HQIC Community of Practice Call

Advances in Health Equity

September 12, 2024

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
HQIC
Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

Introduction

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Models Testing
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Center for Clinical Standards and Quality
Centers for Medicare & Medicaid Services

Welcome

Agenda

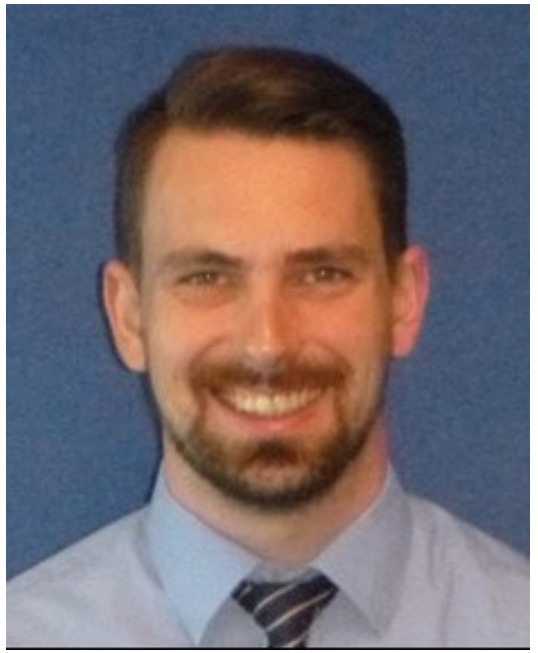
- Introduction
- Today's topic: Advances in Health Equity
- Presenters:
  - **Erica Sanchez**, Quality/Infection Control RN, Lompoc Valley Medical Center
  - **Joshua Hazelton**, Senior Quality Improvement Specialist, Health Services Advisory Group (HSAG)
- Open discussion
- Closing remarks

As You Listen, Ponder…

- What impactful actions can you take as a result of the information shared today?
- How are you able to increase engagement within your facilities to ensure a true change in patient safety?
- Based on what you heard today, what activities do you currently have underway that can leverage immediate action over the next 30, 60 or 90 days?

Meet Your Speakers

Erica Sanchez, RN, BSN
Quality/Infection Control RN
Lompoc Valley Medical Center



Joshua Hazelton, MPH, CPH, CSSGB
Senior Quality Improvement Specialist
Health Services Advisory Group

Healthcare Commitment to Health Equity

Erica Sanchez, RN, BSN
Quality/Infection Control RN

HCHE Domain 1 & 5

Domain 1 :

Identification of Priority Populations: The plan should identify populations experiencing health disparities.

Equity Goals and Action Steps: The plan must outline specific healthcare equity goals, and the steps needed to achieve them.

Dedicated Resources: The plan should specify the resources allocated to reach the equity goals.

Stakeholder Engagement: The plan must describe how the hospital will engage key stakeholders, including community-based organizations.

Domain 5:

Hospital senior leadership, which includes the chief executives, board of trustees, Chief Medical Officer, and senior medical staff, reviews our strategic plan for achieving health equity annually. Additionally, they examine key performance indicators broken down by demographic and social factors each year.

Health Equity Timeline: Phase 1

June-December 2023

- Research regulations, studies, and evidence-based practice
- Review and amend facility's strategic plan to meet Domain I HCHE structural measure requirements
- Develop timeline
- Establish Health Equity Committee

Jan-March 2024

- Review current workflows and data
- Collaborate with registration to fine tune data collection processes for REaL data and gender data questions

April-June 2024

- Collaborate with nursing to establish social determinants of health (SDOH) screening questions and workflow

REaL = race, ethnicity, and language

Health Equity Committee

- Committee Chair: Quality RN
- Quality Incentive Program Coordinator
- Director of Perioperative Services
- Lead Case Manager
- Director of Revenue Cycle
- Clinical Informatics
- Patient Navigator
- 2 Quality RNs
- Executive Leader: Chief of Quality

HCHE Strategic Priority

Identify priority populations who currently experience health disparities by screening social determinants of health, collecting race, ethnicity, and language data, and other elements to be determined.

Goals:

- Health Equity Committee members will identify the current state of race, ethnicity, language, and social determinants of health data & collection and identify opportunities.
- The Health Equity Committee will identify key resources to develop and implement needed actions.
- Allocation of resources: commitment of staff time, key stakeholders' involvement, training & education.
- Identify and collaborate with community-based resources that could potentially positively impact at-risk populations.

HCHE Domain 2 & SDOH

- **Domain 2:** Our hospital collects a wide range of demographic and social determinant of health data from most patients and ensures staff are trained in culturally sensitive data collection methods. This information is recorded in a structured and interoperable format using certified EHR technology.
- **SDOH:** The Screening for Social Drivers of Health Measure evaluates whether hospitals screen all patients aged 18 or older at admission for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. Hospitals must report both the number of these patients screened and the total number of patients aged 18 or older admitted.

Review of Current Process: Opportunities Identified

- Confusion regarding data collection of demographic data for federally incarcerated population
- Incomplete SDOH screening

LVMC Current Process SDOH Screening: Food Insecurity

Centricity Current Admission Note

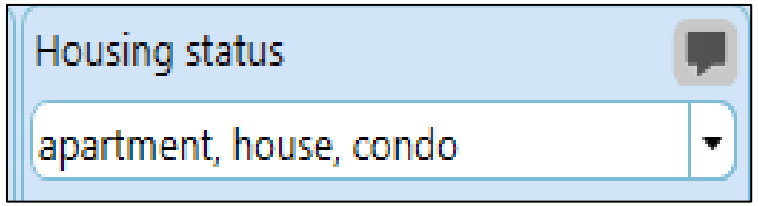
```
==================================
NUTRITIONAL/FUNCTIONAL SCREENING
==================================

Problem with Appetite >5 Days:  No
Chew/Swallow Difficulties:  No
Inappropriate Wt Gain/Loss:  No
Presence Skin Breakdown/Ulcer:  No
Special Diet:  No
Pt Requests Dietician Visit:  No
Hx of Any of the Following?:  N/A
New Diagnosis of:  N/A
Requires Assist w/Ambulation:  No
Uses Assist Device to Ambulate:  No
Pt Requires Help w/ADL's:  No
```

Recommendations:

- Add food insecurity question to nursing admission note, centricity current admission note, case management initial note, and preoperative nursing note.
- Add as a required field.
- Consider adding a script before the question to support staff.
- Positive response, and automatic referral to Case Management.

LVMC Current Process SDOH Screening: Housing Instability

Nursing Admission Note

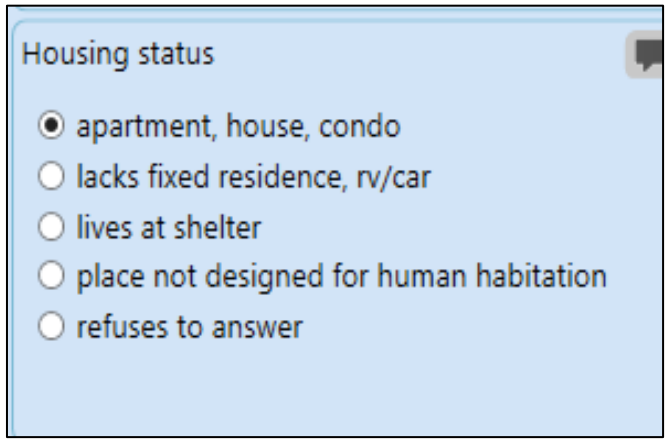


Centricity General Admission Note

==========
LIVING SITUATION/DISCHARGE PLAN
==========

Living Arrangements: Apartment
Adequate Access to:: Electric; Heat; Refrigeration; Plumbing/Running water; Phone; Transportation
WIC Program: Yes
Discharge Pick Up Person: Jose
Person to Help after Discharge: Jose
Currently Using Commun Resources: Yes
Specify Current Resource Used: WIC
Outside Agency/Social Worker: No
Car Seat for Discharge: No
Need Help to Obtain Car Seat: Pt ordered car seat, is not here yet
Adoption Requested: No
Pt Contact w/infant Post Birth: N/A

ED Triage

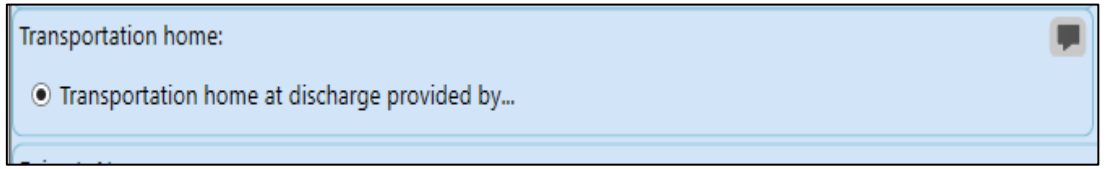


Recommendation:

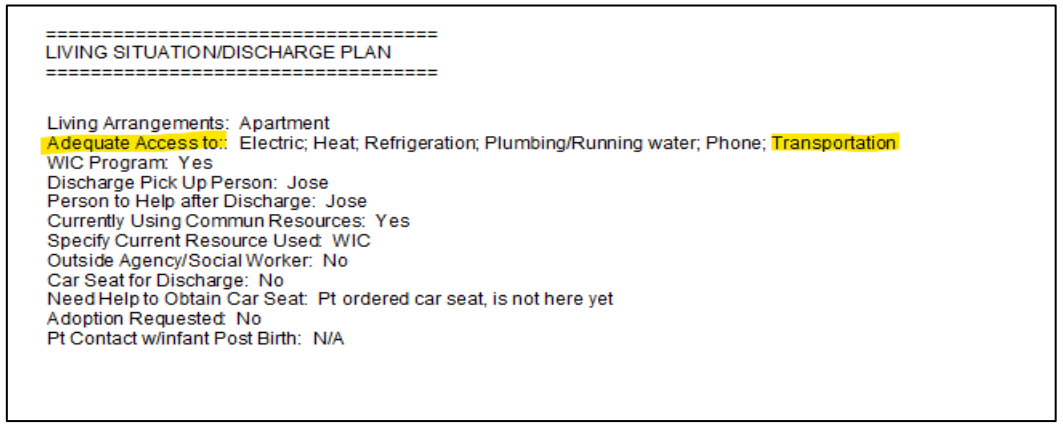
- Consider adding the housing status/living arrangement from the previous slide to the nursing admission note, centricity general admission note, and case management initial note.
- If not already, add as required field.
- Add to preoperative nursing note.
- If they screen positive, then automated Case management referral.

LVMC Current Process SDOH Screening: Transportation

Case Management Initial Note:



Centricity General Admission Note:



Recommendation:

- Add transportation question to admission note, case management initial note, and preoperative screening note.
- Add as a required field.
- Centricity general admission note separate the question from the utilities.
- If positive screen, there will be an automated Case Management referral.

LVMC Current Process SDOH Screening: Utility Difficulties

Centricity General Admission Note

==========
LIVING SITUATION/DISCHARGE PLAN
==========

Living Arrangements: Apartment
Adequate Access to:: Electric; Heat; Refrigeration; Plumbing/Running water; Phone; Transportation
WIC Program: Yes
Discharge Pick Up Person: Jose
Person to Help after Discharge: Jose
Currently Using Commun Resources: Yes
Specify Current Resource Used: WIC
Outside Agency/Social Worker: No
Car Seat for Discharge: No
Need Help to Obtain Car Seat: Pt ordered car seat, is not here yet
Adoption Requested: No
Pt Contact w/infant Post Birth: N/A

Recommendation:

- Add utility difficulties question to the nursing admission note, case management note, and preoperative nursing note.
- Add as a required field.
- If positive screen, automatic referral to Case Management.

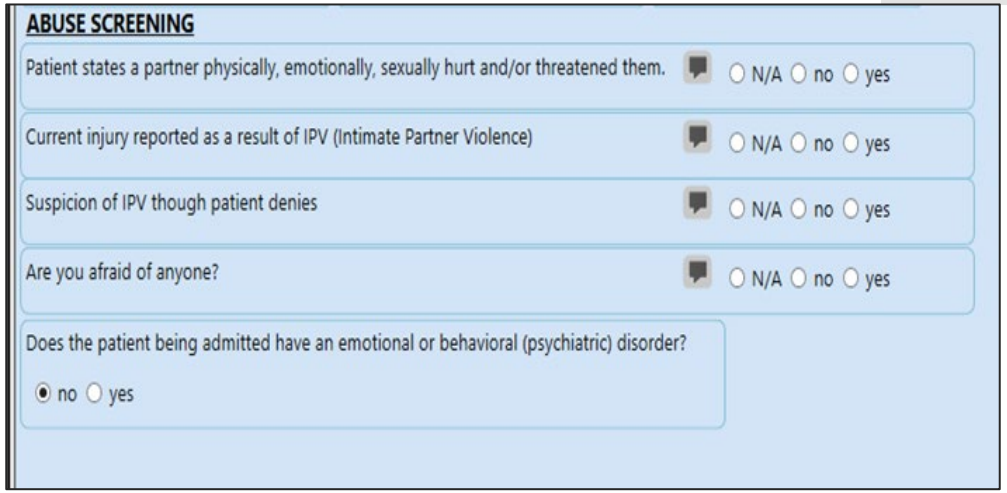
LVMC Current Process SDOH Screening: Interpersonal Safety

Centricity General Admission Note

DOMESTIC VIOLANCE SCREENING
==========

Dom Viol Threatened/Hurt: No
Hx of Abuse/Neglect past 2yrs: No
Feel Unsafe Going Home: No
Addt'l Observ Indicating Abuse: No
Reason Unable to Complete Screen: N/A, Screen Completed
Considered Personal Harm/Suicide: No

Nursing Admission Note



Recommendation:

- Change to a required field.

Health Equity Timeline: Phase 2

SDOH Screening Questions

Social Determinants of Health Screening (SDOH)

Housing instability - Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as part of a household?

- ○ Yes
- ○ No
- ○ Declined to answer
- ○ Unable to answer due to medical condition

Food insecurity - In the past 12 months, have you been concerned that your food would run out before you got money to buy more?

- ○ Yes
- ○ No
- ○ Declined to answer
- ○ Unable to answer due to medical condition

Utility difficulties - In the past 12 months, has the electric, gas, or water company threatened to shut off services in your home?

- ○ Yes
- ○ No
- ○ Declined to answer
- ○ Unable to answer due to medical condition

Transportation Needs - In the past 12 months, has lack of transportation kept you from medical appointments, non-medical appointments, work, or from getting your medicines or things you need?

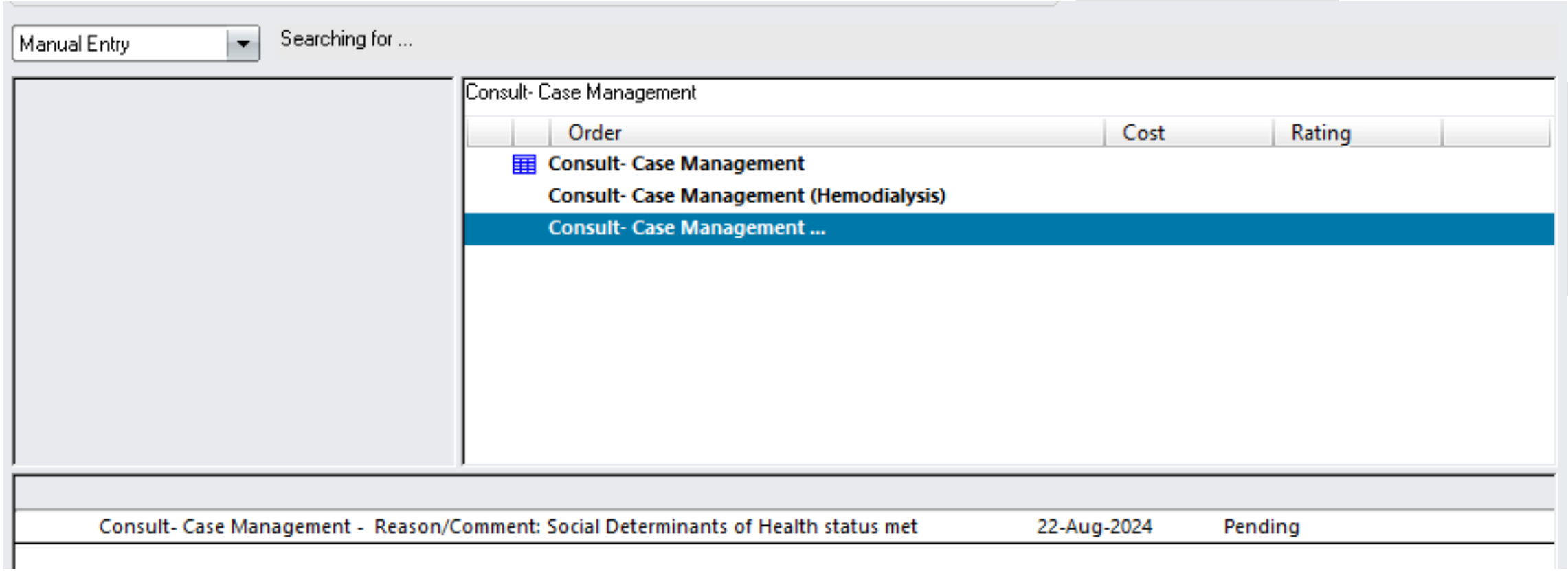
- ◉ Yes
- ○ No
- ○ Declined to answer
- ○ Unable to answer due to medical condition

Due to a positive (yes) answer to any of the SDOH questions above, a Case Management consult must be ordered. Order it here, then choose 'Yes' to indicate it was ordered.

○ Yes ○ No

Consult- Case Management
ENTER ORDER

Case Management Consult



Case Management Initial Note

Housing instability - Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as part of a household?

- (•) Yes
- ( ) No
- ( ) Declined to answer
- ( ) Unable to answer due to medical condition

Interventiion:

- [ ] provided homeless resource guide
- [ ] provided community resource pamphlet

Food insecurity - In the past 12 months, have you been concerned that your food would run out before you got money to buy more?

- ( ) Yes
- ( ) No
- ( ) Declined to answer
- ( ) Unable to answer due to medical condition

Utility difficulties - In the past 12 months, has the electric, gas, or water company threatened to shut off services in your home?

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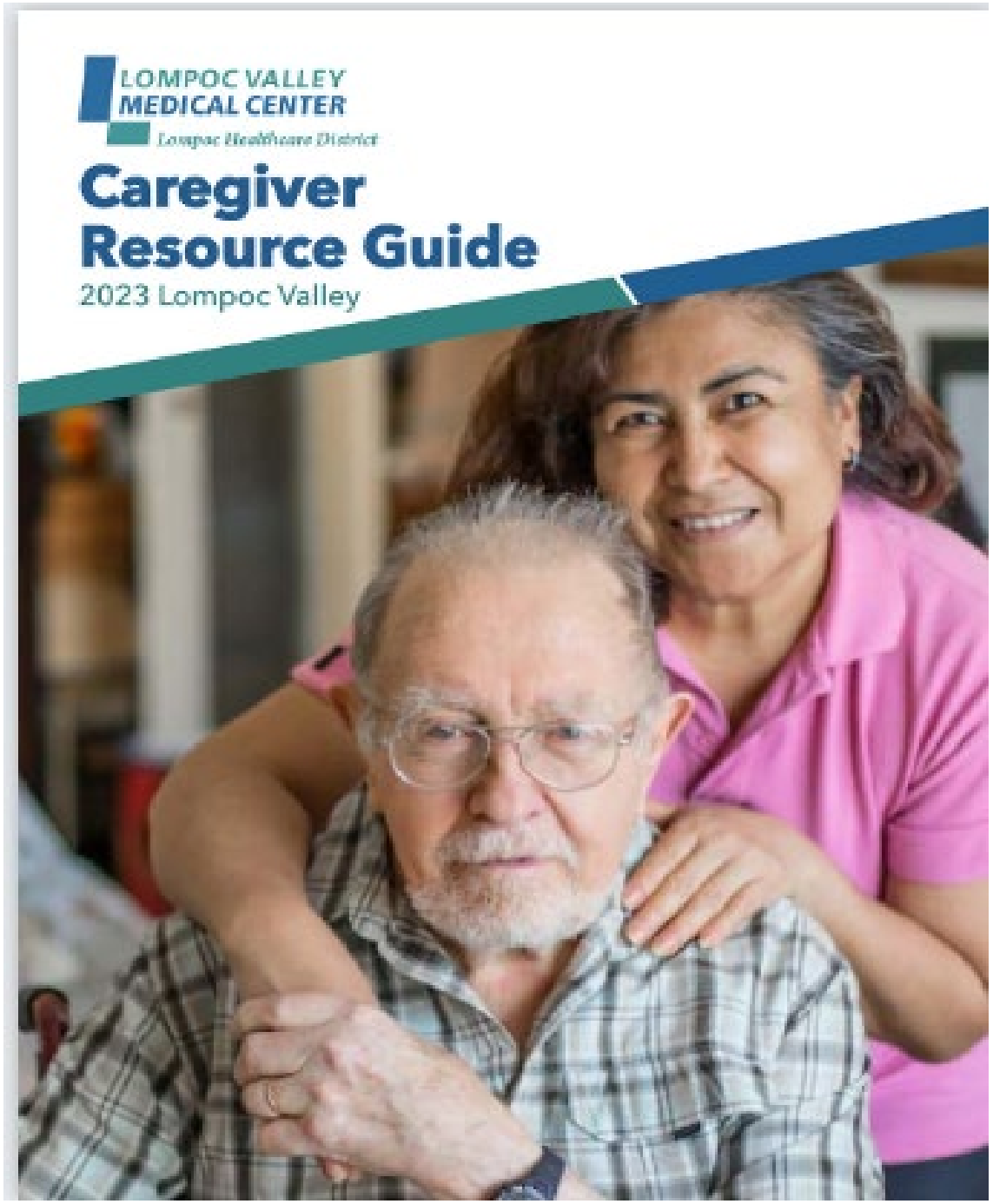
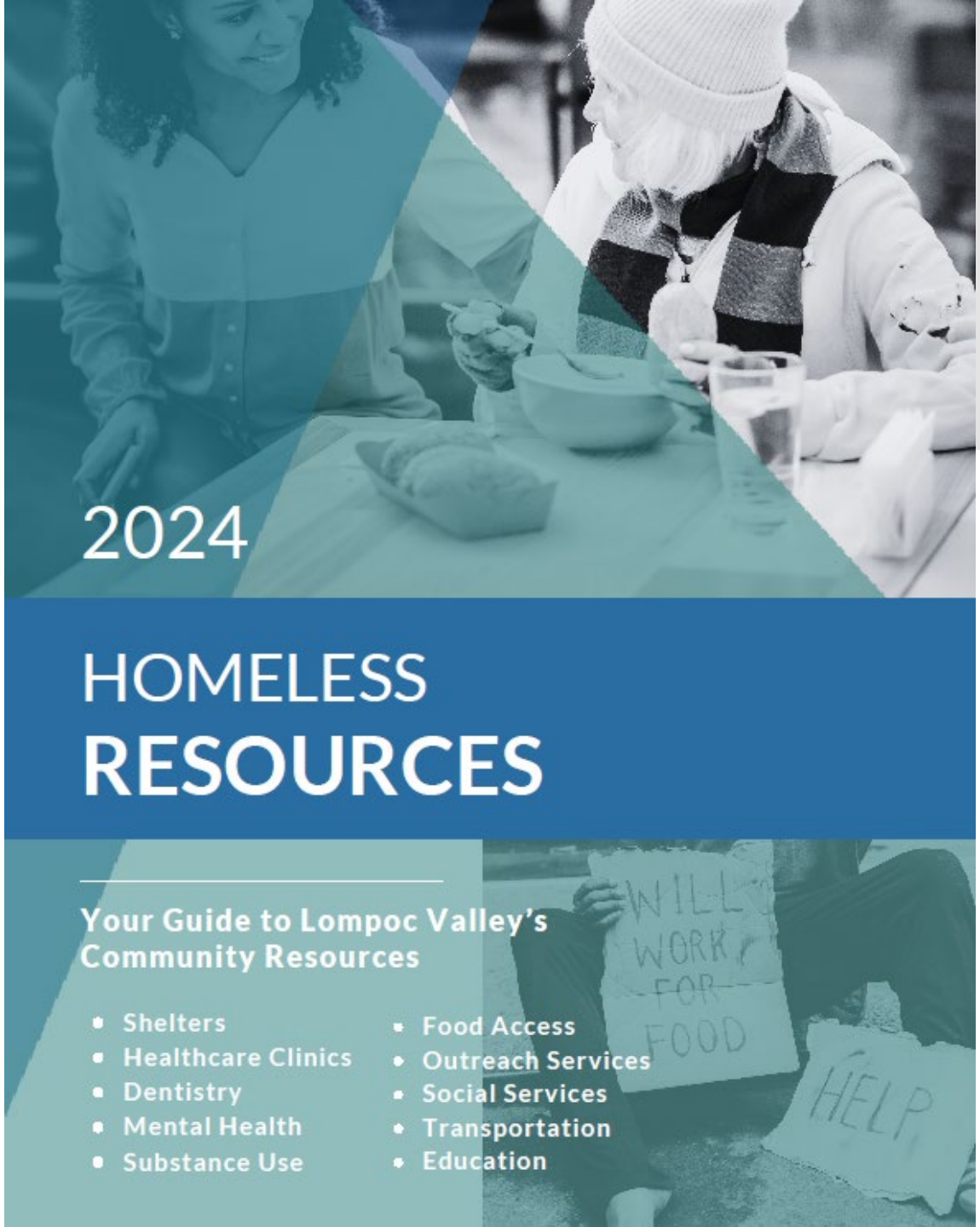
- ( ) Unable to answer due to medical condition



[LVMC Caregiver Resource Guide]

https://www.lompocvmc.com/health-wellness/caregiver-resources/caregiver-resource-guide/


2024
HOMELESS
RESOURCES
Your Guide to Lompoc Valley's Community Resources
Shelters
Healthcare Clinics
Dentistry
Mental Health
Substance Use
Food Access
Outreach Services
Social Services
Transportation
Education
WILL WORK FOR FOOD
HELP

Interpersonal Safety Screening

Domain 3 & 4

Domain 3: Hospital analyzes key performance indicators by demographic and social determinants of health to identify equity gaps, displaying this data on performance dashboards. This involves examining quality measure results across different patient subgroups to pinpoint disparities and monitor performance for priority populations.

Domain 4: Hospital engages in quality improvement activities aimed at reducing health disparities by participating in local, regional, and national initiatives. These efforts include joining collaboratives and partnerships focused on specific patient populations or medical conditions to improve quality and equity.

Health Equity Timeline: Phase 3

LOMPOC VALLEY MEDICAL CENTER
Lompoc Healthcare District

Thank you

References

Centers for Medicare & Medicaid Services (CMS). (2023). Hospital Inpatient Quality Reporting (IQR) Program Attestation Guidance for the Hospital Commitment to Health Equity Measure.

CMS. (2023). Hospital Commitment to Health Equity Structural Measure Specifications.

CMS. (2023). Screening for Social Drivers of Health Measure and the Screen Positive Rate for Social Drivers of Health Measure.

CMS. (2023). Hospital Inpatient Quality Reporting (IQR) Program Frequently Asked Questions: Social Drivers of Health (SDOH) Measure.

Health Services Advisory Group (HSAG). (2023). Health Equity Quickinar Series. https://www.hsag.com/en/hqic/health-equity-quickinar-series/

HSAG HQIC

Community of Practice Call

Health Equity Organizational Assessment (HEOA) and Health Equity Interventions

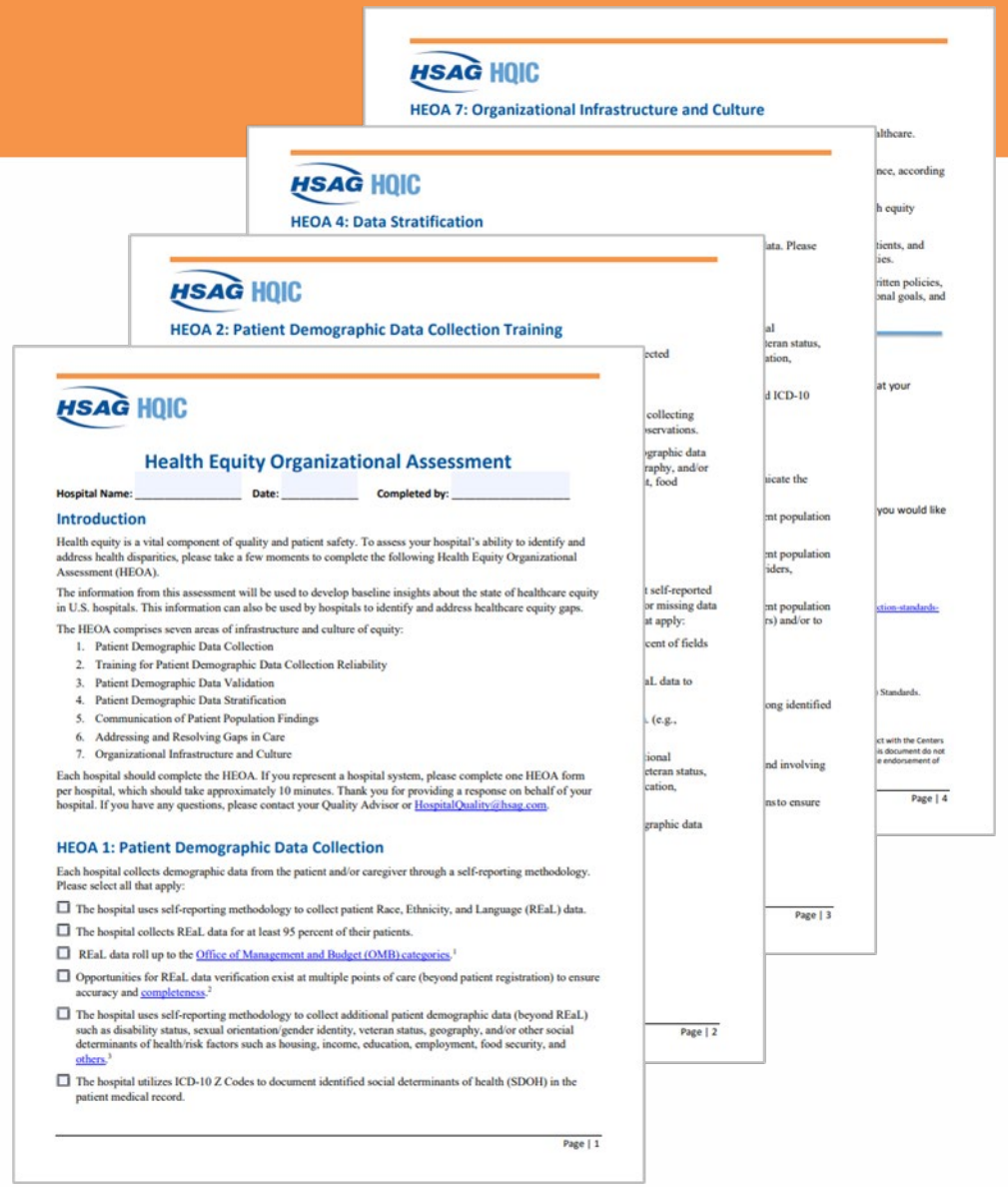
Joshua Hazelton, MPH, CPH
Senior Quality Improvement Specialist
Health Services Advisory Group (HSAG)

- Discuss HSAG HQIC HEOA results and improvements.
- Review HSAG HQIC strategies for addressing health equity with hospitals.
- Identify lessons learned for future work on health equity.

HQIC = Hospital Quality Improvement Contractor

HEOA Analysis

- HSAG HQIC assessed hospital practices on health equity using an HEOA.
  - Measured 7 different categories of hospital organizational infrastructure and culture of equity.
- HSAG HQIC compiled results and compared baseline with remeasurement results to identify where improvement was made.


HSAG HQIC

HEOA 7: Organizational Infrastructure and Culture

HSAG HQIC

HEOA 4: Data Stratification

HSAG HQIC

HEOA 2: Patient Demographic Data Collection Training

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Health Equity Organizational Assessment

Hospital Name: _____ Date: _____ Completed by: _____

Introduction

Health equity is a vital component of quality and patient safety. To assess your hospital's ability to identify and address health disparities, please take a few moments to complete the following Health Equity Organizational Assessment (HEOA).

The information from this assessment will be used to develop baseline insights about the state of healthcare equity in U.S. hospitals. This information can also be used by hospitals to identify and address healthcare equity gaps.

The HEOA comprises seven areas of infrastructure and culture of equity:

1. Patient Demographic Data Collection
2. Training for Patient Demographic Data Collection Reliability
3. Patient Demographic Data Validation
4. Patient Demographic Data Stratification
5. Communication of Patient Population Findings
6. Addressing and Resolving Gaps in Care
7. Organizational Infrastructure and Culture

Each hospital should complete the HEOA. If you represent a hospital system, please complete one HEOA form per hospital, which should take approximately 10 minutes. Thank you for providing a response on behalf of your hospital. If you have any questions, please contact your Quality Advisor or HospitalQuality@hsag.com.

HEOA 1: Patient Demographic Data Collection

Each hospital collects demographic data from the patient and/or caregiver through a self-reporting methodology. Please select all that apply:

- ☐ The hospital uses self-reporting methodology to collect patient Race, Ethnicity, and Language (REaL) data.
- ☐ The hospital collects REaL data for at least 95 percent of their patients.
- ☐ REaL data roll up to the Office of Management and Budget (OMB) categories.[1]
- ☐ Opportunities for REaL data verification exist at multiple points of care (beyond patient registration) to ensure accuracy and completeness.[2]
- ☐ The hospital uses self-reporting methodology to collect additional patient demographic data (beyond REaL) such as disability status, sexual orientation/gender identity, veteran status, geography, and/or other social determinants of health/risk factors such as housing, income, education, employment, food security, and others.[3]
- ☐ The hospital utilizes ICD-10 Z Codes to document identified social determinants of health (SDOH) in the patient medical record.

Page | 1

HEOA Categories

- HEOA 1: Patient Demographic Data Collection
- HEOA 2: Training for Patient Demographic Collection Reliability
- HEOA 3: Patient Demographic Data Validation
- HEOA 4: Patient Demographic Data Stratification
- HEOA 5: Communication of Patient Population Findings
- HEOA 6: Addressing and Resolving Gaps in Care
- HEOA 7: Organizational Infrastructure and Culture

HEOA Baseline Results

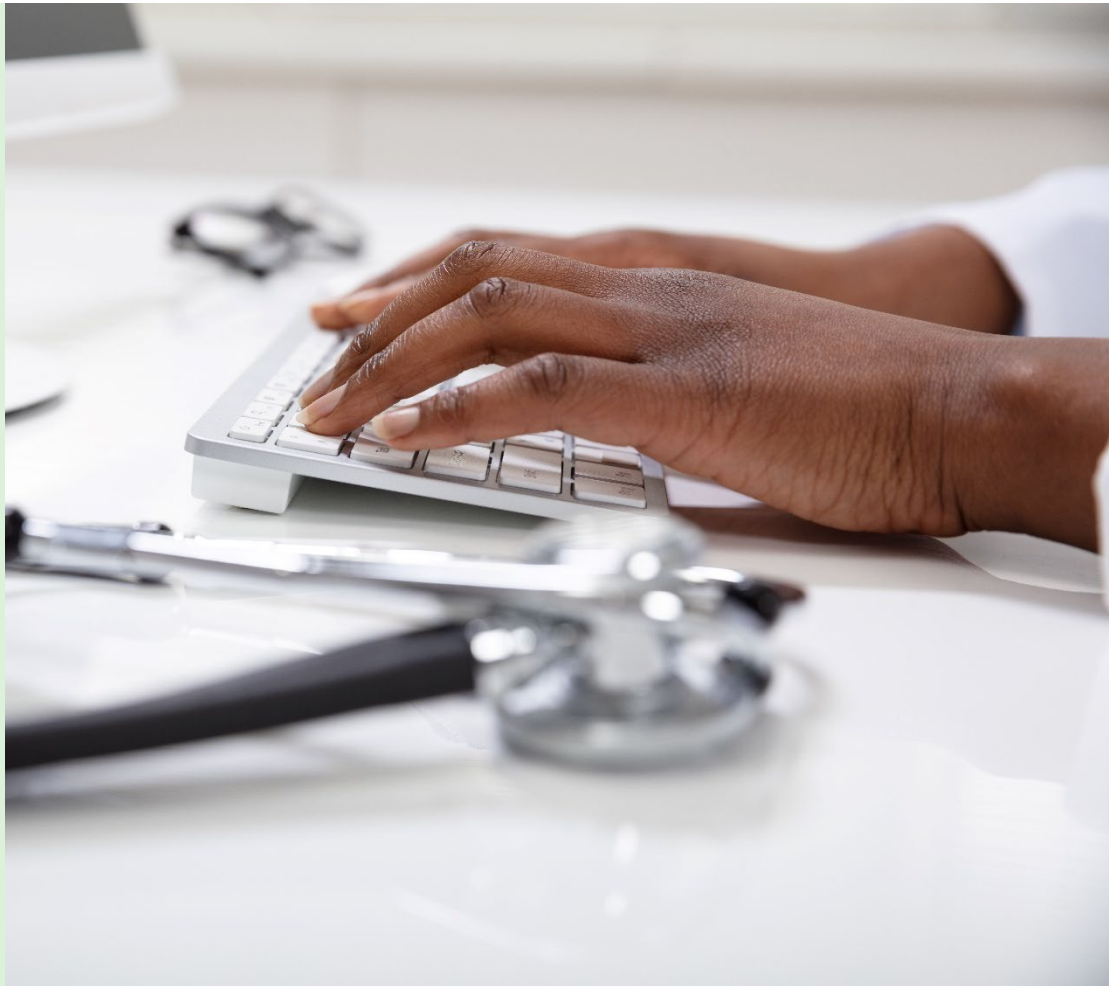
Hospitals With HEOA Basic Implementation Level or Above							
	HEOA 1	HEOA 2	HEOA 3	HEOA 4	HEOA 5	HEOA 6	HEOA 7
Baseline:	123 (52.56%)	220 (94.02%)	37 (15.81%)	128 (54.70%)	80 (34.19%)	83 (35.47%)	213 (52.56%)

- Average number of categories with at least basic implementation level per hospital—3.50.
- 13 hospitals (5.39%) had at least basic implementation level for all categories.
- 7 hospitals (2.90%) had advanced implementation level for all categories.

HSAG HQIC Health Equity Approach

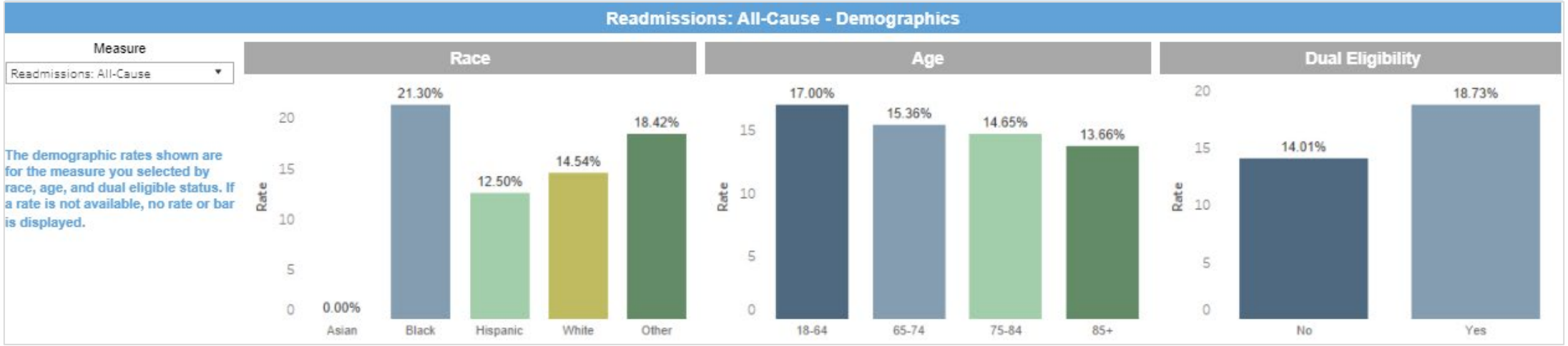
Developed a multi-faceted approach to health equity

- Data solutions
  - HQIC performance dashboard
- Roadmap to Success
- Health equity tools and resources



HSAG HQIC Performance Dashboard

- Stratifies outcome metrics by demographic and geographic categories:
  - Race/ethnicity
  - Age
  - Dual-eligibility (proxy measure for SDOH)
- Allows facilities to identify potential heath disparities in their outcomes



SDOH = social determinants of health

HSAG HQIC Health Equity Change Package

Tools and resources to assist hospitals in meeting HEOA measures and improving health equity

- Roadmap to Success
- SDOH Toolkit
- Health Equity Business Case
- Why Collect REaL Data handout

Health Equity Change Package

CMS Health Equity Measures

Find PDF downloads of specifications and guidance for health equity from the Centers for Medicare & Medicaid Services (CMS) at the links below:

- Hospital Commitment to Health Equity Structural Measure Specification
- Attestation Guidance for the Hospital Commitment to Health Equity Measure for the Hospital Inpatient Quality Reporting (IQR) Program
- Screening for Social Drivers of Health (SDOH) Measure
- FAQs for SDOH Measures

Organizational Assessments and Culture

Health Equity: A Business Case. What is the impact of health disparities? Health disparities can lead to poor patient outcomes and significant excess financial loss. A single-page handout from HSAG.

Building an Organization Response to Health Disparities. A toolkit from the Centers for Medicare & Medicaid Services (CMS).

Health Equity Organizational Assessment (HEOA). A downloadable form that assesses your hospital's ability to identify and address health disparities. From HSAG.

Implementing Health Equity Roadmap to Success

Data Collection, Training, Validation, and Stratification

Improving Health Equity: Building Infrastructure to Support Health Equity. Institute for Healthcare Improvement (IHI) webpage.

Reducing Health Care Disparities Toolkit. American Hospital Association (AHA) toolkit.

Achieving Health Equity. Centers for Medicare & Medicaid Services (CMS) online course.

ICD-10 Z Codes for Disparities. From CMS, this PDF outlines the steps in using Z Codes.

Social Work Assessment. From HSAG, a checklist form.

Interventions and Quality Outcomes

Strategies for Equitable Care. From HSAG, this downloadable strategy tree of tactics, tasks, and tools, offers numerous options that coordinate with the Health Equity Organization Assessment (HEOA).

Health Equity Action Plan. This downloadable Word document from HSAG has examples that can be customized for use by your facility.

Impacting Social Determinants of Health (SDOH) Toolkit. This downloadable HSAG document is designed for hospitals in rural and high-deprivation areas, where people are more likly to experience disparities related to SDOH. It includes strategies and links to resources.

Examples of Healthcare Systems and Addressing Health Equity:

- Building an Organizational Response to Health Disparities: 5 Pioneers from the Field. From CMS, the report includes several business cases.

Tools for Patients

Why Collect REaL Data. From HSAG, this downloadable flyer for patients answers frequently asked questions about why hospitals collect information on patient race, ethnicity, and language.

Why Collect REaL Data. (Spanish)

Zone Tools. Downloadable tools to assist discharging patients in managing a number of common health conditions.

REaL = race, ethnicity, and language

www.hsag.com/hqic-equity

Roadmap to Success: 7 Steps to Your Final Destination

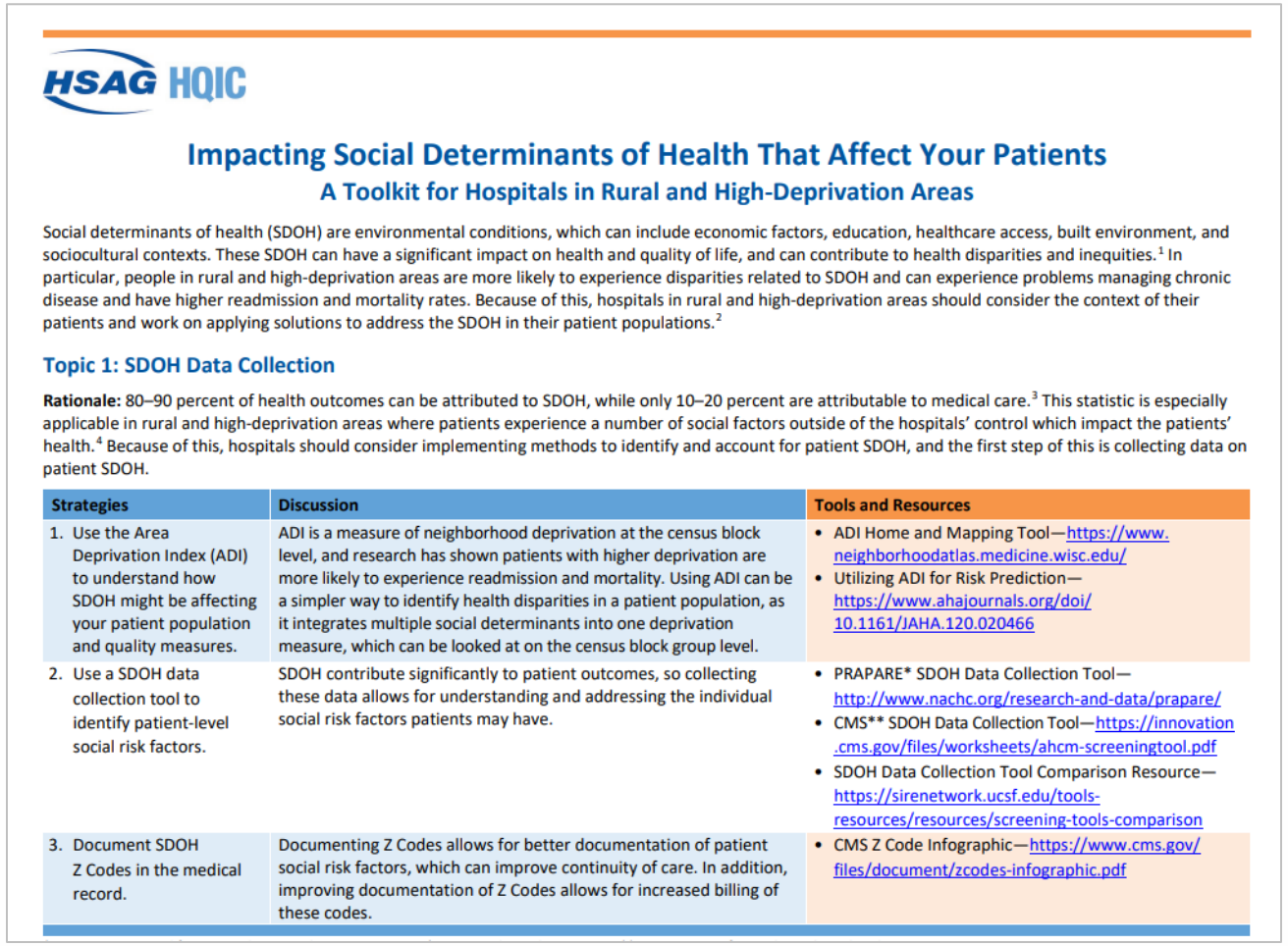
Mile Markers:

1. Commitment
2. HEOA Gap Analysis
3. REaL and SDOH Data Collection
4. REaL and SDOH Data Analysis
5. Intervention Planning
6. Creating Change
7. Share and Expand

HSAG HQIC SDOH Toolkit

For hospitals in rural and high-deprivation areas.

- Focuses on common social drivers of health.
- Provides strategies, tools, and resources to address community-level drivers and individual social needs.



HSAG HQIC

Impacting Social Determinants of Health That Affect Your Patients

A Toolkit for Hospitals in Rural and High-Deprivation Areas

Social determinants of health (SDOH) are environmental conditions, which can include economic factors, education, healthcare access, built environment, and sociocultural contexts. These SDOH can have a significant impact on health and quality of life, and can contribute to health disparities and inequities.[1] In particular, people in rural and high-deprivation areas are more likely to experience disparities related to SDOH and can experience problems managing chronic disease and have higher readmission and mortality rates. Because of this, hospitals in rural and high-deprivation areas should consider the context of their patients and work on applying solutions to address the SDOH in their patient populations.[2]

Topic 1: SDOH Data Collection

Rationale: 80–90 percent of health outcomes can be attributed to SDOH, while only 10–20 percent are attributable to medical care.[3] This statistic is especially applicable in rural and high-deprivation areas where patients experience a number of social factors outside of the hospitals' control which impact the patients' health.[4] Because of this, hospitals should consider implementing methods to identify and account for patient SDOH, and the first step of this is collecting data on patient SDOH.

Strategies	Discussion	Tools and Resources
1. Use the Area Deprivation Index (ADI) to understand how SDOH might be affecting your patient population and quality measures.	ADI is a measure of neighborhood deprivation at the census block level, and research has shown patients with higher deprivation are more likely to experience readmission and mortality. Using ADI can be a simpler way to identify health disparities in a patient population, as it integrates multiple social determinants into one deprivation measure, which can be looked at on the census block group level.	• ADI Home and Mapping Tool—https://www.neighborhoodatlas.medicine.wisc.edu/ • Utilizing ADI for Risk Prediction—https://www.ahajournals.org/doi/10.1161/JAHA.120.020466
2. Use a SDOH data collection tool to identify patient-level social risk factors.	SDOH contribute significantly to patient outcomes, so collecting these data allows for understanding and addressing the individual social risk factors patients may have.	• PRAPARE* SDOH Data Collection Tool—http://www.nachc.org/research-and-data/prapare/ • CMS** SDOH Data Collection Tool—https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf • SDOH Data Collection Tool Comparison Resource—https://sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison
3. Document SDOH Z Codes in the medical record.	Documenting Z Codes allows for better documentation of patient social risk factors, which can improve continuity of care. In addition, improving documentation of Z Codes allows for increased billing of these codes.	• CMS Z Code Infographic—https://www.cms.gov/files/document/zcodes-infographic.pdf

www.hsag.com/globalassets/hqic/hqic_sdoh_toolkit_508.pdf

A Business Case for Health Equity

Patient outcomes and hospital finances are impacted by health disparities.

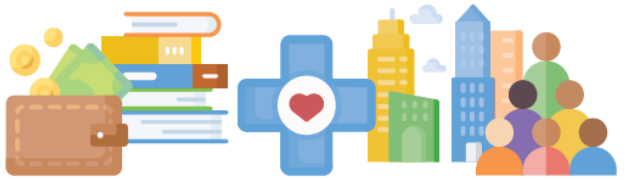
Health outcomes are greatly impacted by social determinants.

Health outcomes can be improved by addressing health disparities.

Consider The Impact of Health Disparities

Health disparities can lead to poor patient outcomes and significant excess financial cost.

Social determinants of health include: economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community contexts.[1]



Health Outcome Contributors

80%-90% social determinants

10%-20% medical care[3]

Yet, an estimated **95%** of health expenditures are on medical costs.[4]

1 in 10 Americans live in poverty with the inability to afford healthcare, healthy food, and housing.[1]

In the United States:

Health disparities have amounted to **$93 billion** in excess medical cost annually.[5]

Dual Eligible Individuals

1.5 times higher hospital utilization

70% higher use of high-risk drugs

18% higher avoidable hospital readmissions

as opposed to non-dual eligible individuals[2]

www.hsag.com/globalassets/hqic/hqic-healthequity-bizcase.pdf

Why Collect REaL Data Handout

HSAG's PFAC developed an FAQ handout for patient education about collection of REaL data.

Frequently Asked Questions

About the Collection of Patient Race, Ethnicity, and Language Information

HSAG HQIC

Q: What if I don't want to answer these questions?
A: It is perfectly alright if you do not want to answer these questions. We will provide you care no matter how you choose to answer. However, knowing the answers to these questions helps our hospital provide more personalized care.

Q: What do my race and ethnicity have to do with my health?
A: Your race and ethnic backgrounds may place you at different risks for some diseases. By knowing more about you, the hospital will be better able to meet your health needs.

Q: Who are you collecting this information from?
A: This hospital collects this information from all patients.

Q: Why am I being asked these questions?
A: This hospital collects information on race, ethnic backgrounds, and the language you speak from all our patients to make sure that everyone receives personalized care. By knowing more about you, we will be better able to meet your health needs.

Q: What will my information be used for at the hospital?
A: Your answers to these questions can help us to offer more personalized services and programs to you and others like you. Hospitals can also use your answers to make sure that all patients are getting the same quality of care no matter their race or ethnicity.

Q: Who will see my information?
A: Your information will be kept private and safe. The only people who will see your race and ethnicity information are members of your care team.

Q: What if I belong to more than one race?
A: You can check off all the races you belong to.

Q: What if I don't know my race or ethnicity?
A: If you don't know your race or ethnicity, you can talk to hospital registration staff and they can help you decide the best way to answer.

Q: Who can I ask questions about this?
A: The hospital registration staff and their supervisors are happy to answer any questions you may have.

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PFAC = Patient and Family Advisory Committee

HSAG. Frequently Asked Questions About the Collection of Patient Race, Ethnicity, and Language Information. Available at www.hsag.com/globalassets/hqic/hqic-ptedwhycollectrealdata.pdf.

HSAG HQIC

Two CMS Health Equity Measures

Measure 1:
Hospital Commitment to Health Equity

Measure 2:

a. Screening for Social Drivers
b. Screen Positive Rate for Social Drivers

Hospital Commitment to Health Equity

Health Equity Commitment Domains[1]
1: Equity is a Strategic Priority
2: Data Collection
3: Data Analysis
4: Quality Improvement
5: Leadership Engagement

- Competencies aimed at achieving health equity
- Must meet all elements under each domain
- Structural measure
- Attest via QualityNet
- Begins CY 2023
- Initial submission deadline May 2024[2]
- Annual submission

1: qualitynet.cms.gov/files/62629ee35e40610016f30140?filename=Hosp_Commit_HlthEqStrct_Meas.pdf
2: www.qualityreportingcenter.com/globalassets/iqr2022events/iqr9122/fy2023_ipps-final-rule-overview-for-hospital-quality-programs-_vfinal508.pdf

Screening for Social Drivers of Health

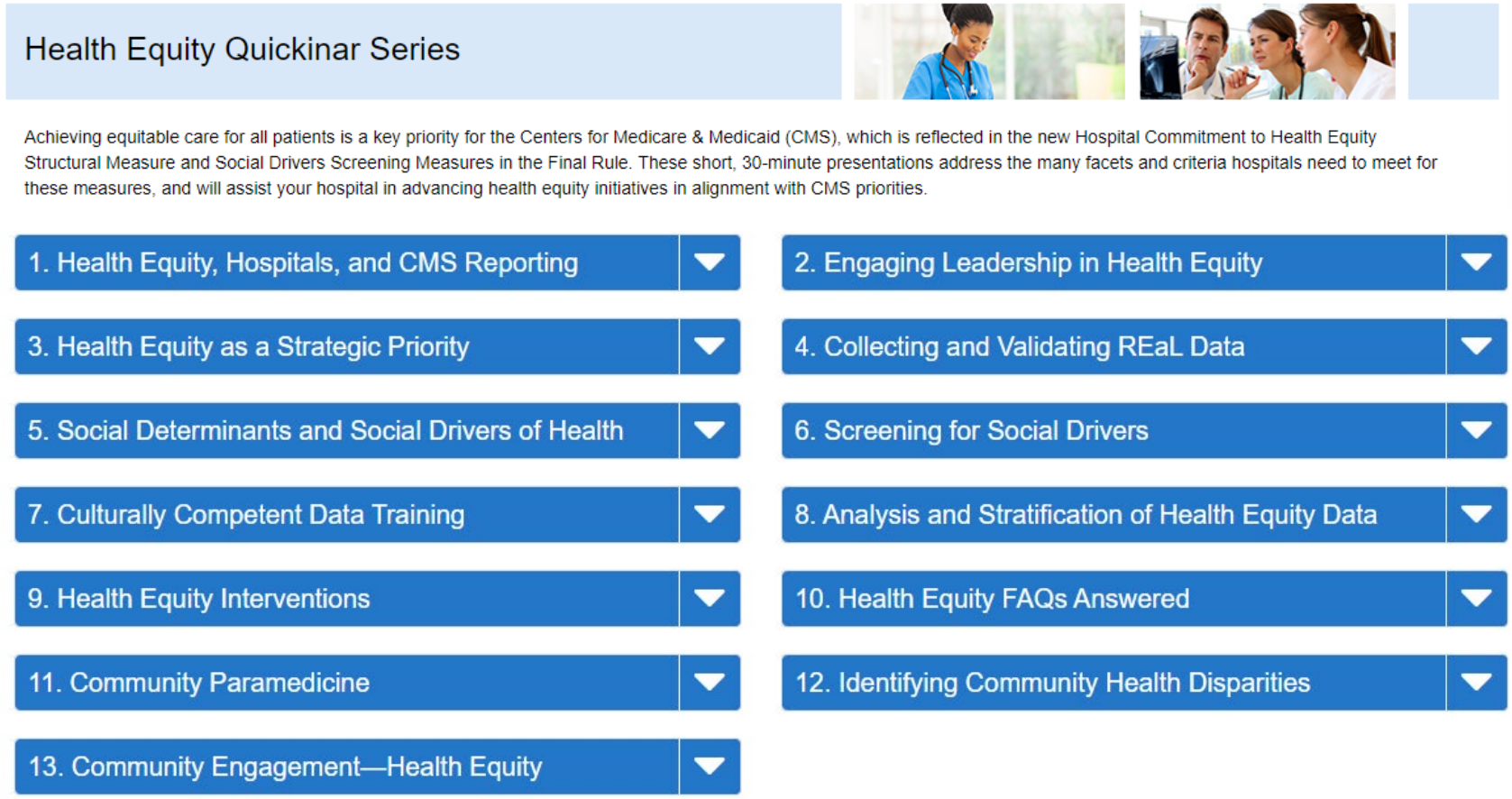
- Structural measure, reported annually
- Six separate rates
  - Number screened for social drivers
  - Screened positive:
    - Food Insecurity
    - Housing Instability
    - Transportation Needs
    - Utility Difficulties
    - Interpersonal Safety
- CY 2023—Voluntary Reporting (May 15, 2024)
- CY 2024—Mandatory Reporting (May 15, 2025)

qualitynet.cms.gov/files/633d7b34a90aef001784784b?filename=IQR_ImpDatesDdlns_Oct2022.pdf
www.qualityreportingcenter.com/globalassets/iqr2022events/iqr9122/fy2023_ipps-final-rule-overview-for-hospital-quality-programs-_vfinal508.pdf

HSAG HQIC Health Equity Quickinar Series

Developed to educate hospitals and prepare to meet health equity measures

- 13 micro-learning sessions
- Focused on CMS health equity measures and HEOA



HEOA Remeasurement Results

Hospitals With HEOA Basic Implementation Level or Above							
	HEOA 1	HEOA 2	HEOA 3	HEOA 4	HEOA 5	HEOA 6	HEOA 7
Baseline:	123 (52.56%)	220 (94.02%)	37 (15.81%)	128 (54.70%)	80 (34.19%)	83 (35.47%)	213 (52.56%)
Remeasurement:	196 (83.76%)	226 (96.58%)	75 (32.05%)	204 (87.17%)	170 (72.65%)	107 (45.73%)	197 (84.19%)
Improvement from Baseline:	73 (31.20%)	6 (2.56%)	38 (16.24%)	76 (32.48%)	90 (38.46%)	24 (10.26%)	74 (31.63%)

- Average number of categories with at least basic implementation level per hospital—5.08.
- 38 hospitals (15.77%) had at least basic implementation level for all categories.
- 12 hospitals (4.98%) had advanced implementation level for all categories.

HEOA Results

- HSAG HQIC helped hospitals improve their health equity programs over the course of the contract.
  - Improved all HEOA measures and provided hospitals with data and resources to address health disparities in their patient populations.
- Hospitals made particularly notable improvement in HEOA 7.
  - HSAG HQIC leveraged data to engage hospitals.
  - HSAG HQIC provided resources and support to foster a culture of equity.
- Still room for improvement—HEOA 3 and HEOA 6.

Contributing Factors

- HQIC hospital composition impacted HEOA results.
  - HQIC was directed to recruit primarily small, rural, and critical access hospitals.
  - Hospitals often had a homogeneous patient population, so buy-in and engagement was difficult to achieve.
- Rollout of CMS health equity and SDOH measures also impacted HEOA results and hospital engagement.

Key Concepts

- HSAG HQIC made notable progress in improving HEOA measures.
- HSAG HQIC provided numerous tools, resources, and data solutions to engage hospitals in health equity.
- Health equity will continue to be an area of opportunity for hospital quality improvement efforts.

Thank you!

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Discussion

- What impactful actions can you take as a result of the information shared today?
- How are you able to increase engagement within your facilities to ensure a true change in patient safety?
- Based on what you heard today, what activities do you currently have underway that can leverage immediate action over the next 30, 60 or 90 days?

Final Thoughts

Thank You!

Your opinion is valuable to us. Please take 4 minutes to complete the post assessment.

We will use the information you provide to improve future events.