



Health Equity Data: The Superhero Strategic Planners Desperately Need



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Acknowledgement



- *The AzHHA Health Equity Collaborative is funded in part by the Arizona Department of Health Services (Contract No: CTR056149, with funding from the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC) through the COVID-19 Health Disparities Grant.*
- *The views expressed are the sole responsibility of AzHHA and Syntellis. They do not necessarily represent the official position of or endorsement by the Centers for Disease Control and Prevention or the Arizona Department of Health Services.*

Objective/Agenda



- To help marketers and strategic planners learn how to analyze and effectively use health equity data to improve their strategic planning efforts, community health needs assessments, and quality plans
- Learning objectives
 1. Understand the impact of health equity data on hospitals
 2. Discover how to leverage health equity data to improve their strategic planning efforts
 3. Practical reasons and tips on developing partnerships with public health and community organizations to improve health and consolidate resources.

Please ask questions during the presentation.

Getting to Know Each Other



- 1 What is your role in your organization?
- 2 Experience with health equity concepts?
- 3 What do you want to get out of this session?
- 4 Are you bored in your job?



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Introductions and Background



AzHHA Health Equity Collaborative



12 Participating
Hospitals



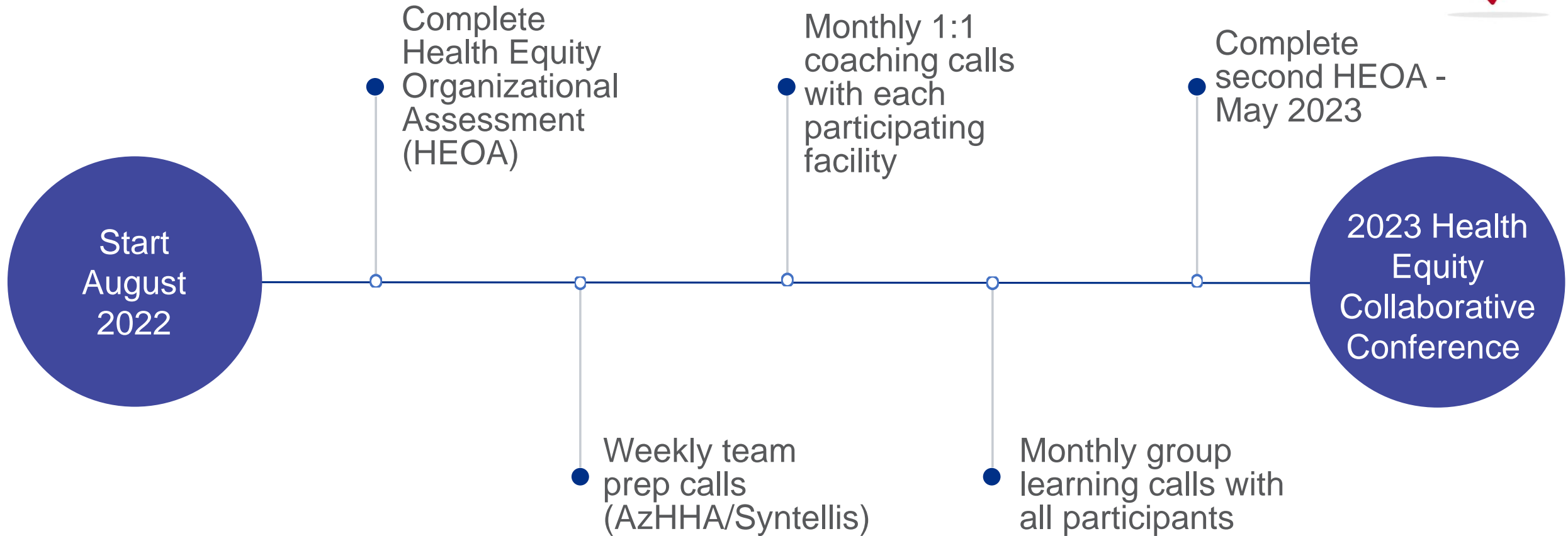
29 Participating
Clinics



4 AzHHA
Staff






4 Syntellis
Staff



AzHHA HEOA Collaborative Overview



Goals for the Collaborative:

-  Reduce healthcare disparities in rural Arizona hospitals and clinics using the CMS HEOA tool to improve patient health outcomes and the patient experience
-  Provide hospitals with data to assist health equity efforts
-  Evoke a sense of community and feelings of accomplishment for participating hospitals

Collaborative Outcomes:

- 47% improvement in health equity organizational assessment (HEOA) scores from August '22 – May '23
- Comprehensive data packs and facilitated monthly coaching provided to all participants
- Networking and learning opportunities offered through ongoing coaching, group learning meetings, and a collaborative-wide conference with state and national thought leaders

Collaborative Counties:

- Cochise
- Gila
- Mohave
- Santa Cruz
- La Paz
- Navajo
- Graham
- Greenlee
- Maricopa



Impact of Health Equity Data on Healthcare

“Equity, as with every other dimension of health care quality including safety, must be defined and codified in the performance of health care systems.” –
Leapfrog Group

Vocabulary



HEOA: Health Equity Organizational Assessment

REaL: Race, Ethnicity, and (or Ancestry) Language

SOGI: Sexual Orientation/Gender Identity

SDOH: Social Determinants (Drivers) of Health

HRSN: Health-Related Social Needs

Health Equity is not a new concept...



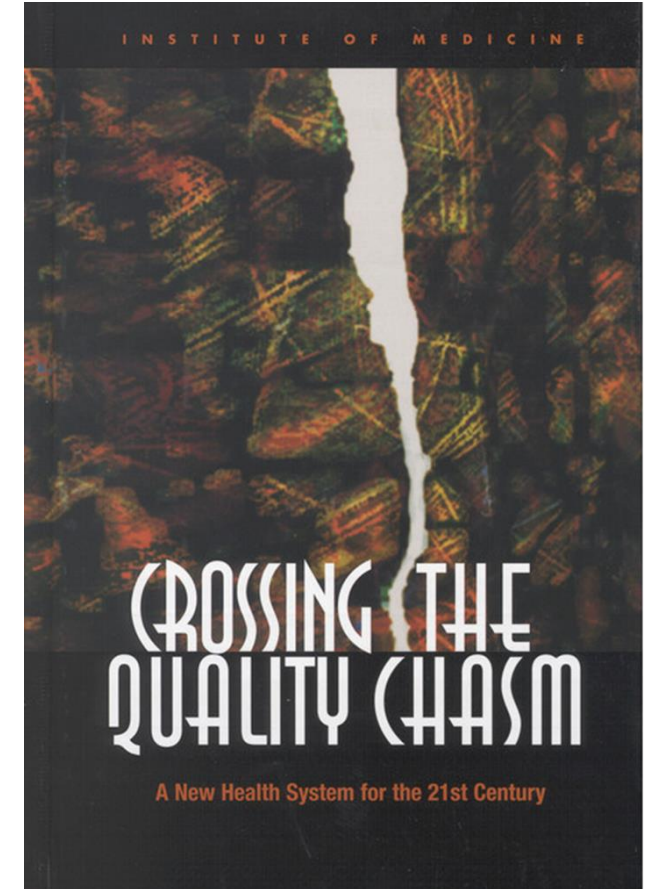
2001

1999



Six Aims of Healthcare:

1. To be Safe
2. To be Effective
- 3. To be Patient-Centered**
4. To be Timely
5. To be Efficient
- 6. To be Equitable**



What happened to reignite focus on health equity?

COVID-19 Pandemic

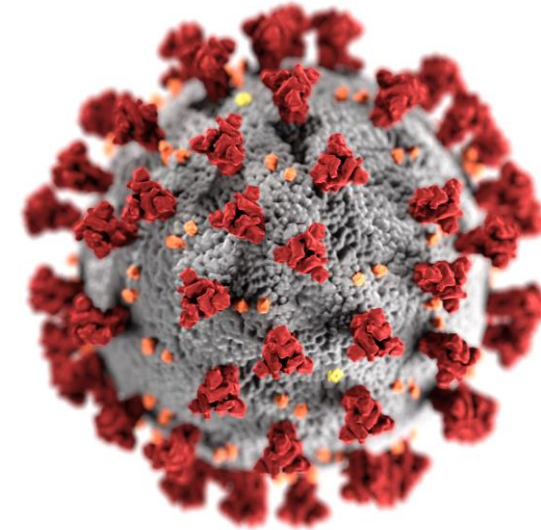


What we uncovered:

- Racial, ethnic, gender, rural disparities in COVID mortality rates
- Barriers to cancer trials
- Maternal mortality differences, etc.

What we discovered:

- Universal access to vaccines
- Provision of mental health services
- Use of Telehealth



Impact of COVID-19



Rate ratios compared to White, Non-Hispanic persons	American Indian or Alaska Native, Non-Hispanic persons	Asian, Non-Hispanic persons	Black or African American, Non-Hispanic persons	Hispanic or Latino persons	Men Compared to Women	Rural Compared to Urban
Cases	1.6x	0.7x	1.1x	2.0x	similar	1.5x
Hospitalization	3.3x	1.0x	2.9x	2.8x		
Death	2.4x	1.0x	1.9x	2.3x	1.6x	2x

Source: U.S. Centers for Disease Control and Prevention. Risk for COVID-19 Infection, Hospitalization, and Death by race/Ethnicity. Available at: <https://www.cdc.gov/coronavirus/2019-ncov-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html>

Tribal water rights: Without water, Navajos hit hard by pandemic (usc.edu)

Increased Public Awareness



Resource: [NPR Illinois May 17, 2021](#) [Gov. Pritzker Signs Equity Driven Healthcare Reform Legislation \(illinois.gov\)](#)

New York Certificate of Need



- New York State Department of Health is requiring effective June 22, 2023, a **Health Equity Impact Assessment (HEIA)** as part of their CON applications.
 1. Meaningful engagement of stakeholders – in person, phone calls, surveys
 2. Demographics
 - Age
 - Race
 - Ethnicity
 - Health Insurance Coverage
 - Disability status
 3. Socioeconomic status
 - % in poverty
 - Median household income
 - Employment status
 - Educational attainment
 - Vehicles available

What is Health Equity?



EQUALITY



EQUITY

Health Equity Data Impact on Healthcare



Leapfrog Group

Added questions to their hospital and ASC surveys.

- **Data collection** (patient self-identified race, ethnicity, primary language, sexual orientation, and gender identity)
- **Data accuracy**
- **Measure stratification**
- Quality improvement
- Internal and external transparency

The Joint Commission

Organizations are required to do the following:

- Identify an individual to lead activities to improve health care equity
- Assess the patient's health-related social needs
- **Analyze quality and safety data** to identify disparities
- Develop an action plan to improve health care equity
- Take action when the organization does not meet the goals in its action plan
- Inform key stakeholders about progress to improve health care equity
- Jan. 1 2023, new standard to address health disparities and **collect race & ethnicity data in more care settings**

CMS

Published CMS Framework for Health Equity. Priorities:

1. Expand the **Collection, Reporting, and Analysis of Standardized Data**
2. Assess Causes of Disparities Within CMS Programs, and Address Inequities in Policies and Operations to Close Gaps
3. Build Capacity of Health Care Organizations and the Workforce to Reduce Health and Health Care Disparities
4. Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services
5. Increase All Forms of Accessibility to Health Care Services and Coverage



The Health Equity Roadmap

**A national initiative to drive
improvement in health care outcomes,
health equity, diversity and inclusion.**



Mentimeter Poll #2



1 Does your organization collect accurate REAL data regularly?

2 Does your organization collect accurate SOGI data regularly?

3 Does your organization collect accurate SDOH or HRSN data regularly?

4 Do you compare your patient demographic data to the service area's demographics?

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Leveraging Health Equity Data

“Where you live should not determine whether you live, or whether you die.”

- *Bono*

Health Equity Organization Assessment



Assessment Category

Data Collection

Hospital uses a self-reporting methodology to collect demographic data from the patient and/or caregiver.

Data Collection Training

Hospital provides workforce training regarding the collection of self-reported patient demographic data.

Data Validation

Hospital verifies the accuracy and completeness of patient self-reported demographic data.

Data Stratification

Hospital stratifies patient safety, quality, and/or outcome measures using patient demographic data.

Communicate Findings

Hospital uses a reporting mechanism (e.g., equity dashboard) to communicate outcomes for various patient populations.

Address & Resolve Gaps in Care

Hospital implements interventions to resolve difference in patient outcomes.

Infrastructure & Culture

Hospital has organizational culture and infrastructure to support the delivery of care that is equitable for all patient populations.

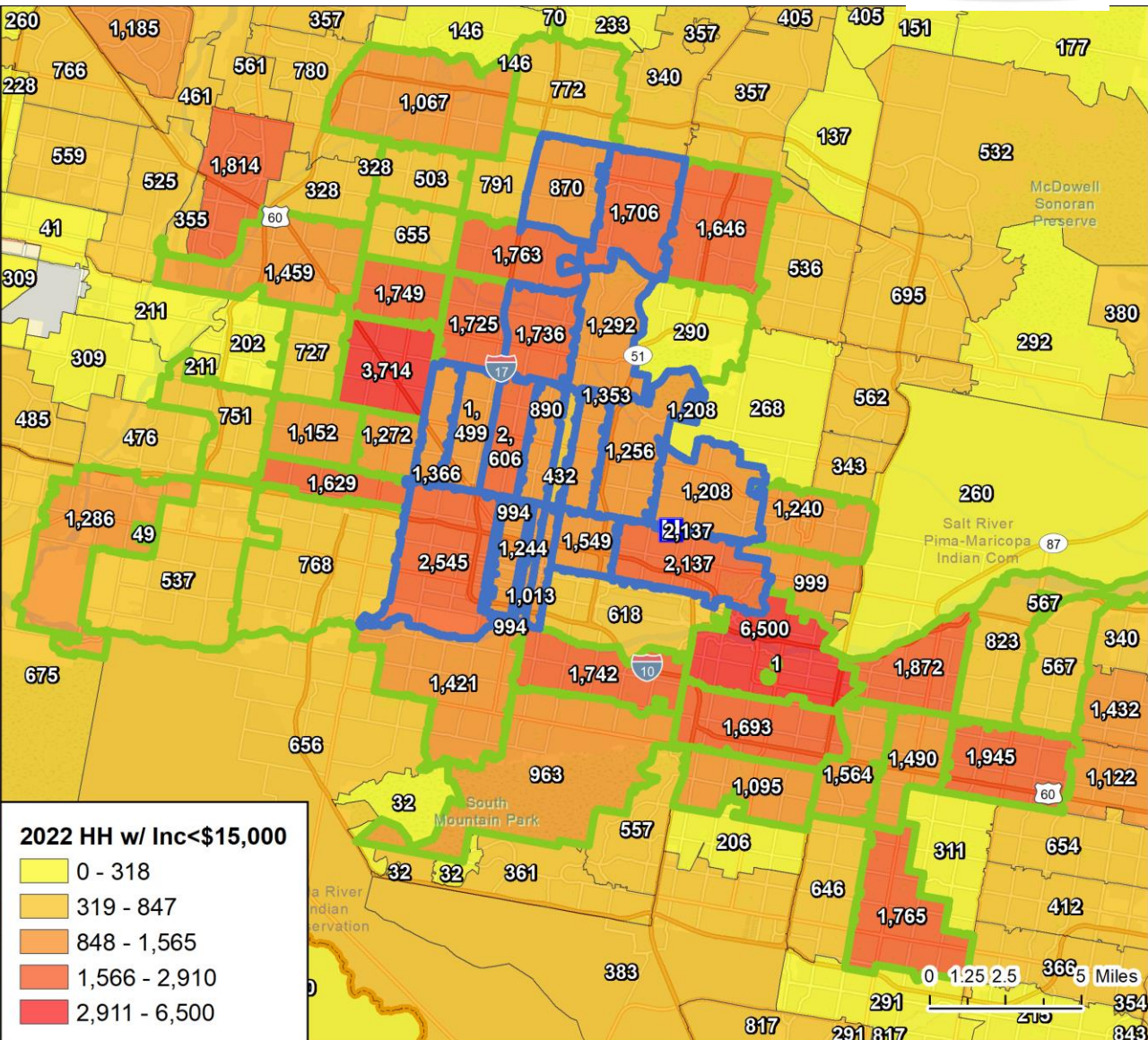
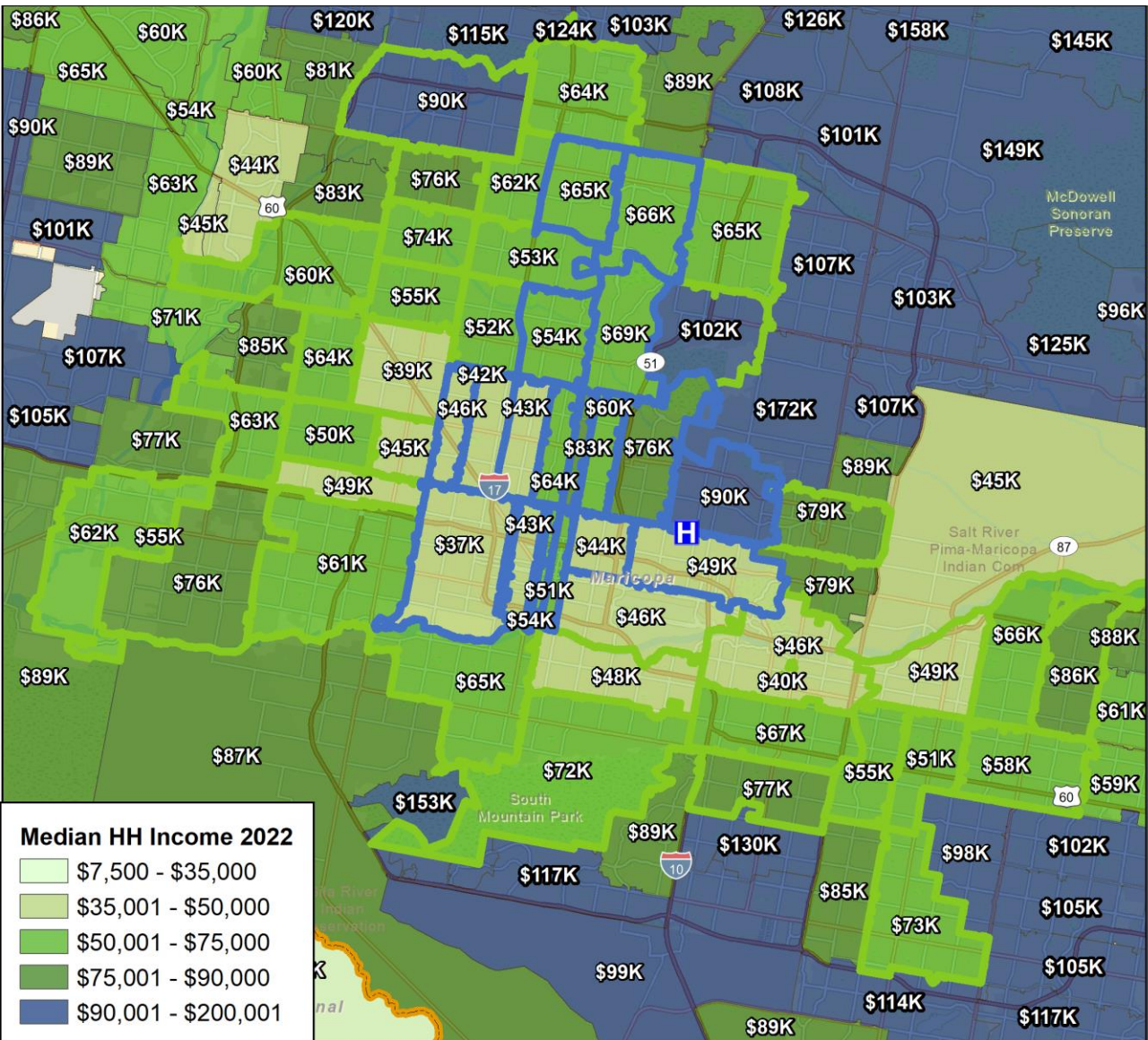


Example Data Gathered for AZ Hospitals



- Data packs were provided for each hospital using demographics, state data, and their internal hospital data
- Goal: Move beyond health equity as a concept to reality
- Geographies:
 - Service area
 - County
 - State
 - U.S.

Median HH Income and Income <\$15k



Gender – Arizona Compared to Service Area



Arizona: Females were 50.3% of the population but accounted for 54.6% of ED visits and 53.4% of IP visits. Therefore, although males were 49.7% of the population, they represented 45.4% of ED visits and 46.6% of IP visits.

Service Area: Females were 49% of the population but accounted for 50.7% of ED visits and 50.4% of IP visits. Therefore, although males were 50.9% of the population, they represented 49.3% of ED visits and 49.6% of IP visits.

Gender	State							Sample Medical Center Service Area						
	Emergency			Inpatient			Pop.	Emergency			Inpatient			Pop.
	Cases	% of Total	Rate per 1,000 Pop	Cases	% of Total	Rate per 1,000 Pop	% of Total	Cases	% of Total	Rate per 1,000 Pop	Cases	% of Total	Rate per 1,000 Pop	% of Total
Female	x,xxx,xxx	54.6%	357	xxx,xxx	53.4%	104	50.3%	xx,xxx	50.7%	466	x,xxx	50.4%	117	49.0%
Male	x,xxx,xxx	45.4%	299	xxx,xxx	46.6%	91	49.7%	xx,xxx	49.3%	437	x,xxx	49.6%	110	50.9%
Other	xxx			xxx				--			--			
Total	x,xxx,xxx	100%	329	xxx,xxx	100%	97		xx,xxx	100%	451	x,xxx	100%	114	

Ethnicity – Arizona Compared to Service Area



Arizona: Hispanic/Latino were 31% of the population and accounted for 27% of ED visits and 21% of IP visits in Arizona, meaning they represent more of the population than visits. The visit rates per 1,000 population were lower for Hispanic/Latino than the Non-Hispanic Latino population for both ED and IP visits. The Hispanic population accesses healthcare at a lower rate than the non-Hispanic population.

Service Area: Hispanic/Latino were 17.5% of the population and accounted for 15.5% of the ED visits and 10.3% of the IP visits. The same trend as in AZ, higher percentage of the population, lower percentage of utilization.

Ethnicity	State					Sample Medical Center Service Area				
	Emergency		Inpatient		Population	Emergency		Inpatient		Population
	% of Total	Rate per 1,000 Pop	% of Total	Rate per 1,000 Pop	% of Total	% of Total	Rate per 1,000 Pop	% of Total	Rate per 1,000 Pop	% of Total
Hispanic/Latino	27.3%	415.6	21.0%	107.0	31%	15.5%	388.1	10.3%	66.1	17.5%
Non-Hispanic/Latino	71.7%	490.6	77.9%	173.0	69%	83.9%	460.8	87.5%	123.6	82.5%
Refused	0.9%		1.1%			0.6%		2.2%		
Total	100%	471.5	100%	154.2		100%	447.7	100%	113.2	

Race - Arizona Compared to Service Area



Key Takeaways:

- American Indian population shows proportional use rates to population
- Asian/Pacific Islander population shows lower use rates compared to the population
- Black/African Americans population shows higher use rates compared to population
- White population shows lower use rates compared to the population

Race	State					Sample Medical Center Service Area				
	Emergency		Inpatient		Population	ED		Inpatient		Population
	% of Total	Rate per 1,000 Pop	% of Total	Rate per 1,000 Pop	% of Total	% of Total	Rate per 1,000 Pop	% of Total	Rate per 1,000 Pop	% of Total
American Indian or Alaska Native	3.9%	316.1	4.3%	106.0	4%	44.8%	468.2	41.8%	112.3	43.0%
Asian/Pacific Islander	1.8%	145.9	2.1%	51.3	4%	0.3%	222.9	0.5%	96.4	0.6%
Black or African American	8.4%	549.5	6.1%	120.4	5%	2.3%	565.4	1.4%	84.6	1.9%
White	84.4%	273.8	85.7%	83.1	87%	51.6%	425.0	53.1%	112.2	54.6%
Refused	1.6%		1.7%			1.0%		3.2%		--
Total	100%	327.6	100%	98.0		100%	449.5	100%	115.4	

More than one race and other were added to the white population due to AZ state data not collecting those categories.

Source(s): State Data, Q3 2021-Q2 2022; Esri (2022)

Payer – Arizona & Sample Medical Center Service Area



Key Takeaways - The service area had:

- Higher Medicaid as a percent of total for both ED visits and inpatient cases
- Lower commercial in the ED and inpatient cases
- Lower Medicare and Medicare Risk as a percent of total for ED visits
- Higher Medicare for inpatient cases
- Lower self pay and charity for both ED visits and inpatient cases

Payer	State		Sample Medical Center Service Area		Differences	
	Emergency	Inpatient	Emergency	Inpatient	Emergency	Inpatient
	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
Medicaid	40.2%	30.2%	53.8%	43.0%	13.5%	12.8%
Commercial (indemnity, HMO, PPO)	27.6%	24.3%	16.6%	13.5%	-11.0%	-10.9%
Medicare	16.0%	29.8%	15.7%	31.3%	-0.3%	1.5%
Medicare Risk	5.8%	9.8%	5.8%	5.6%	0.0%	-4.2%
Indian Health Service	0.2%	0.2%	2.3%	2.3%	2.1%	2.1%
Self Pay/Charity	6.2%	2.3%	2.7%	1.2%	-3.5%	-1.2%
Other	3.9%	3.3%	3.0%	3.2%	-0.9%	-0.2%
Total	100%	100%	100%	100%		

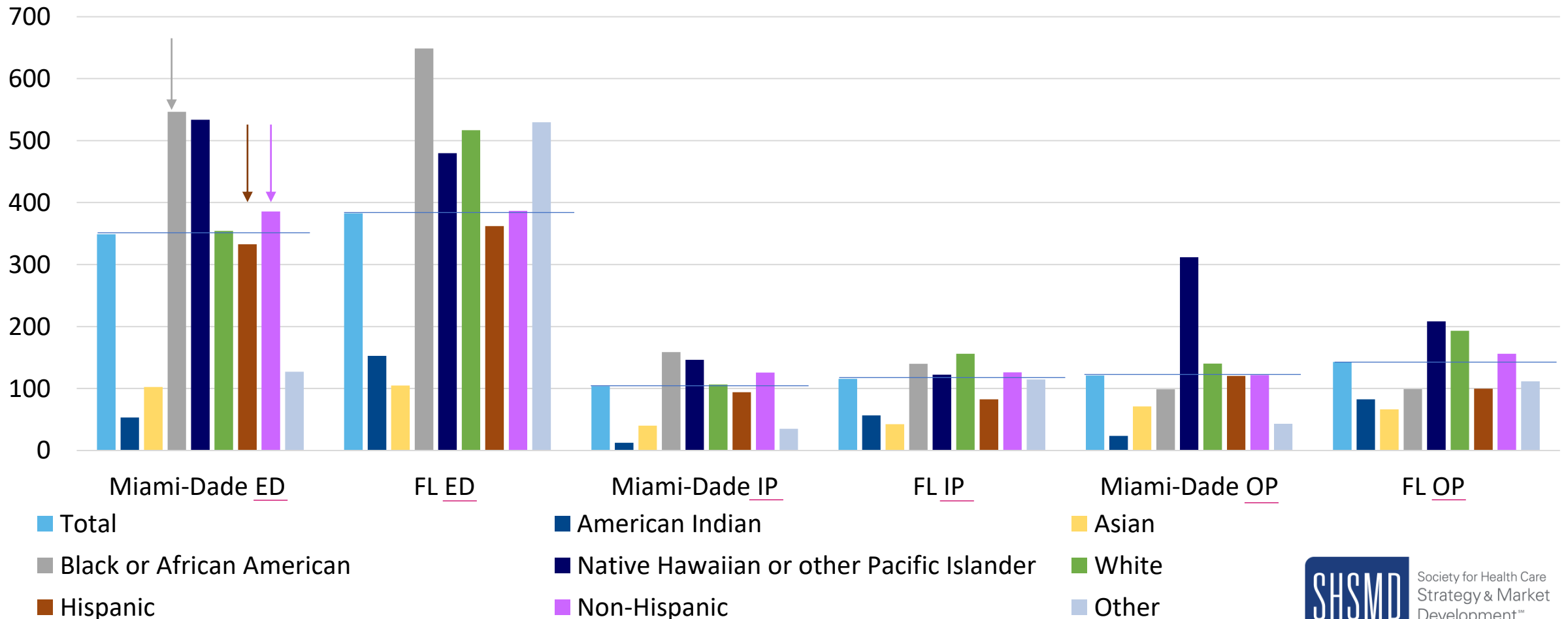
Conclusions



- Women have higher use rates than men for both ED and IP - *Run the World (Girls), obstetrics, and reluctance of men to seek care*
- Non-Hispanic populations have higher use rates for both ED and IP than Hispanic/ Latinx populations – *Could there be differing access? Fear, language*
- Racial differences
 - Asian/Pacific Islander population shows lower use rates compared to others – *generally healthier than the general population (but only when data looked at collectively)*
 - Black/African Americans population shows higher use rates compared to others – *generally less healthy than the White Non-Hispanic population*
- Payer differences – % of Total Service Area to State
 - Higher Medicaid as a percent of total for both ED visits and inpatient cases – *using ER for primary care, delaying care*
 - Lower commercial in the ED and inpatient cases – *rural areas struggle for commercial cases*
 - Lower Medicare and Medicare Risk as a percent of total for ED visits – *lower older population*
 - Higher Medicare for inpatient cases; lower Medicare Risk in inpatient – *healthier MA patients*

Discharge and ED, OP Visit Rates per 1,000 Population

The African American population had higher use rates in most categories than the other populations. Non-Hispanics had higher use rates in all categories than Hispanics. AI/NHPI populations had low volume.



Projects



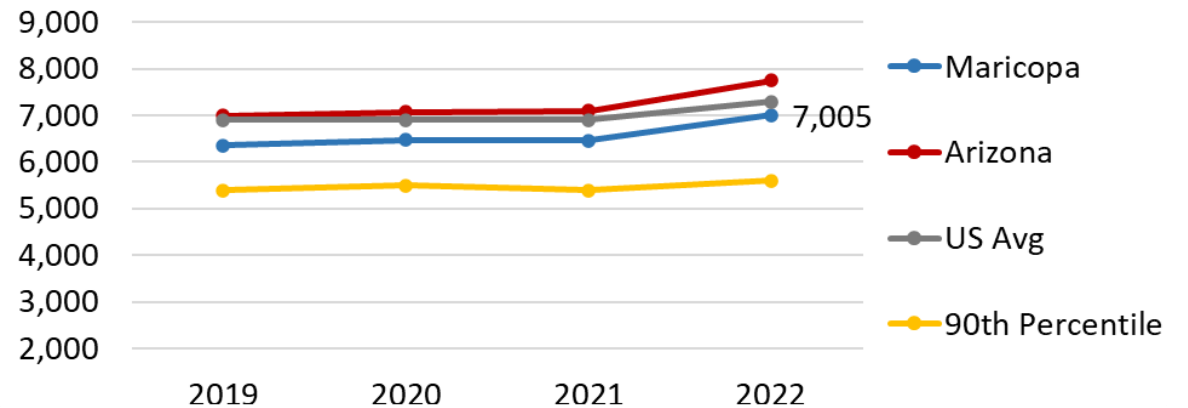
- Collect SOGI data in the outpatient clinics on Phreesia tablets
- Initiate Board of Directors DEI education
- Decrease health disparities in LGBTQ+ population
- Collect and stratify SDOH data; Improve Spanish language signage
- Collect REAL and SOGI data in registration, ensuring the right fields are collected and the data is usable
- Improve discharge planning by receiving correct housing information upon admission to assist the unhoused population with services upon discharge
- Incorporate health equity as a component of outcomes assessment and action planning for quality/process improvement efforts (fall reduction program)
- Improve transportation to specialist appointments
- Train medical staff and hospital and clinic staff to improve cultural sensitivity to the Reservation patients
- Increase the SDOH screening that is occurring, from 5% to 30% for medium to high-risk patients over age 18.

County Health Rankings



- Health indicators with Race & Ethnicity breakdowns
 - Life expectancy
 - Infant mortality (per 1,000 live births)
 - Premature age-adjusted mortality
 - Premature death YPLL
 - Child mortality
 - Low birthweight babies
 - Teen birth rate
 - Preventable hospital stays
 - Flu vaccines
 - Mammography screening
 - Children in poverty
 - Injury deaths
 - Firearm fatalities
 - Driving alone to work

Premature death
(YPLL per 100,000 pop prior to age 75)



Premature death by race/ethnicity
(YPLL per 100,000 pop prior to age 75)

Maricopa Co	2018-2020
American Indian & Alaska Native	14,900
Asian	3,900
Black	10,700
Hispanic	6,700
White	6,600

Leading Causes of Death per 100,000 Pop., by Race & Ethnicity



Cause of Death

Maricopa County

	White	Black	Hispanic	Asian
Heart Disease	140.6	185.4	117.2	87.8
Cancer	125.1	159.8	110.4	83.2
COVID-19*	78.7	95.6	184.8	74.2
Accidents (Unintentional Injuries)	65.8	74.6	61.5	22.7
Respiratory Diseases	36.6	25.6	18.1	11.5
Strokes	32.6	45.7	38.7	23.1
Suicide	15.9	11.6	9.7	NR
Alzheimer's	36.1	42.4	35	27.0
Diabetes	23.2	49.7	43.9	24.3
Hypertension and Hypertensive Renal Disease	11.7	21.9	15.1	NR
Influenza and Pneumonia	11.0	12.4	13.2	NR
Liver Disease	12.6	NR	15.2	NR
Nephritis, nephrosis	6.5	10.2	9.8	NR
Parkinson Disease	11.9	NR	10.7	NR

Age-adjusted rates per 100,000 population.

County data combined from 2017-2020. Age Adjustment Uses 2000 Standard Population.

* COVID-19 Data from 2020



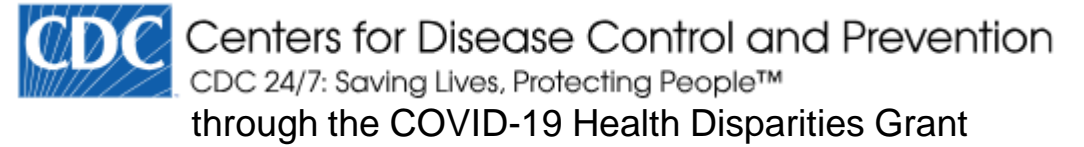
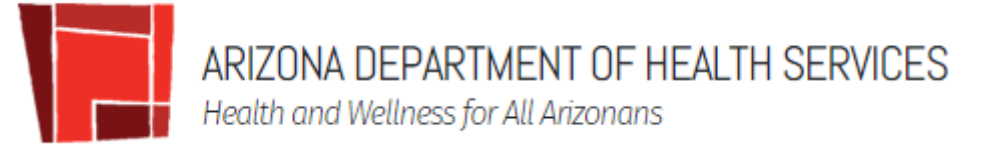


Collaborations and Partnerships

“If you want to go fast, go alone, if you want to go far, go together.”

– *African Proverb*

Collaborators



Work Product - Action Planning



Health Equity Organizational Assessment Collaborative

"Organizations improving health equity together."

Facility Name:

Canyon Vista Medical Center

SMART Goal & End Date:

Board education around diversity, equity, and inclusion to move forward with DEI. Look for a standardized tool, focused education, and training with DEI. Attempt to engage the Board in a Process Improvement Project that involves DEI initiative as part of 2024 Strategic Plan.

Team Members:

Shaun Phillips, CEO
Cosette Britton, CNO
Ruth Quinn, Board Chair

Measures of Success

Phase 1: 13 of 14 responded. See areas of work that need completion based on the survey.

Phase 2: Driven by survey data, have no more than two projects for DEI.

Phase 3: Roll out educational materials in Board Meeting

Phase 4: Present Action Plan at AzHHA Conference

Support Needed

Phase 1: Ensure valid sample from the board.

Phase 2: Governance Committee of Executive Board

Phase 3: AzHHA, LifePoint, educational materials

Phase 4: Continued buy-in from the board. AzHHA continued collaboratives!

Phase 1 Timeline: February 2023

Present materials to the Board on the importance of DEI

Develop and distribute a survey to assess Board DEI awareness

Monitor responses received with goal of 80% completion

Kick off new nomination cycle for open board seat

Phase 2 Timeline: March 2023

Survey analysis, looking for opportunities

Conduct two focus groups with the Board to discuss survey results

Determine first education session

Select resources and materials to meet opportunities identified

Phase 3 Timeline: April 2023

Find other resources for Board Member self work

Prepare educational materials for the Board

Present educational materials and assess impact qualitatively

Determine organizational leadership involvement opportunities

Phase 4 Timeline: May 2023

Determine if more education/re-education is needed

Resurvey the Board to assess impact quantitatively

Assess survey results

Determine Board DEI projects for 2024 strategic plan



Barriers & Challenges

TIME!!!

Competing Priorities

Indifference or "Anti-Wokeness"

Will diverse communities join our board?

Did we mention TIME???

Partner:

Lifepoint Human Resources Department



HEOA Collaborative Culminating Conference



HEOA Score Comparisons: Before & After

HEOA Measure	August 2022 Average Score	May 2023 Average Score	Trend
Data Collection to Drive Action	Storming	Norming	↑
Data Collection Training	Storming	Norming	↑
Data Validation	Storming	Norming	↑
Data Stratification	Forming	Norming	↑
Communicate Findings	Forming	Storming	↑
Address & Resolve Gaps	Forming	Storming	↑
Organizational Infrastructure & Culture	Forming	Storming	↑
Admission Checklist Process	Storming	Norming	↑
Shift Change Huddles	Storming	Norming	↑
Discharge Planning Checklist	Norming	Norming	▬
Patient & Family Engagement Lead or Department	Storming	Storming	▬
Active PFE Committees or Other Committees	Forming	Forming	▬
Avg. Score	1.73	2.45	+48%

Assessment Scores:

Forming (1.0) – Organization recognizes opportunity to improve

Storming (2.0) – Making active effort to improve

Norming (3.0) – Improvement efforts becoming standard practice

Performing (4.0) – Organization-wide adoption and execution

On average, participants' understanding of health equity, health equity data processes, and knowledge of health equity intervention implementation increased by 47% from the beginning to end.

Three Key Takeaways



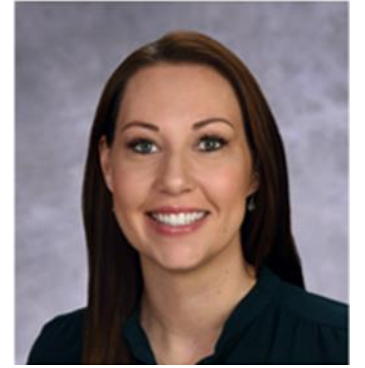
1. Understand how outside organizations are looking at health equity data – LeapFrog Group, CMS, The Joint Commission
2. How to use health equity data to complete a health equity organization assessment and use in strategic planning – assessment tool
3. How to use a collaborative or other partnership to create impact – learn from the AzHHA HEOA collaborative



Thank you for coming!



Megan Trosko, MSN, EMBA, FNP-C



Serves as the Director of Care Improvement for the Arizona Hospital and Healthcare Association. She is responsible for contributing to the organization's mission to 'make Arizona the healthiest state in the nation' by leading collaboratives to improve patient safety and reduce harm in hospitals, improve the patient and family experience, improve healthcare outcomes, and decrease costs. She also sits on the Board of Directors for the Central and Northern Arizona Chapter of the American Red Cross. She is passionate about improving access to healthcare, health equity, patient education, patient safety and quality care for all. Led the AzHHA HEOA collaborative.



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Lee Ann Lambdin, MHA, FACHE

Serves as a Senior Principal Consultant for Syntellis Performance Solutions (formerly Stratason) where she is responsible for the execution of high-touch, strategic engagements such as Community Health Needs Assessments (CHNA), as well as strategic planning engagements. She also serves as a trusted advisor to internal team members and clients, providing industry expertise and high-level strategic direction. Led the AzHHA HEOA collaborative.



Advancing & Innovating Together

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Additional Resources Provided

1. HEOA Assessment Guide
2. Health Equity Resource Guide



Questions?

Please be sure to complete the session evaluation!



Health Equity Organizational Assessment Tool

- HEOA tool used on the following slides for your information.

1. Data Collection to Drive Action

- Hospital uses a self-reporting methodology to collect demographic data from the patient and/or caregiver

Level of Hospital Implementation	Implementation Activities
Forming	Does not meet basic level/Does not apply
Storming Basic/fundamental	<ul style="list-style-type: none"> • Hospital uses self-reporting methodology to collect race, ethnicity and language Race, Ethnicity, Age and Language (REaL) data for all patients. <ul style="list-style-type: none"> • All race and ethnicity categories collected should, at a minimum, roll up to the OMB categories and should be collected in separate fields. Engage Patient/Family Advisors in the collection of REaL data to gain their insights and feedback.
Norming Mid-level intermediate	<ul style="list-style-type: none"> • Hospital meets the above basic/fundamental level of implementation plus: <ul style="list-style-type: none"> • Hospital collects REaL data for at least 95% of their patients with opportunity for verification at multiple points of care (beyond just registration) to ensure accuracy of the data and to prevent any missed opportunities for data collection (e.g., preregistration process, registration/admission process, inpatient units, etc.). Resource here.
Performing Advanced	<ul style="list-style-type: none"> • Hospital meets the above basic/fundamental and mid/ intermediate levels of implementation plus: <ul style="list-style-type: none"> • Hospital uses self-reporting methodology to collect additional demographic data (beyond REaL) for patients such as disability status, sexual orientation/ gender identity (SOGI), veteran status, geography and/or other social determinants of health (SDOH) or social risk factors. • SDOH/social risk factors may include education level, access to housing, food availability, migrant status, income, incarceration history, access to healthcare, and employment status, etc. For additional details Click here.

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2. Data Collection Training

- Hospital provides workforce training regarding the collection of self-reported patient demographic data.

Level of Hospital Implementation	Implementation Activities
Forming	Does not meet basic level/Does not apply
Storming Basic/fundamental	<ul style="list-style-type: none"> • Workforce training is provided to staff regarding the collection of patient self-reported REaL data. <ul style="list-style-type: none"> • Examples of training may include: role playing, scripts, didactic, manuals, on-line modules, or other tools/job aids. • Patient/Family Advisors should be included in the development and delivery of workforce training to collect REaL data.
Norming Mid-level intermediate	<ul style="list-style-type: none"> • Hospital meets the above basic/fundamental level of implementation plus: <ul style="list-style-type: none"> • Hospital evaluates the effectiveness of workforce training on an annual basis to ensure staff demonstrate competency in patient self-reporting data collection methodology (e.g., observations, teach back, post- test, etc.).
Performing Advanced	<ul style="list-style-type: none"> • Hospital meets the above basic/fundamental and mid/intermediate levels of implementation plus: <ul style="list-style-type: none"> • Workforce training is provided to staff regarding the collection of additional patient self-reported demographic data (beyond REaL) such as disability status, sexual orientation/gender identity (SOGI), veteran status, geography and/or other social determinants of health (SDOH) or social risk factors. • SDOH/social risk factors may include education level, access to housing, food availability, migrant status, income, incarceration history, access to healthcare, and employment status, etc. For additional details, click here.

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3. Data Validation

- Hospital verifies the accuracy and completeness of patient self-reported demographic data.

Level of Hospital Implementation	Implementation Activities
Forming	Does not meet basic level/Does not apply
Storming Basic/fundamental	<ul style="list-style-type: none"> • Hospital has a standardized process in place to both evaluate the accuracy and completeness (percent of fields completed) for REaL data and a process to evaluate and compare hospital collected REaL data to local demographic community data.
Norming Mid-level intermediate	<ul style="list-style-type: none"> • Hospital meets the above basic/fundamental level of implementation plus: <ul style="list-style-type: none"> • Hospital addresses any system-level issues (e.g., changes in patient registration screens/fields, data flow, workforce training, etc.) to improve the collection of self-reported REaL data. • Patient/Family Advisors can provide invaluable insights and feedback to address system-level issues regarding the collection of REaL data.
Performing Advanced	<ul style="list-style-type: none"> • Hospital meets the above basic/fundamental and mid/intermediate levels of implementation plus: <ul style="list-style-type: none"> • Hospital has a standardized process in place to evaluate the accuracy and completeness (percent of fields completed) for additional demographic data (beyond REaL) such as disability status, sexual orientation/gender identity (SOGI), veteran status, geography and/or other social determinants of health (SDOH) or social risk factors — and has a process in place to evaluate and compare hospital collected patient demographic data to local demographic community data. • SDOH/social risk factors may include education level, access to housing, food availability, migrant status, income, incarceration history, access to healthcare, and employment status, etc. For additional details, click here.

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4. Data Stratification

- Hospital stratifies patient safety, quality and/or outcome measures using patient demographic data.

Level of Hospital Implementation	Implementation Activities
Forming	Does not meet basic level/Does not apply
Storming Basic/fundamental	<ul style="list-style-type: none"> • Hospital stratifies at least one patient safety, quality and/or outcome measure by REaL.
Norming Mid-level intermediate	<ul style="list-style-type: none"> • Hospital meets the above basic/fundamental level of implementation plus: <ul style="list-style-type: none"> • Hospital stratifies more than one (or many) patient safety, quality and or outcome measure by REaL.
Performing Advanced	<ul style="list-style-type: none"> • Hospital meets the above basic/fundamental and mid/intermediate levels of implementation plus: <ul style="list-style-type: none"> • Hospital stratifies more than one (or many) patient safety, quality and/or outcome measure by REaL and other demographic data (beyond REaL) such as disability status, sexual orientation/gender identity (SOGI), veteran status, geography and/or other social determinants of health (SDOH) or social risk factors. • SDOH/social risk factors may include education level, access to housing, food availability, migrant status, income, incarceration history, access to healthcare, and employment status, etc. For additional details, click here.

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5. Communicate Findings

- Hospital uses a reporting mechanism (e.g., equity dashboard) to communicate outcomes for various patient populations.

Level of Hospital Implementation	Implementation Activities
Forming	Does not meet basic level/Does not apply
Storming Basic/fundamental	<ul style="list-style-type: none"> • Hospital uses a reporting mechanism (e.g., equity dashboard) to routinely communicate patient population outcomes to hospital senior executive leadership (including medical staff leadership) and the Board.
Norming Mid-level intermediate	<ul style="list-style-type: none"> • Hospital meets the above basic/fundamental level of implementation plus: <ul style="list-style-type: none"> • Hospital uses a reporting mechanism (e.g., equity dashboard) to routinely communicate patient population outcomes widely within the organization (e.g., quality staff, front line staff, managers, directors, providers, committees and departments or service lines).
Performing Advanced	<ul style="list-style-type: none"> • Hospital meets the above basic/fundamental and mid/intermediate levels of implementation plus: <ul style="list-style-type: none"> • Hospital uses a reporting mechanism (e.g., equity dashboard) to share/communicate patient population outcomes with patients and families (e.g., PFAC members) and/or other community partners or stakeholders

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6. Address & Resolve Gaps in Care

- Hospital implements interventions to resolve differences in patient outcomes.

Level of Hospital Implementation	Implementation Activities
Forming	Does not meet basic level/Does not apply
Storming Basic/fundamental	<ul style="list-style-type: none"> • Hospital engages multidisciplinary team(s) to develop and test pilot interventions to address identified disparities in patient outcomes. <ul style="list-style-type: none"> • Multidisciplinary teams can include: diversity & inclusion committee, data/analytics, Patient and Family Advisory Councils (PFACs), patient safety committee, information technology, quality/ performance improvement, patient experience, corporate auditing and finance, etc. • PRACTICAL EXAMPLE: Hospital organized a team [nursing, linguistic services, case management, providers and Patient and Family Advisory Council (PFAC) member] to pilot test the mandatory use of in-person interpreters at the point of discharge for all patients/families with limited English proficiency (LEP) for 3 months and monitor readmissions rates.
Norming Mid-level intermediate	<ul style="list-style-type: none"> • Hospital meets the above basic/fundamental level of implementation plus: <ul style="list-style-type: none"> • Hospital implements interventions (e.g., redesigns processes, conducts system improvement projects and/or develops new services) to resolve identified disparities and educates staff/workforce regarding findings. • PRACTICAL EXAMPLE: Pilot data shows reduction in readmissions in LEP patients. Due to positive results, linguistic resources were broadened, policy was changed to make in-person interpreter mandatory at discharge and triggers were built in the EHR to alert staff to use in-person interpreters at the point of discharge.
Performing Advanced	<ul style="list-style-type: none"> • Hospital meets the above basic/fundamental and mid/intermediate levels of implementation plus: <ul style="list-style-type: none"> • Hospital has a process in place for ongoing review, monitoring, recalibrating interventions (as needed) to ensure changes are sustainable. • PRACTICAL EXAMPLE: Linguistic services and case management keep dashboards to monitor LEP related readmissions, in person interpreter utilization with EHR triggers and report this to leadership on a monthly basis.

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7. Organizational Infrastructure & Culture

- Hospital has organizational culture and infrastructure to support the delivery of care that is equitable for all patient populations.

Level of Hospital Implementation	Implementation Activities
Forming	Does not meet basic level/Does not apply
Storming Basic/fundamental	<ul style="list-style-type: none"> • Hospital has a standardized process to train its workforce to deliver culturally competent care and linguistically appropriate services (according to the CLAS standards). <ul style="list-style-type: none"> • Training should routinely involve patient and family input (e.g., Patient and Family Advisory Councils (PFACs)) and can include cultural competency/ intelligence regarding racial and ethnic minorities, patients with physical and mental disabilities, veterans, limited English proficient patients, lesbian, gay, bisexual and transgender (LGBT) patients, elderly patients, etc.
Norming Mid-level intermediate	<ul style="list-style-type: none"> • Hospital meets the above basic/fundamental level of implementation plus: <ul style="list-style-type: none"> • Hospital has named an individual (or individuals) who has leadership responsibility and accountability for health equity efforts (e.g., manager, director or Chief Equity, Inclusion and Diversity Officer/Council/Committee) who engages with clinical champions, patients and families (e.g., Patient and Family Advisory Councils (PFACs)) and/or community partners in strategic and action planning activities to reduce disparities in health outcomes for all patient populations. Note: This doesn't have to be a member of the C-Suite.
Performing Advanced	<ul style="list-style-type: none"> • Hospital meets the above basic/fundamental and mid/intermediate levels of implementation plus: <ul style="list-style-type: none"> • Hospital has made a commitment to ensure equitable health care is prioritized and delivered to all persons through written policies, protocols, pledges or strategic planning documents by organizational leadership and Board of Directors (e.g. mission/vision/values reflect commitment to equity and is demonstrated in organizational goals and objectives). Example: #123forEquity Pledge

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