# Six Steps to Hospital Health Equity Action Planning

**Rosa Abraha, MPH, Alliant Health Solutions**

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ALLIANT HEALTH SOLUTIONS | HQIC Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES iQUALITY IMPROVEMENT & INNOVATION GROUP

# Rosa Abraha, Alliant Health Solutions

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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.

# Six Steps for Hospital Health Equity Action Planning

# Step #1: Hospital Leadership Engagement and Health Equity Team

| | |
|---|---|
| CMS HCHE<br>*Mandatory CY23* | **MUC 2021-106 \| Domain 5A**<br>Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews our strategic plan for achieving health equity. |
| TJC<br>*Mandatory 1/1/24* | **Standard LD.04.03.08**<br>Reducing healthcare disparities for the [organization's] [patients] is a quality and safety priority.<br>**EP 1**<br>The [organization] designates an individual(s) to lead activities to reduce healthcare disparities for the [organization's] [patients]. |

# Building Your Baseline Health Equity Team

**You may not have a big hospital or large teams so at minimum your hospital health equity team could include the following key personnel if you have them:**

- Case Management
- Quality Team
- Registrar Team
- Social worker(s)
- Involved department leadership
  - i.e., ED, MedSurg, Rehabilitation, Swing bed

- **Hospital Staff Pertaining to the 5 CMS SDOH Domains:**
  - **Food Insecurity**: Dietary/Nutrition Dept., swing bed
  - **Transportation:** EMS, Paramedics, ED
  - **Homelessness:** Social worker, discharge planners, swing bed
  - **Utility Difficulties:** Social worker, discharge planners, swing bed
  - **Interpersonal Violence:** Social worker, discharge planners, swing bed
  - **All Domains:** Language line interpretation services/personnel

# Model Structure for Your Hospital Health Equity Team

| | |
|---|---|
| Hospital Senior Leadership | • John Doe |
| Quality Team Members | • John Doe |
| Case Management Team Members | • John Doe |
| Physician Team Members | • John Doe |
| Registration Team Members | • John Doe |
| Patient and Family Advisory Council – | • John Doe |

This is an example model for structuring your hospital health equity team. Insert names of people on your team in the boxes to the right. This team should be meeting on a recurring basis (monthly, quarterly etc. to plan and execute health equity activities.

# Step #2: Data Collection - REaL and SDOH Patient Demographic Data

| | |
|---|---|
| CMS HCHE<br><br>*Mandatory CY23* | **MUC 2021-106**<br>**Domain 2A**<br>Our hospital collects demographic information, including self-reported race and ethnicity and/or social determinant of health information on the majority of our patients.<br>**Domain 2B**<br>Our hospital has training for staff in culturally sensitive collection of demographic and/or social determinant of health information.<br>**Domain 2C**<br>Our hospital inputs demographic and/or social determinant of health information collected from patients into structured, interoperable data elements using a certified EHR technology. |
| TJC<br><br>*Mandatory 1/1/24* | **Standard RC.02.01.01**<br>The [medical] record contains information that reflects the [patient's] care, treatment, and services.<br>**EP 28**<br>The medical record contains the patient's race and ethnicity. |

# Data Collection: 5 CMS Domains of SDOH Screening

1. **Food Insecurity**
   Food insecurity is defined as limited or uncertain access to adequate quality and quantity of food at the household level.

2. **Housing Instability**
   Housing instability encompasses multiple conditions ranging from the inability to pay rent or mortgage, frequent changes in residence including temporary stays with friends and relatives, living in crowded conditions, and actual lack of sheltered housing in which an individual does not have a personal residence.

3. **Transportation Needs**
   Unmet transportation needs include limitations that impede transportation to destinations required for all aspects of daily living.

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

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

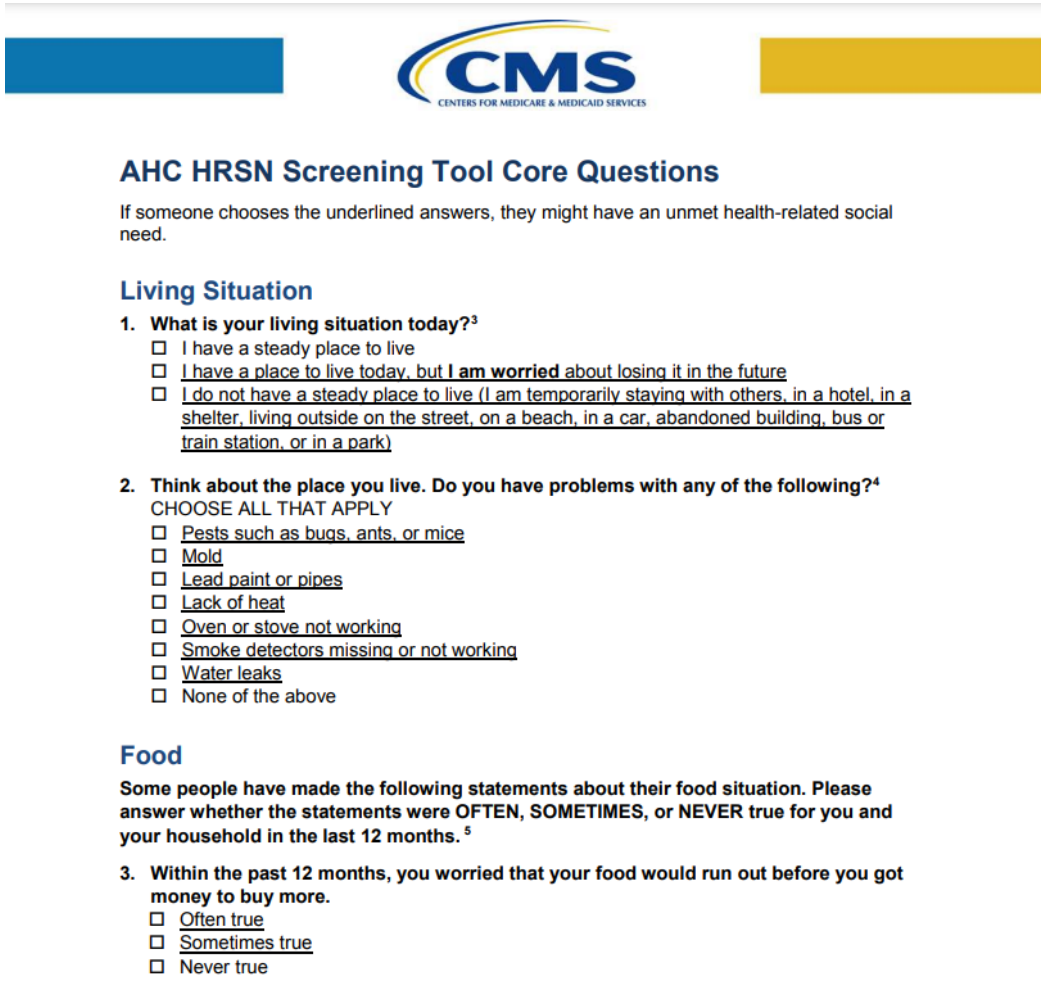
# Data Collection: Screening Patients for SDOH

| | |
|---|---|
| ● CMS SDH<br><br>*Voluntary CY23*<br>*Mandatory CY24* | **Screening for Social Drivers of Health MUC2021–136**<br>Numerator: Number of beneficiaries 18 and older screened for food insecurity, housing instability, transportation needs, utility assistance, and interpersonal violence.<br>Denominator: Number of beneficiaries 18 and older in practice (or population).<br>**Screen Positive Rate for Social Drivers of Health MUC2021–134**<br>Numerator: Number of beneficiaries 18 and older that screen positive for food insecurity, housing instability, transportation needs, utility assistance or interpersonal violence.<br>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 AHC HRSN - SDOH Screening Tool



## AHC HRSN Screening Tool Core Questions

If someone chooses the underlined answers, they might have an unmet health-related social need.

### Living Situation

1. **What is your living situation today?**[3]
   - ☐ I have a steady place to live
   - ☐ I have a place to live today, but **I am worried** about losing it in the future
   - ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. **Think about the place you live. Do you have problems with any of the following?**[4]
   CHOOSE ALL THAT APPLY
   - ☐ Pests such as bugs, ants, or mice
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Lack of heat
   - ☐ Oven or stove not working
   - ☐ Smoke detectors missing or not working
   - ☐ Water leaks
   - ☐ None of the above

### Food

**Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months.** [5]

3. **Within the past 12 months, you worried that your food would run out before you got money to buy more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

- 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) .
- This tool is currently embedded into EPIC EHR.

https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

# INSERT YOUR HOSPITAL NAME – Health Equity Data Collection

**What data do you already collect and how is it collected?**

- Example: Race, Ethnicity and Language (REaL) Data
  - Self-reported at registration
  - *Suggested registrar training: (https://ifdhe.aha.org/hretdisparities/collecting-data-nuts-bolts)*

**What data do need to start collecting to meet CMS standards and how do you plan to do that?**

- SDOH Data
  - Example: Patient screen completed by admitting nurse for all incoming patients. Case Management consult triggered when a patient screens positive for the SDOH domains

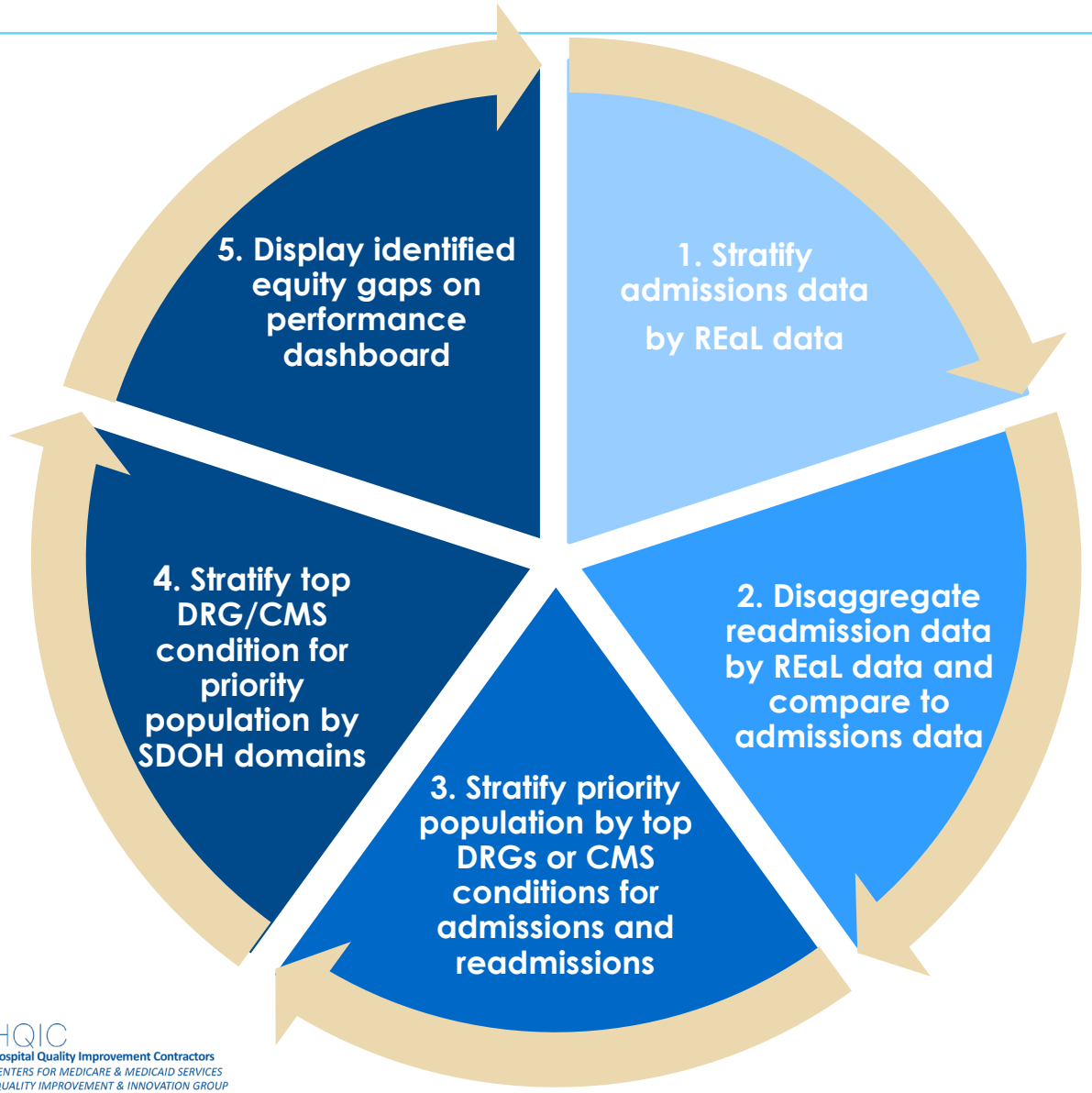
**Information Systems:**

- Does your EMR have a custom report built into it for collecting this data into a report? If not, please contact your EMR provider to request that information so you can track monthly data trends.

# Step #3: Data Analysis and Stratification by Hospital Quality Measures

| | |
|---|---|
| ● CMS HCHE<br><br>*Mandatory CY23* | **MUC 2021-106**<br>**Domain 3A**<br>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.<br>**Domain 1B**<br>Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews key performance indicators stratified by demographic and/or social factors. |
| ● TJC<br><br>*Mandatory 1/1/24* | **Standard LD.04.03.08**<br>Reducing healthcare disparities for the [organization's] [patients] is a quality and safety priority.<br>**EP 3**<br>The [organization] identifies healthcare disparities in its [patient] population by stratifying quality and safety data using the sociodemographic characteristics of the [organization's] [patients]. |

# Example Process for Health Equity Data Analysis

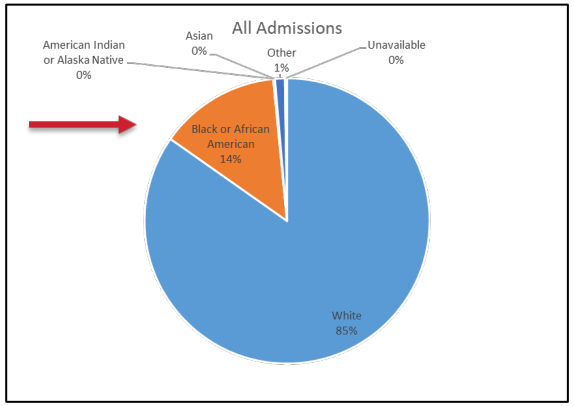



- These steps exist to ensure removal of medical bias and selection bias.
- The main goal is to eliminate assumptions about who your priority populations are and what the root-cause of their disparities might be.
- Instead, we want to allow the data to drive our priority populations of focus and in turn the interventions, resources and community partnerships necessary to provide the best and most trusted care to those patients.

# Example from Tift Regional Hospital in GA

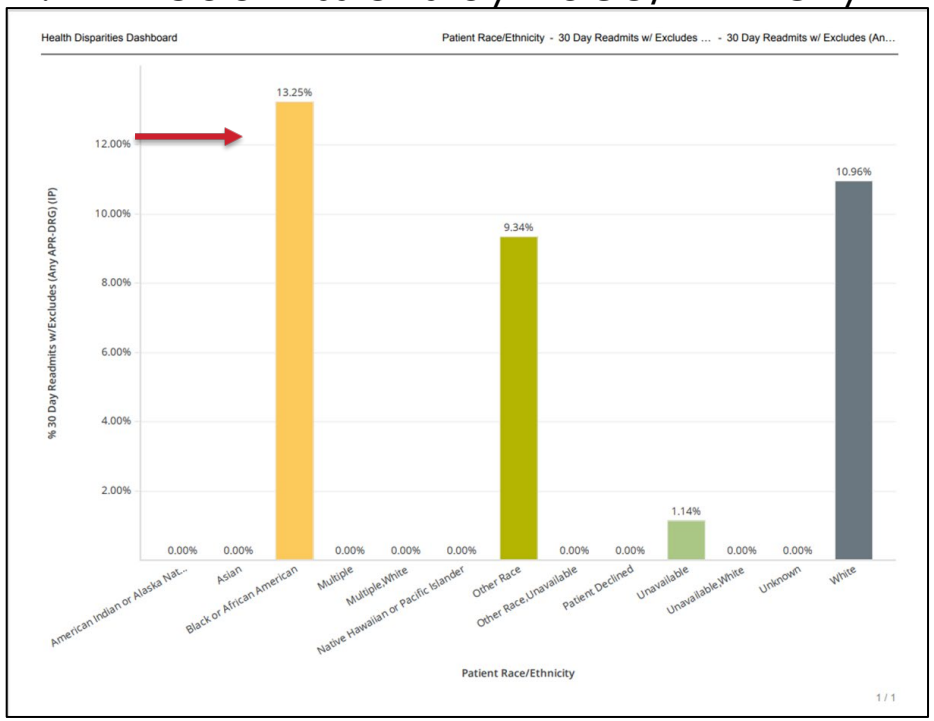
## 1. All Admissions by Race/Ethnicity

Black/African American

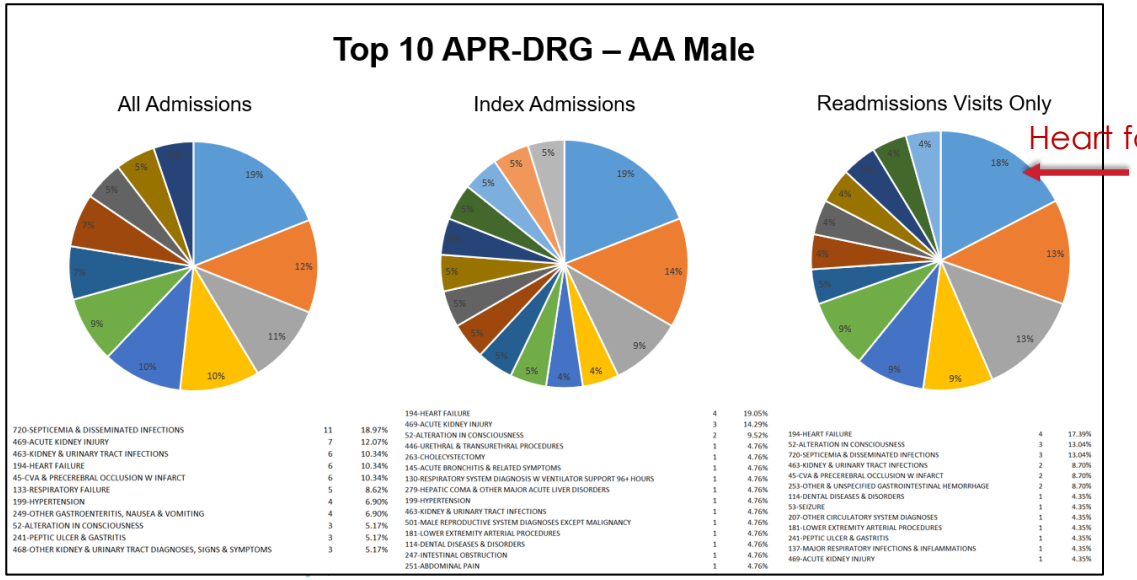



## 2. All Readmissions by Race/Ethnicity

Black/African American

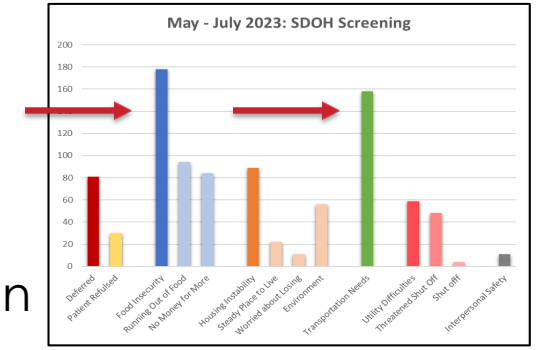



## 3. Black/African American Males Readmissions, Heart Failure




Heart failure

## 4. SDOH screening revealed food insecurity and transportation needs for readmitted population



# INSERT YOUR HOSPITAL NAME - Stratification by Quality Measures

**What are key CMS conditions that your hospital needs to improve upon?**

- Example: 30-day All Cause Readmissions
- Are there are any more to think about?

**How will you map these CMS conditions against REaL and SDOH data?**

- See slide 16 as an example for how to do this for readmissions. Write out your steps in and feel free to tweak them to make sense for your hospital.

**How will you embed this data into your hospital dashboards?**

- Should this be built into custom dashboards that are pre-existing?

# Step #4: Health Equity Priority Population

| | |
|---|---|
| ● CMS HCHE<br><br>*Mandatory CY23* | **MUC 2021-106**<br>**Domain 1A**<br>Our hospital strategic plan identifies priority populations who currently experience health disparities.<br>**Domain 1B**<br>Our hospital strategic plan identifies healthcare equity goals and discrete action steps to achieving these goals.<br>**Domain 1C**<br>Our hospital strategic plan outlines specific resources which have been dedicated to achieving our equity goals. |
| ● TJC<br><br>*Mandatory 1/1/24* | **Standard LD.04.03.08**<br>Reducing healthcare disparities for the [organization's] [patients] is a quality and safety priority.<br>**EP 4**<br>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.<br>**EP 5**<br>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**
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5. **Interpersonal Safety**
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# Step #5: Health Equity Goals and Action Steps

| | |
|---|---|
| ● CMS HCHE<br><br>*Mandatory CY23* | **MUC 2021-106**<br>**Domain 1A**<br>Our hospital strategic plan identifies priority populations who currently experience health disparities.<br>**Domain 1B**<br>Our hospital strategic plan identifies healthcare equity goals and discrete action steps to achieving these goals.<br>**Domain 1C**<br>Our hospital strategic plan outlines specific resources which have been dedicated to achieving our equity goals. |
| ● TJC<br><br>*Mandatory 1/1/24* | **Standard LD.04.03.08**<br>Reducing healthcare disparities for the [organization's] [patients] is a quality and safety priority.<br>**EP 4**<br>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.<br>**EP 5**<br>The [organization] acts when it does not achieve or sustain the goal(s) in its action plan to reduce healthcare disparities. |

# Critical Elements for a Hospital Health Equity Strategic Plan

- **Executive Summary**
  - This should include that this is a Board approved health equity strategic plan for the purposes of achieving the CMS/TJC health equity standards

- **Background on County Level and Hospital Level Demographic or SDOH Data**
  - Pull data from the Department of Public Health or other publicly available reports that list General Demographic Statistics (Age, race, disability status), SDOH statistics (high school educated, per capita income etc.) and chronic disease statistics (diabetes prevalence, infant mortality, and any CMS conditions)
  - Also pull hospital level data

- **Health Equity Statement**
  - Ex. To improve patient health outcomes and reduce healthcare disparities through data-driven health equity interventions and quality services

- **Strategic Goals** *(discussed in more detail next slide)*
  - Focus on meeting the CMS standard requirements
  - Include short- and long-term action steps with dates to achieve each goal

- **Priority Population Health Equity Goals**
  - If you don't already have your priority population identified, describe the steps for how you will do that and what you plan to do once you have identified them *(see slide 17-19)*

- **References**

# Developing Your Hospital's Health Equity Goals and Action Steps

- **Main goal categories that Rosa recommends:**
  - Promote a **culture of health equity** that improves the quality, safety, and effectiveness of health services for underserved populations and those experiencing health disparities
  - Collect and evaluate **race, ethnicity and language (REaL) data and social determinant of health (SDOH) data** to conduct a root-cause analysis in patient outcomes and drive evidence-based interventions
  - Develop **culturally and linguistically responsive healthcare interventions that promote health equity** and adequately train hospital staff in identified best practices
  - Bolster integral **community partnerships to identify community assets that can help address patients' health related social needs**, especially in the five CMS SDOH domains (i.e., housing instability, transportation needs, utility difficulties, interpersonal safety and food insecurity)

- Each goal must have **short-term (next 3-6 months) and long-term action steps (next 6-12 months)**
  - Ex. *Goal #3: Culturally and Linguistically Responsive Healthcare Interventions*
    - **Short-Term Action:** By December 2023, provide mandatory health equity training via HealthStream across the case management team, registration staff, nursing staff and all necessary service lines utilizing the Alliant Health Solutions trainings, bite-sized learning videos and toolkits on health equity best practices and cultural and linguistic standards (CLAS).

    - **Long-Term Action**: By March 2024, review and improve discharge processes to include critical referral services for patients with social needs to appropriate community partner resources, especially in the five CMS SDOH domains (i.e., housing instability, transportation needs, utility difficulties, interpersonal safety and food insecurity)

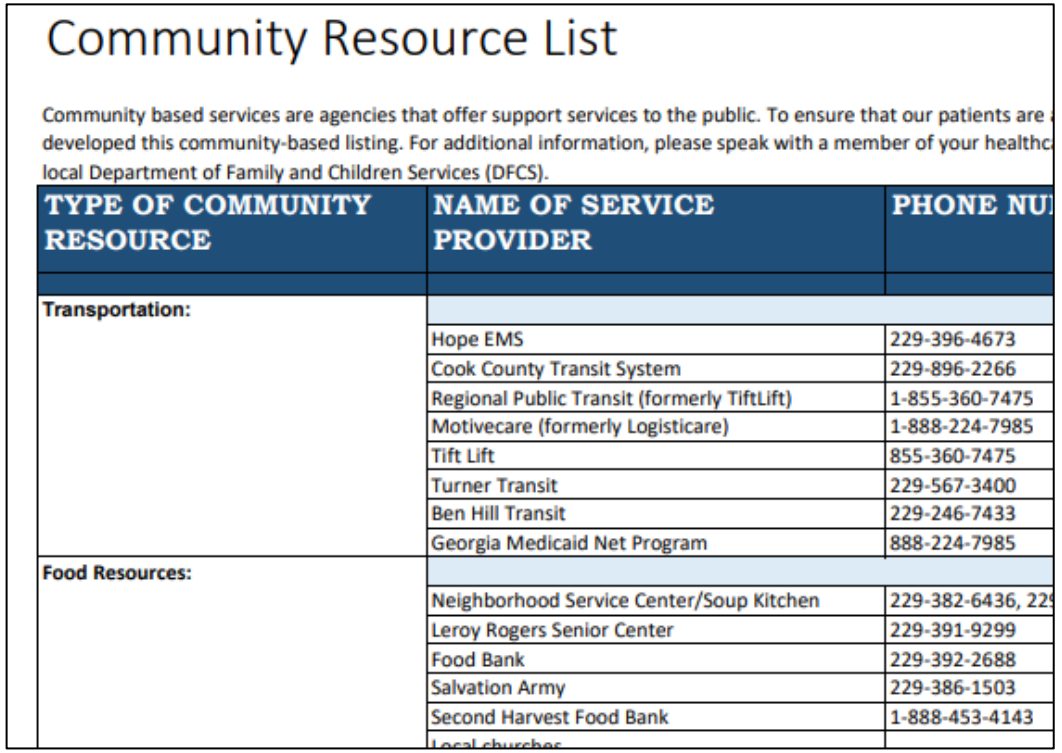
# Step #6: Health Equity Community Partnerships

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

# A Culture of Health Equity: Key Clinical-Community Partnerships

# INSERT YOUR HOSPITAL NAME - Health Equity Community Partnerships

- **Who are your trusted local community partner for addressing SDOH?**
  - Categorize your partner lists by the 5 SDOH domains
    - Example to the right from Tift Regional Hospital in GA
- **Who are your trusted statewide community partners for addressing SDOH?**
  - Ex. Alliant Health Solutions "Healthy Gulf Coast" Partnership for Community Health
- **Who are your trusted national partners for addressing SDOH?**
- **Future Action Steps:**
  - Ex. Community Health Needs Assessment is a great opportunity to bring together potential partners to participate in the assessment. Include community leaders representing the diversity of your population.



Community Resource List

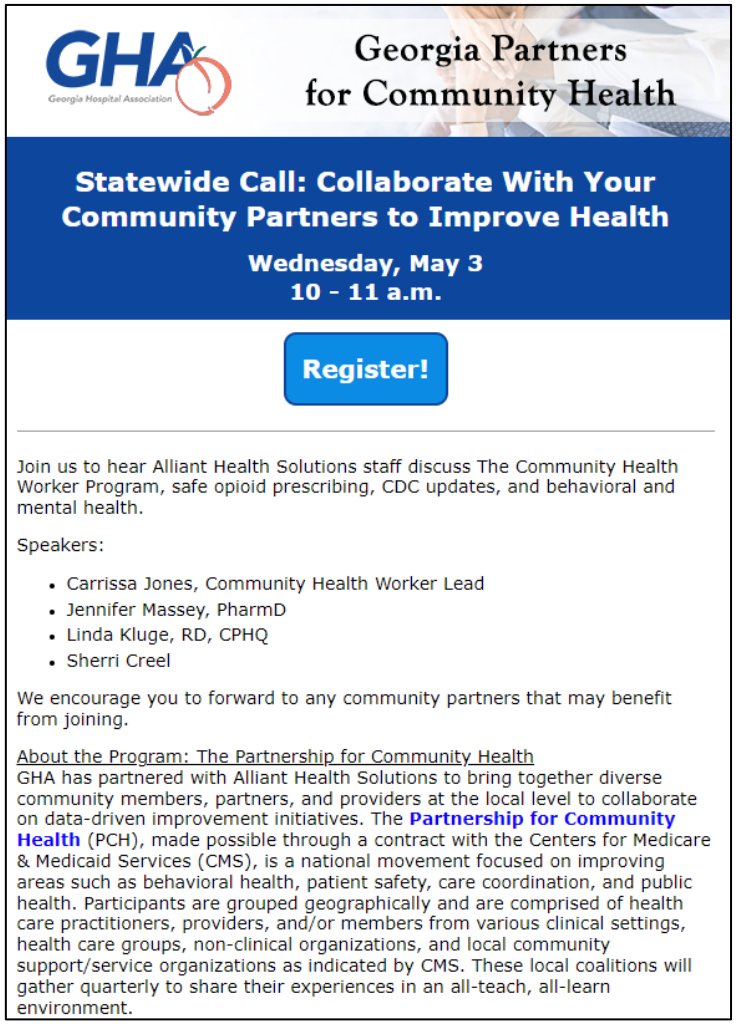
Community based services are agencies that offer support services to the public. To ensure that our patients are
developed this community-based listing. For additional information, please speak with a member of your healthc
local Department of Family and Children Services (DFCS).

| 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 | |

# Ways to Engage with Alliant Health Solutions 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
- Contact your AHS state quality manager below:

| | |
|---|---|
| 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 |



GHA Georgia Hospital Association

Georgia Partners for Community Health

**Statewide Call: Collaborate With Your Community Partners to Improve Health**

**Wednesday, May 3**
**10 - 11 a.m.**

**Register!**

Join us to hear Alliant Health Solutions staff discuss The Community Health Worker Program, safe opioid prescribing, CDC updates, and behavioral and mental health.

Speakers:

- Carrissa Jones, Community Health Worker Lead
- Jennifer Massey, PharmD
- Linda Kluge, RD, CPHQ
- Sherri Creel

We encourage you to forward to any community partners that may benefit from joining.

About the Program: The Partnership for Community Health
GHA has partnered with Alliant Health Solutions to bring together diverse community members, partners, and providers at the local level to collaborate on data-driven improvement initiatives. The **Partnership for Community Health** (PCH), made possible through a contract with the Centers for Medicare & Medicaid Services (CMS), is a national movement focused on improving areas such as behavioral health, patient safety, care coordination, and public health. Participants are grouped geographically and are comprised of health care practitioners, providers, and/or members from various clinical settings, health care groups, non-clinical organizations, and local community support/service organizations as indicated by CMS. These local coalitions will gather quarterly to share their experiences in an all-teach, all-learn environment.

# CMS Attestation Guidance on Health Equity

**For CY 2023 Reporting Period/FY 2025 Payment Determination**

- For the CY 2023 reporting period/FY 2025 payment determination under the Hospital IQR Program, hospitals will need to confirm that they engaged in the activities described in this Attestation Guidance Document during the period of January 1, 2023, to December 31, 2023. If hospitals participate or complete qualifying activities at any time within the reporting year, they may answer yes to their attestation. **Hospitals must complete their attestation for the CY 2023 reporting period/FY 2025 payment determination between April 1, 2024, and May 15, 2024.**
- https://qualitynet.cms.gov/inpatient/iqr/measures#tab2

| File Name | File Type | File Size | |
|---|---|---|---|
| Attestation Guidance for the Hospital Commitment to Health Equity Measure (06/2023) | PDF | 485 KB | Download |
| Hospital Commitment to Health Equity Structural Measure Specifications (06/2023) | PDF | 305 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 |

# Alliant Health Solutions Health Equity Coaching Package

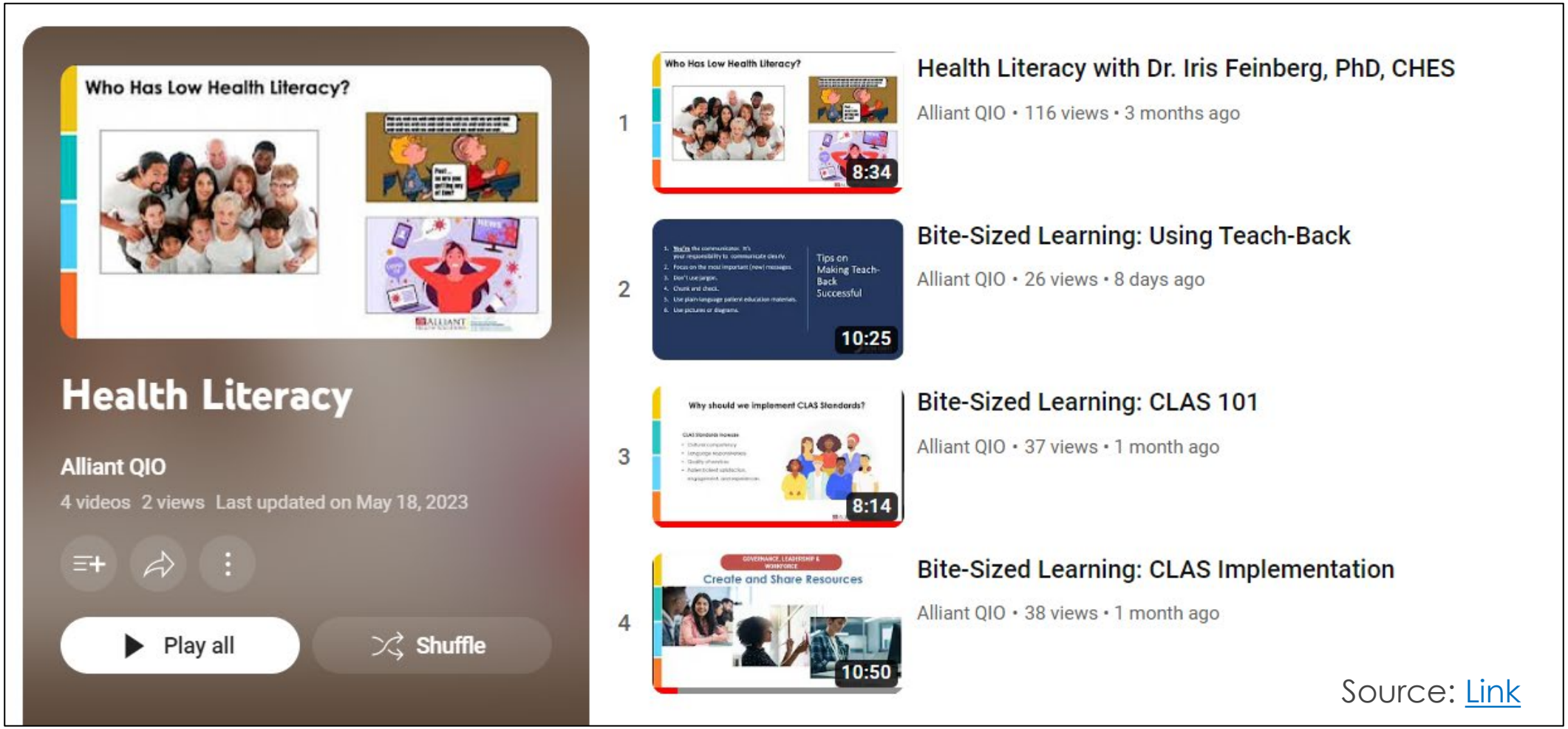
## HEALTH EQUITY — COACHING PACKAGE

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)<br>Health Equity Snapshot: A Toolkit for Outcomes<br>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)*<br>*Contains links to other resources |

https://quality.allianthealth.org/wp-content/uploads/2023/04/2023-Coaching-Package-Health-Equity_508.pdf

# Cultural and Linguistically Appropriate Services (Alliant Health Solutions CLAS Video Toolkit)




Source: Link

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

# 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.

# Questions?

Email us at HospitalQuality@allianthealth.org

or call us 678-527-3681.

# Upcoming Events

## Alliant HQIC Health Equity Planning Office Hours

**Thursday, November 16, 2023**

**Thursday, December 21, 2023**

**3 – 3:45 p.m. EST**

**REGISTER HERE**

# Making Health Care Better *Together*

**COLLABORATORS:**

Alabama Hospital Association
Alliant Health Solutions
Comagine Health
Georgia Hospital Association
KFMC Health Improvement Partners
Konza

# Hospital Quality Improvement

**@AlliantQIO**

**@AlliantQIO**

## Thank you for joining us!
## How did we do today?

**Alliant Health Solutions**

**AlliantQIO**

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ALLIANT HEALTH SOLUTIONS

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