

HEOA 1: Patient Demographic Data Collection

Tactics	Tasks	Linked Tools
<p>1. Use self-reporting methodology to collect patient race, ethnicity, and language (REaL) data.</p>	<ul style="list-style-type: none"> • Allow patients to self-report their REaL data—never assume based on observations alone. Data can be self-identified by the patient or by the registration staff members. Provide options: <ul style="list-style-type: none"> — Paper format (provides privacy). — Electronic kiosks/tablets (auto-entry to electronic medical record [EMR]). — Verbal discussion (patients with limited literacy or English proficiency). • Refine race and ethnicity category descriptions to help members of minority populations self-identify appropriate category for themselves. 	<ul style="list-style-type: none"> • New York State Partnership for Patients (NYSPFP): e-Learning REaL Data Collection: How and Why We Ask
<p>2. Collect REaL data for at least 95% of patients.</p>	<p>Calculate the following:</p> <ul style="list-style-type: none"> • Percentage of patients who have all three REaL data elements documented. Set goal at 95%. • Percentage of patients who were documented as Declined, Unavailable, and/or Unknown. Set goal < 5% for each element/field. 	
<p>3. Roll up REaL data to the Office of Management and Budget (OMB) categories.</p>	<ul style="list-style-type: none"> • Ensure health information technology (HIT) is set-up to align with OMB standards. • Add “Declined” or “Unavailable” or “Unknown” categories to ethnicity and race fields. • Ensure an aggregation method does not lead to double counting. 	<ul style="list-style-type: none"> • U.S. Department of Health and Human Services (DHHS): Data Standards for Granularity on Race and Ethnicity That Roll up to OMB Categories
<p>4. Examine opportunities for REaL data verification at multiple points of care (beyond patient registration) to ensure accuracy and completeness.</p>	<ul style="list-style-type: none"> • Design multiple REaL data collection process entry points: at time of check-in, pre-visit, over the phone, pre-exam, at time of discharge, and post-discharge (evaluation). • Engage staff members across all roles in cultural sensitivity, data collection training, and processes. 	
<p>5. Use self-reporting methodology to collect additional patient data (beyond REaL).</p>	<p>Collect other demographic data such as disability status, sexual orientation/gender identity, veteran status, geography and/or data on other social determinants of health/social risk factors—housing, income, education, employment, food security, and others.</p>	<ul style="list-style-type: none"> • Accountable Health Communities Screening (AHCS) Tool (Health-Related Social Needs [HRSN] Screening Tool) • Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences (PRAPARE) Assessment Tool

HEOA 2: Patient Demographic Data Collection and Training

Tactics	Tasks	Linked Tools
<p>1. Provide training regarding collection of patient self-reported REaL data.</p>	<ul style="list-style-type: none"> • Train staff members to understand that REaL data are collected to reduce healthcare disparities. Include all front-line registration staff members (inpatient, ambulatory, and primary care). • Adopt an interactive training program. Incorporate scripts or role playing to help staff members become accustomed to patient self-reporting and to practice challenging questions they may receive from patients. • Require training at orientation and annually to maintain your data collection program. 	<ul style="list-style-type: none"> • Health Research & Education Trust (HRET) toolkit for collecting REaL and additional demographic data on disability • HRET: Scripts and PowerPoint for addressing concerns from patients • New York State Partnership for Patients (NYSPFP): e-Learning REaL Data Collection: How and Why We Ask
<p>2. Evaluate training for effectiveness on at least an annual basis to ensure staff member competency in collecting patient demographic data.</p>	<ul style="list-style-type: none"> • Analyze REaL data before and after the training program has been implemented. • Evaluate data once per quarter to determine if you have met your measurable objectives. • If the hospital has not met objectives, additional interventions: <ul style="list-style-type: none"> — Conduct supplementary training. — Coach staff members or managers as needed. • Evaluation can include methods like tests, role playing, and observations. 	
<p>3. Provide training regarding collection of additional patient self-reported demographic data (beyond REaL).</p>	<p>Incorporate additional demographic variables beyond REaL into your self-reported data collection training programs. This could include:</p> <ul style="list-style-type: none"> • Disability status, sexual orientation/gender identity, veteran status, geography and/or data on other social determinants of health/social risk factors—housing, income, education, employment, food security, and others. 	<ul style="list-style-type: none"> • Health Research & Education Trust (HRET) toolkit for collecting REaL and additional demographic data on disability

HEOA 3: Patient Demographic Data Validation

Tactics	Tasks	Linked Tools
<p>1. Evaluate accuracy and completeness (percent of fields completed) of REaL data.</p>	<p>Examine data for:</p> <ul style="list-style-type: none"> • Accuracy—Are the data self-identified and correctly recorded? Are there differences in categorization among data sources? • Completeness—Are REaL data captured across all service areas? What is the percentage of unknown, other, unavailable, or declined data? <p>Consider also examining data for:</p> <ul style="list-style-type: none"> • Uniqueness—Are individual patients represented only once? • Timeliness—Are data kept up to date? How often is the data updated? • Consistency—Are data internally consistent? Do the data reflect the patient population served? 	<ul style="list-style-type: none"> • HRET: A Framework for Stratifying REaL Data
<p>2. Evaluate and compare hospital-collected REaL data to local community demographic data.</p>	<p>Compare internally collected REaL data to other demographic data sources:</p> <ul style="list-style-type: none"> • Federal data sources (e.g., U.S. Census Bureau) • State data sources (e.g., local schools and counties) • City and district data sources 	<ul style="list-style-type: none"> • U.S. Census Bureau • University of Missouri Extension: Community Commons, Community Health Needs Assessment Report • Los Angeles County: City and Community Health Profiles
<p>3. Address system-level issues to improve the collection of self-reported REaL data.</p>	<ul style="list-style-type: none"> • Regularly interview patients and staff members to assess efficiency and accuracy of the process. Use results to improve collection methods. • Examples are changes in patient registration screens/fields, data flow, workforce training, etc. 	
<p>4. Evaluate accuracy and completeness of additional demographic data (beyond REaL).</p>	<ul style="list-style-type: none"> • Incorporate additional demographic variables beyond REAL into your data validation process. 	
<p>5. Compare hospital-collected additional demographic data (beyond REaL) to local community demographic data.</p>	<p>Compare other hospital-collected demographic data to local community demographic data such as disability status, sexual orientation/gender identity, veteran status, geography and/or data on other social determinants of health/ social risk factors—housing, income, education, employment, food security, and others.</p>	<ul style="list-style-type: none"> • U.S. Census Bureau • California Department of Education: DataQuest <i>(also applies to HEOA 3, tactic 2)</i>

HEOA 4: Data Stratification

Tactics	Tasks	Linked Tools
<p>1. Stratify at least one patient safety, quality, and or outcome measure by REaL.</p>	<p>Determine what outcome measures to review:</p> <ul style="list-style-type: none"> • Focus on: <ul style="list-style-type: none"> — Healthcare disparities-sensitive measures <ul style="list-style-type: none"> — Care with high degree of discretion. — Communication-sensitive services. — Social determinant dependent measures. • High prevalence conditions among minority populations. • Conditions/outcomes with a large gap in quality between the disparity population and the highest quality group. • Common measures: inpatient quality reporting (IQR) measures, 30-day readmissions, Hospital CAHPS® (Hospital Consumer Assessment of Healthcare Providers and Systems) scores. <p>Determine what group to use as a reference point:</p> <ul style="list-style-type: none"> • Best practice: choose the historically advantaged group. <p>Determine what sample size to use:</p> <ul style="list-style-type: none"> • To increase power, combine smaller groups into broader categories and/or years of data together (e.g., using OMB categories instead of measures of greater granularity. This may increase risk of masking disparities). • Analyze smaller sample sizes to identify areas for improvement; they are unlikely to be statistically significant. Small groups may represent “low-hanging fruit” for quality improvement. 	<ul style="list-style-type: none"> • HRET: Reducing Health Care Disparities: Collection and Use of REaL Data • HRET: A Framework for Stratifying REAL Data
<p>2. Stratify more than one patient safety, quality, and/or outcome measure by REaL.</p>	<p>Stratify groups further to examine differences in quality by racial/ethnic substrata. Highlight areas of the greatest potential for intervention.</p> <ul style="list-style-type: none"> • There may be interaction effects initially unapparent (ex: race-sex interaction may be driving result, not just race or sex alone) 	<ul style="list-style-type: none"> • HRET: Reducing Health Care Disparities: Collection and Use of REaL Data
<p>3. Stratify more than one patient safety, quality, and/or outcome measure by additional demographic data (beyond REaL).</p>	<p>Stratify outcomes by other demographic data such as disability status, sexual orientation/gender identity, veteran status, geography and/or data on other social determinants of health/social risk factors—housing, income, education, employment, food security, and others.</p>	<ul style="list-style-type: none"> • HRET: Reducing Health Care Disparities: Collection and Use of REaL Data

HEOA 5: Communicating Patient Demographic Findings

Tactics	Tasks	Linked Tools
<p>1. Use a HE dashboard to routinely communicate patient population outcomes to hospital executive leadership (including medical staff leadership) and the board.</p>	<ul style="list-style-type: none"> • Create awareness through development and promotion of a HE dashboard/scorecard/report composed of key quality measures stratified by race and ethnicity. • Create a standing agenda item for HE for hospital executive, board, and other leadership meetings. 	<ul style="list-style-type: none"> • American Hospital Association (AHA): #123forEquity Pledge to Act • HRET: A Framework for Stratifying REaL Data
<p>2. Use a HE dashboard to routinely communicate patient population outcomes within the organization.</p>	<ul style="list-style-type: none"> • Create awareness among staff members by sharing the HE dashboard/scorecard/report widely within the organization. • Create a standing agenda item for HE on all staff member meetings. • Communicate within the organization to front-line staff members, quality staff members, managers, directors, providers, committees, departments, service lines, etc. 	
<p>3. Use a HE dashboard to routinely communicate patient population outcomes to patients and families.</p>	<ul style="list-style-type: none"> • Develop partnerships with community organizations providing insight into cultural differences in the community served to better inform strategies to reduce healthcare disparities. • Create awareness among patients and families, other community partners, and/or stakeholders. <ul style="list-style-type: none"> — Identify a mechanism to share the HE dashboard to patients and families, to other community partners, and stakeholders. — Consider reviewing the HE dashboard in PFAC meetings. • Communicate to Patient and Family Advisory Council (PFAC) members and/or to other community partners or stakeholders. 	

HEOA 6: Addressing and Resolving Gaps in Care

Tactics	Tasks	Linked Tools
<p>1. Develop and pilot test interventions to address identified healthcare disparities.</p>	<ul style="list-style-type: none"> • Use data stratification results to identify specific populations and outcomes for intervention. • Once possible disparity is identified, create SMART (specific, measurable, attainable, relevant, time-based) aims/goals using the worksheet tool. Be realistic in what you can achieve. Stakeholder collaboration is the key when setting goals. • Develop an action plan and pilot test. • Post the written goal visible on your units. Regularly communicate the goal during meetings to stay focused. Remind front-line staff members that everyone is working toward the same goal. 	<ul style="list-style-type: none"> • The Centers for Medicare & Medicaid Services (CMS) goal setting worksheet: SMART Goals • CMS Driver Diagram • Institute for Healthcare Improvement (IHI) Science of Improvement: Driver Diagram
<p>2. Implement interventions to resolve identified healthcare disparities, continuously inform, and involve staff members/workforce in support of the process.</p>	<ul style="list-style-type: none"> • If the pilot program is successful, create a plan for spread. 	<ul style="list-style-type: none"> • IHI Science of Improvement: Spreading Change • IHI Spread Planner
<p>3. Develop a process for ongoing review, monitoring, and recalibrating interventions to ensure changes are sustainable.</p>	<ul style="list-style-type: none"> • Create a process/policy to ensure continuous quality improvement (CQI). • Decide who will report progress to whom and how often will you review progress. • Report progress to leadership on a monthly basis. Remind leadership of the importance of this work. Allow the team to follow your progress. • Review outcomes to identify further opportunities for healthcare disparity interventions. 	<ul style="list-style-type: none"> • IHI Project Planning Form

HEOA 7: Organizational Infrastructure and Culture

Tactics	Tasks	Linked Tools
<p>1. Train workforce in cultural and linguistic competence according to Culturally and Linguistically Appropriate Services (CLAS) Standards.</p>	<ul style="list-style-type: none"> • Conduct a cultural and linguistic audit in the facility to assess organizational competence. • Create a written education plan to address gaps in CLAS using national CLAS standards. • Include CLAS standards concepts in educational curriculum for new and existing staff members. 	<ul style="list-style-type: none"> • DHHS: National CLAS Standards Implementation Checklist • CMS: A Practical Guide to Implementing the National CLAS Standards
<p>2. Name individual(s) with leadership responsibility and accountability for HE efforts.</p>	<ul style="list-style-type: none"> • Build out a leadership role and title of the designated individual to spearhead HE efforts and be held accountable for efforts (e.g., Chief Diversity Officer). • Use various approaches to facilitate leadership buy-in: <ul style="list-style-type: none"> — Use REAL data and identified healthcare disparities for strategic planning and to help appropriately allocate resources. — Provide published data about how decreasing healthcare disparities can lower medical harm and hospital expense. — Build a business case for HE • Senior leaders serve as executive champions for the cultural competency work. • Tie senior management annual goals to equitable healthcare delivery. 	
<p>3. Identify a leader to engage clinical champions, patients and families, and/or community partners in strategic and action planning activities to reduce healthcare disparities.</p>	<ul style="list-style-type: none"> • Conduct an environmental scan of community resources and develop an asset map for improving HE. • Work with community partners to gain insight into the cultural differences and diversity that exists between various ethnic groups. • Name a community board or advisors, establish regular check-ins with your community, and find opportunities to dialogue with patients. • Create formal and informal relationships. Convene and learn from each other. • Write out timelines or list key dates when planning to engage your community, patients, and local partners. 	<ul style="list-style-type: none"> • Internal Revenue Services (IRS): CHNA • American Hospital Association (AHA): #123forEquity Pledge to Act
<p>4. Ensure leadership and board commitment to equitable healthcare through written policies, protocols, pledges, or strategic planning.</p>	<ul style="list-style-type: none"> • Use a multidisciplinary disparities committee to consolidate efforts and drive strategic plan. • Use senior-level champions to help lend support and push process forward. • Integrate disparities efforts with existing performance improvement infrastructure. • Document examples: mission/vision/values, organizational goals, and objectives. 	<ul style="list-style-type: none"> • AHA: A Diversity, Equity and Cultural Competency Assessment Tool for Leaders

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