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

COMMUNITIES

FAMILIES

INDIVIDUALS

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READY

Supporting equity at scale across HQIC-enrolled hospitals

Nicole Ford, MBA, CPHQ

Project manager, Healthcare Association of New York State

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.

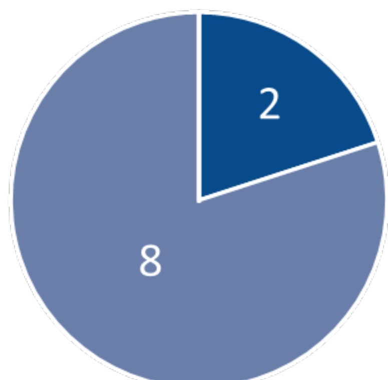
EQIC is an initiative of HANYS in partnership with other state hospital associations to support member hospitals' improvement work with education, tools, resources and direct project management as part of the CMS Hospital Quality Improvement Contract.

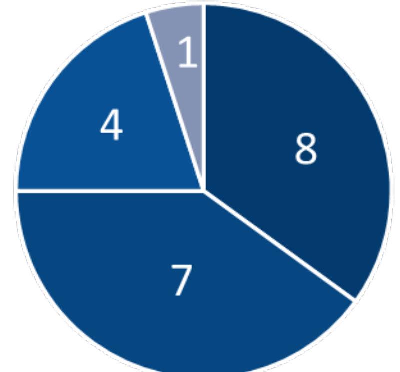
EQIC PARTNERS

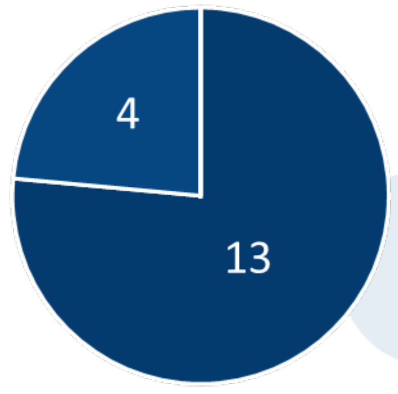
- Connecticut Hospital Association
- Foundation for Healthy Communities/ New Hampshire Hospital Association
- North Carolina Healthcare Foundation
- Vermont Association of Hospitals and Health Systems
- Vermont Program for Quality in Health Care, Inc.
- West Virginia Hospital Association

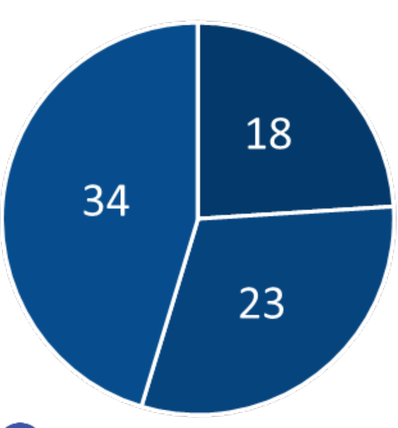
EQIC hospitals

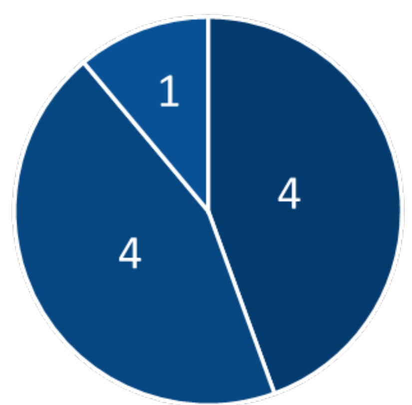
Hospital totals	
Connecticut	10
North Carolina	20
New Hampshire	17
New York	75
Vermont	9
West Virginia	30
Grand total	**161**

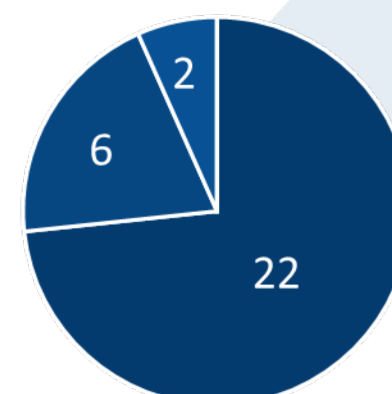












- CAH
- Rural IPPS
- Urban
- Tribal

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.

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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.	○	○	○	
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.	○	○	○	
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.	○	○	○	
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.	○	○	○	

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: FULLY	PARTIALLY	NONE	ACTION PLAN/ NEXT STEPS List specific activities your team will seek to accomplish to fully implement each practice recommendation
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 clinical care and services, including within operations/ 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 mechanism) with key stakeholders.	Transparently sharing health equity data (i.e., REaL stratified, patient experiences, outcomes and quality data) helps to identify clinical 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.	○			

HEALTH EQUITY GAP ANALYSIS

ELEMENT	BEST PRACTICE RECOMMENDATION	IMPLEMENTATION STATUS: FULLY	PARTIALLY	NONE	ACTION PLAN/ NEXT STEPS List specific activities your team will seek to accomplish to fully implement each practice recommendation
DATA COLLECTION AND UTILIZATION					
Hospital collects and utilizes data about the demographic and socioeconomic status of patient population(s) 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 (e.g., 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 >90%).	Standardized processes are in place to both evaluate the accuracy and completeness (percent of fields completed) of self-reported REaL data, including petcent 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 outcome 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 measure(s) 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 EQUITY GAP ANALYSIS

ELEMENT	BEST PRACTICE RECOMMENDATION	IMPLEMENTATION STATUS: FULLY	PARTIALLY	NONE	ACTION PLAN/ NEXT STEPS List specific activities your team will seek to accomplish to fully implement each practice recommendation
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 to maximize cross-sector partnerships and meet patients' and communities' needs.	Effective, sustainable partnerships between healthcare 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 scalability) are key to addressing social needs, optimizing patient navigation strategies and improving overall health and well-being of individuals and communities served.	○	○	○	

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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

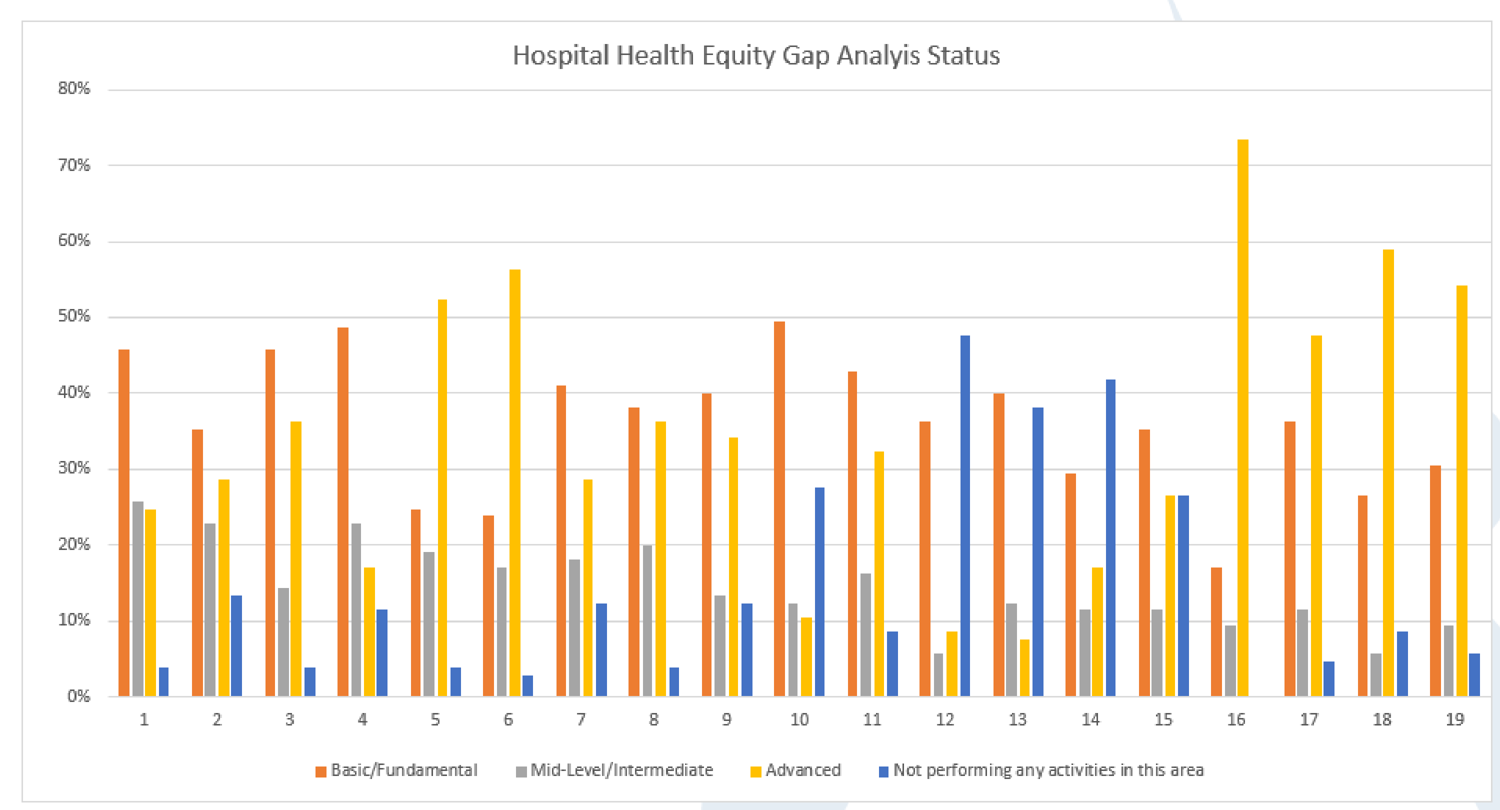
Results

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



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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.

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

A Practical Approach to Hospital Health Equity Implementation

COMMUNITIES

FAMILIES

INDIVIDUALS

READY

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

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!

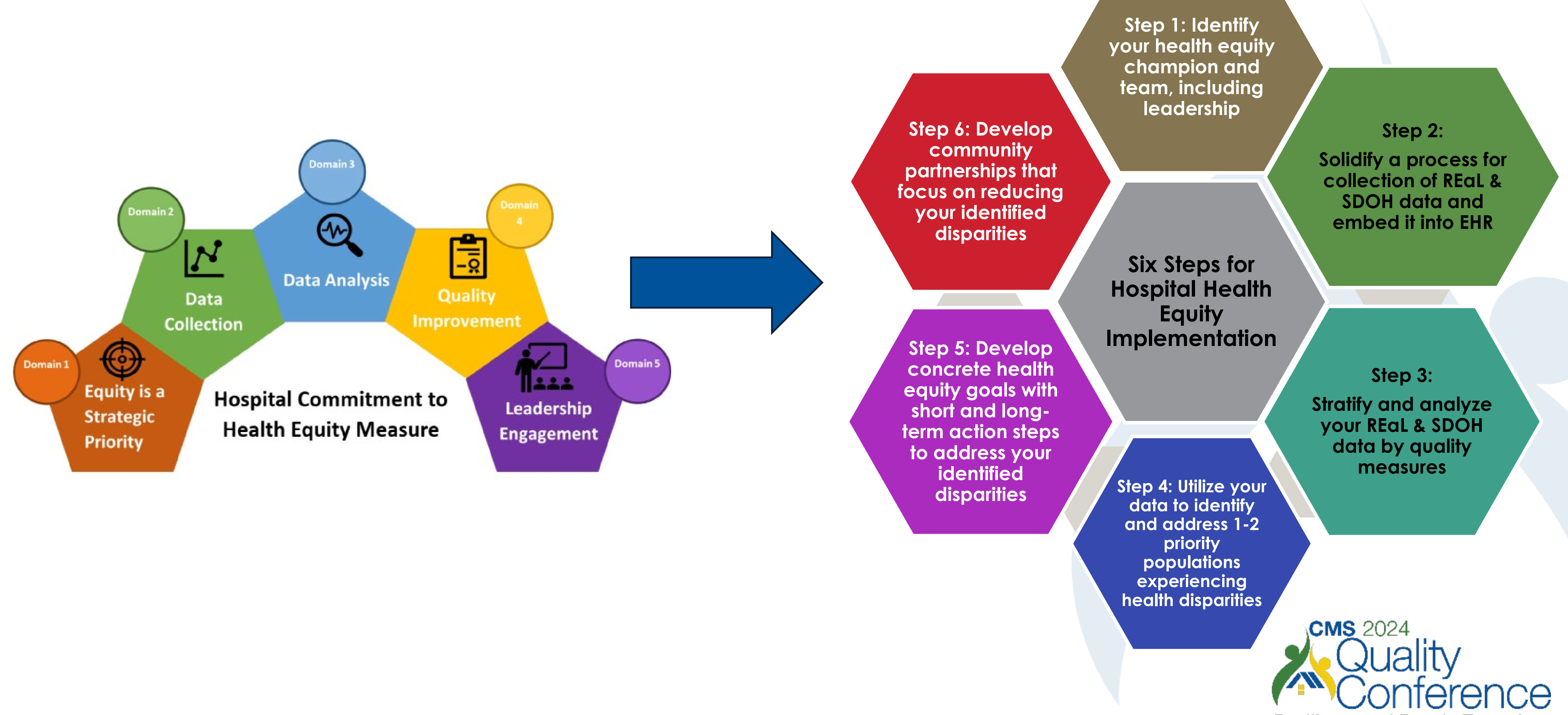
LeAnn Pritchett, MSN RN CPHQ
System Director of Quality & Safety
Tift Regional Medical Center - Southwell

- 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.

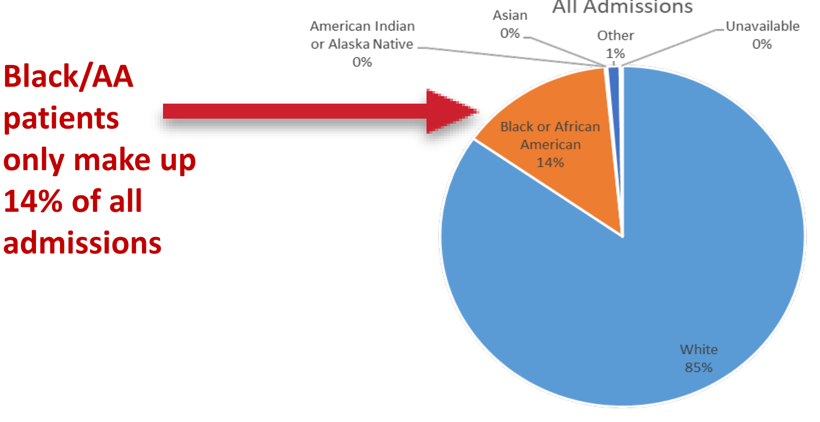
AHS Six Step Model for Hospital Health Equity Implementation



Tift Regional Medical Center Identifies Inequities in Readmissions

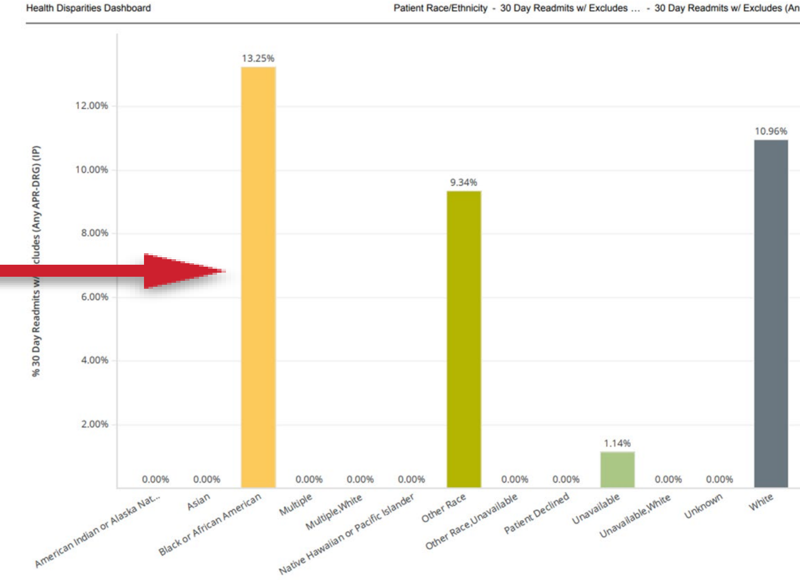
1. All Admissions by Race/Ethnicity

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



2. All Readmissions by Race/Ethnicity

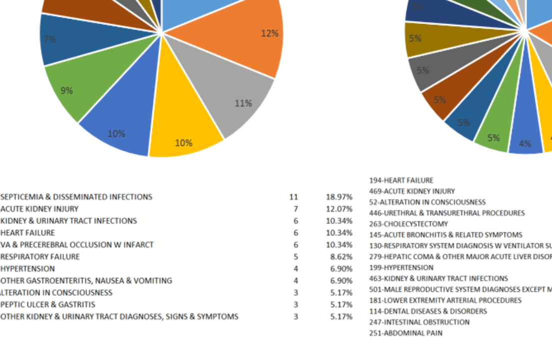
However, Black/AA patients disproportionately make up the largest % of readmissions at 13%



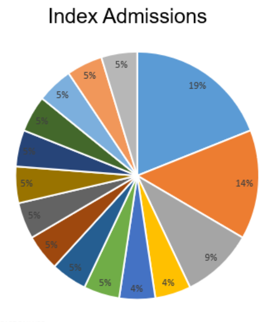
3. Black/African American Males Readmissions, Heart Failure

Top 10 APR-DRG – AA Male

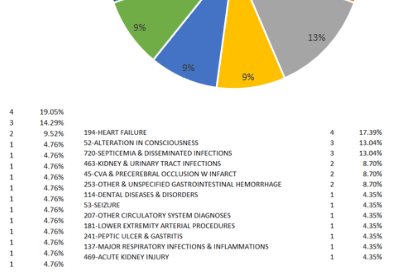
All Admissions



APR-DRG	Count	%
720-SEPTICEMIA & DISSEMINATED INFECTIONS	11	18.97%
469-ACUTE KIDNEY INJURY	7	12.07%
463-KIDNEY & URINARY TRACT INFECTIONS	6	10.34%
194-HEART FAILURE	6	10.34%
45-CVA & PRECEREBRAL OCCLUSION W INFARCT	6	10.34%
133-RESPIRATORY FAILURE	5	8.62%
199-HYPERTENSION	4	6.90%
249-OTHER GASTROENTERITIS, NAUSEA & VOMITING	4	6.90%
52-ALTERATION IN CONSCIOUSNESS	3	5.17%
241-PEPTIC ULCER & GASTRITIS	3	5.17%
468-OTHER KIDNEY & URINARY TRACT DIAGNOSES, SIGNS & SYMPTOMS	3	5.17%



Index Admissions



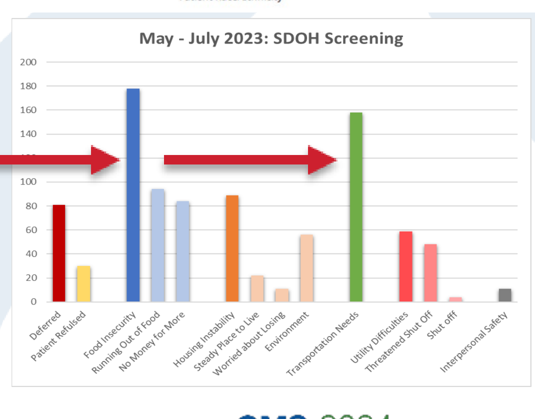
APR-DRG	Count	%
194-HEART FAILURE	4	19.05%
469-ACUTE KIDNEY INJURY	3	14.29%
52-ALTERATION IN CONSCIOUSNESS	2	9.52%
446-URETHRAL & TRANSURETHRAL PROCEDURES	1	4.76%
263-CHOLECYSTECTOMY	1	4.76%
145-ACUTE BRONCHITIS & RELATED SYMPTOMS	1	4.76%
130-RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	1	4.76%
279-HEPATIC COMA & OTHER MAJOR ACUTE LIVER DISORDERS	1	4.76%
199-HYPERTENSION	1	4.76%
463-KIDNEY & URINARY TRACT INFECTIONS	1	4.76%
501-MALE REPRODUCTIVE SYSTEM DIAGNOSES EXCEPT MALIGNANCY	1	4.76%
181-LOWER EXTREMITY ARTERIAL PROCEDURES	1	4.76%
114-DENTAL DISEASES & DISORDERS	1	4.76%
247-INTESTINAL OBSTRUCTION	1	4.76%
251-ABDOMINAL PAIN	1	4.76%

Readmissions Visits Only

APR-DRG	Count	%
194-HEART FAILURE	4	17.39%
52-ALTERATION IN CONSCIOUSNESS	3	13.04%
720-SEPTICEMIA & DISSEMINATED INFECTIONS	3	13.04%
463-KIDNEY & URINARY TRACT INFECTIONS	2	8.70%
45-CVA & PRECEREBRAL OCCLUSION W INFARCT	2	8.70%
253-OTHER & UNSPECIFIED GASTROINTESTINAL HEMORRHAGE	2	8.70%
114-DENTAL DISEASES & DISORDERS	1	4.35%
53-SEIZURE	1	4.35%
207-OTHER CIRCULATORY SYSTEM DIAGNOSES	1	4.35%
181-LOWER EXTREMITY ARTERIAL PROCEDURES	1	4.35%
241-PEPTIC ULCER & GASTRITIS	1	4.35%
137-MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS	1	4.35%
469-ACUTE KIDNEY INJURY	1	4.35%

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



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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	• **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	• 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	• 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	• Improved data analytics to better understand causal link between SDOH and patient outcomes and action plan	11/30/ 2023
Implement Best Practices	• 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	• 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

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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/

ALLIANT HEALTH SOLUTIONS | HQIC

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:

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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: ____________

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quality.alliantheath.org

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https://quality.alliantheath.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/nqiic/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

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 (GA) 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.

Six Steps to Hospital Health Equity Action Planning
- Step 1: Identify your health equity champion and team, including leadership
- Step 2: Solidify a process for collection of REaL & SDOH data and embed it into EHR
- Step 3: Stratify and analyze your REaL & SDOH data by quality measures
- Step 4: Utilize your data to identify and address 1-2 priority populations experiencing health disparities
- Step 5: Develop concrete health equity goals with short and long-term action steps to address your identified disparities
- Step 6: Develop community partnerships that focus on reducing your identified disparities

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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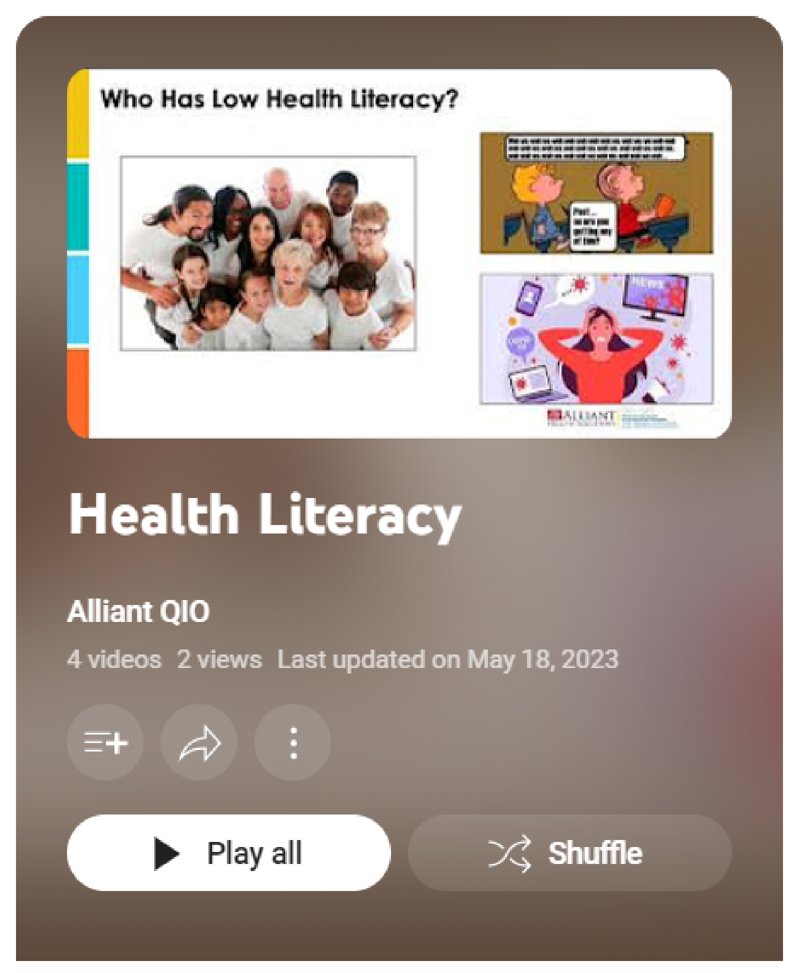
FEATURED SPEAKERS:

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

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



1

Health Literacy with Dr. Iris Feinberg, PhD, CHES
Alliant QIO • 116 views • 3 months ago

2

Bite-Sized Learning: Using Teach-Back
Alliant QIO • 26 views • 8 days ago

3

Bite-Sized Learning: CLAS 101
Alliant QIO • 37 views • 1 month ago

4

Bite-Sized Learning: CLAS Implementation
Alliant QIO • 38 views • 1 month ago

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

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

COMMUNITIES

FAMILIES

INDIVIDUALS

RESILIENT

READY

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

Laura Benzel, MS, BS, CSSGB

IPRO Health Equity Lead

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

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

IPRO HEALTH EQUITY TASK FORCE

IPRO HEALTH EQUITY TASK FORCE

Health Equity Strategy

- Technical Assistance
- Staff Training & Collaboration
- Data-Driven Reports, Tools & Dashboards
- Multimedia Resources Development & Dissemination
- Learning & Action Networks
- Health Equity Presentations

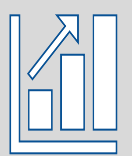
Health Equity Organizational Assessment (HEOA)

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

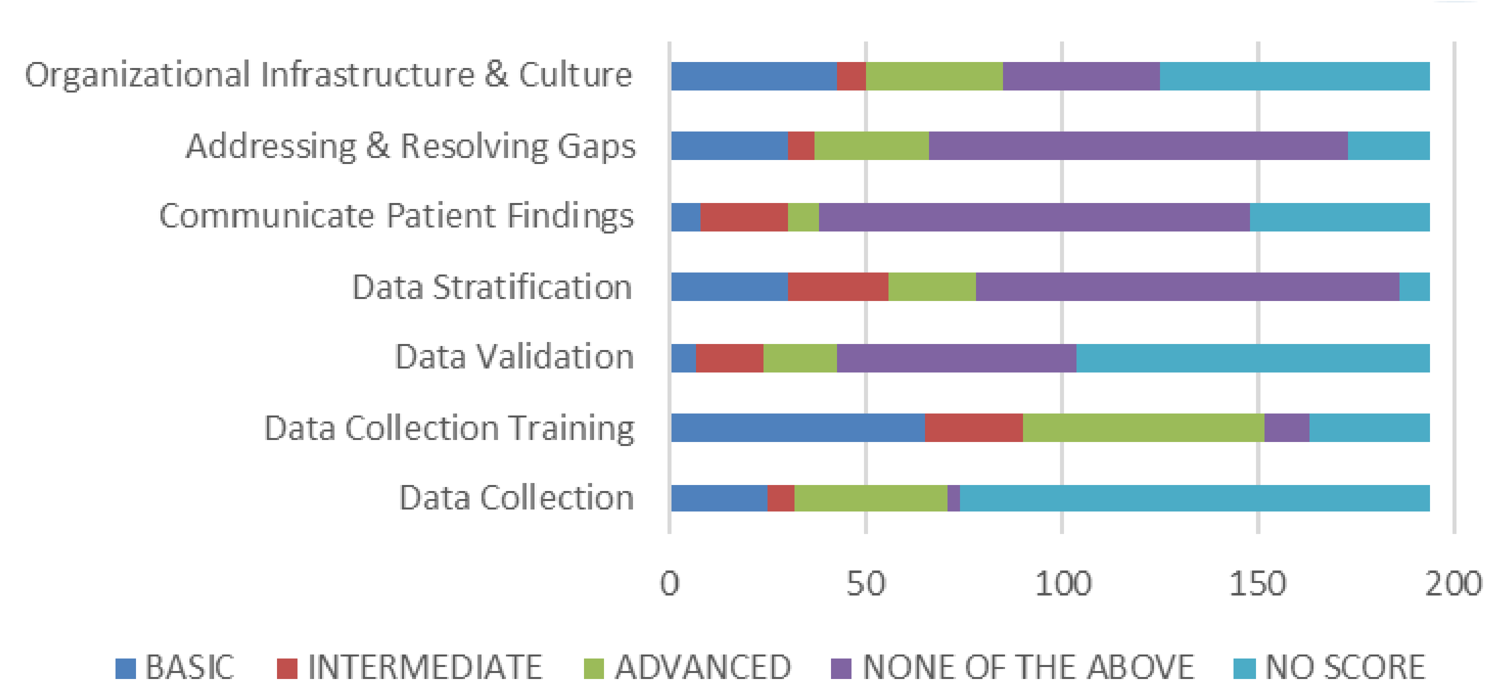
Organizations complete the online HEOA Assessment and use the IPRO Report to identify opportunities for improvement

- 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.

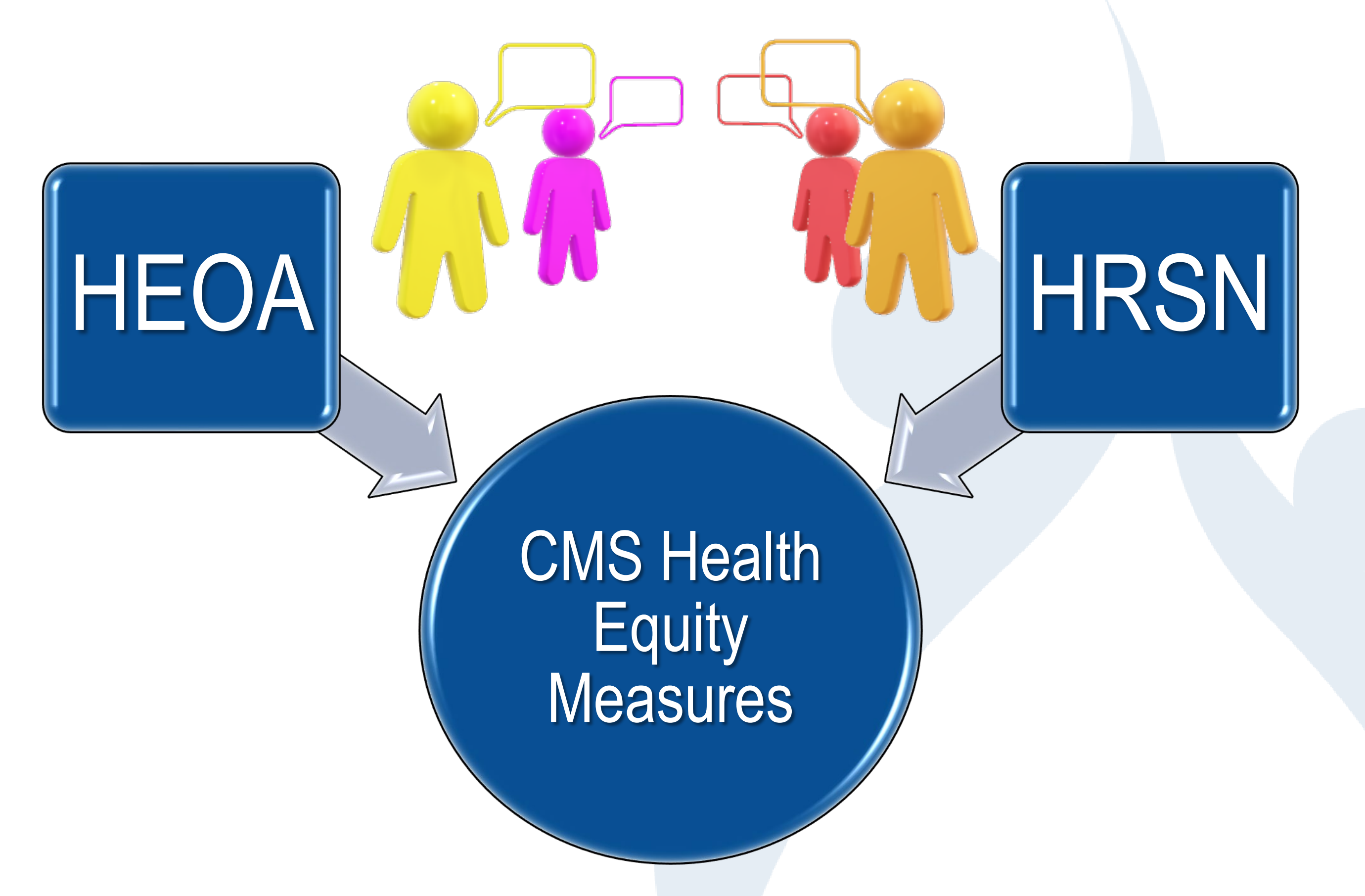


HQIC HEOA Aggregate Results



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

CMS 2024 Quality Conference
Resilient and Ready Together

Assessment Results

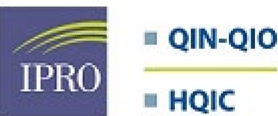
Does your facility collect REaL data?

Does your facility collect REaL Data?

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

2019
2021Q3
2021Q4
2022Q1
2022Q2
2022Q3
2022Q4
2023Q1
2023Q2

I don't know
No plans to implement
No, but will be implemented in the future
Yes, but a work in progress
Yes, successfully implemented



Does your facility use data to identify gaps in care?

Does your facility use data to identify gaps in care?

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

2019 2021Q3 2021Q4 2022Q1 2022Q2 2022Q3 2022Q4 2023Q1 2023Q2

I don't know | No plans to implement | No, but will be implemented in the future | Yes, but a work in progress | Yes, successfully implemented

Does your facility collect SDOH data?

Does your facility collect SDOH data?

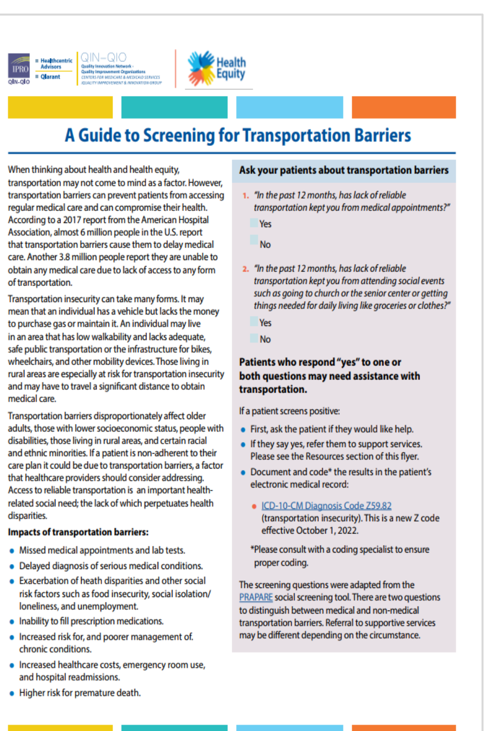
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

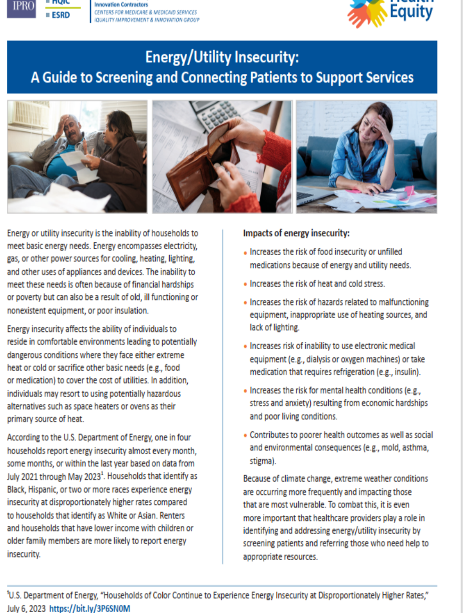
2019 | 2021Q3 | 2021Q4 | 2022Q1 | 2022Q2 | 2022Q3 | 2022Q4 | 2023Q1 | 2023Q2

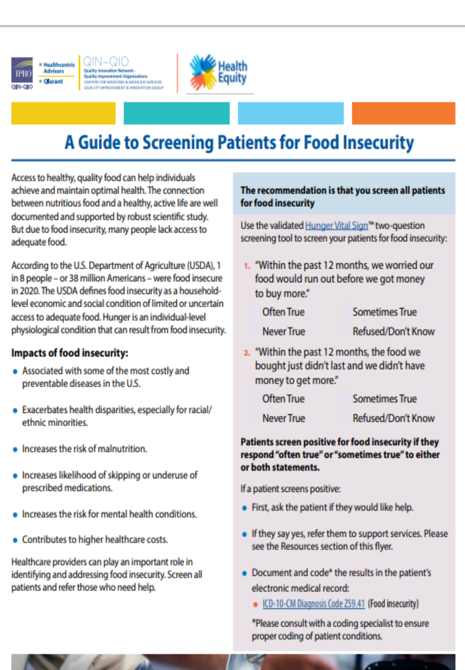
I don't know | No plans to implement | No, but will be implemented in the future | Yes, but a work in progress | Yes, successfully implemented

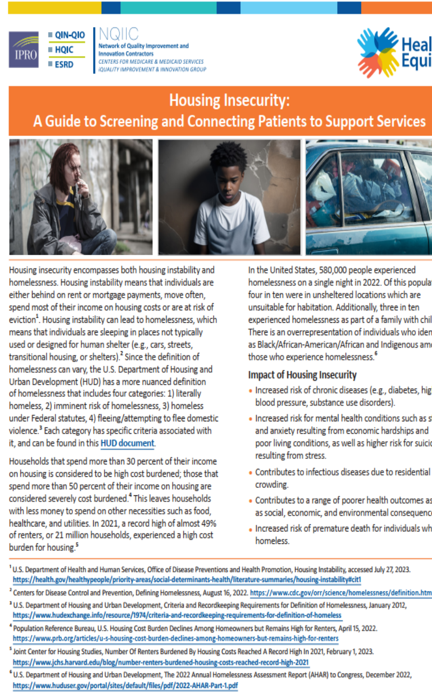
Social Drivers of Health Resources

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


A Guide to Screening for Transportation Barriers


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


A Guide to Screening Patients for Food Insecurity


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

[HQIC Resource Library (ipro.org)](https://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

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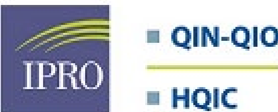
Contact Information

IPRO Health Equity Lead

Laura Benzel

Qlarant

benzell@qlarant.com



Connect with us!

https://qi.ipro.org

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Working to ensure high-quality, safe, and effective health care.

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.

View Events | View our Blog

Highlighted Blog Posts

We've added new COVID-19 resources — Read More

Free Training: Nursing Home COVID-19 Preparedness — Read More

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

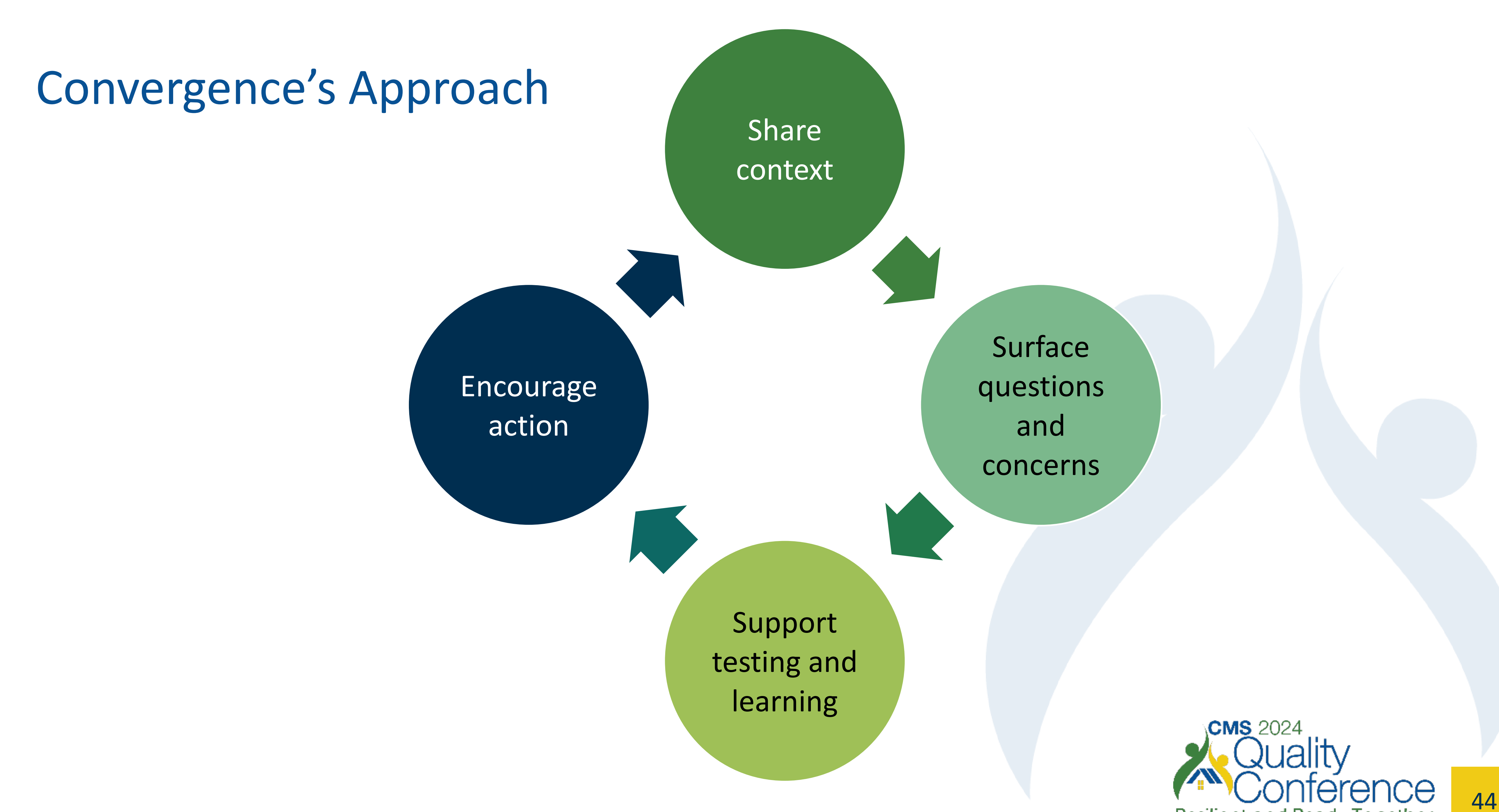
Supporting Hospitals to Screen for and Address Social Drivers of Health

Lessons from Convergence Health's Sociotechnical Approach

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

CMS 2024
Quality
Conference
Resilient and Ready Together

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=AttstGdnceHCHEMeas_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

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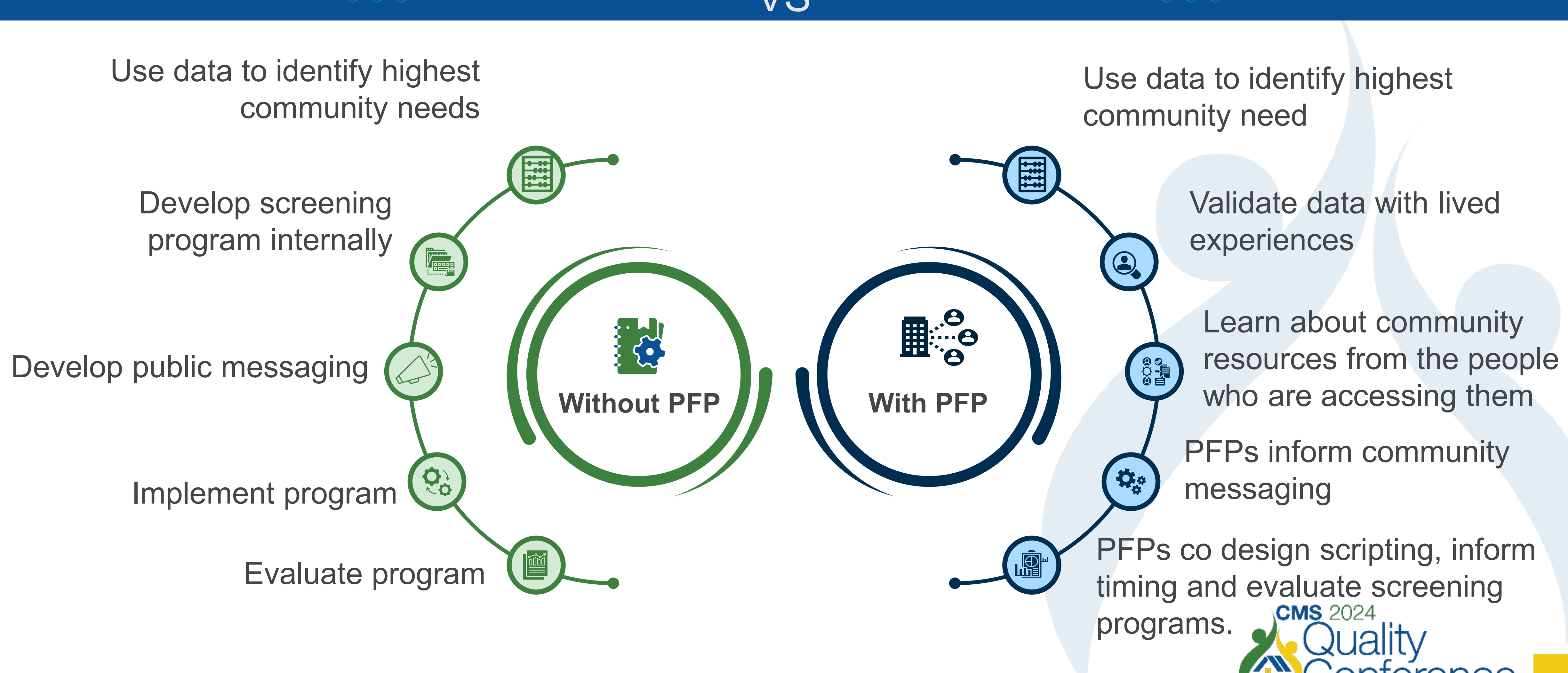
Engaging Patient Family Partners in SDOH Screening Programs



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

PLEASE
WAIT FOR
DIAL TONE
1
ABC 2
DEF 3
GHI 4
JKL 5
MNO 6
PRS 7
TUV 8
WXY 9
0 OPERATOR