Sample Guide for Completing Priority Area Fields in the HCAI Hospital Equity Report

Suggested Structure for Each Section

1. Overview - What this area means in your hospital's context
2. Equity Considerations - How you integrate equity in this domain
3. Programs & Practices - Specific initiatives or interventions
4. Performance Data - Metrics, trends, disparities
5. Improvements & Plans - What you're doing to improve, with timelines
6. Community Partnerships - If applicable

1. Person-Centered Care

Definition: Care that is respectful of and responsive to individual patient preferences, needs, and values.

Prompts to Consider:

- How are patient voices incorporated into care planning?
- Do you collect and act on patient experience data by race/ethnicity/language?
- Are interpreters and culturally tailored materials consistently available?

Example:

We screen all patients for language preference and use qualified interpreters for 98% of non-English encounters. Our advisory councils include diverse community members who co-design discharge instructions to improve cultural relevance.

2. Patient Safety

Definition: Minimizing risks and harm to patients during care delivery.

Prompts to Consider:

- Do your safety metrics (e.g., falls, medication errors) vary by demographic group?
- What equity-focused training or protocols are in place to prevent harm?
- How do you engage patients and families in safety?

Example:

CLABSI and pressure injury rates are reviewed quarterly by race and insurance type. Disparities identified in fall rates among Spanish-speaking elders led to staff retraining and redesigned signage.

3. Addressing Patient Social Determinants of Health

Definition: Screening for and responding to factors like housing, food, income, and transportation.

Prompts to Consider:

- Do you screen for SDOH? What tool do you use?
- How do you refer patients to community resources?
- What populations experience unmet needs?

Example:

In 2024, we screened 82% of admitted patients using the PRAPARE tool. Food insecurity was highest among Medi-Cal patients. We refer to the county's community food network and now fund a part-time SDOH navigator.

4. Effective Treatment

Definition: Providing evidence-based, timely, and appropriate clinical care.

Prompts to Consider:

- Are there disparities in guideline-concordant treatment?
- How is equity built into clinical decision support?
- What performance metrics show variation by subgroup?

Example:

Heart failure patients with LEP had lower rates of discharge beta-blocker prescriptions. After EHR alert modifications and provider education, the gap closed by 60%.

5. Care Coordination

Definition: Ensuring care is organized across providers, settings, and time.

Prompts to Consider:

- How do you ensure smooth transitions (e.g., hospital to home) for diverse populations?
- Do you use patient navigators or community health workers?
- Are there disparities in follow-up rates?

Example:

Black and unhoused patients had lower post-discharge primary care visit completion. We launched a CHW-led coordination program that increased follow-up by 40% among this group.

6. Access to Care

Definition: The ability of patients to obtain timely, culturally appropriate services.

Prompts to Consider:

- What are the barriers (e.g., transportation, hours, insurance)?

- Are there disparities in wait times or appointment availability?
- How have you adjusted services to improve access?

Example:

LGBTQ+ patients reported difficulty accessing affirming mental health care. We expanded telehealth options and recruited two new providers with expertise in this area.

General Tips

- Be specific: Name programs, dates, data points.
- Show trends: If metrics improved, say by how much.
- Tie to equity: Always explain how efforts affect diverse or vulnerable populations.
- Use patient voice: Include quotes, satisfaction trends, or engagement approaches if available.