



Health Equity Quickinar Series

Session 10

Health Equity Frequently Asked Questions (FAQs) Answered

OBJECTIVES

- Review best practices for advancing health equity.
- Examine Centers for Medicare & Medicaid Services (CMS) health equity commitment domains.
- Discuss FAQs on health equity measures.

Health Equity Series Review

- Multiple topics to help hospitals prepare for the health equity measures.
 - CMS reporting
 - engaging leadership
 - prioritizing health equity
 - defining SDOH terms
 - screening for social drivers
 - culturally competent data collection
 - data stratification
 - health equity intervention
- Further guidance has been published by the Inpatient Quality Reporting (IQR) Program.



Hospital Commitment to Health Equity

5 Health Equity Commitment Domains¹

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 2024²
- Annual submission

CY = calendar year, FY = fiscal year

General FAQs

- What is the attesting period for these measures?
 - Your hospital will need to attest that it engaged in the measures from January 1–December 31, 2023. It is not necessary to have engaged in the activities for the entire year, but if your facility has engaged in activities related to the measure any time in that period, your facility may attest “yes” to the measure.
- What is the reporting period for these measures?
 - Attestation for all measures must be completed between April 1–May 15, 2024.

Engage in Measures

CY 2023

Attest to Measures

Apr. 1–May 15, 2024

Domain 1: Equity as a Strategic Priority

Facility 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 the approach for engaging key stakeholders and community organizations/resources.

Domain 1 FAQs—Equity Is a Strategic Priority

- What must our hospital have in place for our strategic plan?
 - The strategic plan must be a written plan, which includes all the elements listed in the subdomains for measure 1.
- What is the definition of *priority population* for this domain?
 - *Priority population* depends on your hospital and the population you serve. Examples of populations you may identify include: racial/ethnic minorities, members of the LGBTQI+ community, those in rural and high-deprivation areas, persons with disabilities, and others, depending on your hospital service area.



For more information, refer to Health Equity Quickinar #3 [Health Equity as a Strategic Priority](#).

Domain 2: Data Collection

Facility must demonstrate that it:



Collects demographic information including, race/ethnicity **and/or** SDOH information on the **majority** of patients.



Trains staff in culturally sensitive collection of demographic **and/or** SDOH information.



Inputs demographic **and/or** SDOH information into structured, interoperable data elements using a certified EHR.*

Domain 2 FAQs—Data Collection

- Does CMS require these data be collected in a specific way in order to meet this domain?
 - CMS does not require a specific method of collection at this time, so hospitals should attest “yes” if they collect these data in any way.
- Are there scripts my hospital can use for the collection of these data?



Refer to Health Equity Quickinar #4 [Collecting and Validating REaL Data](#) and #7 [Culturally Competent Data Training](#) for guidance on how to collect REaL and SDOH data.

REaL = Race, Ethnicity, and Language

Domain 3: Data Analysis

Facility must have a data analysis plan that:



Stratifies key performance indicators by demographic and/or SDOH variables to identify equity gaps and includes this information on **hospital performance dashboards.**



Domain 3 FAQs—Data Analysis

- What performance indicators are required to stratify this domain?
 - CMS does not prescribe specific measures that must be stratified in order to attest “yes” for this domain. The purpose of this measure is to identify if any populations are experiencing gaps in care, so monitor measures and populations that are appropriate for your hospital.
- Does our hospital have to develop a health equity-specific dashboard for this domain?
 - Your hospital does not have to develop a health equity dashboard but should monitor metrics stratified by priority populations using existing dashboards and tracking mechanisms.



For more information, refer to Health Equity Quickinar #8 [Analysis and Stratification of Health Equity Data](#)

Domain 4: Quality Improvement

Facility must demonstrate that it:



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



Domain 4—Quality Improvement

- What are some examples of quality improvement activities in which our hospital could participate?
 - CMS is not prescriptive with this measure. Hospitals can attest to this measure if they participate in collaboratives or community partnerships that have a focus on improving quality and addressing health equity.
 - Hospitals can attest to work with Quality Innovation Networks-Quality Improvement Organizations, such as HSAG, for this domain.

Domain 5: Leadership Engagement

Facility must demonstrate that it:



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.

Domain 5—Leadership Engagement

- What level of leadership needs to be engaged in order to meet this domain?
 - CMS defines “hospital senior leadership” as the C-suite and board of trustees, as well as the chief medical officer and senior leaders among hospital medical staff.



For more information on this domain, refer to Health Equity Quickinar #2 [Engaging Leadership in Health Equity](#).

Attestation Guidance Document



For further guidance on attestation for each of the 5 domains, refer to the [Attestation Guidance for the Hospital Commitment to Health Equity Measure for the Hospital Inpatient Quality Reporting \(IQR\) Program.](#)

Social Drivers of Health—2 Measures

Screening for Social Drivers of Health Measure

- Food insecurity
- Housing instability
- Transportation needs
- Utilities 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

Screen Positive Rate for Social Drivers of Health Measure

- Food insecurity
- Housing instability
- Transportation needs
- Utility difficulties
- Interpersonal safety

Numerator

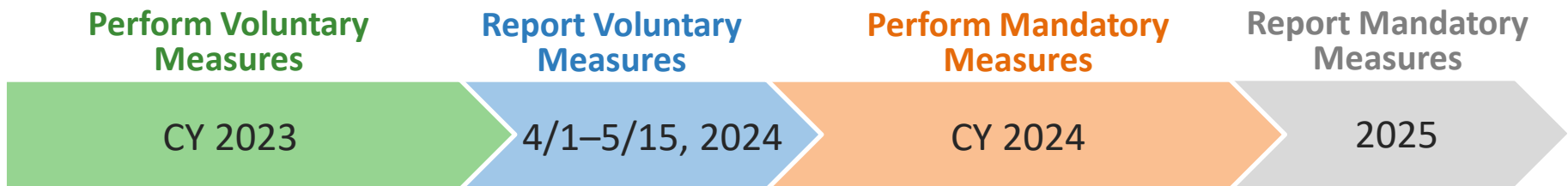
Number of patients who screened positive for each driver

Denominator

Number of patients 18 or older admitted as an inpatient and screened for social drivers

SDOH Screening Measures FAQs

- When are these measures mandatory for reporting?
 - SDOH measures are voluntary for CY 2023 and will be reported April 1–May 15, 2024.
 - The measures become mandatory for CY 2024 and will be reported in 2025.



- When should screening for social drivers occur at the hospital?
 - Screening can occur at any point prior to patient discharge. The most appropriate time for screening will depend on patient and hospital characteristics.

SDOH Screening Measures FAQs (cont.)

- What should we do if a patient refuses to participate or is unable to complete the screening?
 - If a patient refuses or is unable to be screened, the patient should be excluded from the denominator for both measures.
- How will these measures be reported to CMS?
 - CMS has not finalized how the reporting for these measures will occur. Hospitals will be required to submit aggregate numerators and denominators for the measures, but more guidance on the specific method of reporting will be released prior to the start of the voluntary reporting period.

SDOH Screening Measures FAQs (cont.)

- What patients should be counted as an “admission”? Should observation or overnight ED stays be included?
 - Overnight ED stays and observation patients are not included as admissions.



For more information on what CMS defines as an inpatient admission, refer to www.medicare.gov/publications/11435-Inpatient-or-Outpatient.pdf

- Is there recommended scripted language to invite patients to participate in screening?
 - CMS has not released scripted language.



HSAG provides examples of language for introducing SDOH screening which, can be found on Health Equity Quickinar #7 [Culturally Competent Data Training](#).

SDOH Screening Measures FAQs (cont.)

- How frequently should a patient be screened for social needs?
 - Screening should occur during each hospital admission, and answers should be updated. However, even if a patient is screened multiple times during a year, they only contribute once to the numerator and denominator. The most recent results of the screening should be used for the calculation of the numerators and denominators.

SDOH Screening Measures FAQs (cont.)

- Are there questions or specific screening tools that CMS is requiring?
 - CMS is not being prescriptive on how hospitals should conduct the screening to allow hospitals flexibility to use whatever tool is best for their specific context.



For more information on screening tools your hospital can use, refer to Health Equity Quickinar #5 [Social Determinants and Social Drivers of Health](#).

IQR SDOH Screening FAQ Document



For more FAQs and answers, please refer to:
[Hospital IQR Program Frequently Asked Questions: SDOH Measures](#)

Key Concepts

- HSAG has covered multiple topics and has released multiple quickinars to assist hospitals in advancing health equity.
- Find guidance on the measures and FAQs from IQR documents and the HSAG Health Equity quickinar series.



Join Us for the Patient and Family Engagement (PFE) Quickinar Series: 1st and 3rd Thursdays

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

1. Intro to PFE



3. Preparing for PFE Programs



5. PFE to Prepare for Hospital Discharge



7. Bedside Hand Off to Improve Patient Outcomes



9. Role of the PFE Advisor



11. PFE in Critical Access & Small Rural Hospitals



9. Role of the PFE Advisor



The Role of the Hospital Patient and Family Engagement Advisor

Thursday, June 1, 2023 | 1 p.m. ET | 12 noon CT | 11 a.m. MT | 10 a.m. PT

Objectives:

- Identify key skills for a PFE advisor.
- Identify roles and responsibilities of the PFE advisor to leadership, staff, and Patient and Family Advisory Council (PFAC) members.
- Explore how to integrate PFE advisor roles into existing positions.

2. Achieving Patient/Family Centered Care



4. PFE to Prepare for Hospital Admission



6. Role of PFE in Readmission Prevention



8. Adverse Event Transparency



10. Selecting/Training/Engaging Advisors



12. PFE in Acute Care Hospitals



Join Us for the Health Equity Quickinar Series: 2nd and 4th Thursdays

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

11. Community Paramedicine

11. Community Paramedicine to Address Disparities in Health Equity

Thursday, June 8, 2023 | 1 p.m. ET | 12 noon CT | 11 a.m. MT | 10 a.m. PT

Objectives:

- Review the key components of a paramedicine program.
- Identify the role of paramedicine in addressing health equity.
- Discuss best practices in successful paramedicine programs.

1. Health Equity, Hospitals, and CMS Reporting



2. Engaging Leadership in Health Equity



3. Health Equity as a Strategic Priority



4. Collecting 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. Health Equity FAQs Answered



11. Community Paramedicine



12. Identifying Community Health Disparities



13. Community Engagement—Health Equity



QUESTIONS?



Thank you!

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