

CMS 2024
Quality
Conference
Resilient and Ready Together

Creating an Optimal
Environment for Quality
Healthcare for Individuals,
Families, and Communities

Supporting equity at scale
across HQIC-enrolled hospitals

Nicole Ford, MBA, CPHQ

Project manager, Healthcare Association of New York State



COMMUNITIES

FAMILIES



INDIVIDUALS



RESILIENT



READY



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Nicole Ford, MBA, CPHQ (she/her)

Nicole Ford is a project manager for HANYS and the Eastern US Quality Improvement Collaborative (EQIC) and brings more than 10 years of program management experience to her role leading health equity, quality improvement and patient safety initiatives.

Ford works with hospitals and health systems to achieve measurable outcomes and develops programming to build organizational capacity to eliminate health disparities and advance health equity.

She holds a Master of Business Administration in healthcare administration from Excelsior College and is a certified professional in healthcare quality.



Who we are (1)

HANYS represents and advocates on behalf of all NY hospitals and health systems at all levels of the federal and state government to advance the health of individuals and communities.

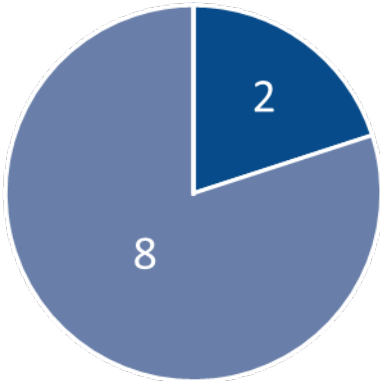
EQIC is an initiative of HANYS in partnership with other state hospital associations to support member hospitals' improvement work with education, tools, resources and direct project management as part of the CMS Hospital Quality Improvement Contract.

EQIC PARTNERS

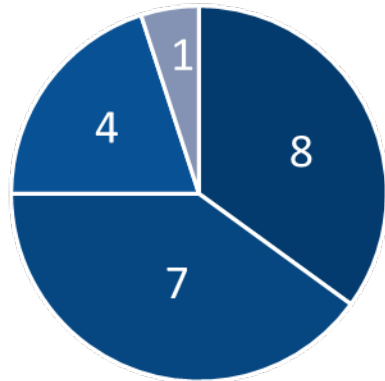
- Connecticut Hospital Association
- Foundation for Healthy Communities/ New Hampshire Hospital Association
- North Carolina Healthcare Foundation
- Vermont Association of Hospitals and Health Systems
- Vermont Program for Quality in Health Care, Inc.
- West Virginia Hospital Association

EQIC hospitals

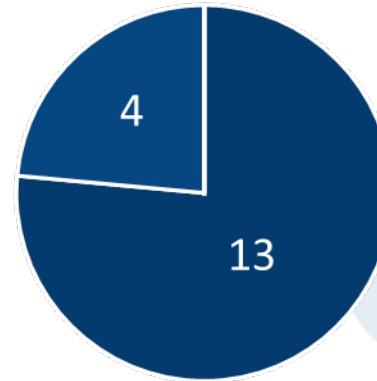
Connecticut



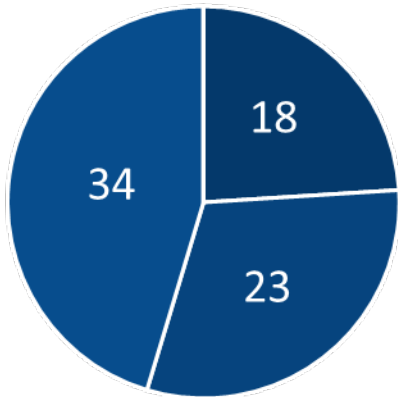
North Carolina



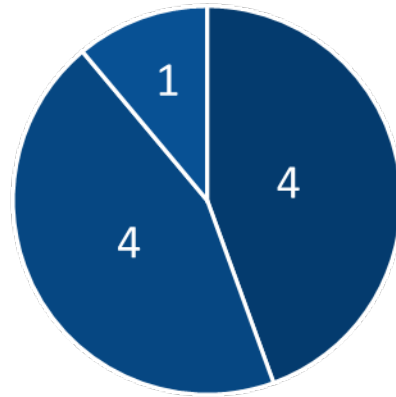
New Hampshire



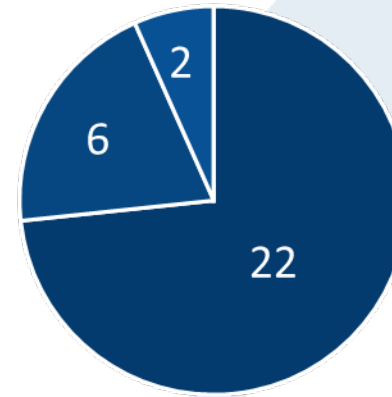
New York



Vermont



West Virginia



Hospital totals

Connecticut	10
North Carolina	20
New Hampshire	17
New York	75
Vermont	9
West Virginia	30
Grand total	161

- CAH
- Rural IPPS
- Urban
- Tribal

Building and strengthening our infrastructure for assessment

- 1 OUR CHALLENGE:** Achieving equity and eliminating health disparities requires an organization-wide commitment supported by strategic planning to embed equity into overall operations.
- 2 ACTION:** A gap analysis tool was designed to support hospitals in assessing their current state to identify potential gaps for improvement and work towards CMS' health equity goals to reduce disparities.
- 3 OUTCOME:** Action plans were developed by hospital teams to track progress toward advancing each level of implementation across all seven assessment categories.

EQIC's Health Equity Gap Analysis

A hospital roadmap to drive action and achieve equity at scale

ELEMENT	BEST PRACTICE RECOMMENDATION	IMPLEMENTATION STATUS			ACTION PLAN/ NEXT STEPS List specific activities your team will seek to accomplish to fully implement each practice recommendation
		FULLY	PARTIALLY	NONE	
ORGANIZATIONAL LEADERSHIP					
Health equity is a key strategic priority with established structures and processes in place to eliminate disparities and ensure equitable healthcare is prioritized and delivered to all patient populations.	Health equity is articulated as a key organization-wide priority (e.g., goals and objectives, strategic plan, policy, protocol, pledges, mission/vision/values, data transparency, leadership buy-in, community partnerships, diverse workforce) supported by a clear business case and plan for operationalizing health equity strategies and interventions that address multiple determinants of health, decrease institutional racism and strengthen community partnerships to improve health and equity.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Hospital has designated a leader(s) or functional area (i.e., health equity committee) responsible for advancing health equity and who actively engages in strategic and action planning activities to reduce disparities.	Health equity leaders are designated and held accountable for disparities reduction with established roles and responsibilities to champion equity and improve quality of care. Designated leaders actively engage hospital staff, patients and families and create linkages with community stakeholders to support health equity improvement activities.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
WORKFORCE TRAINING					
Hospital workforce training is provided to staff who collect self-reported race, ethnicity and language data.	Training must be provided during orientation to staff who collect demographic data. Effectiveness of training should be periodically evaluated using the self-reporting methodology to remove guesswork and ensure accurate data is collected. Training updates are recommended. At a minimum, training is provided to registration/admission staff. Training may include role-playing scripts, didactic methods or take place online.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Hospital workforce training is provided to clinicians involved in the care of the patient regarding the standardized collection of SDOH data.	Training to ensure a standardized approach to screening for and documenting social needs enables hospitals to track and aggregate data across patients, target social determinants strategies, identify population health trends and guide community partnerships. Accurate documentation of social determinants also supports Z code utilization and is key to understanding how to support patients at greatest risk and ensuring patient social support, home and community-based services are enabled to manage their conditions and improve coordination of healthcare delivery.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

Checklist assessment categories

1. Organizational leadership
2. Workforce training
3. Data collection and utilization
4. Data validation
5. Data stratification
6. Health literacy, cultural competence and language
7. Community partnerships

HEALTH EQUITY GAP ANALYSIS

ELEMENT	BEST PRACTICE RECOMMENDATION	IMPLEMENTATION STATUS			ACTION PLAN/ NEXT STEPS List specific activities your team will seek to accomplish to fully implement each practice recommendation
		FULLY	PARTIALLY	NONE	
WORKFORCE TRAINING					
Hospital provides cultural competency education and training to all hospital employees and clinicians.	Implementing and monitoring a cultural competency training program helps to ensure culturally responsive and clinical care services, including within operational/strategic planning efforts. Successful programs include a cultural assessment, multiple training methods, ongoing education and measurement and tracking.	○			
DATA COLLECTION AND UTILIZATION					
Hospital uses a self-reporting methodology to collect REAL data from the patient, family member and/or care partner.	State/national requirements and federal policies include collecting and reporting REAL data. Self-reported patient data is preferred. All race and ethnicity categories collected should, at a minimum, roll up to the OMB categories in separate fields in addition to collecting granular ethnicity data beyond the OMB categories. Hospital staff should receive data collection training.	○			
Hospital has standardized processes in place to collect REAL data for at least 95% of its patients with an opportunity for verification at multiple points of care beyond registration.	Although most hospitals collect patient REAL data, these data are not collected in a systematic or standard manner leading to missing, incomplete or inaccurate data. Establishing data integrity checks, processes and protocols (e.g., hard stop) for self-reported REAL data collection and verification at multiple points of care beyond registration prevents missed opportunities to collect data (e.g., during pre-registration process, registration/admission process, inpatient units, prior to discharge, etc.). The timely, accurate and consistent collection of patient information allows hospitals to provide appropriate and tailored patient education, language assistance services and track quality indicators and health outcomes to improve quality and equity of care.	○			
Hospital uses a self-reporting methodology to collect SDOH data (i.e., transportation, food insecurity, housing, etc.) from the patient, family member or care partner.	Best practice recommendations include collection of SDOH/social risk factors to mitigate health disparities, which can drive as much as 80% of health outcomes. Collecting these data helps organizations identify existing disparities, address health-related social needs and connect patients with resources to address unmet needs.	○			
Hospital uses self-reporting methodology to collect sexual orientation and gender identity data.	Implementing SOGI data collection improves quality of care for LGBTQ+ patients and provides healthcare institutions information to identify and close quality of care gaps, improve patient satisfaction and expand patient population. Research has shown SOGI questions are widely understood and accepted by diverse patient populations across the country.	○			
Hospital data demonstrating health equity gaps are shared broadly (i.e., use of equity dashboards or other reporting mechanisms) with key stakeholders.	Transparently sharing health equity data (i.e., REAL, stratified, patient experiences, outcomes and quality data) helps to identify critical areas where potential inequities exist, analyze root causes, set aims to address gaps and target/implement interventions to close gaps and improve quality of care. Reporting: Adding REAL, SDOH and other patient demographic data to reports can inform value-based care opportunities to advance health equity.	○			

ELEMENT	BEST PRACTICE RECOMMENDATION	IMPLEMENTATION STATUS			ACTION PLAN/ NEXT STEPS List specific activities your team will seek to accomplish to fully implement each practice recommendation
		FULLY	PARTIALLY	NONE	
HEALTH EQUITY GAP ANALYSIS					
DATA COLLECTION AND UTILIZATION					
Hospital collects and utilizes data about the demographic and socioeconomic status of patient populations) served and the surrounding community (social determinants) to target interventions and address health-related needs.	Collection and utilization of needs assessments can help your program determine where and how resources may best be targeted. Collecting data by demographic and socioeconomic subgroups of patients allows hospitals to identify gaps in care delivery and other factors that may influence health outcomes to improve quality, patient safety and communication between providers and patients, care partners and families. Examples: surveys, questionnaires, focus groups and secondary data sources, i.e., demographic data, vital statistics, hospital records and M&M reports. Combining quantitative and qualitative data can help to explain community trends.	○	○	○	
Hospital analyzes SDOH "Z code" data to improve quality, care coordination and experience of care.	SDOH health-related Z codes ranging from Z55-Z65 are the ICD-10-CM encounter reason codes used to document SDOH data (i.e., housing, food insecurity, transportation, etc.). Coders can assign SDOH Z codes based on self-reported data and/or information documented in an individual's healthcare record, and data analysis of SDOH Z code data can be used to identify individual's social risk factors and unmet needs, inform healthcare and services and trigger referrals to social services and between providers and social service organizations.				
DATA VALIDATION					
Hospital verifies the accuracy and completeness of patient self-reported demographic data to improve reliability and identification of disparities in care and target quality interventions (Goal #9C).	Standardized processes are in place to both evaluate the accuracy and completeness (percent of fields completed) of self-reported REAL data, including percent of 'unknown', 'refused/declined' or 'unavailable' with a cumulative goal of <5%. Analysis of these percentages is a valuable tool for identifying and improving issues within data collection systems and processes. Increasing the accuracy and completeness of self-reported REAL data allows hospitals to better identify disparities in patient populations and implement programs to improve outcomes.				
DATA STRATIFICATION					
Hospital stratifies patient safety, quality and/or outcomes measures (e.g., 30-day readmission rates) by race, ethnicity and language to examine differences and equity of care provided.	Stratifying patient safety, quality and/or outcome measured using patient self-reported REAL data helps to identify differences in patient outcomes, areas of opportunity and target interventions. Information can be gathered routinely at registration, updated at regular intervals and used, for example, to do predictive modeling to address factors that influence readmissions.				
HEALTH LITERACY, CULTURAL COMPETENCE AND LANGUAGE					
Health literacy level screened and documented within 24hrs of admission.	Patients with low health literacy are at risk for readmission. Assessing patients' ability to understand health information and responding appropriately to patients' level of health literacy is essential.	○	○	○	
Patients are screened for language access/assistance services.	Patients with limited English proficiency are at higher risk for preventable readmission than English-speaking patients. Collect data on language by asking the patient's preferred spoken language for care, as well as preferred written language.	○	○	○	
Patient cultural preferences documented to individualize care/treatment plan.	Effective clinician-patient communication is directly linked to improved patient satisfaction, adherence and health outcomes. Best practices include documenting and tailoring care in alignment with patients' cultural practice and beliefs when planning, providing and evaluating care.	○	○	○	
Patient disability status/assessment documented.	People with disabilities have more complex admissions. Collecting patient disability status can help ensure necessary information is gathered to provide appropriate care, interventions, services and a smooth transition after hospitalization.	○	○	○	
COMMUNITY PARTNERSHIPS					
Hospital partners with community-based organizations and CBOs (e.g., providing direct assistance to address health-related social needs, use of Bridge Model of transitional care, use of innovative models to enhance integration processes and meet patients' and communities' needs).	Effective, sustainable partnerships between health-care organizations and CBOs (e.g., providing direct assistance to address health-related social needs, use of Bridge Model of transitional care, use of innovative models to enhance integration processes and improve stability) are key to addressing social needs, optimizing patient navigation strategies and improving overall health and well-being of individuals and communities served.	○	○	○	

Equity in action: Jamaica Hospital Medical Center

Following the completion of HANYS' Health Equity Gap Analysis, MediSys Health Network:

- appointed a health equity leader and created a health equity and inclusion committee;
- targeted performance improvement strategies to promote health equity; and
- set a top goal to improve health equity service line projects to reduce health disparities among at-risk populations.

Making equity a reality

Project example

- Established the Violence Elimination and Trauma Outreach (VETO) Program.
- The pilot included 213 eligible gunshot wound patients.
- An SDOH screening tool was built in the EHR
- Social service workers address HRSNs and provide survivors of gun violence with the following crisis interventions:
 - weekly follow-up calls
 - intensive case management; and
 - counseling and referrals to wraparound services.

Outcomes

- Nearly 20% of GSW patients had previous hospital admissions due to unrelated traumatic injuries.
- Data showed that after a two-year pilot evaluation, program graduates had a lower trauma recidivism rate than non-graduates, with one out of 75 (1.33%) pilot graduates versus nine out of 138 (6.52%) pilot non-graduates readmitted due to a violent injury.

2023 Health Equity Gap Analysis

- 105 hospitals participated
- A majority met the *Basic/Fundamental* level across all seven assessment categories



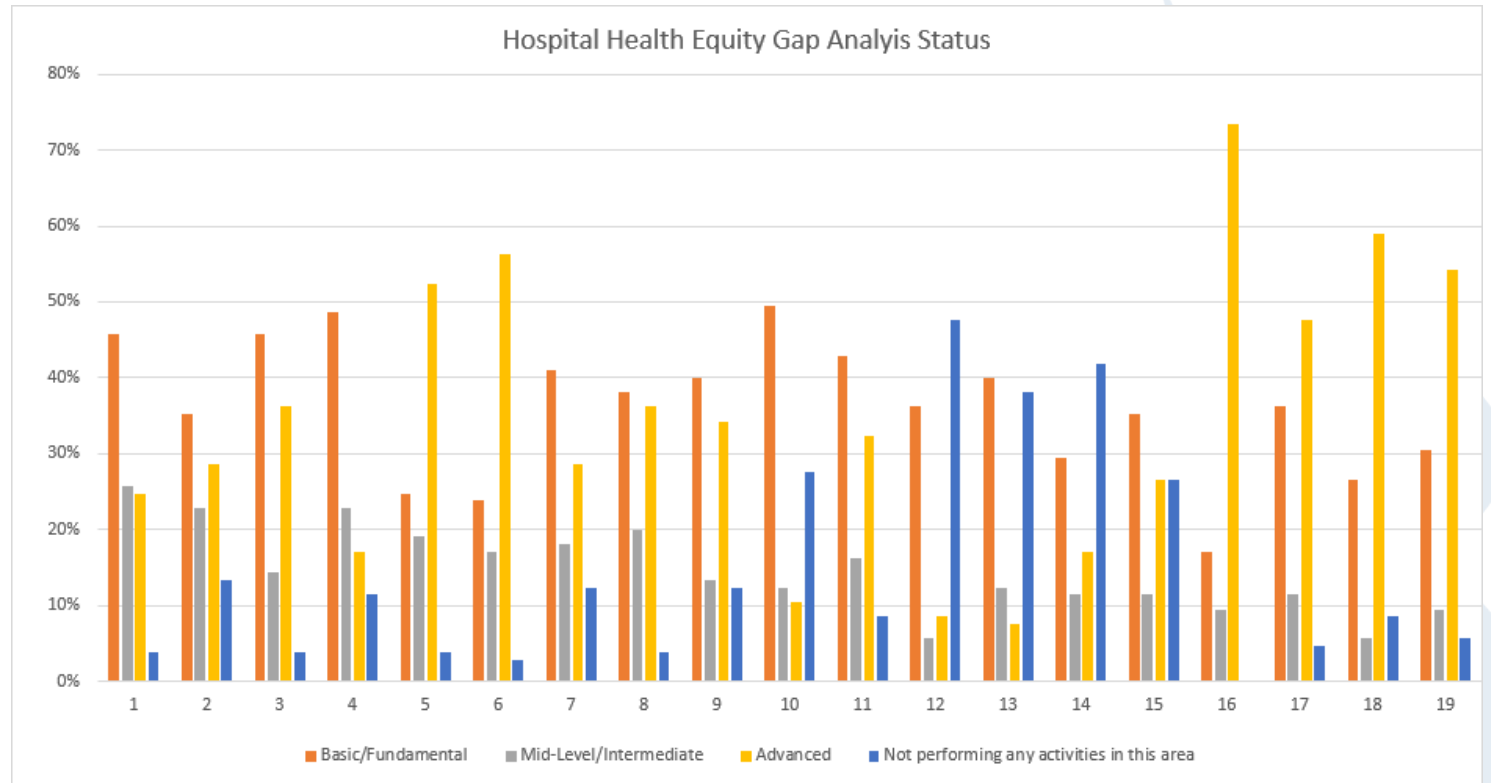
Results

Top advanced areas

REaL data collection, cultural competence training, screening for language access/services, disability status documentation and partnering with community-based organizations

Top areas of opportunity

Data validation and stratification by REaL, analyzing SDOH Z codes to improve quality, care coordination and experience of care



Cultivating pathways to equity success

- Target top priority focus areas to inform roadmap activities.
- Support hospitals in designing equitable solutions to improve health outcomes.
- Optimize results to guide strategic action planning and the elimination of health disparities.
- Harness peer-to-peer learning platforms to share challenges and spread successes.



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Creating an Optimal
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Healthcare for Individuals,
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A Practical Approach to Hospital Health Equity Implementation



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Rosa Abraha

Health Equity Lead

Alliant Health Solutions

Rosa leads Alliant Health Solution's health equity strategic portfolio and embeds health equity in the core of Alliant's work. She has 10+ years of experience in public health advisory for premier agencies, including the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), and the Food and Drug Administration (FDA). Rosa holds a master of public health in health policy and management from Emory University.

Who We Are (2)

- Alliant was founded in Atlanta, Georgia in 1970 and currently has customers in 19 states consisting of federal, state, and local organizations.
- Clinically-led and data-driven organization with one goal of improving health care for everyone.
- **QIN-QIO for both the 12th SOW and Hospital Quality Improvement Contractor (HQIC).**
- Alliant HQIC supports **146 enrolled hospitals from 13 states.**
- In 2023, Alliant was named one of the “Healthiest Employers” and “2023 Best Places To Work” by the Atlanta Business Chronicle. This was the 12th time in 15 years that Alliant has been named a top employer.



Innovative people using data-driven insights and agile processes and tools – making health care better

Embedding Health Equity in Hospital Planning

- **48% of our HQIC hospitals operate in a rural or critical access designation and thus may not have adequate staff support. We developed the following list of key personnel that all hospitals should include to address health disparities effectively:**
 1. Case Management
 2. Quality Team
 3. Registrar Team
 4. Social worker(s)
 5. Involved department leadership
 - i.e., ED, MedSurg, Rehabilitation, Swing bed
- **Hospital Staff Pertaining to the Five CMS SDOH Domains:**
 - **Food Insecurity:** Dietary/Nutrition Dept., swing bed
 - **Transportation:** EMS, Paramedics, ED
 - **Homelessness:** Social worker, discharge planners, swing bed
 - **Utility Difficulties:** Social worker, discharge planners, swing bed
 - **Interpersonal Violence:** Social worker, discharge planners, swing bed
 - **All Domains:** Language line interpretation services/personnel



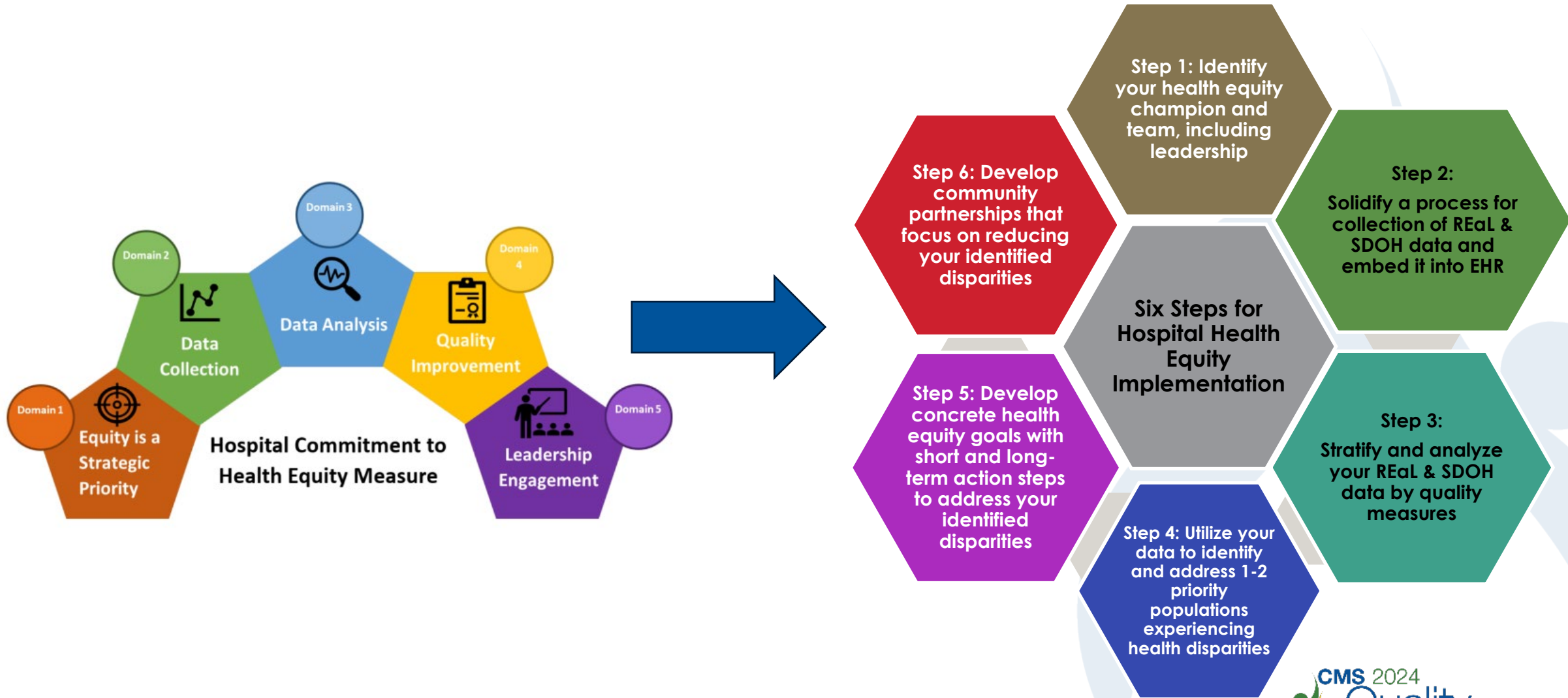
Hospital Champion – Making Health Equity Practical!



LeAnn Pritchett, MSN RN CPHQ
System Director of Quality & Safety
Tift Regional Medical Center - Southwell

- AHS has partnered with one of HQIC’s health equity superstars, Tift Regional Medical Center in Georgia. The main medical center has a 181-bed regional referral hospital located in Tifton, but their Southwell Medical location is an acute care facility in Cook County with a 12-bed geriatric psychiatric unit and a 95-bed skilled rehabilitation facility.
- Collectively, we’ve developed a step-wise practical approach to health equity implementation that we’ve taught collaboratively through two health equity strategy sessions. These events have been highly successful and served 110+ participants across 50+ HQIC hospitals in 11 states.
- To learn more, here are the materials from [Session #1](#) and [Session #2](#).

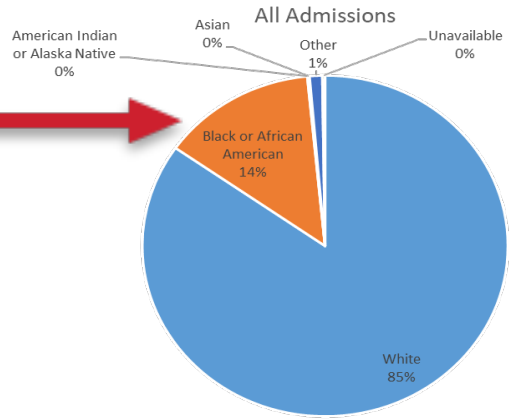
AHS Six Step Model for Hospital Health Equity Implementation



Tift Regional Medical Center Identifies Inequities in Readmissions

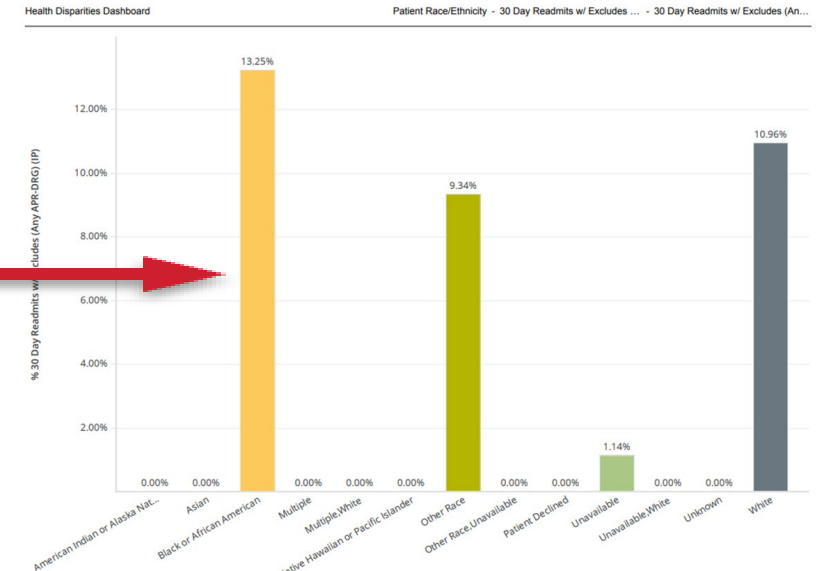
1. All Admissions by Race/Ethnicity

Black/AA patients only make up 14% of all admissions



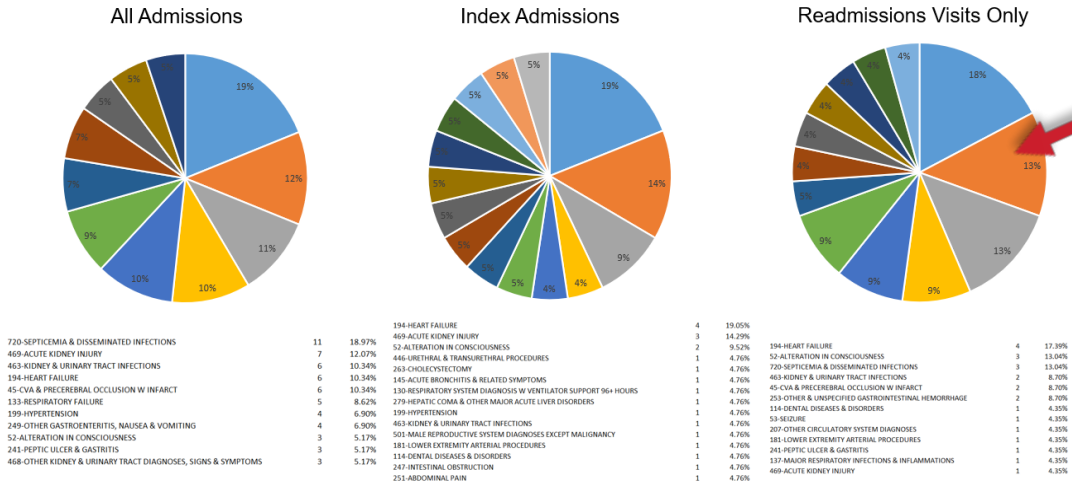
However, Black/AA patients disproportionately make up the largest % of readmissions at 13%

2. All Readmissions by Race/Ethnicity



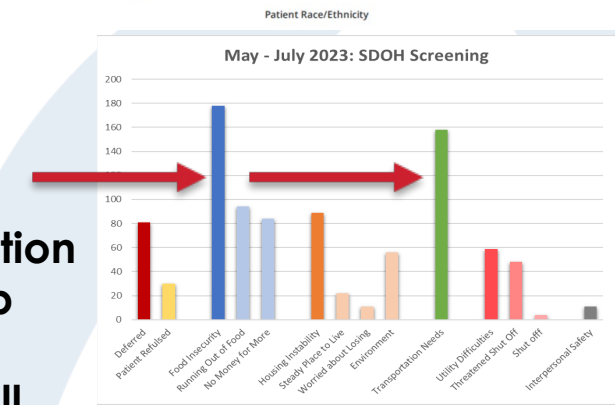
3. Black/African American Males Readmissions, Heart Failure

Top 10 APR-DRG – AA Male



Heart failure is the top recurring diagnosis in readmissions among Black/AA males

4. Food Insecurity and Transportation are the top two SDOH needs in all readmissions




Tift Regional Medical Center – Health Equity Goals and Action Steps

Health Equity Improvement Plan FY 2023			
Goal	Intervention / Action / Best Practice	Expectation	Target Date
Decrease % 30-Day All-Cause Readmissions for Black/African American Males	<ul style="list-style-type: none"> • Provide resource list at discharge for those who screen SDOH positive and increase follow-up calls with patients' post-discharge • Collect patient feedback on barriers and factors related to readmission to help reimagine the discharge process • Cardiologist at Southwell Medical to attend the Community Health Center twice a month to build rapport with patients • Conduct a HF Roundtable with physicians to understand physician perspective on why patients are readmitting • Conduct CPR Hands Free Events in the community to help save lives where major transportation gaps exist • Create a dedicated follow-up phone number for this population 	<ul style="list-style-type: none"> • Patient-centered focus on needs and barriers (access/transportation) will decrease readmissions. • Understanding why AA male patients are missing appointments and readmitting to address gaps. • Decrease risk related to SDOH. • Improved communication, learn and establish trust. • Improved community education and trust. 	9/30/2023
Improve Health Equity Data Collection, Analysis, and Comms	<ul style="list-style-type: none"> • New Information System update to include health equity data collection and consistent reporting – includes the 5 CMS SDOH variables + additional ones like insurance type and income 	<ul style="list-style-type: none"> • Improved data analytics to better understand causal link between SDOH and patient outcomes and action plan 	11/30/ 2023
Implement Best Practices	<ul style="list-style-type: none"> • Engage patient/family in pre-admission process, bedside shift change/huddles, collaborative rounds, and discharge planning • Utilize CHNA to engage community partners • Ensure community partners and PFAC are embedded in co-development and collaboration of health equity priorities and solutions • Began participating in all community opportunities – most recent was an AA church led meeting on homelessness 	<ul style="list-style-type: none"> • Improved action planning and community engagement. • Improved patient experience, engagement in care, and outcomes. • Identify community needs of populations not identified in internal data and fosters community partnerships • Improved resources to meet patient needs 	12/30/2023

Alliant Tool for Hospital Health Equity Strategic Planning

- The purpose of this tool is to provide a framework for hospital leadership and staff in the development of a health equity strategic plan that meets the CMS Hospital Inpatient Quality Reporting (IQR) Program Attestation Guidance for the Hospital Commitment to Health Equity Measure. Per Domain 5 Leadership Engagement in the guidance, this plan is to be reviewed and updated at least annually.
- December 2023 training session and materials, including an example completed strategic plan, can be found here: <https://quality.allianthealth.org/conference/hqic-health-equity-planning-office-hours-december-21-2023/>



HOSPITAL HEALTH EQUITY STRATEGIC PLANNING TOOL

This tool provides a framework for hospital leadership and staff to develop a health equity strategic plan that meets the [CMS Hospital Inpatient Quality Reporting \(IQR\) Program Attestation Guidance for the Hospital Commitment to Health Equity Measure](#). Per Domain 5 Leadership Engagement in the guidance, the health equity plan should be reviewed and updated *at least annually*. To view an example of a completed hospital health equity strategic plan, visit our Alliant HQIC website [here](#).

Hospital Name: _____
Chief Health Equity Officer/Health Equity Champion: _____
Strategic Plan Approved by Senior Leadership and the Hospital Board on: _____

Executive Summary:

Hospital(s) Background:

Health Equity Statement:

NEW! Alliant Tool for Social Determinants of Health Referral at Discharge



SOCIAL DETERMINANTS OF HEALTH (SDOH) DISCHARGE REFERRAL LIST

This tool helps your healthcare team address any social challenges that might affect your health and connect you and your caregiver with essential community resources that promote your total well-being.

HEALTH LITERACY – The degree to which individuals have the capacity to obtain, process and understand basic health information and services necessary to make appropriate health decisions.

Primary Language: _____

Needs interpreter

Language Line: _____

Interpreter 1: _____

Phone: _____

Interpreter 2: _____

Phone: _____

SOCIAL ISOLATION – The lack of relationships with others and little to no social support or contact.

Senior Center 1: _____

Contact person: _____

Phone: _____

Senior Center 2: _____

Contact person: _____

Phone: _____

Adult Day Center: _____

Contact person: _____

Phone: _____

HOUSING INSTABILITY – Encompasses multiple conditions ranging from the inability to pay rent or mortgage, frequent changes in residence, including temporary stays with friends and relatives, living in crowded conditions, and lack of sheltered housing in which an individual does not have a personal residence.

Inability to pay rent/mortgage

Frequent changes in residence

Crowded conditions

Lack of sheltered housing

Shelter 1: Male Female Family

Contact person: _____

Phone: _____

Shelter 2: Male Female Family

Contact person: _____

Phone: _____

Shelter 3: Male Female Family

Contact person: _____

Phone: _____

UTILITY DIFFICULTIES – Inconsistent availability of electricity, water, oil and gas services. This is directly associated with housing instability and food insecurity.

Electricity Water

Oil and/or gas

Electric Company: _____

Contact person: _____

Phone: _____

Water Company: _____

Contact person: _____

Phone: _____

Gas/Oil Company: _____

Contact person: _____

Phone: _____

Faith-Based Organization: _____

Contact person: _____

Phone: _____

Other Organization: _____

Contact person: _____

Phone: _____

FOOD INSECURITIES – Limited or uncertain access to adequate quality and quantity of food at the household level.

Meals on Wheels Program: _____

Contact person: _____

Phone: _____

Local Area Agency on Aging: _____

Contact person: _____

Phone: _____

Food Bank/Food Pantry: _____

Contact person: _____

Phone: _____

Food Bank/Food Pantry: _____

Contact person: _____

Phone: _____

Food Bank/Food Pantry: _____

Contact person: _____

Phone: _____

Other Organization: _____

Contact person: _____

Phone: _____

TRANSPORTATION DIFFICULTIES – Limitations that impede transportation to destinations required for all aspects of daily living.

Medical Non-emergent

Medical Transport Company 1: _____

Contact person: _____

Phone: _____

Medical Transport Company 2: _____

Contact person: _____

Phone: _____

Medical Transport Company 3: _____

Contact person: _____

Phone: _____

Non-Emergency Transport Company 1: _____

Contact person: _____

Phone: _____

Non-Emergency Transport Company 2: _____

Contact person: _____

Phone: _____

Non-Emergency Transport Company 3: _____

Contact person: _____

Phone: _____

United Way (Local Chapter): _____

Contact person: _____

Phone: _____

Faith-Based Organization with Van: _____

Contact person: _____

Phone: _____

Faith-Based Organization with Van: _____

Contact person: _____

Phone: _____

Faith-Based Organization with Van: _____

Contact person: _____

Phone: _____

Other: _____

Contact person: _____

Phone: _____



This material was prepared by Alliant Health Solutions, a Quality Innovation Network – Quality Improvement Organization (QIN – QIO) and 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 material 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 Number: 1250W-AHS-QIN-QIO-T01-PCH-T03-HQIC-4934-12/27/23

https://quality.allianthealth.org/wp-content/uploads/2023/12/SDOH-Discharge-Referral-List-Fillable_508.pdf



Monthly Hospital Health Equity Office Hours Continuing in 2024!



Home Programs Events Resources

What can we help you find?

Education on Demand

HQIC Office Hours

- HQIC Health Equity Planning Office Hours - December 21, 2023
- HQIC Health Equity Planning Office Hours - November 16, 2023
- HQIC Infection Prevention Chats | October 25, 2023
- HQIC Health Equity Planning Office Hours - October 19, 2023

HQIC LAN Events

- The Core Elements for Antibiotic Stewardship in Action - Tracking, Reporting and Education | Oct. 24, 2023
- Health Equity Strategy Series: How to Make it Work for Your Hospital - Part 2 | Sept. 27, 2023
- The Core Elements for Antibiotic Stewardship in Action - Pharmacy Expertise and Action | Sept. 19, 2023

HQIC Community of Practice Calls (COP) Events

- The Core Elements for Antibiotic Stewardship in Action - National Antibiotic Stewardship Updates | Nov. 9, 2023
- Rural Governance: Activating Your Hospital Board as Partners in Improving Outcomes | Oct. 12, 2023
- Building Reliable Sepsis Mortality Prevention Practices | Sep. 21, 2023

<https://quality.allianthealth.org/nqic/hqic/>

JOIN OUR UPCOMING WEBINAR EVENT

ALLIANT HQIC
Health Equity Office Hours

Tues, Jan. 16 from 3-4:00 p.m. ET & Every 3rd Thursday from 3-4:00 p.m. ET from February through August 2024 via ZOOM

[01.16.24_TO3_HQIC Health Equity Office Hours](#)

[02.15.24_TO3_HQIC Health Equity Office Hours](#)

[03.21.24_TO3_HQIC Health Equity Office Hours](#)

[04.18.24_TO3_HQIC Health Equity Office Hours](#)

[05.16.24_TO3_HQIC Health Equity Office Hours](#)

[06.20.24_TO3_HQIC Health Equity Office Hours](#)

[07.18.24_TO3_HQIC Health Equity Office Hours](#)

[08.15.24_TO3_HQIC Health Equity Office Hours](#)

CLICK ON TITLES TO REGISTER

FEATURED SPEAKERS:

ROSA ABRAHA, MPH
Health Equity Lead
Alliant Health Solutions

LEANN PRITCHETT, MSN, RN, CPHQ
System Director of Quality and Safety
Tift Regional Medical Center

AUDIENCE:
Health equity team leaders, quality and patient safety professionals, clinical social workers, community and population health professionals, clinical team members, leadership

OVERVIEW:
Interested in networking with peers and learning about the health equity regulatory requirements and best ways to implement at your hospital? Join our subject matter experts from Alliant Health Solutions and Tift Regional Medical Center (TR) for monthly interactive office hours.

Office hours are participant driven and with minimum slide presentations. Discussions will focus on the six health equity planning and action steps as well as other questions from the hospitals, e.g., CEO engagement.


Office Hours will be held the 3rd Thursday of the month from 3-4:00 p.m. ET. Please register to attend.

Jan. 16, 2024 • Feb. 15, 2024 • Mar. 21, 2024 • Apr. 18, 2024
May 16, 2024 • Jun. 20, 2024 • Jul. 18, 2024 • Aug. 15, 2024

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Cultural and Linguistically Appropriate Services (CLAS): Bite-Sized Learning Video Toolkit



Who Has Low Health Literacy?

Health Literacy

Alliant QIO
4 videos 2 views Last updated on May 18, 2023

Play all Shuffle



Health Literacy with Dr. Iris Feinberg, PhD, CHES

Alliant QIO • 116 views • 3 months ago



Bite-Sized Learning: Using Teach-Back

Alliant QIO • 26 views • 8 days ago



Bite-Sized Learning: CLAS 101

Alliant QIO • 37 views • 1 month ago



Bite-Sized Learning: CLAS Implementation

Alliant QIO • 38 views • 1 month ago

<https://www.youtube.com/playlist?list=PLXWmxni-xNHvBQp3MQt8DXRae06CGF2JI>

CMS 2024
**Quality
Conference**
Resilient and Ready Together

Creating an Optimal
Environment for Quality
Healthcare for Individuals,
Families, and Communities

Collaborating For Equity: Supporting the Integration of Social Care into Hospital Care Delivery

Laura Benzel, MS, BS, CSSGB

IPRO Health Equity Lead



COMMUNITIES

FAMILIES



INDIVIDUALS



RESILIENT



READY



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

The IPRO HQIC

- A federally funded Medicare Hospital Quality Improvement Contractor (HQIC) in 12 states
- IPRO collaborates with several organizations to reach hospitals.

■ IPRO

■ Healthcentric Advisors

■ Kentucky Hospital Association

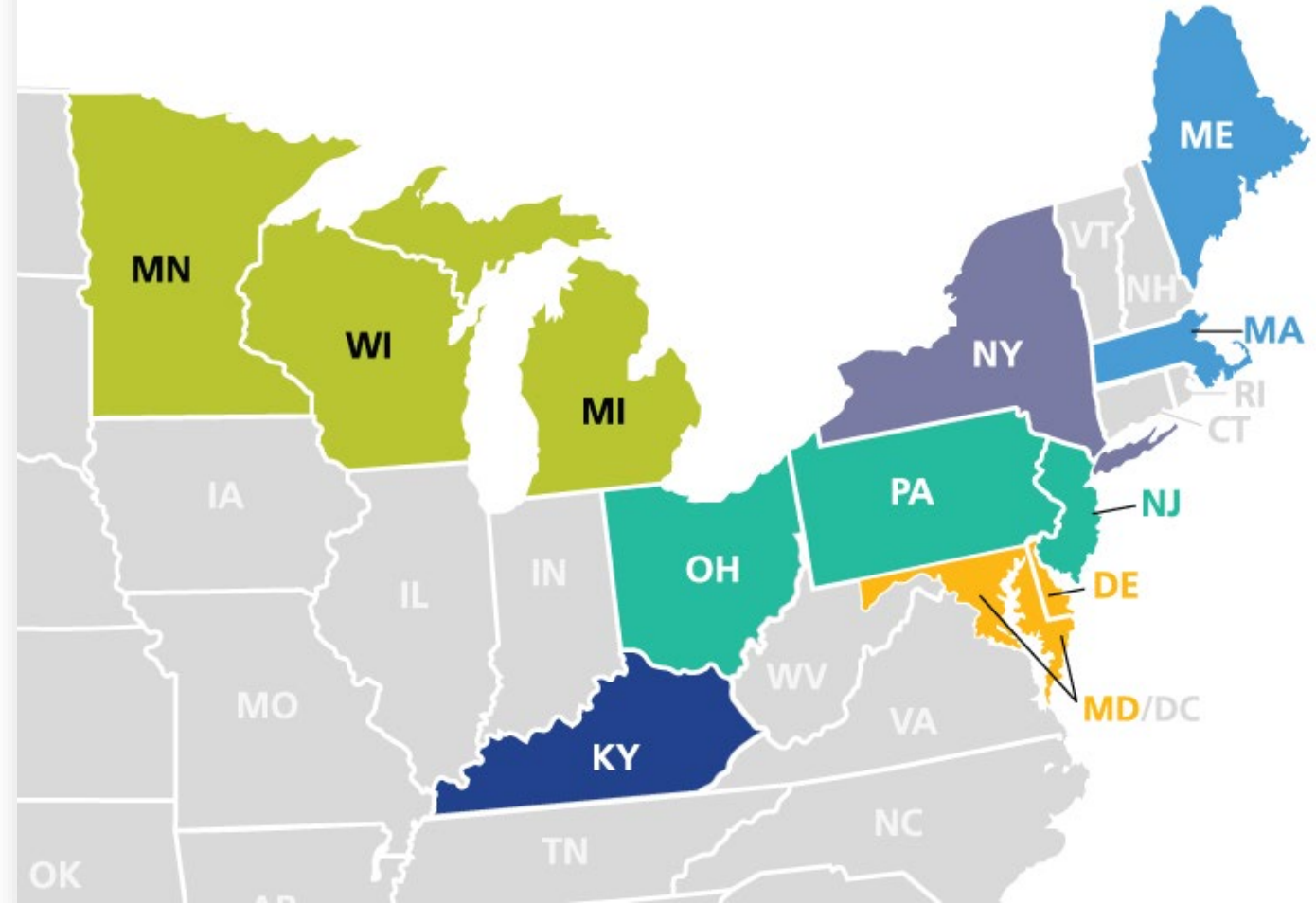
■ Qlarant

■ Q3 Health Innovation Partners

■ Superior Health Quality Alliance

American Institutes for Research (AIR)

QSource Health Equity Subject Matter Experts



■ QIN-QIO
■ HQIC



CMS 2024 Quality Conference

Resilient and Ready Together

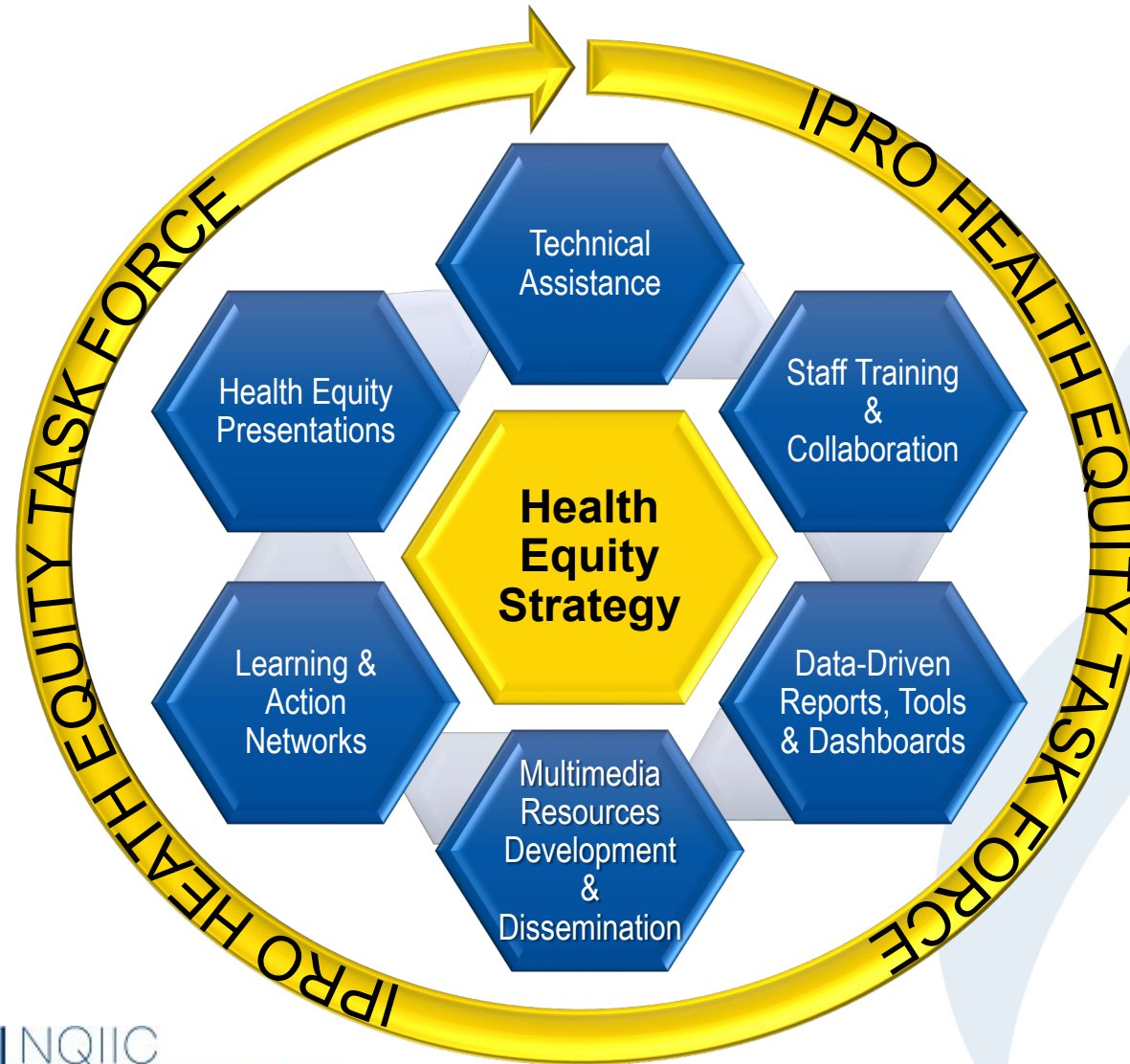
Creating an Optimal
Environment for Quality
Healthcare for Individuals,
Families, and Communities



**Laura Benzel, MS,
BS, CSSGB**

Laura is a Project Director at Qlarant and supports the IPRO Quality Innovation Network – Quality Improvement Organization (QIN-QIO), a Centers for Medicare & Medicaid Services program, as a health equity subject matter expert across 11 states (NY, NJ, OH, MD, DE, and the 6 New England states) and the District of Columbia. Since 2016, Laura has served as an advisor, consultant and subcontractor to NORC @ University of Chicago for a national healthcare disparities quality improvement initiative for the CMS Office of Minority Health. Laura holds a Masters of Science in Health Systems Management and is Six Sigma Green Belt Certified.

IPRO Cross-Task Health Equity Task Force



- QIN-QIO
- HQIC

NQIIC
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QUALITY IMPROVEMENT & INNOVATION GROUP



Health Equity Organizational Assessment (HEOA)



Assesses an organization's ability to collect, validate, and stratify patient sociodemographic data to identify and act once disparities have been identified.

Organization
Infrastructure & Culture

Data Collection

Data Collection Training

Data Validation

Data Stratification

Communicate Findings

Address & Resolve Gaps
in Care

IPRO assists facilities to develop and implement an action plan to address opportunities for improvement.



Organizations complete the online HEOA Assessment and use the IPRO Report to identify opportunities for improvement

[IPRO HEOA Resources](#)



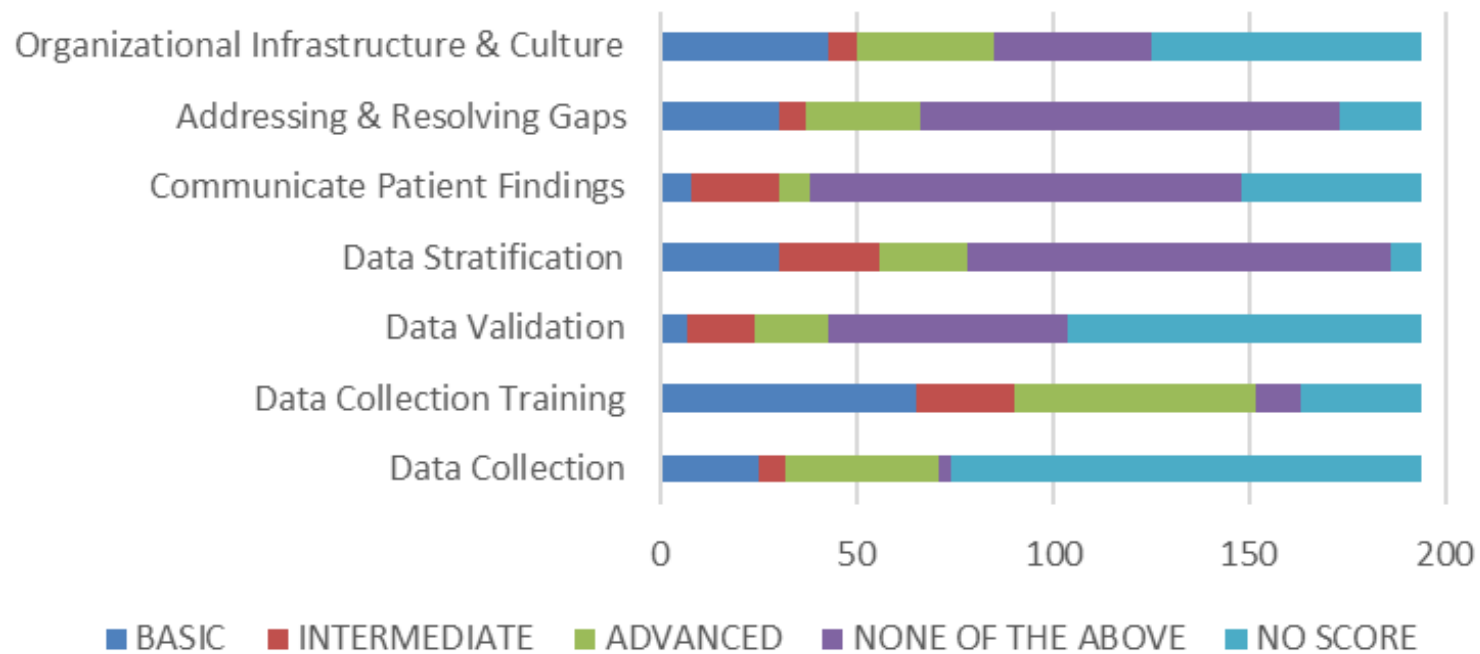
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HQIC HEOA Aggregate Results

IPRO HQIC HEOA RESULTS BY CATEGORY

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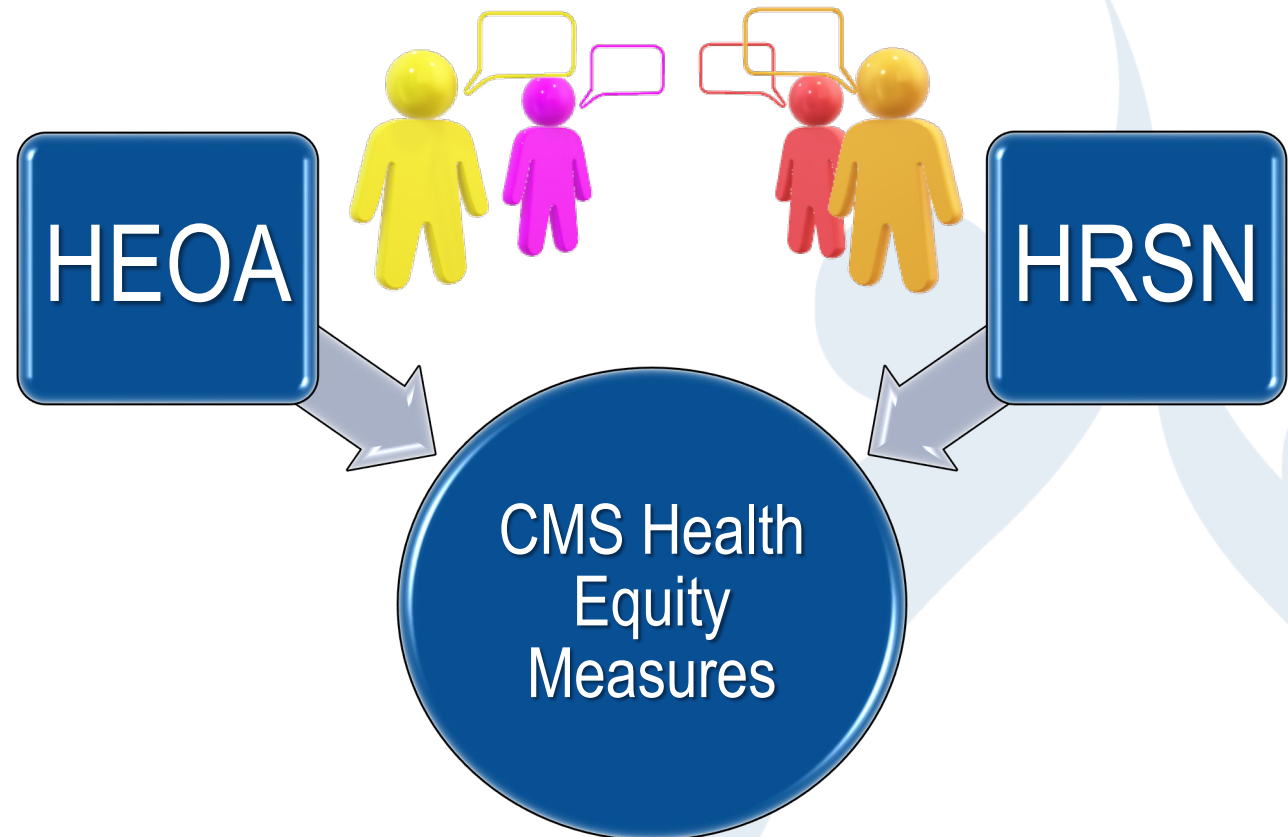


QIN-QIO
HQIC



Affinity Groups

- Assist hospitals to prepare to meet the CMS health equity measures.
- Includes peer-to-peer learning and sharing.
- Facilitated by IPRO Health Equity Leads
- Detailed summary disseminated after each session.



HRSN Education Sessions & Resources

Education Sessions

■ CMS

- Inpatient Quality Reporting
- Hospital Commitment to Health Equity Measure
- Social Drivers of Health Measure
- Health Equity Payment Rules

■ The Joint Commission

- Health Equity Standards
- Health Equity Certification

Resources

■ Five Social Drivers of Health

- Food Insecurity
- Housing Instability
- Transportation Needs
- Utility Difficulties
- Interpersonal Safety

■ Curated Resources

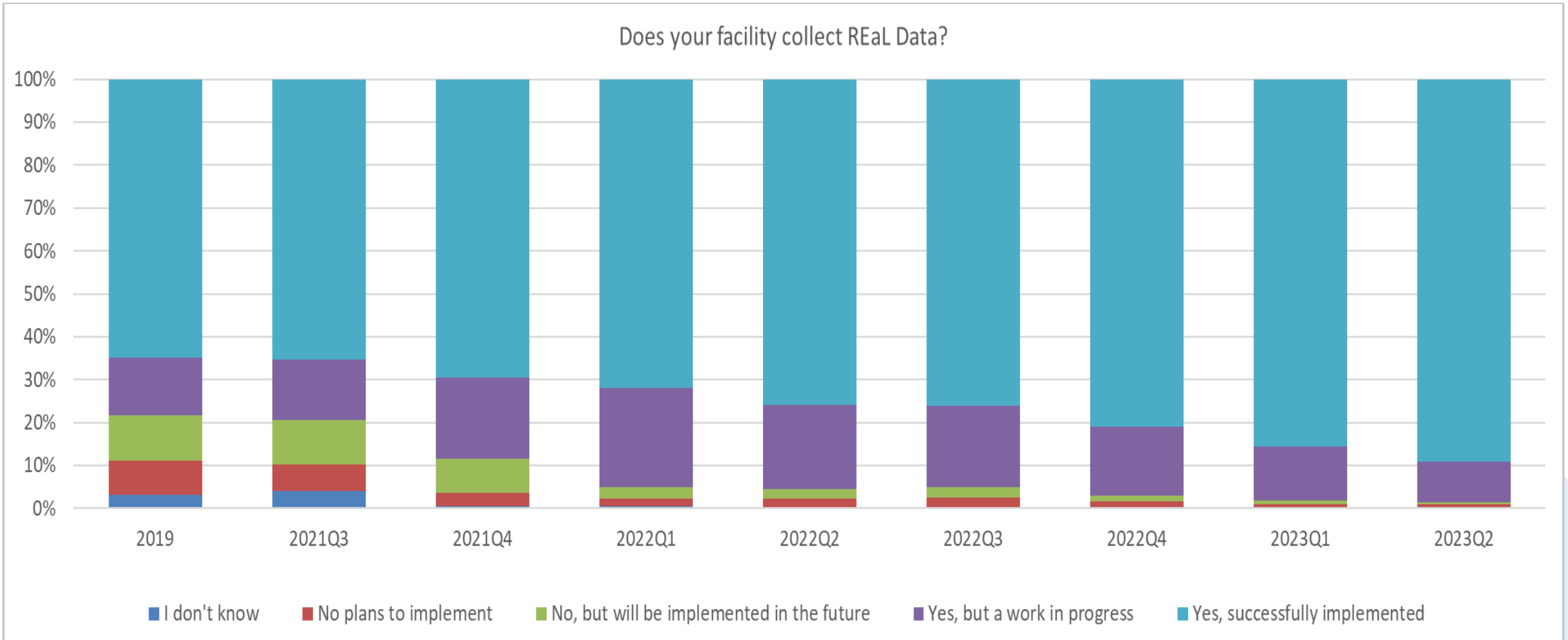
- Affinity groups
- Educational sessions





Assessment Results

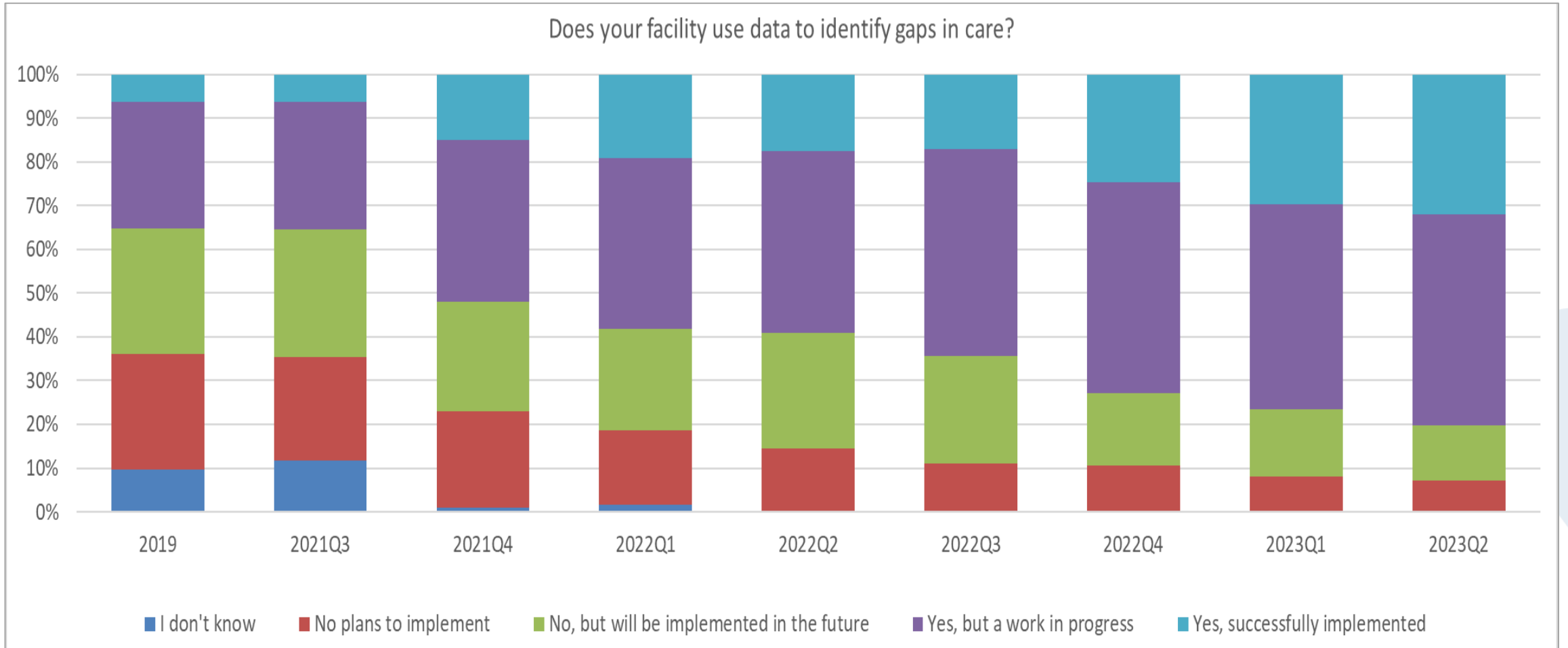
Does your facility collect REaL data?



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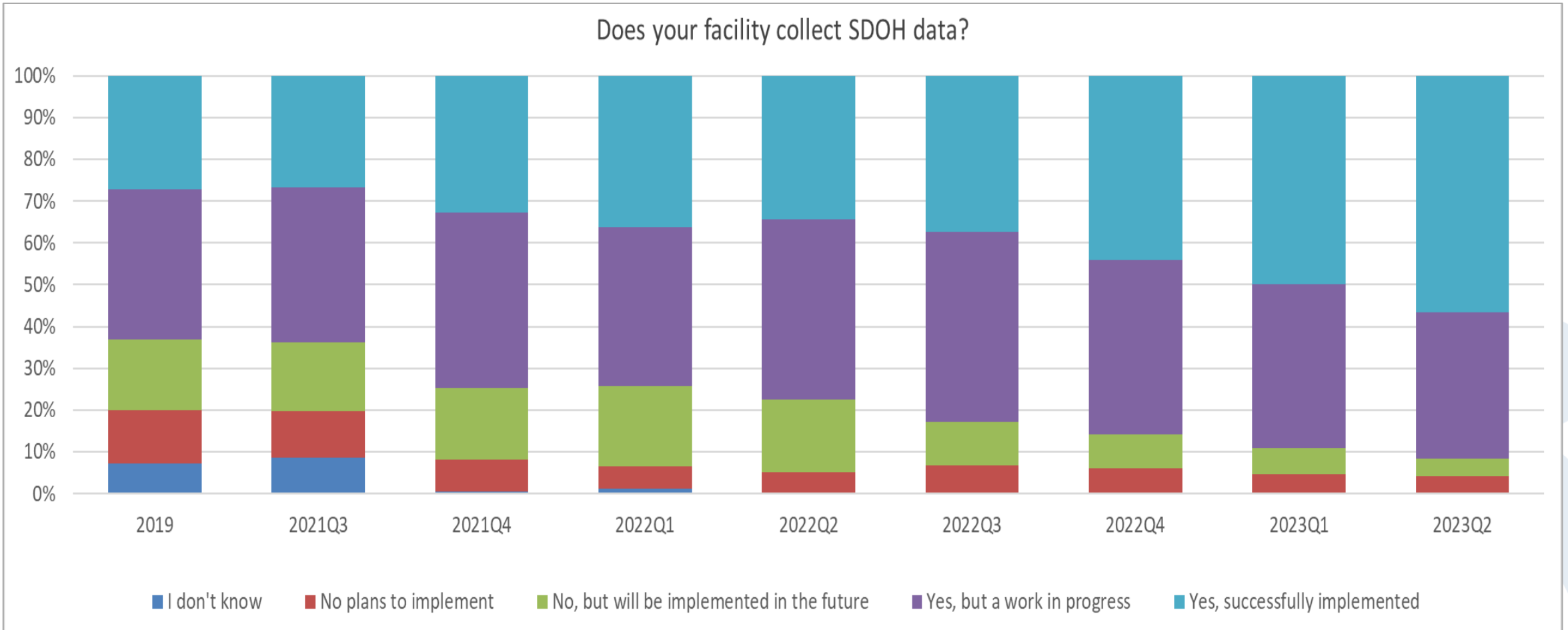
Does your facility use data to identify gaps in care?



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Does your facility collect SDOH data?




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Social Drivers of Health Resources

Interpersonal Safety:
A Guide to Screening and Connecting Patients to Support Services



Violence and abuse by family members or friends can cause physical and/or emotional harm. Even insults or threats of violence or abuse can be detrimental to an individual's health. Domestic violence encompasses intimate partner violence, child abuse, elder abuse, and adolescent dating violence. Intimate partner violence is defined as "abuse or aggression that occurs in a romantic relationship" and encompasses a range of behaviors including aggression, stalking, and sexual and physical violence.¹

In the U.S., approximately 30% of women and 10% of men experience rape, physical violence, and/or stalking by an intimate partner. Twelve million people each year are affected by intimate partner violence.²

Women aged 18 to 24 and 25 to 34 experience the highest rates of intimate partner violence.³ Children that reside in households with intimate partner violence are more likely to be victims of child abuse and physical and sexual assaults. Intimate partner violence can also have intergenerational health effects such as unintended pregnancy, low-birthweight infants, and/or pre-term births.⁴

Teen dating violence also affects millions of teenagers and can impact their lifelong health and wellbeing. Among U.S. high school students, one in 12 experiences physical or sexual dating violence.⁵

Close to five million adults over 60 years of age, or nearly one in ten older adults, are abused each year; frequently the abuser is someone they trust and/or their caregiver.⁶ This includes financial abuse and neglect, and emotional, physical, and sexual abuse.

Impacts of lack of interpersonal safety
Increases the risk of:

- Physical injuries and disabilities
- Chronic conditions
- Sexually transmitted and other infectious diseases
- Post-traumatic stress disorder, depression, and anxiety
- Suicidal thoughts and attempted suicide
- Substance and opioid use disorders
- Mortality.

¹ Centers for Disease Prevention and Control, Violence Prevention, October 11, 2022. <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/faqfact.html>

² National Domestic Violence Hotline, Domestic Violence Statistics, accessed September 18, 2023. <https://www.thehotline.org/stakeholders/domestic-violence-statistics>

³ National Domestic Violence Hotline, Domestic Violence Statistics, accessed September 18, 2023. <https://www.thehotline.org/stakeholders/domestic-violence-statistics>

⁴ Office of the Assistant Secretary for Planning and Evaluation, Screening for Domestic Violence in Health Care Settings, July 13, 2010. <https://hhs.gov/ohr/10-070>

⁵ Centers for Disease Prevention and Control, Teen Dating Violence, October 11, 2022. <https://www.cdc.gov/violenceprevention/teendatingviolence/faqfact.html>

⁶ Centers for Disease Prevention and Control, Teen Dating Violence, October 11, 2022. <https://www.cdc.gov/violenceprevention/teendatingviolence/faqfact.html>

⁷ National Council on Aging, Get the Facts on Elder Abuse, February 23, 2021. <https://www.ncoa.org/article/get-the-facts-on-elder-abuse>

Transportation Barriers:
A Guide to Screening for Transportation Barriers

When thinking about health and health equity, transportation may not come to mind as a factor. However, transportation barriers can prevent patients from accessing regular medical care and can compromise their health. According to a 2017 report from the American Hospital Association, almost 6 million people in the U.S. report that transportation barriers cause them to delay medical care. Another 3.8 million people report they are unable to obtain any medical care due to lack of access to any form of transportation.

Transportation insecurity can take many forms. It may mean that an individual has a vehicle but lacks the money to purchase gas or maintain it. An individual may live in an area that has low walkability and lacks adequate, safe public transportation or the infrastructure for bikes, wheelchairs, and other mobility devices. Those living in rural areas are especially at risk for transportation insecurity and may have to travel a significant distance to obtain medical care.

Transportation barriers disproportionately affect older adults, those with lower socioeconomic status, people with disabilities, those living in rural areas, and certain racial and ethnic minorities. If a patient is non-adherent to their care plan it could be due to transportation barriers, a factor that healthcare providers should consider addressing. Access to reliable transportation is an important health-related social need the lack of which perpetuates health disparities.

Impacts of transportation barriers:

- Missed medical appointments and lab tests.
- Delayed diagnosis of serious medical conditions.
- Exacerbation of health disparities and other social risk factors such as food insecurity, social isolation/loneliness, and unemployment.
- Inability to fill prescription medications.
- Increased risk of, and poorer management of, chronic conditions.
- Increased healthcare costs, emergency room use, and hospital readmissions.
- Higher risk for premature death.

Ask your patients about transportation barriers

- "In the past 12 months, has lack of reliable transportation kept you from medical appointments?"
Yes
No
- "In the past 12 months, has lack of reliable transportation kept you from attending social events such as going to church or the senior center or getting things needed for daily living like groceries or clothes?"
Yes
No

Patients who respond "yes" to one or both questions may need assistance with transportation.


If a patient screens positive:

- First, ask the patient if they would like help.
- If they say yes, refer them to support services. Please see the Resources section of this flyer.
- Document and code* the results in the patient's electronic medical record:
ICD-10-CM Diagnosis Code Z59.82 (transportation insecurity). This is a new Z code effective October 1, 2022.

*Please consult with a coding specialist to ensure proper coding.

The screening questions were adapted from the **PRAPENR** social screening tool. There are two questions to distinguish between medical and non-medical transportation barriers. Referral to supportive services may be different depending on the circumstance.

Energy/Utility Insecurity:
A Guide to Screening and Connecting Patients to Support Services



Energy or utility insecurity is the inability of households to meet basic energy needs. Energy encompasses electricity, gas, or other power sources for cooling, heating, lighting, and other uses of appliances and devices. The inability to meet these needs is often because of financial hardships or poverty but can also be a result of old, ill-functioning or non-existent equipment, or poor insulation.

Energy insecurity affects the ability of individuals to reside in comfortable environments leading to potentially dangerous conditions when they face either extreme heat or cold or sacrifice other basic needs (e.g., food or medication) to cover the cost of utilities. In addition, individuals may resort to using potentially hazardous alternatives such as space heaters or ovens as their primary source of heat.

According to the U.S. Department of Energy, one in four households report energy insecurity almost every month, some months, or within the last year based on data from July 2021 through May 2023.¹ Households that identify as Black, Hispanic, or two or more races experience energy insecurity at disproportionately higher rates compared to households that identify as White or Asian. Renters and households that have lower income with children or other family members are more likely to report energy insecurity.

Impacts of energy insecurity:

- Increases the risk of food insecurity or unfilled medications because of energy and utility needs.
- Increases the risk of heat and cold stress.
- Increases the risk of hazards related to malfunctioning equipment, inappropriate use of heating sources, and lack of lighting.
- Increases risk of inability to use electronic medical equipment (e.g., dialysis or oxygen machines) or take medication that requires refrigeration (e.g., insulin).
- Increases the risk for mental health conditions (e.g., stress and anxiety) resulting from economic hardships and poor living conditions.
- Contributes to poorer health outcomes as well as social and environmental consequences (e.g., mold, asthma, stigma).

Because of climate change, extreme weather conditions are occurring more frequently and impacting those that are most vulnerable. To combat this, it is even more important that healthcare providers play a role in identifying and addressing energy/utility insecurity by screening patients and referring those who need help to appropriate resources.

¹ U.S. Department of Energy, "Households of Color Continue to Experience Energy Insecurity at Disproportionately Higher Rates," July 6, 2023. <https://bit.ly/3P6S10M>

Food Insecurity:
A Guide to Screening Patients for Food Insecurity

Access to healthy, quality food can help individuals achieve and maintain optimal health. The connection between nutritious food and a healthy active life are well documented and supported by robust scientific study. But due to food insecurity, many people lack access to adequate food.

According to the U.S. Department of Agriculture (USDA), 1 in 8 people – or 38 million Americans – were food insecure in 2020. The USDA defines food insecurity as a household-level economic and social condition of limited or uncertain access to adequate food. Hunger is an individual-level physiological condition that can result from food insecurity.

Impacts of food insecurity:

- Increases the risk of malnutrition.
- Increases likelihood of skipping or underuse of prescribed medications.
- Increases the risk for mental health conditions.
- Contributes to higher healthcare costs.

Healthcare providers can play an important role in identifying and addressing food insecurity. Screen all patients and refer those who need help.

The recommendation is that you screen all patients for food insecurity

Use the validated **Hunger Vital Sign** ™ two-question screening tool to screen your patients for food insecurity:


1 "Within the past 12 months, we worried our food would run out before we got money to buy more."	Often True	Sometimes True	Never True	Refused/Don't Know
2 "Within the past 12 months, the food we bought just didn't last and we didn't have money to get more."	Often True	Sometimes True	Never True	Refused/Don't Know

Patients screen positive for food insecurity if they respond "often true" or "sometimes true" to either or both statements.

If a patient screens positive:

- First, ask the patient if they would like help.
- If they say yes, refer them to support services. Please see the Resources section of this flyer.
- Document and code* the results in the patient's electronic medical record:
ICD-10-CM Diagnosis Code Z59.41 (Food Insecurity)

*Please consult with a coding specialist to ensure proper coding of patient conditions.



Housing Insecurity:
A Guide to Screening and Connecting Patients to Support Services



Housing insecurity encompasses both housing instability and homelessness. Housing instability means that individuals are either behind on rent or mortgage payments, move often, spend most of their income on housing costs or are at risk of eviction.¹ Housing instability can lead to homelessness, which means that individuals are sleeping in places not typically used or designed for human shelter (e.g., cars, streets, transitional housing, or shelters).² Since the definition of homelessness can vary, the U.S. Department of Housing and Urban Development (HUD) has a more nuanced definition of homelessness that includes four categories: 1) literally homeless, 2) imminent risk of homelessness, 3) homeless under Federal statutes, 4) fleeing/attempting to flee domestic violence.³ Each category has specific criteria associated with it, and can be found in this [HUD document](https://www.hud.gov).

Households that spend more than 30 percent of their income on housing is considered to be high cost burdened, those that spend more than 50 percent of their income on housing are considered severely cost burdened.⁴ This leaves households with less money to spend on other necessities such as food, healthcare, and utilities. In 2021, a record high of almost 49% of renters, or 21 million households, experienced a high cost burden for housing.⁵

In the United States, 580,000 people experienced homelessness on a single night in 2022. Of this population, four in ten were in unstable locations which are unsuitable for habitation. Additionally, three in ten experienced homelessness as part of a family with children. There is an overrepresentation of individuals who identify as Black/African-American/Hispanic and Indigenous among those who experience homelessness.⁶

Impact of Housing Insecurity

- Increased risk of chronic diseases (e.g., diabetes, high blood pressure, substance use disorders).
- Increased risk for mental health conditions such as stress and anxiety resulting from economic hardships and poor living conditions, as well as higher risk for suicides resulting from stress.
- Contributes to infectious diseases due to residential crowding.
- Contributes to a range of poorer health outcomes as well as social, economic, and environmental consequences.
- Increased risk of premature death for individuals who are homeless.

¹ U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Housing Instability, accessed July 21, 2023. <https://health.gov/healthypeople/priority-action/social-determinants-of-health/literature-summaries/housing-instability#01>

² Centers for Disease Control and Prevention, Defining Homelessness, August 16, 2022. <https://www.cdc.gov/orcn/science/homelessness/definition.html>

³ U.S. Department of Housing and Urban Development, Criteria and Recertification Requirements for Definition of Homelessness, January 2021. <https://www.hudexchange.info/resources/documents/criteria-and-recertification-requirements-for-definition-of-homelessness>

⁴ Population Reference Bureau, U.S. Housing Cost Burden Declines Among Homeowners but Remains High for Renters, April 15, 2022. <https://www.prb.org/articles/u-s-housing-cost-burden-declines-among-homeowners-but-remains-high-for-renters>

⁵ Joint Center for Housing Studies, Number Of Renters Burdened By Housing Costs Reached A Record High In 2021, February 1, 2023. <https://www.jchs.harvard.edu/blog/number-renters-burdened-housing-costs-reached-record-high-2021>

⁶ U.S. Department of Housing and Urban Development, The 2022 Annual Homelessness Assessment Report (AHAR) to Congress, December 2022. <https://www.huduser.gov/portal/sites/default/files/pdf/2022-AHAR-Final.pdf>

HQIC Resource Library (ipro.org)




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Social Drivers of Health Resources con't

Each Resource Includes:

- Introduction
 - Findings from research
 - Data/prevalence
 - References
- Validated screening questions
- Helpful tips for introducing the topic to patients
- Additional screening tools and surveys
- Resources for patients who screen positive
- ICD-10 Z codes
- How to contact IPRO for technical assistance



Contact Information

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<https://qi.ipro.org>

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Free Training: Nursing Home COVID-19 Preparedness Read More

As the **IPRO QIN-QIO**, we bring together communities of healthcare providers across the care continuum, stakeholders, and patients in data-driven initiatives to achieve national health quality goals.

As the **IPRO HQIC**, we provide targeted quality improvement assistance to small, rural, critical access hospitals, and additional hospitals requiring technical assistance.

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Creating an Optimal
Environment for Quality
Healthcare for Individuals,
Families, and Communities

Supporting Hospitals to Screen for and Address Social Drivers of Health

Lessons from Convergence Health's Sociotechnical Approach

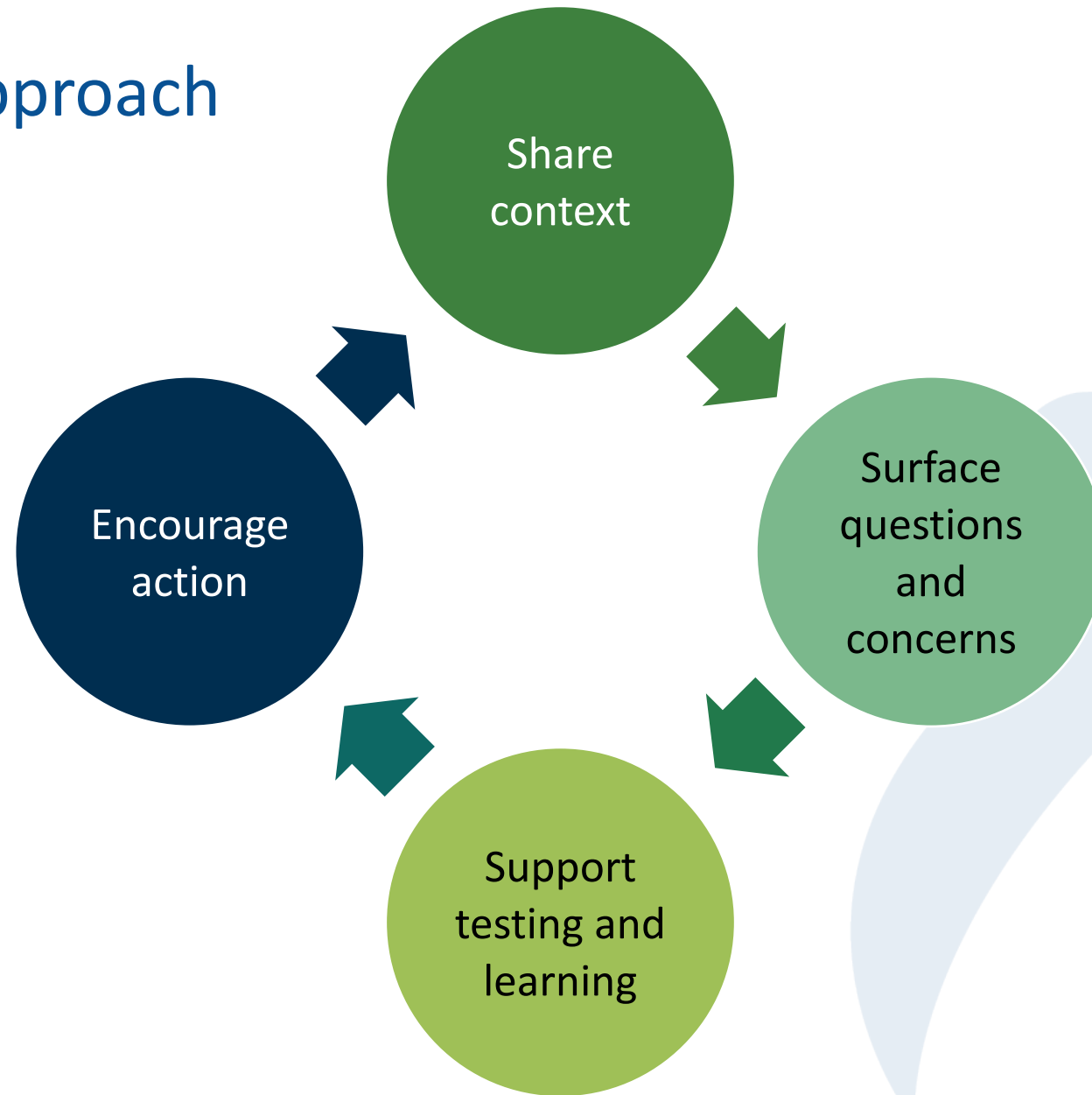
*Presented by: Natalie Graves, Convergence Health Consulting (HQIC)
(Hospital Quality Improvement Contractor)
CMS Quality Conference, April 2024*







Convergence's Approach



“These are complex, nonlinear, and open work systems, so it’s not straightforward to model them,” she says. “It’s hard to predict what will happen next. You’ve got individuals with a variety of educational levels and skillsets, teamwork, organizational culture, and physical environment, all interacting with sophisticated technologies. All of that needs to be designed, and often redesigned given the dynamic nature of work, so we can improve processes and, as a result, improve outcomes.”

Convergence SDOH Support, 2022-2024

Goals

1. Share context
2. Surface questions and concerns
3. Support testing and learning
4. Encourage action

Approach

1. Webinars to review CMS requirements; Mini-course
2. Storming sessions; Online Community; Listserv
3. Mini-course; Webinars with hospital speakers; Data Collection Tool
4. Ask questions that don't yet have answers

What We're Learning

This is (still) new
and complex

Describe your
“why”

An interdisciplinary
approach is a must

Engage patients
and families in
every step

Screening won't
solve all challenges
but it shines a light
on needs

Support is needed
to translate data
into action

2022: Focus on the Practicalities

	Hospital Commitment to Health Equity	SDOH-1 and SDOH-2
Reporting Process	Inpatient Quality Reporting program: https://qualitynet.cms.gov/inpatient/iqr	
Optional Reporting Period	N/A	CY2023
Mandatory Reporting Period	CY2023	CY2024
Publicly Reported?	Yes	No
IQR Guidance Docs/FAQ	https://qualitynet.cms.gov/files/6481de126f7752001c37e34f?filename=AttstGdnceHCHEM_eas_v1.1.pdf	https://qualitynet.cms.gov/files/643473d9a484cd0017883d92?filename=SDOH_Measure_FAQs_April2023.pdf
IQR Specifications	https://qualitynet.cms.gov/files/6481de2304f753001cd056d1?filename=HCHEStrctMeasSpecs_v2.1.pdf	https://qualitynet.cms.gov/files/643473c59920e9001651eddf?filename=ScrnSocDrvrs_Scrn_Pos_Specs.pdf
Resources	https://blog.medisolv.com/articles/a-guide-to-cms-new-health-equity-measure	https://blog.medisolv.com/articles/intro-cms-sdoh-measures

2023: Focus on People and How to Build Trust



Engaging Patient Family Partners in SDOH Screening Programs

VS



Recommendations from Patient Family Partners

- How can I engage patients and families in designing my SDOH screening program?
 - Share the goals of the screening program with your patient family partners and ask about concerns or new ideas
 - Explore existing resources in the community that you can refer to and/or partner with
 - Co-design scripts or messaging about SDOH screening programs with patient and family advisory council members
 - Host listening sessions with people with lived experience to identify potential adjustments that could meet community needs
 - Share your plans with community-based organizations or social service agency leaders and invite feedback and ideas
 - Convene community meetings to address common social drivers of health

Tips for 2024 Screening: Building Trust

- In the inpatient setting, face-to-face conversations may be best
- Let the patient know why you're asking
- Ask the same question multiple ways and give context
- Scripting helps, but so does practice
- It is ok to ask even if you don't have all of the answers or a clear solution

2024: Interpreting Data and Taking Action

- Consider how to take action at two levels:
 - One patient at a time
 - Community or population health view
- Support hospitals to:
 - Aggregate and analyze data
 - Work with partners in new ways
 - Make headway on complex challenges



