# Health Equity Action Plan—Guidance

Use this form to develop your quality improvement plan. Clarification for each component is provided below and a blank template.

| ORGANIZATION NAME |
| --- |
| **Action Plan for PROJECT****Initiated DATE–Updated DATE** |
| **Goal Statement:** | *Clearly state the aim/goal that you are trying to accomplish.**The aim should be SMART:** *Specific*
* *Measurable*
* *Attainable*
* *Relevant*
* *Time-Bound*
 |
| **ITEM** | **ROOT CAUSE** | **PLAN** | **RESPONSIBILITY** | **DATE DUE/COMPLETED** | **MEASUREMENT PLAN** | **STATUS** | **RESULTS/LESSONS LEARNED** |
| *Identify key areas for improvement.* | *Identify the root cause of the problem (findings of the root cause analysis [RCA]). The root cause is the factor that when fixed prevents the problem fromre-occurring.* | *Identify plan for accomplishing the improvement in each area identified for change.* | *Identify project leader and/or team. Make sure to include individuals that directly work in the area that is under improvement. Assign clear responsibilities to each team member.* | *Set deadlines. Identify when completed.**Due (D)**Completed (C)**D—xx/xx/xx**C—xx/xx/xx* | *Describe the plan to collect information to evaluate the results and to monitor progress.* | *Describe the status of progress over time* | *Plan-do-study-act (PDSA)** *Record what you have learned.*
* *What has worked/not worked?*
* *Identify changes you would make to your project plan and plans you have moving forward.*
* *Identify potentials to spread good practices across your organization.*
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Portions of this material were originally developed by Ohio KEPRO and was adapted by Health Services Advisory Group (HSAG), a Hospital Quality Improvement Contractor (HQIC) under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this document do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. Publication No. XS-HQIC-DIS-01022024-01

# Health Equity Action Plan

| Hospital Name |
| --- |
| **Action Plan for Health Equity CommitteeInitiated mm/dd/yr. Updated mm/dd/yr.** |
| **Goal Statement:** | To improve health disparities of our patients by committing to equity as a strategic priority, collecting and analyzing data, improving quality for at risk populations, and documenting leadership engagement with a written plan and attestation of activities by (mm/dd/yr. |
| **Domain 1** | Equity as a Strategic Priority |
| **Domain 2** | Data Collection |
| **Domain 3** | Data Analysis |
| **Domain 4** | Quality Improvement |
| **Domain 5** | Leadership Engagement |

| ITEM | ROOT CAUSE | PLAN | RESPONSIBILITY | DATE DUE/ COMPLETED | MEASUREMENT PLAN | STATUS | RESULTS/LESSONS LEARNED |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Verify due dates. | Lack of familiarity | Meet with Health Services Advisory Group (HSAG). |  | D: 12/31/23 | Maintain up-to-date action plan. |  | * Engage in measures anytime in CY 2023
* Attest 04/01/2024–05/15/2024
 |
| Verify due dates. | Lack of familiarity | Review resources. |  | D: 12/31/23 |  |  | [Attestation Guidance](https://qualitynet.cms.gov/files/63a0a19a76962e0016ad92f2?filename=AttstGuide_CmmtHlthEqStrctMeas.pdf)  |
| Screen | Lack of standardization | Charter Health Equity Committee and develop action plan. |  |  |  |  |  |
| Domain 1: Identify priority populations.  | We don’t know what we don’t know | Stratify quantitative and qualitative data. |  |  | * Review existing EHR data.
* Review reports such as: readmissions, complications, mortalities, hospital associated infection, etc.
* Review demographic data.
 |  |  |
| Domain 2: Collect data. | We don’t know what we don’t know | Collect race, ethnicity, and language (REaL) data. |  |  | Collect data on > 95% of patients. |  |  |
| Domain 2: Collect data. | We don’t know what we don’t know | Screen for social determinants of health (SDOH): food insecurity, housing instability, transportation needs, utility difficulties, interpersonal safety at any point during the patient’s hospitalization. |  |  | Collect data on > 95% 95% of patients. |  |  |
| Domain 2: Collect data. | We don’t know what we don’t know |  |  |  |  |  |  |
| Domain 2: Train staff in culturally sensitive collection of demographic and/or SDOH information. | Lack of familiarity with current guidelines | Increase awareness of why this data is collected.We ask because we care. |  |  | 100% of providers and staff can speak to why we collect demographic and/or SDOH information.  |  |  |
| Domain 2: Train staff in culturally sensitive collection of demographic and/or SDOH information. | Lack of familiarity with current guidelines | Train registration, nursing, case management, and social services staff.  |  |  | Train 100% of all staff tasked with collection of demographic and/or SDOH information. |  |  |
| Domain 2: Input demographic and/or SDOH information into structured, interoperable data elements using a certified electronic health record (EHR).  | We don’t know what we don’t know | Determine if we have a certified EHR:* Epic
* Cerner
* Allscripts
* Meditech
 |  |  |  |  | [CMS Certified EHR Technology](https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/certification#:~:text=In%20order%20to%20efficiently%20capture,data%20in%20a%20structured%20format)<https://chpl.healthit.gov/#/search>  |
| Domain 3: Stratify key performance indicators (KPI). | We don’t know what we don’t know | Stratify KPI and include on hospital performance dashboards. |  |   | * N: # patients who screened positive for each driver
* D: # inpatients > 18 years of age screened for SDOH
* Food insecurity
* Housing instability
* Transportation needs
* Utility difficulties
* Interpersonal safety
 |  |  |
| Domain 4: Participate in local, regional, or national quality improvement focusing on health equity. | Potential disconnect with community | 1. Partner with HSAG.
2. Participate in Health Equity quickinars.
3. Meet with Quality Advisor.
4. Health equity consult prn.
 |  |  | Attest |  |  |
| Domain 5: Demonstrate leadership engagement. | Competing priorities | Senior leadership (including chief executives and hospital board of trustees) annually reviews the strategic plan for achieving health equity. |  |  |  |  |  |
| Domain 5: Demonstrate leadership engagement. | Competing priorities | Senior leadership (including chief executives and hospital board of trustees) annually reviews the KPI stratified by demographic and/or social factors.  |  |  |  |  |  |

**Tools and Resources**:

1. Centers for Disease Control and Prevention (CDC). What is Health Equity? <https://www.cdc.gov/healthequity/whatis/index.html>
2. CHAMP Software. Social Needs vs. SDOH: What Is the Difference and How to Document Them at the Local Level. <https://www.champsoftware.com/2021/02/03/social-needs-vs-social-determinants-of-health-what-is-the-difference-and-how-to-document-them-at-the-local-level>
3. Centers for Medicare & Medicaid Services (CMS). Screening tool (innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf)
4. CMS. CMS Framework for Health Equity 2022–2032. April 2022. <https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf>
5. CMS. FY2023 Final Rule IPPS/LTCH PPS Final Rule Overview for Hospital Quality Programs. <https://www.qualityreportingcenter.com/globalassets/iqr2022events/iqr9122/fy2023_ipps-final-rule-overview-for-hospital-quality-programs-_vfinal508.pdf>.
6. CMS. IQR Important Dates and Deadlines. October 2022. <https://qualitynet.cms.gov/files/633d7b34a90aef001784784b?filename=IQR_ImpDatesDdlns_Oct2022.pdf>
7. CMS. Hospital Commitment to Health Equity Structural Measures Specifications. <https://qualitynet.cms.gov/files/62629ee35e40610016f30140?filename=Hosp_Commit_HlthEqStrct_Meas.pdf>
8. CMS. Screening for Social Drivers of Health Measure and the Screen Positive to Social Drivers of Health Measure. <https://qualitynet.cms.gov/files/6269ba5b5e40610016f30237?filename=ScrnSocDrvrs_%20Scrn_Pos_Specs.pdf>
9. CMS Strategic Framework. <https://www.cms.gov/files/document/cms-strategic-framework-fact-sheet.pdf>
10. Encyclopedia.com. Stratification of Data. [www.encyclopedia.com/education/encyclopedias-almanacs-transcripts-and-maps/stratification-data](http://www.encyclopedia.com/education/encyclopedias-almanacs-transcripts-and-maps/stratification-data)
11. The Joint Commission. Prioritize, Plan and Take Action. [www.jointcommission.org/our-priorities/health-care-equity/accreditation-standards-and-resource-center/prioritize-plan-and-take-action/#t=\_StrategiesTab&sort=relevancy](http://www.jointcommission.org/our-priorities/health-care-equity/accreditation-standards-and-resource-center/prioritize-plan-and-take-action/#t=_StrategiesTab&sort=relevancy)
12. HSAG Hospital Quality Improvement Contractor (HQIC). Consider the Impact of Health Disparities. <https://www.hsag.com/globalassets/hqic/hqic-healthequity-bizcase.pdf>
13. HSAG HQIC. Health Equity Organizational Assessment. <https://www.hsag.com/globalassets/hqic/hqic_healthequityorgassessment.pdf>
14. HSAG HQIC. Health Equity Quickinar Series. <https://www.hsag.com/en/hqic/health-equity-quickinar-series/>
15. HSAG HQIC. Impacting Social Determinants of Health That Affect Your Patients. <https://www.hsag.com/globalassets/hqic/hqic_sdoh_toolkit_508.pdf>
16. HSAG HQIC. Quality and Safety Series: SMART Goals. [www.hsag.com/globalassets/hqic/qualityseriessmartgoals.pdf](http://www.hsag.com/globalassets/hqic/qualityseriessmartgoals.pdf)
17. HSAG HQIC. The Roadmap to Success. <https://www.hsag.com/globalassets/hqic/hsaghqic_heoaroadmap_final.pdf>
18. HSAG Social Work Assessment. [www.hsag.com/globalassets/hqic/hqic\_socialworkassessment.pdf](http://www.hsag.com/globalassets/hqic/hqic_socialworkassessment.pdf)
19. HSAG HQIC. Why Collect REaL Data? Patient Handout. [www.hsag.com/hqic/tools-resources/pfe-health-equity](http://www.hsag.com/hqic/tools-resources/pfe-health-equity)
20. OASH. Economic Stability. <https://health.gov/healthypeople/objectives-and-data/browse-objectives/economic-stability>
21. PRAPARE tool prapare.org
22. QualityNet SDOH FAQs. <https://qualitynet.cms.gov/files/643473d9a484cd0017883d92?filename=SDOH_Measure_FAQs_April2023.pdf>
23. Screening tool comparison sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison
24. U.S. Dept. of Health and Human Services (HHS). Office of Disease Prevention and Health Promotion (OASH). SDOH. <https://health.gov/healthypeople/priority-areas/social-determinants-health>
25. World Health Organization. SDOH. <https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1>

**References**:

1. deBeaumont. Health Affairs: Meeting Individual Social Needs Falls Short of Addressing SDOH. Available at <https://debeaumont.org/news/2019/meeting-individual-social-needs-falls-short-of-addressing-social-determinants-of-health>
2. Heath S. Health Payer Intelligence xtelligent Healthcare Media. Most Medicare Dual-Eligibles See SDOH. May 29, 2019. <https://healthpayerintelligence.com/news/most-medicare-dual-eligibles-see-social-determinants-of-health>
3. Magnan S. National Academy of Medicine. SDOH 101 for Health Care: Five Plus Five. <https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/>
4. Schooner H. Health Catalyst. Health Equity: Why It Matters and How to Achieve It. March 6, 2018. [www.healthcatalyst.com/insights/health-equity-why-it-matters-how-to-achieve-it](http://www.healthcatalyst.com/insights/health-equity-why-it-matters-how-to-achieve-it)
5. Spinner M. Healthcare Financial Management Association (HFMA). 3 ways the patient financial experience can improve health equity. April 25, 2022. [www.hfma.org/topics/hfm/2022/may/3-ways-the-patient-financial-experience-can-improve-health-equity.html](http://www.hfma.org/topics/hfm/2022/may/3-ways-the-patient-financial-experience-can-improve-health-equity.html)