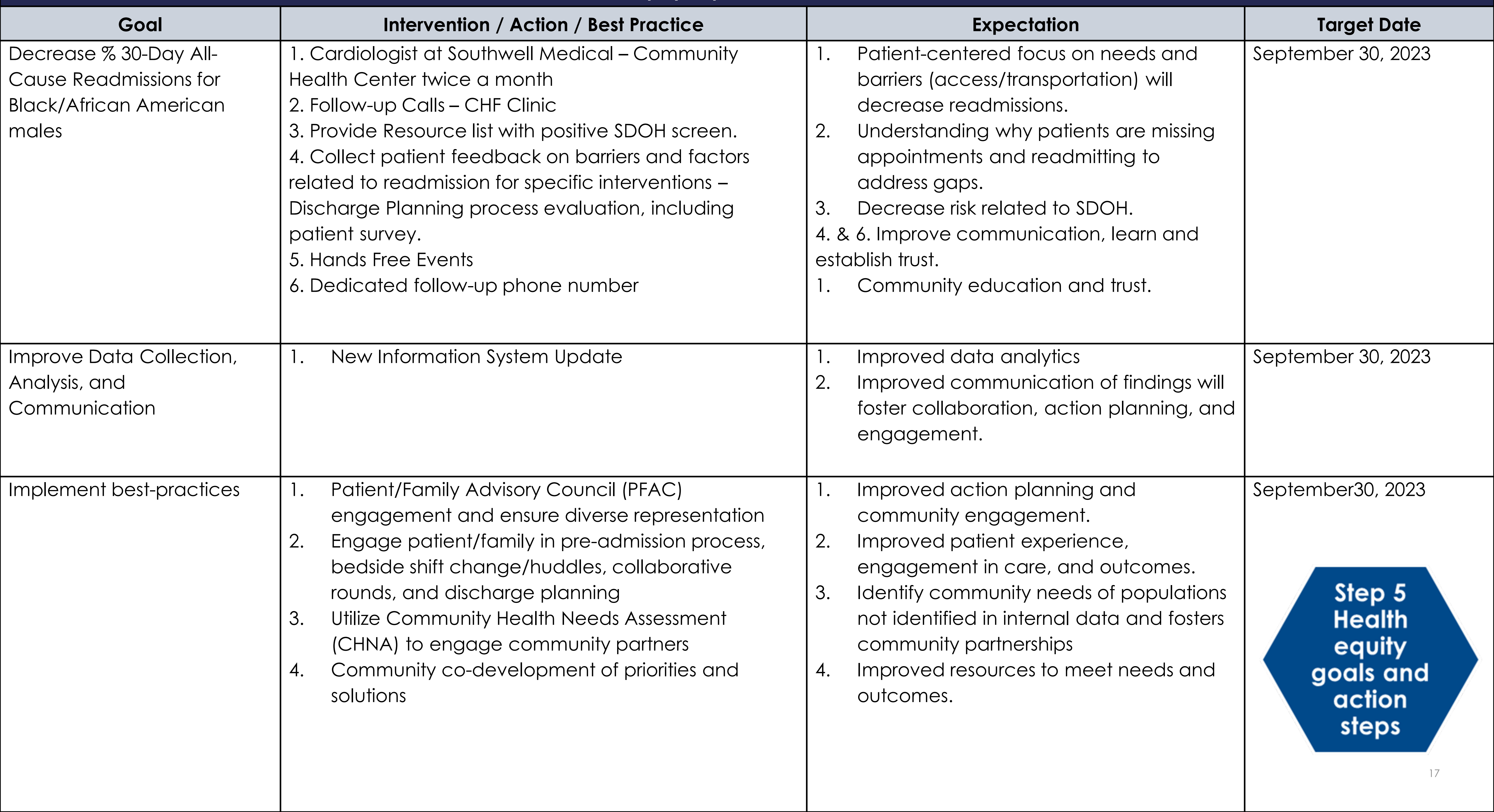
Step 5: Tift Regional Medical Center Health Equity Goals and Discrete Action Steps



Step 5: Tift Regional Medical Center Health Equity Strategic Plan and Goals

- Mission, Vision, Values
  - Our mission is to deliver a lifetime of quality and compassionate care for each patient we serve.
  - Our vision is to be the system of choice for exceptional, patient-centered healthcare in every community we serve.
  - Excellence – We strive for high quality patient-centered and equitable care absent from preventable harm.
- Executive Summary
- Health Equity Statement
- Short- and Long-term actions
- Strategic Objectives
  - Improve Access to Healthcare Services
  - Identify and address Social Determinants of Health
  - Enhance Cultural Competence and Health Literacy
  - Data Collection and evaluation
  - Collaboration and Partnerships
  - Monitor Progress and Accountability
  - Implementation and Resources
- Reference to the Quality Improvement Plan – Priority Population and goals
- Key Definitions

- Priority Population Health Equity Goals
  - Incorporated into our Readmissions A3 (PDSA)



Health Equity Improvement Plan FY 2023

Goal	Intervention / Action / Best Practice	Expectation	Target Date
Decrease % 30-Day All-Cause Readmissions for Black/African American males	1. Cardiologist at Southwell Medical – Community Health Center twice a month 2. Follow-up Calls – CHF Clinic 3. Provide Resource list with positive SDOH screen. 4. Collect patient feedback on barriers and factors related to readmission for specific interventions – Discharge Planning process evaluation, including patient survey. 5. Hands Free Events 6. Dedicated follow-up phone number	1. Patient-centered focus on needs and barriers (access/transportation) will decrease readmissions. 2. Understanding why patients are missing appointments and readmitting to address gaps. 3. Decrease risk related to SDOH. 4. & 6. Improve communication, learn and establish trust. 1. Community education and trust.	September 30, 2023
Improve Data Collection, Analysis, and Communication	1. New Information System Update	1. Improved data analytics 2. Improved communication of findings will foster collaboration, action planning, and engagement.	September 30, 2023
Implement best-practices	1. Patient/Family Advisory Council (PFAC) engagement and ensure diverse representation 2. Engage patient/family in pre-admission process, bedside shift change/huddles, collaborative rounds, and discharge planning 3. Utilize Community Health Needs Assessment (CHNA) to engage community partners 4. Community co-development of priorities and solutions	1. Improved action planning and community engagement. 2. Improved patient experience, engagement in care, and outcomes. 3. Identify community needs of populations not identified in internal data and fosters community partnerships 4. Improved resources to meet needs and outcomes.	September30, 2023

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.

COMMUNITY PARTNERSHIPS

What is your hospital's implementation status with partnering with community-based organizations to maximize cross-sector partnerships and meet patients' and communities' needs?

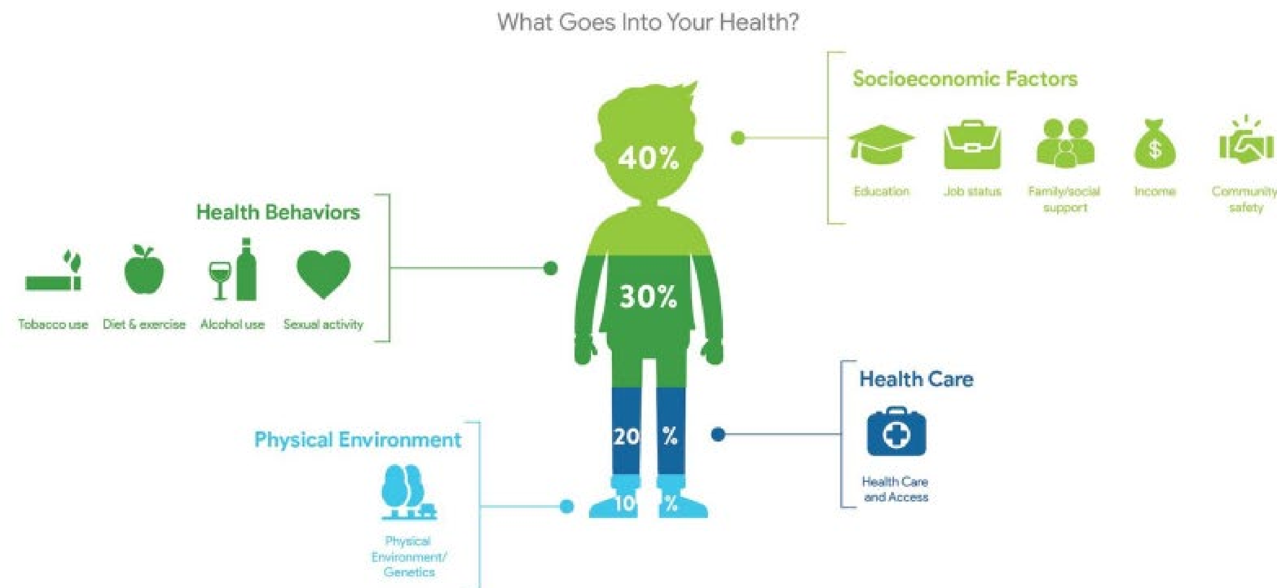
IMPLEMENTATION STATUS		
FULLY	PARTIALLY	NONE
○	○	○

Step 6: Health Equity Community Partnerships

CMS HCHE *Mandatory CY 23*	**MUC 2021-106** **Domain 4A** Our hospital participates in local, regional, or national quality improvement activities focused on reducing health disparities.
CMS HCHE *Mandatory CY 23*	**MUC 2021-106 Domain 1D** Our hospital strategic plan describes our approach for engaging key stakeholders, such as community-based organizations.
TJC *1/1/23*	**Standard LD.04.03.08** Reducing healthcare disparities for the [organization's] [patients] is a quality and safety priority. **EP 2** The [organization] assesses the [patient's] health-related social needs and provides information about community resources and support services.

What are Social Determinants of Health

Non-medical factors that influence the equitable health outcomes of the patient community we serve



Social Determinants of Health - Healthy People 2030 | health.gov

A Culture of Health Equity: Key Clinical-Community Partnerships

Example Clinical Partners

- Facilities (i.e., hospitals, nursing homes)
- Critical Service Areas (i.e., ED)
- Individual Clinicians and Critical Service Areas (i.e., ED, Case Management Team)
- Dialysis Centers
- Behavioral Health Clinics
- Social Services
- Pharmacies
- EMS

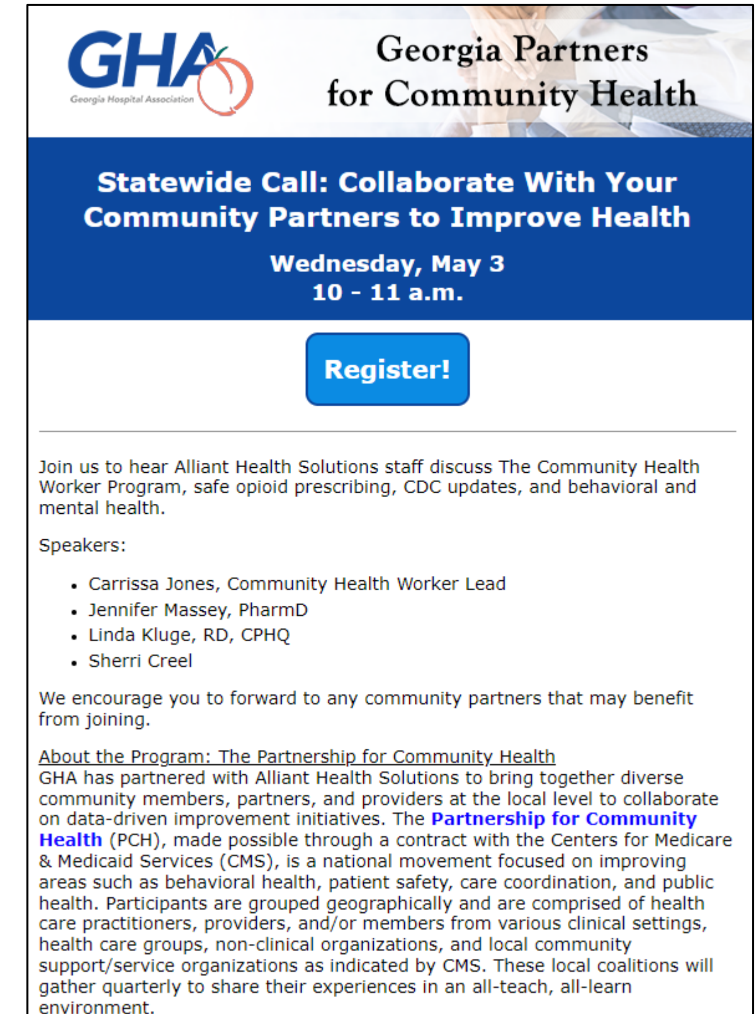
Example Community Partners

- United Way
- Area Agency On Aging
- Area Medicaid Reps
- Faith-Based Organizations
- Local Business (i.e., Barbershops, Grocery Stores)
- Local Employee Retiree Organizations
- Local Senior Centers
- Local Political Organizations
- Local Power Company
- Community Health Workers
- Local Transportation Agencies
- Housing Agencies
- Food Pantries/Shelters
- Literacy Volunteers
- Police and Fire Depts.
- Veterans Association
- Universities/Research Centers

Ways to Engage with Community Coalitions/PCHs

- Attend PCH meeting to learn what community outreach is going on in your region or state
- Engage with affinity or work groups – share best practices
- Use coaching calls to get questions answered
- Attend regional and statewide community coalition meetings
- State contacts:

LA: Carla Schuler	Carla.schuler@allianthealth.org
TN: Julie Clark	julie.clark@allianthealth.org
GA: Mel Brown	melody.brown@allianthealth.org
NC: Marilee Johnson	Marilee.johnson@allianthealth.org
FL: Renee DelMonico	renee.delmonico@allianthealth.org
KY: Leighann Sauls	Leighann.sauls@allianthealth.org
AL: Beth Greene	beth.greene@allianthealth.org



Step 6: Tift Regional Medical Center: Health Equity Community Partnerships

- Local, state, and national collaboratives
  - HQIC
  - Alliant Health Solutions
  - Vizient, Inc.
- Summits, symposiums, and educational events
- Community Partnerships
  - Developing a resource list will facilitate the development of community partnerships
  - Hospital employees serve on councils and resource Boards
  - Trusted community partners – Who are they for key populations?
  - Hands Only CPR with local barbershop owner
  - Community Health Needs Assessment – Opportunity to bring together potential partners to participate in the assessment. Include community leaders representing the diversity of your population.

Community Resource List

Community based services are agencies that offer support services to the public. To ensure that our patients are
developed this community-based listing. For additional information, please speak with a member of your healthc
local Department of Family and Children Services (DFCS).

TYPE OF COMMUNITY RESOURCE	NAME OF SERVICE PROVIDER	PHONE NU
Transportation:		
	Hope EMS	229-396-4673
	Cook County Transit System	229-896-2266
	Regional Public Transit (formerly TiftLift)	1-855-360-7475
	Motivecare (formerly Logisticare)	1-888-224-7985
	Tift Lift	855-360-7475
	Turner Transit	229-567-3400
	Ben Hill Transit	229-246-7433
	Georgia Medicaid Net Program	888-224-7985
Food Resources:		
	Neighborhood Service Center/Soup Kitchen	229-382-6436, 22
	Leroy Rogers Senior Center	229-391-9299
	Food Bank	229-392-2688
	Salvation Army	229-386-1503
	Second Harvest Food Bank	1-888-453-4143
	Local churches	

Steps 4, 5, and 6 Discussion

Step 4:

Identify health disparities and priority population

Step 5:

Write health equity goals, action plan, and steps

Step 6:

Develop community partnerships to support culture of health equity

Polling Question Next Steps

4. If interested, what is the best availability for monthly Health Equity Office Hours (45 mins) hosted by Rosa Abraha? Office Hours are scheduled time with subject matter experts and do not include presentations but time to ask questions among peers. (Multiple Choice)
   A. 3rd Tues after 2 p.m. ET
   B. 3rd Thurs after 2 p.m. ET
   C. 4th Tues after 2 p.m. ET
   D. 4th Thurs after 2 p.m. ET

Asked and Answered

1. Scripting for asking sex element question; Registration or Nursing? Registration
2. What method is recommended for keeping a Health Equity Dashboard for all the data collected? Suggest Excel worksheet with tabs for different components
   https://ifdhe.aha.org/system/files/media/file/2020/12/ifdhe_inclusion_dashboard.pdf
3. When are we required to submit the attestation statement?
   https://qualitynet.cms.gov/inpatient/iqr/resources
4. What is the most respectful way to have front-end registrars obtain some of the more sensitive type questions?

   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.

5. Can you provide a format of what the strategic plan should include? I wish to adhere to The Joint Commission Standards. See slides 16 and 17. Other suggestions include:
   - Executive summary, specific goals, population data/census, accountability, processes, resourcing/budget, performance data, sustainability plan, communication
   - Use the standards and EPs as the "what" and write the "how" for your hospital. Don't forget the NPSGs.
   - Could be for the organization or Emergency Department; one year or multiple years

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

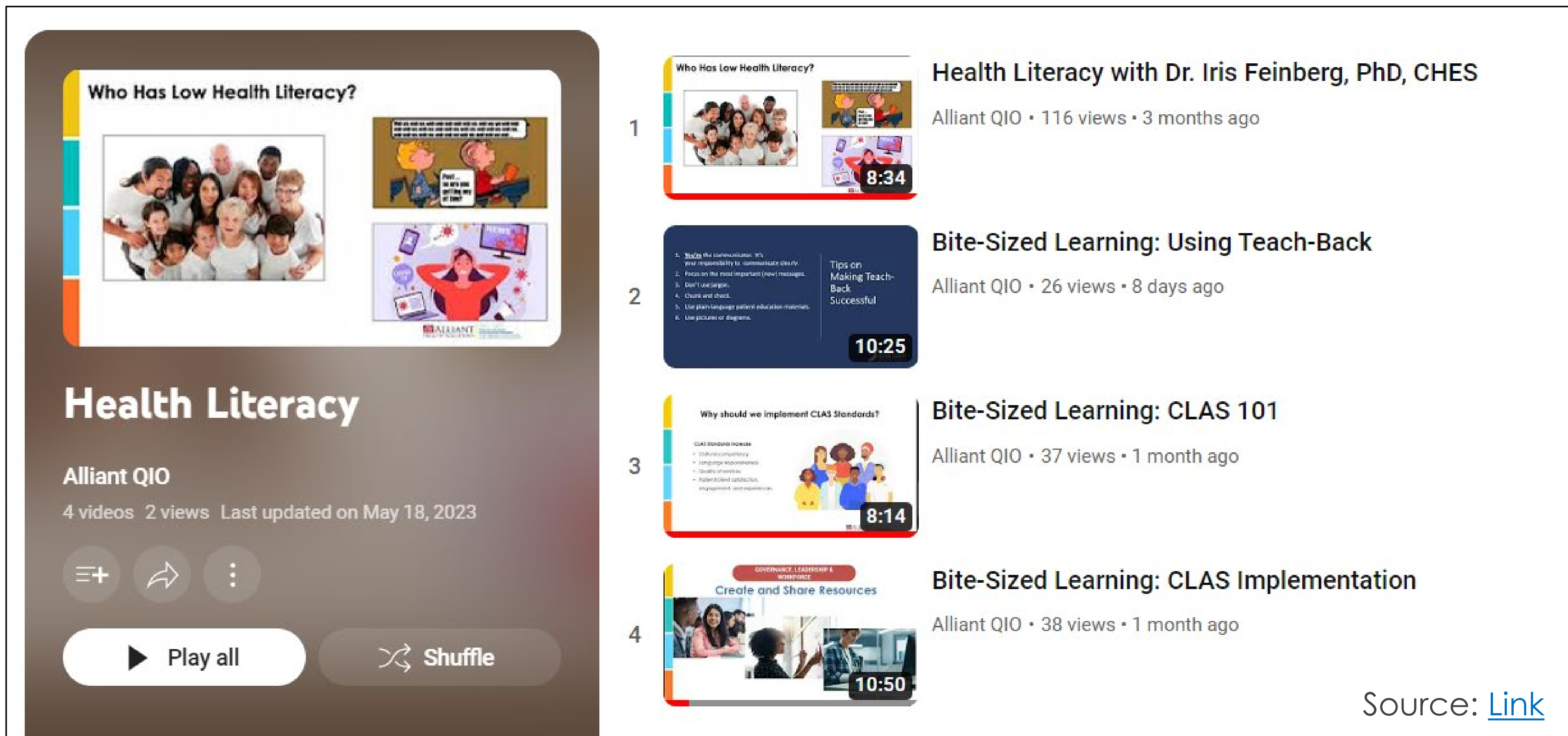
1. AHA Institute for Diversity and Health Equity https://ifdhe.aha.org/

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. 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

4. The CMS Office of Minority Health (CMS OMH) released a **new Z code infographic entitled: Improving the Collection of Social Determinants of Health (SDOH) Data with ICD-10-CM Z Codes (2023)**. This resource aims to assist providers with understanding and using Z codes to improve the quality and collection of health equity data.

Cultural and Linguistically Appropriate Services (Alliant CLAS Video Toolkit)



https://www.youtube.com/playlist?list=PLXWmxni-xNHvBQp3MQt8DXRae06CGF2JI

Webinars

- Alliant HQIC Health Equity Strategy Session 1 (Aug 29) slides and recording on Alliant HQIC website or below

https://quality.allianthealth.org/conference/health-equity-strategy-series-how-to-make-it-work-for-your-hospital-part-1/

Education on Demand

Infection Prevention (IP) Office Hours

HQIC Infection Prevention Chats | July 26, 2023

HQIC Infection Prevention Chats | April 26, 2023

HQIC Monthly Office Hours - Infection Prevention (IP) Chats | Oct. 26, 2022

HQIC Monthly Office Hours - Infection Prevention (IP) Chats | Sept. 28, 2022

HQIC LAN Events

The Core Elements for Antibiotic Stewardship in Action - Pharmacy Expertise and Action | Sept. 19, 2023

The Core Elements for Antibiotic Stewardship in Action - Leadership and Accountability | Aug. 29, 2023

Health Equity Strategy Series: How to Make it Work for Your Hospital - Part 1 | Aug. 29, 2023

HQIC LAN: How to Rebuild, Reengage and

HQIC Community of Practice Calls (COP) Events

Innovative Approaches to Addressing Health Equity and Social Determinants in Rural Communities | July 13, 2023

HQIC COP - Reducing Hospital Onset C. Difficile Through Diagnostic Stewardship | June 8, 2023

HQIC COP - Partnering with Patients and Families to Prevent All-Cause Harm | May 11, 2023

- Register here **for the Joint Commission National Health Equity Grand Rounds event, "Creating Accountability Through Data," scheduled for Oct. 10, from 2-3:30 p.m. ET, to earn free continuing medical education (CME) credit** and to reimagine how demographic data can be used to advance healthcare equity, address disparities, and hold powerful institutions accountable.
- This activity has been approved for *1.5 AMA PRA Category 1 Credit(s)™* *
- Registration Link:

https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/joint-commission-online/sept-6-2023/Oct-10-Grand-Rounds

Q&A/Wrap Up

- Please type questions and comments in Chat
- Please complete evaluation polling questions upon exit

Asked and Answered (from Session #1)

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 (from Session #1)

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 the next slide. 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

THANK YOU FOR ATTENDING!

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