GA FLEX Health Equity Improvement Project Monthly Meeting:
Topic: 2023/2024 CMS/TJC Hospital Health Equity Requirements
Speaker: Rosa Abraha, MPH
June 27, 2023
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 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.
Hospital Leadership Engagement in HE

**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].
HOW TO: Engage Hospital Leadership in HE

**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>
</tr>
</thead>
</table>

<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></td>
<td></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>FULLY</td>
<td>PARTIALLY</td>
</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>
<td>FULLY</td>
<td>PARTIALLY</td>
</tr>
</tbody>
</table>

- **This template** aims to help organizations assess the extent to which they have incorporated health equity best practices as part of its overall operations.

- There are 7 **major categories** for evaluation in this analysis: organizational leadership, workforce training, data collection, data validation, data stratification, health literacy/cultural competence, community partnerships.

(Source: Eastern US Quality Improvement Collaborative)
Health Equity Action Plan

<table>
<thead>
<tr>
<th>CMS HCHE</th>
<th>TJC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mandatory CY23</strong></td>
<td><strong>Mandatory 1/1/24</strong></td>
</tr>
<tr>
<td><strong>CMS HCHE</strong></td>
<td><strong>TJC</strong></td>
</tr>
<tr>
<td>MUC 2021-106</td>
<td><strong>Standard LD. 04.01.08</strong></td>
</tr>
<tr>
<td>Domain 1A</td>
<td>Reducing healthcare disparities for the [organization’s] [patients] is a quality and safety priority.</td>
</tr>
<tr>
<td>Domain 1B</td>
<td><strong>EP 4</strong></td>
</tr>
<tr>
<td>Our hospital strategic plan identifies priority populations who currently experience health disparities.</td>
<td>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.</td>
</tr>
<tr>
<td>Domain 1C</td>
<td><strong>EP 5</strong></td>
</tr>
<tr>
<td>Our hospital strategic plan identifies healthcare equity goals and discrete action steps to achieving these goals.</td>
<td>The [organization] acts when it does not achieve or sustain the goal(s) in its action plan to reduce healthcare disparities.</td>
</tr>
<tr>
<td>Domain 1C</td>
<td></td>
</tr>
<tr>
<td>Our hospital strategic plan outlines specific resources which have been dedicated to achieving our equity goals.</td>
<td></td>
</tr>
</tbody>
</table>
CMS has released a full attestation document which includes a breakdown on each of the domains required to fulfill the hospital commitment to health equity. This screenshot includes details on what to include in your hospital action plan. (Source: CMS)
HOW TO: Create a Hospital Health Equity Action Plan

This fillable worksheet guides the development of a 5-step action plan to identify health disparities and priority populations, define goals, establish a health equity strategy, determine what your organization needs to implement its strategy. (Source: CMS)
Data Collection: REaL and SDOH Patient Demographic Data

**CMS HCHE**

**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.

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**TJC**

**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.
CMS has released a full **attestation document** which includes a breakdown on each of the domains required to fulfill the hospital commitment to health equity. This screenshot includes details on what to include in your REAL and SDOH collection. (Source: CMS)
HOW TO: Scripting on REaL Data Collection for Hospital Staff

REAL Data Collection Script and Definition

This document can be provided to staff during orientation or training on the collection of REAL data to ensure consistent screening and documentation are being collected across all points of registration. These are recommended script and suggested responses when screening patients.

Recommended Script for Patient’s Ethnicity, Race, and Language Screening

“I would like to tell me your race and ethnic background. We use this information to review the treatment patients received and make sure everyone gets the highest quality of care.”

- First, do you consider yourself Hispanic or Latino? (See ethnicity definition at end of document)
  - Yes
  - No
  - Declined
  - Unknown/ Unavailable

- Which category or categories best describe your race? (See race definitions at end of document)
  - American Indian or Alaska Native
  - Asian
  - Black or African American
  - Native Hawaiian or Other Pacific Islander
  - White
  - Declined
  - Unknown
  - Other Race

- What language do you feel most comfortable speaking with your doctor or nurse (patient’s primary language)?
  - Provide a list of options. Consider the community you serve, for example if your community is mostly Asian, provide a list of Asian languages (i.e., Mandarin, Hindi, Japanese, etc.) along with your commonly spoken language such as English and Spanish.
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

<table>
<thead>
<tr>
<th>CMS SDH</th>
<th>Screening for Social Drivers of Health MUC2021–136</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Numerator: Number of beneficiaries 18 and older screened for food insecurity, housing instability, transportation needs, utility assistance, and interpersonal violence.</td>
</tr>
<tr>
<td></td>
<td>Denominator: Number of beneficiaries 18 and older in practice (or population).</td>
</tr>
</tbody>
</table>

**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 exists 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 5 unique rates for each of the 5 categories of social drivers of health.
• 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 EHR as it contains 2 questions in each of the 5 core domains that CMS will be evaluating for both structural measures (SDOH-1 and SDOH-2).
NOTE: Hospitals may use any self-reported screening tool but it’s recommended not required to use as many questions as possible from the CMS AHC Health-Related Social Needs Screening Tool.
You must **report these measures once annually using the web-based data collection tool within the HQR (Hospital Quality Reporting) system** online (Ex. similar to submission as the Maternal Morbidity structural measure).

CMS has not officially released the submission deadline but in the final rule they said it would follow the same submission schedule as the other structural measures. In the case of the Maternal Morbidity structural measure, you collect the data during the calendar year and submit it by May 15 of the following year. It is likely to work like this.

**Potential Reporting Period:**
- **Voluntary reporting**
  - Collection period: January 1, 2023 – December 31, 2023
  - Submission deadline: May 15, 2024
- **Mandatory reporting**
  - Collection period: January 1, 2024 – December 31, 2024
  - Submission deadline: May 15, 2025

Source: [Link]
## Z-Code Billing for 5 CMS SDOH Categories

### Table 1
ICD-10-CM Code Categories

<table>
<thead>
<tr>
<th>ICD-10-CM Code Category</th>
<th>Problems/Risk Factors Included in Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z55 – Problems related to education and literacy</td>
<td>Illiteracy, schooling unavailable, underachievement in a school, less than a high school diploma, no general equivalence degree (GED), educational maladjustment, and discord with teachers and classmates.</td>
</tr>
<tr>
<td>Z58 – Problems related to physical environment</td>
<td>Inadequate drinking-water supply, and lack of safe drinking water.</td>
</tr>
<tr>
<td>Z59 – Problems related to housing and economic circumstances</td>
<td>Sheltered homelessness, unsheltered homelessness, residing in street, inadequate housing, housing instability, discord with neighbors, lodgers and landlord, problems related to living in residential institutions, inadequate food, lack of adequate food, food insecurity, extreme poverty, low income, and insufficient social insurance and welfare support.</td>
</tr>
</tbody>
</table>

Source: Link
# Data Analysis and Stratification by Hospital Quality Measures

<table>
<thead>
<tr>
<th>CMS HCHE</th>
<th>MUC 2021-106</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain 3A</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Domain 1B</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>TJC</strong></th>
<th>Standard LD.04.03.08</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mandatory 1/1/24</strong></td>
<td>Reducing healthcare disparities for the [organization’s] [patients] is a quality and safety priority.</td>
</tr>
<tr>
<td><strong>EP 3</strong></td>
<td>The [organization] identifies healthcare disparities in its [patient] population by stratifying quality and safety data using the sociodemographic characteristics of the [organization’s] [patients].</td>
</tr>
</tbody>
</table>
CMS has released a full attestation document which includes a breakdown on each of the domains required to fulfill the hospital commitment to health equity. This screenshot includes details on how to stratify REaL and SDOH data by quality measure. (Source: CMS)
BMCS participated in our Fall ‘22 HQIC readmission cohort and they were early adopters of embedding SDOH questions into their admissions/readmissions process. Over a 90-day window, they identified their top SDOH barrier for 30-day readmission patients was homelessness and they developed community partnerships to reduce that rate by 10%.
### Primary Interventions
*(in the hospital setting)*

1. Initiate Charity Care applications where available.
2. Develop follow up plan for medical care (primary and specialty).
3. Look to shelters/group homes for basic needs (housing, food, etc.).
4. Offer a short-term placement option for those able to afford low-cost extended stay motels.
5. Connect patient with housing authority, sober living options, utilize local church organizations, VA resources if appropriate, etc.

### Secondary Interventions
*(in the community setting)*

1. Review social support network and current involvement.
2. Ensure DC meds are filled before discharge (up to 90 days).
3. If no form of contact for patient is provided, locate the CCM office number to schedule weekly calls and/or as needed.
4. Conduct reminder calls before follow-up appointments.
5. Offer transportation assistance to follow-up appts if needed.
6. Enroll in Medicaid/Insurance specific CCM program for after 30-day period.
## Interventions for Patients with SDOH Needs and Health Disparities

<table>
<thead>
<tr>
<th></th>
<th><strong>CMS HCHE</strong></th>
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</thead>
</table>
| | **MUC 2021-106**  
**Domain 4A**  
Our hospital participates in local, regional, or national quality improvement activities focused on reducing health disparities. |

<table>
<thead>
<tr>
<th></th>
<th><strong>CMS HCHE</strong></th>
</tr>
</thead>
</table>
| | **MUC 2021-106** **Domain 1D**  
Our hospital strategic plan describes our approach for engaging key stakeholders, such as community-based organizations. |

<table>
<thead>
<tr>
<th></th>
<th><strong>TJC</strong></th>
</tr>
</thead>
</table>
| | **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. |
HOW TO: CMS Requirements for Quality Improvement Activities

CMS has released a full attestation document which includes a breakdown on each of the domains required to fulfill the hospital commitment to health equity. This screenshot includes details on how to engage in quality improvement activities to reduce health disparities. (Source: CMS)
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:

<table>
<thead>
<tr>
<th>State</th>
<th>Contact Name</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>LA</td>
<td>Carla Schuler</td>
<td><a href="mailto:Carla.schuler@allianthealth.org">Carla.schuler@allianthealth.org</a></td>
</tr>
<tr>
<td>TN</td>
<td>Julie Clark</td>
<td><a href="mailto:julie.clark@allianthealth.org">julie.clark@allianthealth.org</a></td>
</tr>
<tr>
<td>GA</td>
<td>Mel Brown</td>
<td><a href="mailto:melody.brown@allianthealth.org">melody.brown@allianthealth.org</a></td>
</tr>
<tr>
<td>NC</td>
<td>Marilee Johnson</td>
<td><a href="mailto:Marilee.johnson@allianthealth.org">Marilee.johnson@allianthealth.org</a></td>
</tr>
<tr>
<td>FL</td>
<td>Renee DelMonico</td>
<td><a href="mailto:renee.delmonico@allianthealth.org">renee.delmonico@allianthealth.org</a></td>
</tr>
<tr>
<td>KY</td>
<td>Leighann Sauls</td>
<td><a href="mailto:Leighann.sauls@allianthealth.org">Leighann.sauls@allianthealth.org</a></td>
</tr>
<tr>
<td>AL</td>
<td>Beth Greene</td>
<td><a href="mailto:beth.greene@allianthealth.org">beth.greene@allianthealth.org</a></td>
</tr>
</tbody>
</table>

Culturally and Linguistically Appropriate Services (CLAS) Standards

<table>
<thead>
<tr>
<th>TJC</th>
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</table>

**PC.02.01.21**
The hospital effectively communicates with patients when providing care, treatment, and services.

**EP 1**
The hospital identifies the patient’s oral and written communication needs, including the patient’s preferred language for discussing healthcare.

**EP 2**
The hospital communicates with the patient during the provision of care, treatment, and services in a manner that meets the patient’s oral and written communication needs.
HOW TO: Train Staff on CLAS Standards (Alliant CLAS Videos)

1. Health Literacy with Dr. Iris Feinberg, PhD, CHES
   Alliant QIO • 116 views • 3 months ago

2. Bite-Sized Learning: Using Teach-Back
   Alliant QIO • 26 views • 8 days ago

3. Bite-Sized Learning: CLAS 101
   Alliant QIO • 37 views • 1 month ago

4. Bite-Sized Learning: CLAS Implementation
   Alliant QIO • 38 views • 1 month ago

Source: Link
### 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>
</thead>
<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>
</tr>
<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>
</tr>
</tbody>
</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

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**HEALTH EQUITY**

**COACHING PACKAGE**

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

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