HEALTH EQUITY

ALLIANT HEALTH SOLUTIONS | SORH State Office of Rural Health, A Division of the Georgia Department of Community Health

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
		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
Data Collection (HEOA #1)	Hospitals use self-reporting methodology to collect race, ethnicity and language (REaL) data for all patients. All race and ethnicity categories collected should, at a minimum, roll up to the OMB categories and be collected in separate fields	Inventory of Resources for Standardized Demographic and Language Data Collection (CMS 2021)
		Reducing Healthcare Disparities: Collection and Use of Real Data (AHA, 2013)
		Improving Health Equity through Data Collection and Use: A Guide for Hospital Leaders (AHA, 2011)
		How Race and Ethnicity Data is Collected and Used (Colorado Trust, 2013)

Data Collection (HEOA #1)	Hospital uses self-reporting methodology to collect additional demographic data (beyond REAL) for patients such as disability status, sexual orientation/gender identity (SOGI), veteran status, geography and/or other social determinants of health (SDOH) or social risk factors	The PRAPARE SDOH Screening Tool
		Health-Related Social Needs (HRSN) Screening Tool
		American Academy of Family Physicians (AAFP) SDOH Screening Tool
		SDOH for Rural People
		Tools to Help Healthcare Organizations Address SDOH (AHRQ)
	Enhance data collection with social determinants of health (SDOH) and track Z codes	Using Z Codes: The Social Determinants of Health (SDOH) (CMS, 2021)
Data Collection Training (HEOA #2)	Workforce training is provided to staff regarding the collection of patient self-reported REAL data. Examples of training may include role playing, scripts, didactic, manuals, on-line modules, or other tools/job aids	AHA Disparities Toolkit - Staff Training
	FAQs for patients on why hospitals collect race, ethnicity, and language data	FAQs for Collection of Race, Ethnicity and Language Data (HSAG HQIC, 2021)
	Hospitals evaluate the effectiveness of workforce training annually to ensure staff demonstrate competency in patient self- reporting data collection methodology (e.g., observations, teach back, post-test, etc.)	Race and Ethnicity Data Improvement Toolkit (AHRQ, 2014)
Data Validation (HEOA #3)	Hospital has a standardized process in place to both evaluate the accuracy and completeness (percent of fields completed) for REAL data	Race and Ethnicity Data Improvement Toolkit - Measuring the Effectiveness of Education and Training (AHRQ, 2014)
Data Validation (HEOA #3)	Compare internally collected REaL data to other demographic data sources: • Federal data sources (e.g., U.S. Census Bureau) • State data sources (e.g., local schools and counties)	Using Data to Advance Health Equity in Your Community (RWF, 2023)
		U.S. Census Bureau
		Mapping Medicare Disparities
		ATSDR/CDC Social Vulnerability Index
		USDA (Food Insecurity)
		County Health Rankings (Severe Housing Problems)

Data Validation (HEOA #3)	Hospitals have a process to evaluate and compare hospital collected REAL data to local demographic community data or the Community Health Needs Assessment (CHNA)	CMS The Path Forward: Improving Data to Advance Health Equity Solutions
	Hospital addresses any system-level issues (e.g., changes in patient registration screens/fields, data flow, workforce training, etc.) to improve the collection of self-reported REAL data	AHA Toolkit for Eliminating Health Disparities
Data Stratification (HEOA #4)	Hospital stratifies at least one patient safety, quality and or outcome measure by REaL data	A Framework for Stratifying Race Ethnicity and Language Data (AHA, 2014)
	Hospital stratifies more than one (or many) patient safety, quality and/or outcome measure by REAL and other demographic data (beyond REAL) such as disability status, sexual orientation/gender identity (SOGI), veteran status, geography and/or other social determinants of health (SDOH) or social risk factors.	Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations
	Health care teams and coding professionals use Z codes to stratify and identify opportunities for improvement	ICD-10-CM Coding for Social Determinants of Health (AHA, 2022)
Communicate Findings (HEOA #5)	Reporting mechanism (e.g., equity dashboard) or annual report to communicate patient population outcomes widely within the organization and with community partners or stakeholders	Health Equity, Diversity & Inclusion Measures for Hospitals and Health System Dashboards (IFDHE)
Address Gaps in Care (HEOA #6)	Choose a quality measure to stratify by race, ethnicity or language preference or other sociodemographic variables (such as income, disability status, veteran status, sexual orientation, and gender, or other) that are important to our community's health	Annual Diversity and Health Equity Report, 2020-2021 (AnMed Health) Using Data to Reduce Disparities and Improve Quality (AHE, 2021) Using SDOH Data to Reduce Breast Cancer (Parkland Health Case Study)
	Locate and review your hospital's Community Health Needs Assessment (CHNA) to identify improvement areas	Community Health Needs Assessment (CHNA) CHNA Example: Crisp Regional Hospital, 2019 CHNA Example: St. Marys Health System CHNA and Implementation Strategy

Address Gaps in Care (HEOA #6)	Hospital engages multidisciplinary team(s to develop and test pilot interventions to address identified disparities in patient outcomes. *Multidisciplinary teams can include diversity & inclusion committee, Patient and Family Advisory Councils (PFACs), patient safety committee, quality improvement, etc.*	**Henry Ford Health System: Health Equity Campaign** **Addressing Disparities in Care to Achieve Health Equity (MHA)**
	Hospital implements interventions (e.g., redesigns process, conducts system improvement projects and/ or develops new services) to resolve identified disparities and educates staff/workforce regarding findings	**Guide to Reducing Readmissions (CMS, 2018)** **Guide to Reducing Health Disparities in Readmissions (CMS, 2018)** **Neighborhood Navigator**
	Hospitals have a process in place for ongoing review, monitoring, recalibrating interventions (as needed) to ensure changes are sustainable	
Organizational Infrastructure and Culture (HEOA #7)	Hospital has a standardized process to train its workforce to deliver culturally competent care and linguistically appropriate services (according to the CLAS standards)	**A Practical Guide to Implementing the National CLAS Standards: For Racial, Ethnic and Linguistic Minorities, People with Disabilities and Sexual and Gender Minorities (CMS, 2016)** **HHS Minority Health CLAS Standards**
	Hospital has named an individual (or individuals) who has leadership responsibility and accountability for health equity efforts (e.g., manager, director or Chief Equity, Inclusion and Diversity Officer/ Committee) who engages with clinical champions, patients, and families (e.g., Patient and Family Advisory Councils (PFACs)) and/ or community partners in strategic and action planning activities to reduce disparities in health outcomes	**Chief Diversity, Inclusion and Equity Officer (Wellstar Health System)**
	Hospital has made a commitment to ensure equitable health care is prioritized and delivered to all persons through written policies, protocols, pledges or strategic planning documents by organizational leadership and Board of Directors, e.g., #123forEquity Pledge	**#123 for Equity Pledge to Act Campaign (IFDHE)**

Organizational Infrastructure and Culture (HEOA #7)	Write health equity goals into critical documents such as mission statements, strategic plans, etc.	Recruiting for a Diverse Health Care Board
Patient and Family Advisory Councils	Enhance diversity of PFACs or selection of board members	Improving Diversity in PFACs (IPFCC) Partnering with Patient and Family Advisors to Achieve Health Equity (IPRO. 2021)

Professional Association/Other Websites
AHA Institute for Diversity and Health Equity
CMS Health Equity Grants and Awards
Social Determinants of Health (SDOH) (CDC, 2021)
Healthy People 2030
Sentinel Event Alert 64: Addressing health care disparities by improving quality and safety (TJC, 2021)

Visit the Alliant HQIC Website for More Resources, Webinars, and Success Stories
Alliant HQIC website
A Practical Guide for Advancing Health Equity (Feb 28, 2023 LAN)
Reducing the Health Disparities Gap: A Practical Framework (CoP (Community of Practice) Webinar April 14, 2022)
One Hospital's Journey to a Culture of Health Equity: Lessons Learned from a Rural Community (Nov 2021 Learning and Action Network)

Subject Matter Experts
Karen Holtz, MT(ASCP), MS, CPHQ Karen.Holtz@AlliantHealth.org