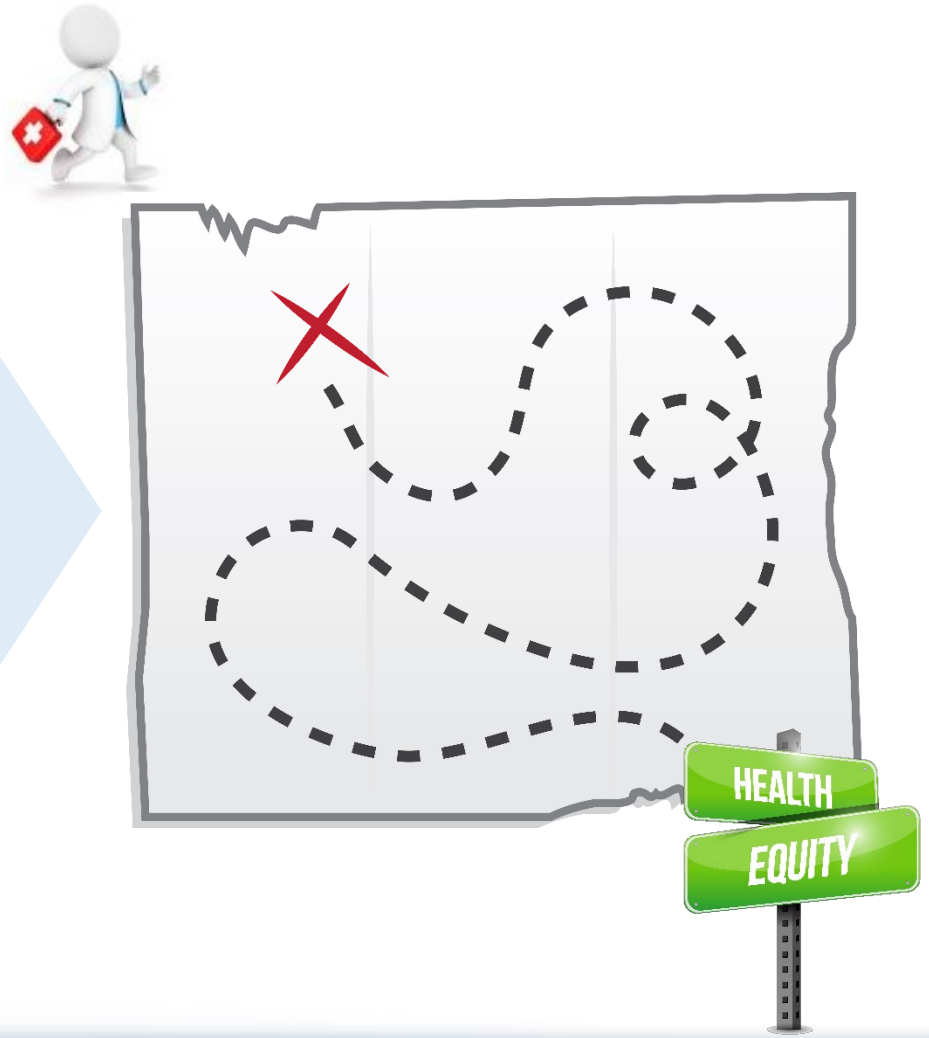
Health Equity Quickinar Series
Session 1

Health Equity, Hospitals, and CMS* Reporting

*CMS = Centers for Medicare & Medicaid Services

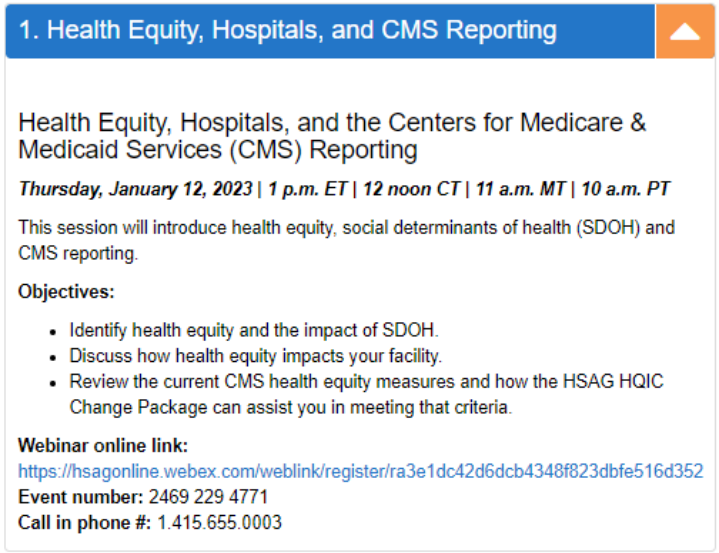
Health Equity Quickinar Series Overview

- 12 sessions
- Live and on-demand
- 2nd and 4th Thursdays
- 30 minutes or less
- Support to advance health equity in your facility
- Assistance in meeting new CMS health equity measures



HSAG Health Equity Series Website

Recordings, slides, and resource links will be posted for on-demand access after every session.



- 1. Health Equity, Hospitals, and CMS Reporting
- 2. Engaging Leadership in Health Equity
- 3. Health Equity as a Strategic Priority
- 4. Collection and Validating REaL Data
- 5. Social Determinants and Social Drivers of Health
- 6. Screening for Social Drivers
- 7. Culturally Competent Data Training
- 8. Analysis and Stratification of Health Equity Data
- 9. Health Equity Interventions
- 10. Best Practices in Health Equity Interventions
- 11. Community Paramedicine
- 12. Identifying Community Health Disparities
- 13. Community Engagement—Health Equity

www.hsag.com/health-equity-quickinars

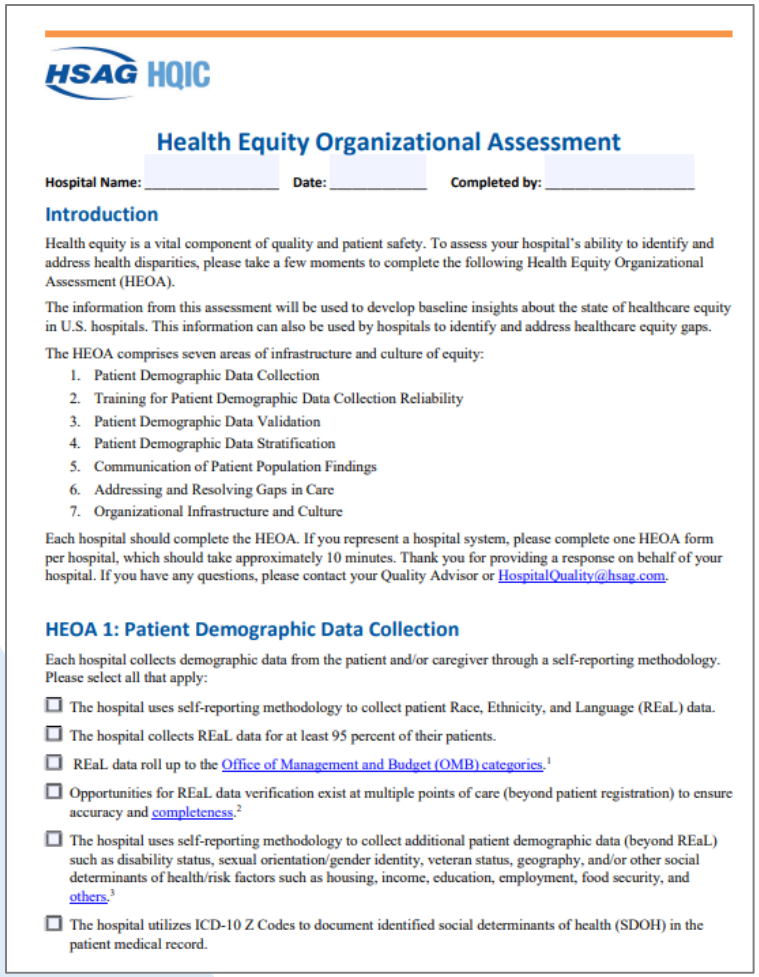
Health Equity Video

www.hsag.com/health-equity-quickinars

- Short video—1:21
- Importance of health equity
- Your "elevator speech"
- Assists with getting buy-in

HSAG HQIC Hospitals—HEOA*

The Health Equity Quickinar Series will also assist hospitals participating in the CMS HQIC.*



HSAG HQIC

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.

*HEOA = Health Equity Organizational Assessment
HQIC = Hospital Quality Improvement Contract

OBJECTIVES

- Identify health equity and the role that social determinants of health play.
- Discuss how health equity impacts your facility.
- Review the current CMS health equity measures and how the HSAG HQIC Change Package can assist you in meeting that criteria.

What Are Health Disparities?

Health Disparities

*"**Health disparities** are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by populations that have been disadvantaged."* —CDC

Some racial and ethnic minorities experience high rates of poor health and increased rates of chronic conditions.

- Diabetes
- Hypertension
- Obesity
- Asthma
- Heart disease
- Cancer
- Pre-term birth

These disparities exists even when adjusted for demographics and socioeconomic factors.

Centers for Disease Control and Prevention (CDC). https://www.cdc.gov/healthequity/whatis/index.html

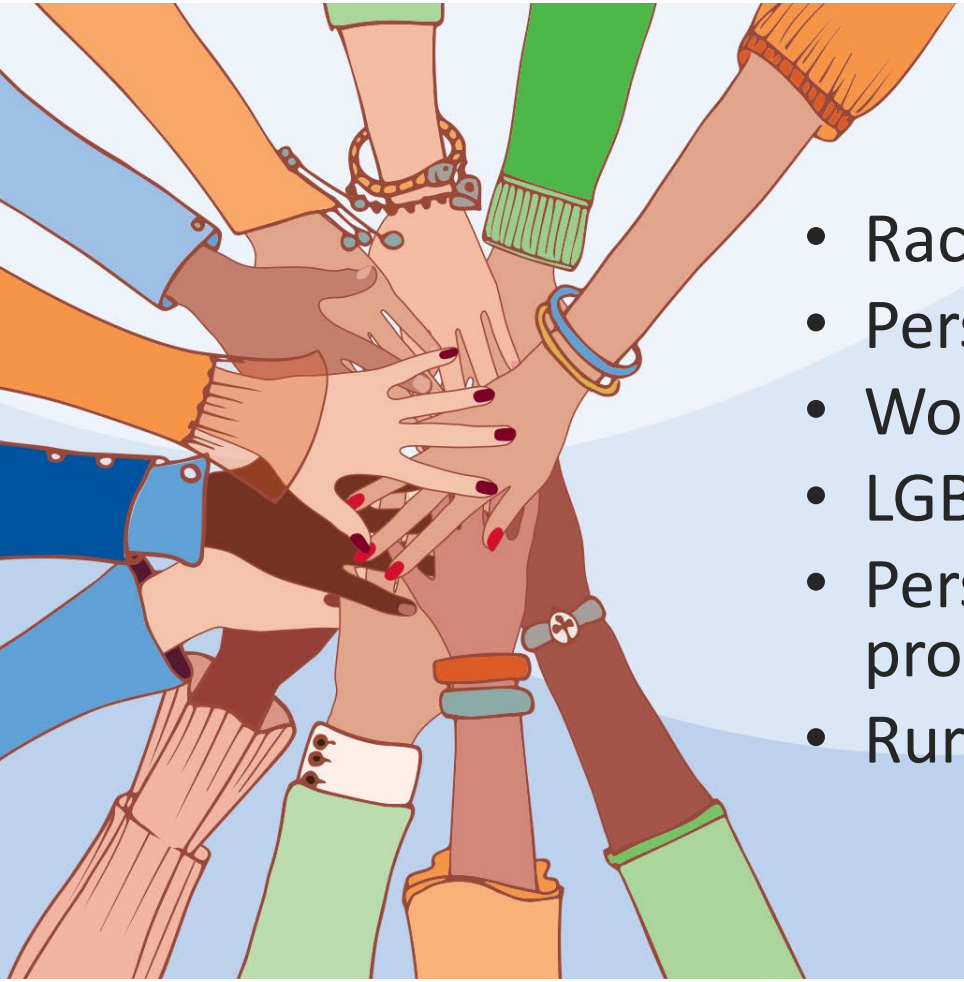
Race and Ethnicity

Race is defined as "a group sharing some outward physical characteristics and some commonalities of culture and history."

Ethnicity "refers to markers acquired from the group with which one shares cultural, traditional, and familial bonds."

https://www.merriam-webster.com/words-at-play/difference-between-race-and-ethnicity

Populations Experiencing Disparities



- Racial and ethnic minority groups
- Persons with disabilities
- Women
- LGBTQI +
- Persons with limited English proficiency
- Rural populations

https://www.cdc.gov/healthequity/whatis/index.html

What Is Health Equity?

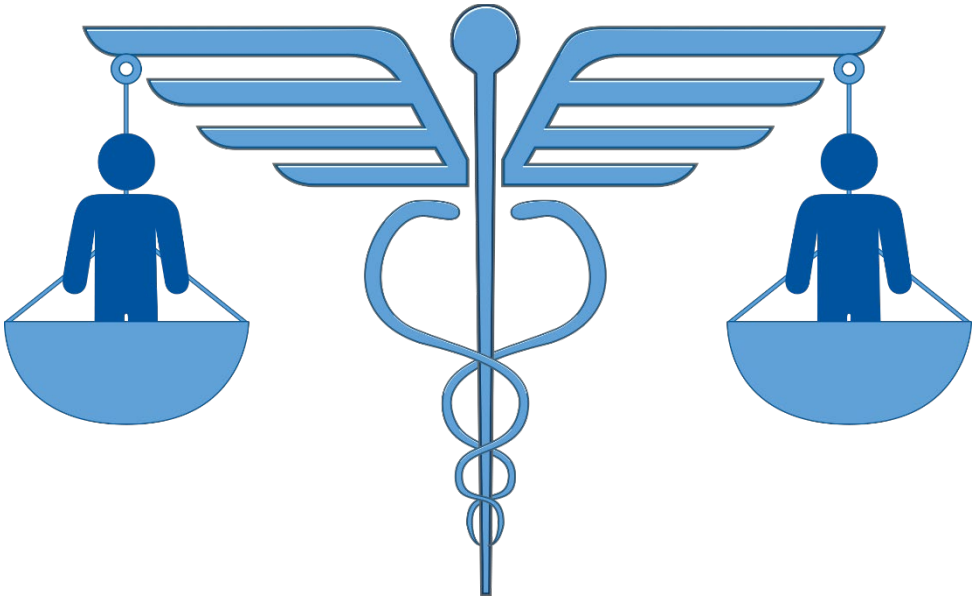
Health Equity

Health equity is achieved when every person has the opportunity to attain his or her full health potential and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances." —CDC

- Length of life
- Rates of disease, disability, and death
- Severity of disease
- Access to treatment

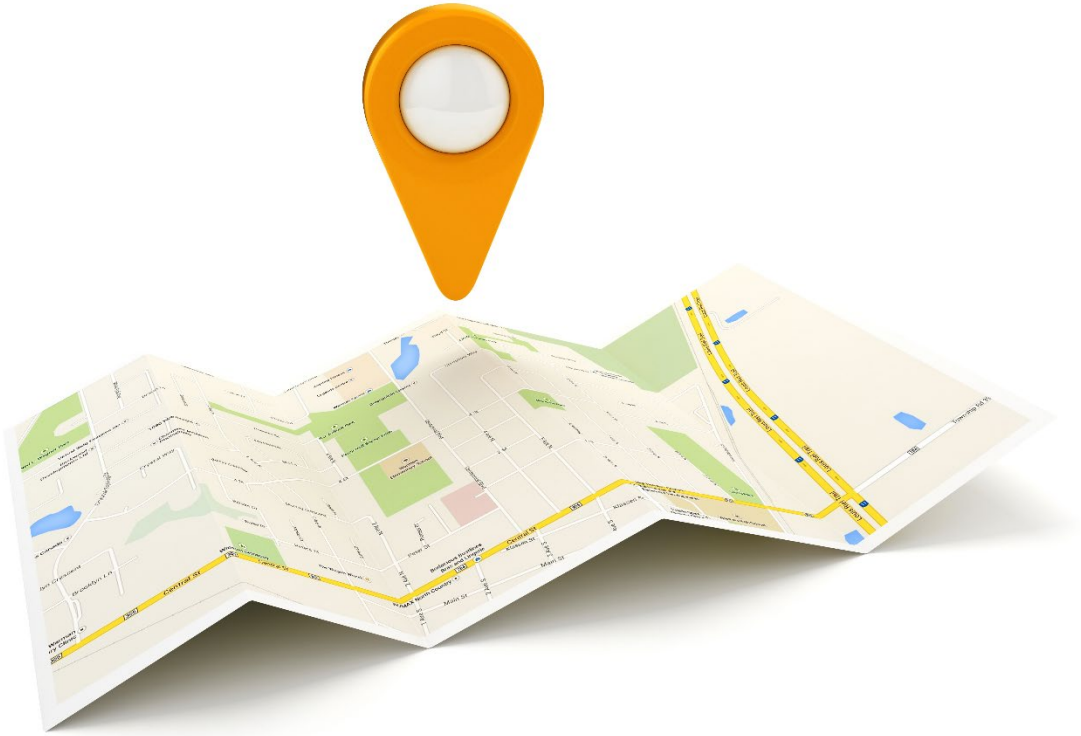
https://www.cdc.gov/chronicdisease/healthequity/index.htm

The Impact of Health Equity



Greatest Predictor of Life Expectancy

Your **ZIP Code**



https://www.cdc.gov/nchs/data-visualization/life-expectancy/index.html

The Impact of Social Determinants of Health

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

Dual Eligible Patients

(Patients on Medicare and Medicaid)[2]

1.5 times higher hospital utilization

70% higher prescribing of "high-risk" drugs

Anticoagulants, glycemic agents, opioids

18% higher avoidable readmissions

1. https://health.gov/healthypeople/objectives-and-data/browse-objectives/economic-stability
2. Heath, S. Health Payer Intelligence xtelligent Healthcare Media. 2019. https://healthpayerintelligence.com/news/most-medicare-dual-eligibles-see-social-determinants-of-health

Social Determinants as a Healthcare Driver

Social Determinants of Health

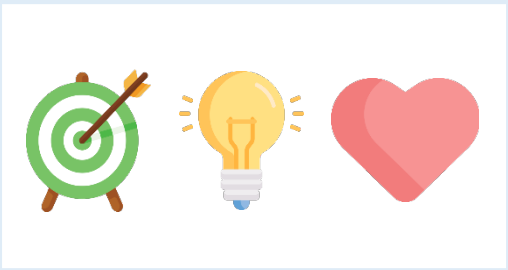
Healthcare

80% to 90% of health outcome contributors are social determinants of health.

—National Academy of Medicine

https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/

Why Address Health Disparities



- Part of a hospital's mission, vision, values
- To serve the underserved
- Part of community health needs assessment
- Human toll

- High resource utilization
- Increased readmission rate
- Increased non-compliance
- Increased emergency department utilization
- Increased chronic conditions

- $93 billion in excess medical costs annually[1]
- Expected to rise to $1 trillion by 2040[2]
- Increase in unreimbursed care
- Value-based payment penalties due to increases in adverse outcomes

1. WK Kellogg Foundation. https://wkkf.issuelab.org/resource/business-case-for-racial-equity.html
2. MedPageToday. https://www.medpagetoday.com/special-reports/features/99398

CMS Health Equity Measures

Two New 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

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

- Competencies aimed at achieving health equity
- Must meet all elements under each domain
- Structural measure
- Attest via QualityNet
- Begins CY 2023/FY 2025
- Initial submission deadline May 2024[2]
- Annual submission

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

Domain 1: Equity as a Strategic Priority

Must have a strategic plan that:

- Identifies priority populations currently experiencing health disparities.
- Identifies healthcare equity goals and action steps to achieving those goals.
- Outlines specific, dedicated resources focused on achieving health equity goals.
- Describes approach for engaging key stakeholders and community organizations/resources.

Domain 2: Data Collection

- Collects demographic information including race/ethnicity **and/or** social determinants of health information on **majority** of patients.
- Trains staff in culturally sensitive collection of demographic **and/or** social determinants of health information.
- Inputs demographic **and/or** social determinants of health information into structured, interoperable data elements using certified EHR.*

*EHR = electronic health record

Domain 3: Data Analysis

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.**

Domain 4: Quality Improvement

Participates in local, regional, or national quality improvement activities focused on reducing health disparities.

Domain 5: Leadership Engagement

- Annually reviews, by senior leadership (including chief executives and the entire hospital board of trustees), the strategic plan for achieving health equity.
- Annually reviews, by senior leadership (including chief executives and the entire hospital board of trustees), key performance indicators stratified by demographic and/or social factors.

Social Drivers of Health—Two Measures

Screening for Social Drivers of Health Measure	Screen Positive Rate for Social Drivers of Health Measure
• Food insecurity • Housing instability • Transportation needs • Utilities difficulties • Interpersonal safety	• Food insecurity • Housing instability • Transportation needs • Utility difficulties • Interpersonal safety
Numerator: Number of patients who were screened for **one or all** social drivers Denominator: Number of patients 18 or older admitted as an inpatient	Numerator: Number of patients who screened positive for each driver Denominator: Number of patients 18 or older admitted as an inpatient and screened for social drivers

https://qualitynet.cms.gov/files/6269ba5b5e40610016f30237?filename=ScrnSocDrvrs_%20Scrn_Pos_Specs.pdf

Screening for Social Drivers of Health

- Report annually
- Structural measure
- Report 6 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)

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

Putting the Pieces Together

- Start now!
- Identify your team.
- Attend the HSAG Health Equity Quickinar Series.
- Discover how to recognize and advance health equity.
- HSAG will help you meet the metrics!

Thank you!

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