Building CMS-Compliant Health Equity Programs

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Conflict of Interest Disclosure

Christine Martini-Bailey, MSN, RN, CSSGB reported no relevant financial relationships or relationships she has with ineligible companies of any amount during the past 24 months.

Building a CMS Compliant Health Equity Program

October 16, 2023

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Objectives

1. Define health equity and discuss disparities and social determinants as related to addressing health equity.
2. Discuss importance of health equity in the national CMS Quality Strategy.
3. Review the new CMS Health Equity Metrics.
4. Identify strategies to advance health equity and meet the CMS metrics.

CMS = Centers for Medicare & Medicaid Services

HSAG:
Who Are We?

About

We Are on a Mission to Make Healthcare Better

Since our beginning in 1979, HSAG has been committed to improving the quality of healthcare services in order to achieve the best possible patient outcomes.

We provide:

- **Healthcare quality expertise to those who deliver care and those who receive care.**
- **Tools and resources for patients, families, and caregivers to be advocates for their own health.**

Quality: It's Who We Are and What We Do

We embody quality in all we do: in the services we provide, in the knowledge we share, and in the relationships we build with providers, patients, families, and caregivers. Quality is our way of doing business, and directs all of our actions and work.

HSAG Business Lines

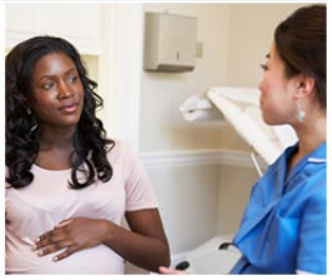
Medicare Quality Improvement (QIO)

Hospital Quality Improvement (HQIC)

End Stage Renal Disease (ESRD) Networks

Healthcare Policy and Quality Measurement

Medicaid External Quality Review (EQR)



Data Science & Advanced Analytics

Surveys

Audit and Validation Services

What Is Health Equity?

Health Equity

Health equity is achieved when every person has the opportunity to attain his or her full health potential and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances." —Centers for Disease Control and Prevention (CDC)

- Length of life
- Rates of disease, disability, and death
- Severity of disease
- Access to treatment

CDC. National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP). Available at https://www.cdc.gov/chronicdisease/healthequity/index.htm.

What Are Health Disparities?

Health Disparities

*"**Health disparities** are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by populations that have been disadvantaged."* —CDC

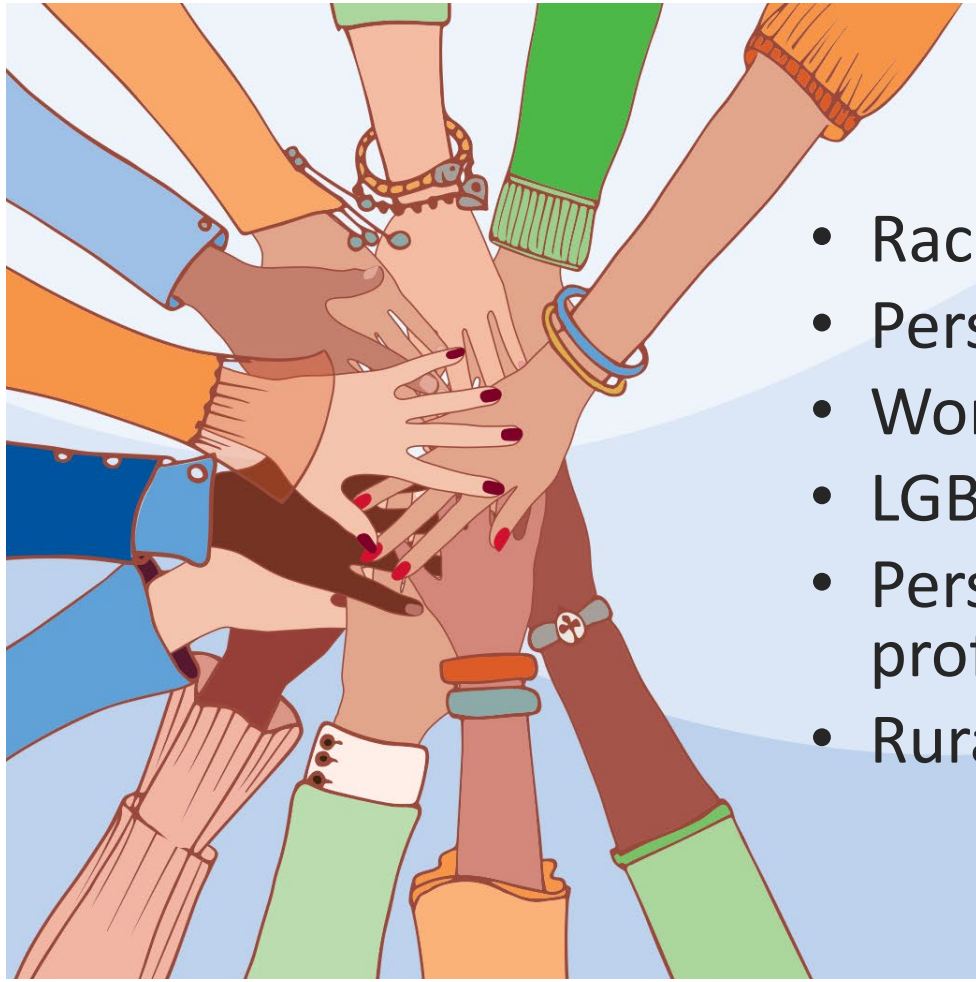
Some racial and ethnic minorities experience high rates of poor health and increased rates of chronic conditions.

- Diabetes
- Hypertension
- Obesity
- Asthma
- Heart disease
- Cancer
- Pre-term birth

These disparities exists even when adjusted for demographics and socioeconomic factors.

CDC. What is Health Equity? Available at https://www.cdc.gov/healthequity/whatis/index.html.

Populations Experiencing Disparities



- Racial and ethnic minority groups
- Persons with disabilities
- Women
- LGBTQI+
- Persons with limited English proficiency
- Rural populations

CDC. What is Health Equity? Available at https://www.cdc.gov/healthequity/whatis/index.html.

Social Determinants of Health (SDOH)

What Are SDOH?

Healthy People 2030 describes SDOH as the "conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."

U.S. Dept. of Health and Human Services (HHS). Office of Disease Prevention and Health Promotion (OASH). SDOH. Available at https://health.gov/healthypeople/priority-areas/social-determinants-health.

deBeaumont. Health Affairs: Meeting Individual Social Needs Falls Short of Addressing SDOH. Available at https://debeaumont.org/news/2019/meeting-individual-social-needs-falls-short-of-addressing-social-determinants-of-health.

Social Determinants of Health

- Income and Social Protection
- Education
- Unemployment and Job Insecurity
- Working Life Conditions
- Food Insecurity
- Housing and the Environment
- Early Childhood Development
- Social Inclusions and Non-Discrimination
- Structural Conflict
- Access to Affordable Health Services of Decent Quality

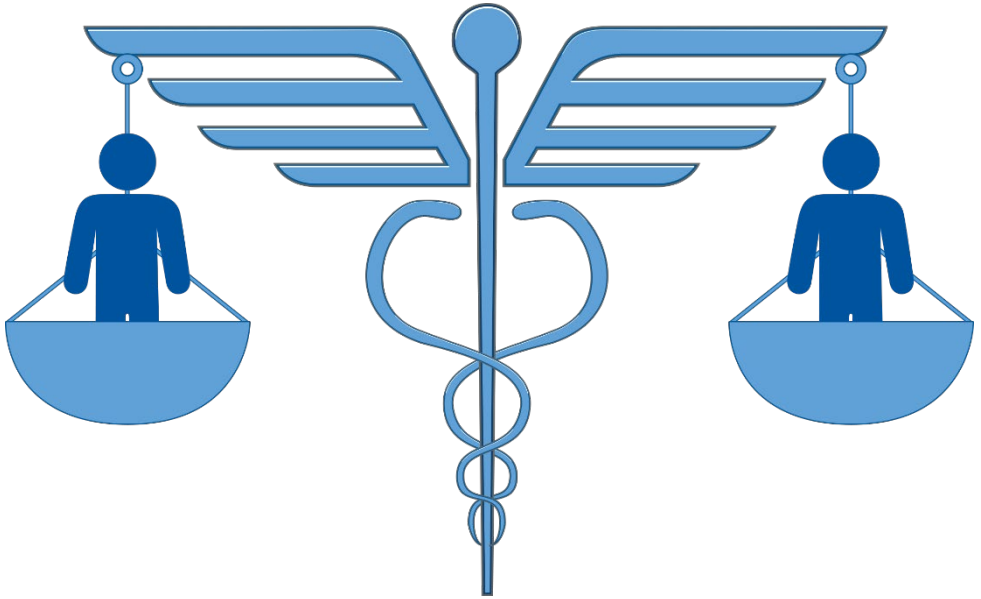
World Health Organization. SDOH. Available at https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.

Individual and Community Needs

Social Needs
(Individual Level)

Social Drivers/Social Determinants
(Community Level)

The Impact of Health Equity



The Impact of Social Determinants of Health

1 in 10 Americans live in poverty with the inability to afford healthcare, healthy food, and housing.[1]

Dual Eligible Patients

(Patients on Medicare and Medicaid)[2]

1.5 times higher hospital utilization

70% higher prescribing of "high-risk" drugs

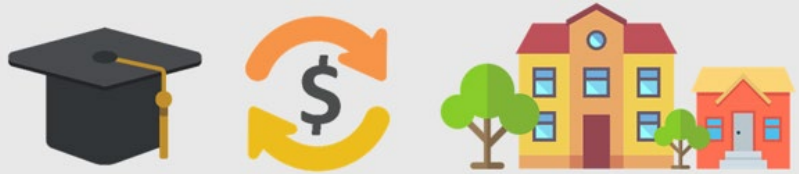
Anticoagulants, glycemic agents, opioids

18% higher avoidable readmissions

1. OASH. Economic Stability. Available at https://health.gov/healthypeople/objectives-and-data/browse-objectives/economic-stability.
2. Heath, S. Health Payer Intelligence xtelligent Healthcare Media. Most Medicare Dual-Eligibles See SDOH. May 29, 2019. Available at https://healthpayerintelligence.com/news/most-medicare-dual-eligibles-see-social-determinants-of-health.

Social Determinants as a Health Care Driver

Social Determinants of Health



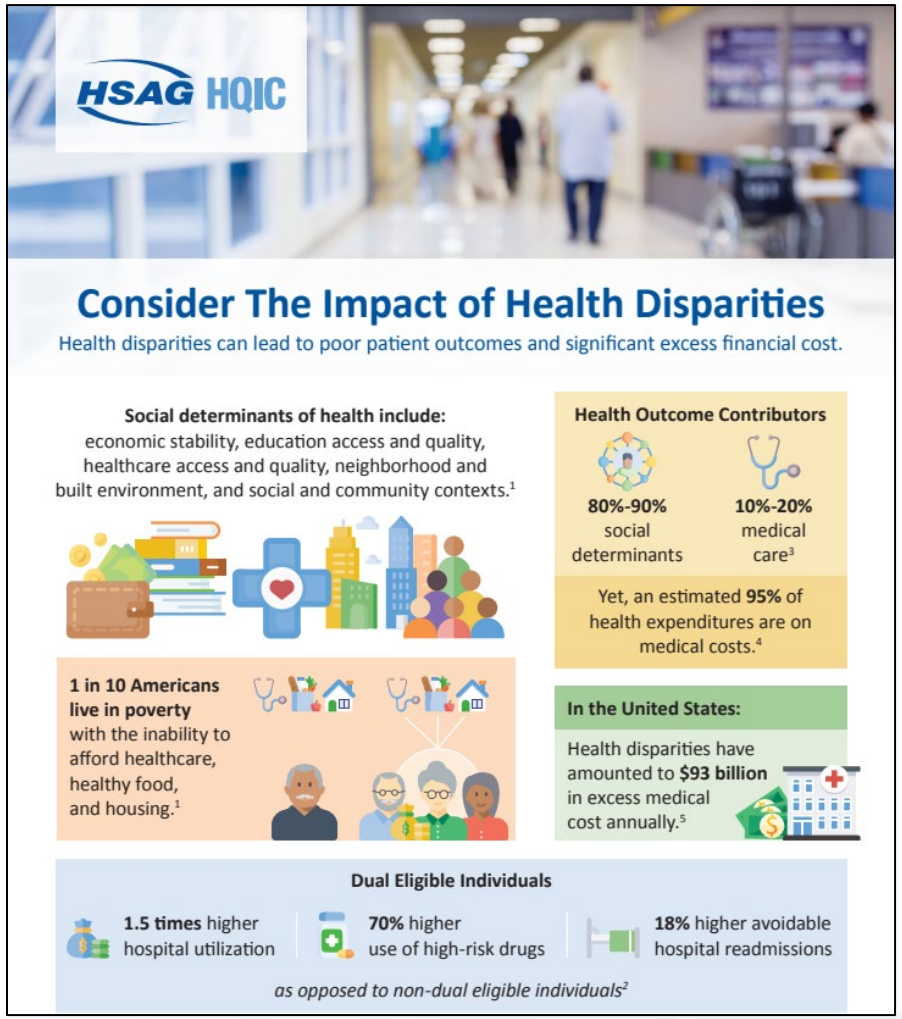
Health Care

80% to 90% of health outcome contributors are social determinants of health.

—National Academy of Medicine

Magnan, S. National Academy of Medicine. SDOH 101 for Health Care: Five Plus Five. Available at https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/.

Key Resource:
HSAG Business Case for Health Equity



- Health equity is a critical focus of health care
- Most leaders and staff are aware of the importance and support initiatives aimed at addressing health equity
- HSAG Business Case for Health Equity highlights the human and financial factors

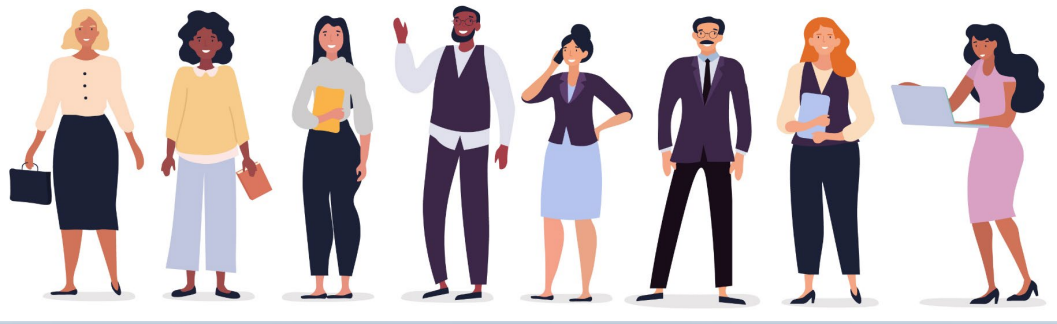
HSAG HQIC. Consider the Impact of Health Disparities. Available at https://www.hsag.com/globalassets/hqic/hqic-healthequity-bizcase.pdf.

CMS Priority

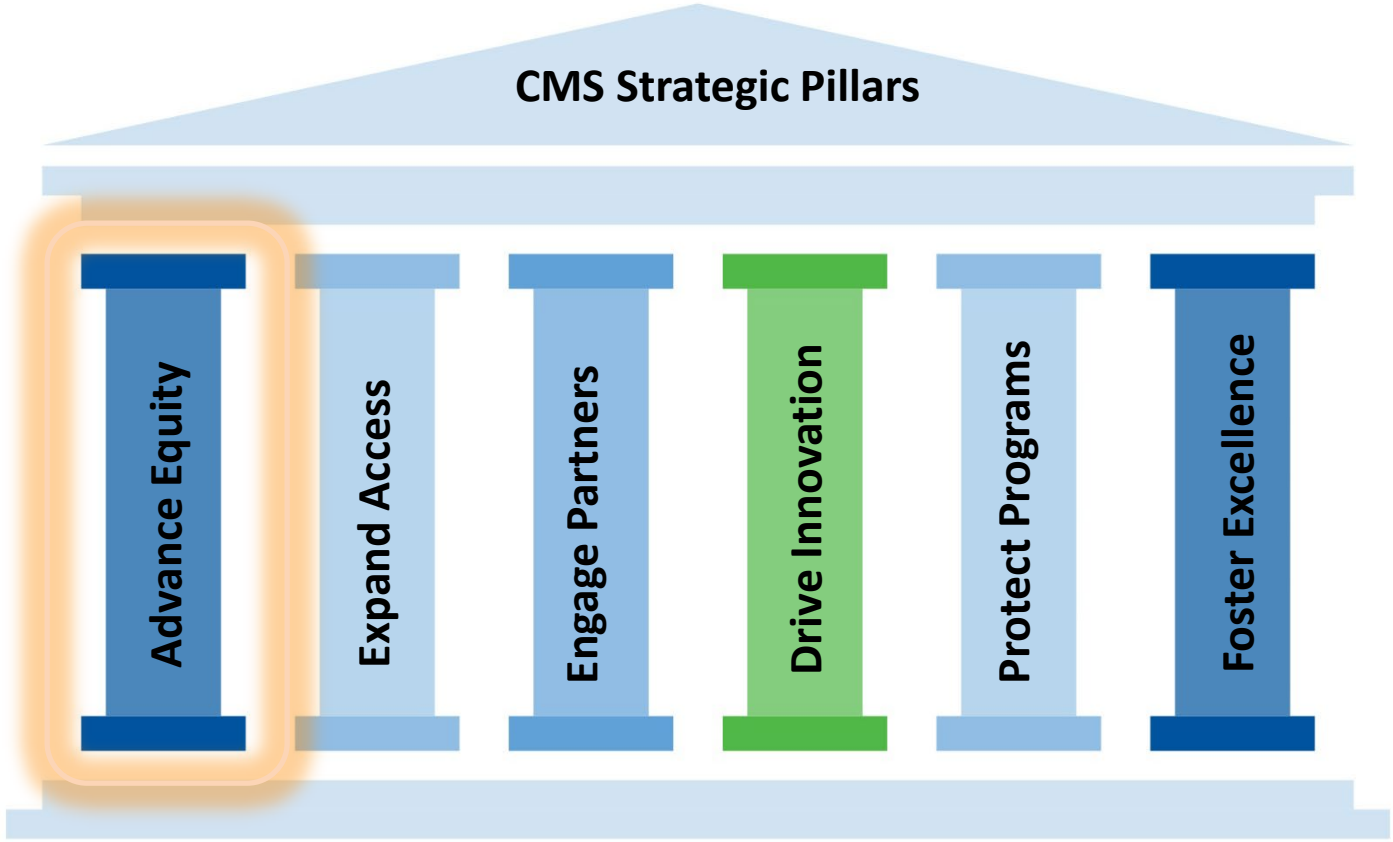
CMS Statement on Health Equity

"As the nation's largest health insurer, the Centers for Medicare & Medicaid Services has a critical role to play in driving the next decade of health equity for people who are underserved. Our unwavering commitment to advancing health equity will help foster a health care system that benefits all for generations to come."

- Dr. LaShawn McIver, Director, CMS Office of Minority Health



CMS Strategic Plan



CMS. CMS Strategic Framework. Available at https://www.cms.gov/files/document/cms-strategic-framework-fact-sheet.pdf.

CMS Framework for Health Equity

CMS. CMS Framework for Health Equity 2022–2032. April 2022. Available at https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf.

CMS Health Equity Measures

Two New CMS Health Equity Measures

Measure 1:
Hospital Commitment to Health Equity

Measure 2:
a. Screening for Social Drivers
b. Screen Positive Rate for Social Drivers

Hospital Commitment to Health Equity

5 Health Equity Commitment Domains[1]
Domain 1: Equity is a Strategic Priority
Domain 2: Data Collection
Domain 3: Data Analysis
Domain 4: Quality Improvement
Domain 5: Leadership Engagement

- Competencies aimed at achieving health equity
- Must meet all elements under each domain
- Structural measure
- Attest via QualityNet
- Begins CY 2023/FY 2025
- Initial submission deadline May 2024[2]
- Annual submission

1: CMS. Hospital Commitment to Health Equity Structural Measures Specifications. Available at https://qualitynet.cms.gov/files/62629ee35e40610016f30140?filename=Hosp_Commit_HlthEqStrct_Meas.pdf.
2: CMS. FY2023 Final Rule IPPS/LTCH PPS Final Rule Overview for Hospital Quality Programs. Available at https://www.qualityreportingcenter.com/globalassets/iqr2022events/iqr9122/fy2023_ipps-final-rule-overview-for-hospital-quality-programs-_vfinal508.pdf.

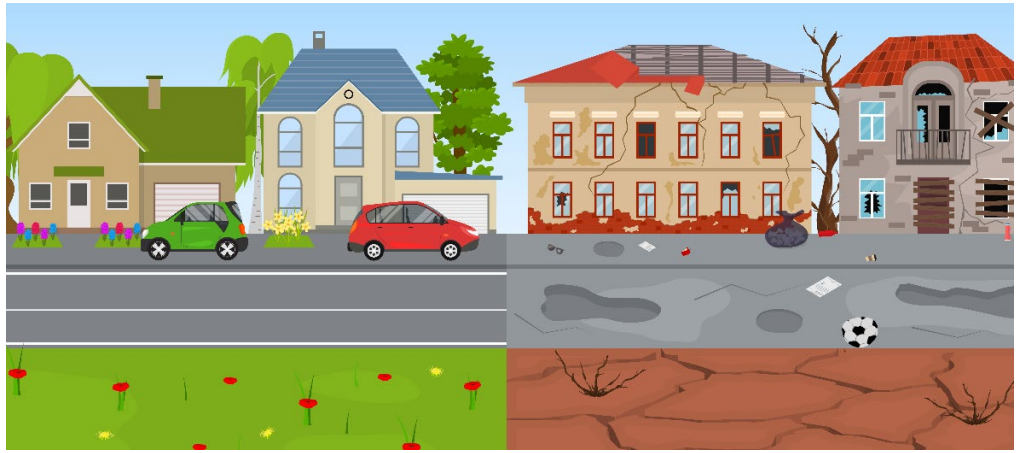
Domain 1: Equity as a Strategic Priority

Must have a strategic plan that:

- Identifies priority populations currently experiencing health disparities
- Identifies health care equity goals and action steps to achieving those goals
- Outlines specific, dedicated resources focused on achieving health equity goals
- Describes approach for engaging key stakeholders and community organizations/resources

Subdomain 1—Priority Populations

- Priority populations differ based on hospital service area
  - Populations could include racial/ethnic minorities, the elderly, the socioeconomically disadvantaged, or others
- Hospitals can use multiple methods to identify priority populations
  - Stratify outcomes data to identify populations experiencing disparities
  - Use the CHNA to identify populations with needs
  - Area Deprivation Index



CHNA = Community Health Needs Assessment

The Joint Commission. Prioritize, Plan and Take Action. Available at www.jointcommission.org/our-priorities/health-care-equity/accreditation-standards-and-resource-center/prioritize-plan-and-take-action/#t=_StrategiesTab&sort=relevancy.

Subdomain 2—Health Care Equity Goals

- Assess outcomes in priority populations and identify areas where improvement can be made
  - Perform a gap analysis to identify any areas of opportunity or disparities in practice
- Set goals for improvement from baseline
  - Ensure goals are SMART
- Identify concrete action steps to work toward goals
  - Enact quality improvement initiatives that address any identified gaps in care

HSAG HQIC. Quality and Safety Series: SMART Goals (PPt). Available at www.hsag.com/globalassets/hqic/qualityseriessmartgoals.pdf.

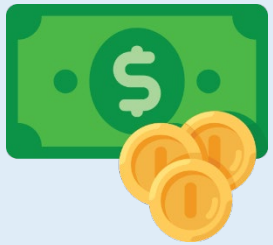
Subdomain 3—Resources

Resources can include:

Personnel

(full-time or part-time)

Chief diversity officer, patient experience staff, community liaison, case managers, social workers, community navigators



Financial resources

Support community projects, provide transportation vouchers, offer flexible and empathic patient financing

Facilities

Provide space for clinics, use hospital facilities for community events

Schooner, H. Health Catalyst. Health Equity: Why It Matters and How to Achieve It. March 6, 2018. Available at www.healthcatalyst.com/insights/health-equity-why-it-matters-how-to-achieve-it.
Spinner, M. Healthcare Financial Management Association (HFMA). 3 ways the patient financial experience can improve health equity. April 25, 2022. Available at www.hfma.org/topics/hfm/2022/may/3-ways-the-patient-financial-experience-can-improve-health-equity.html

Subdomain 4—Engaging Stakeholders

Based on priority populations, hospitals will need to engage different stakeholders:

- Community resource providers
- Faith-based organizations
- Community leadership
- Outside health care providers (primary care, HHAs, SNFs, behavioral health providers)

Hospitals can engage these stakeholders in a variety of ways:

- Participate in/support existing initiatives.
- Invite stakeholders to participate in decision making.
- Increase PFAC/PFE activities at your hospital.
- Use hospital facilities for community events.

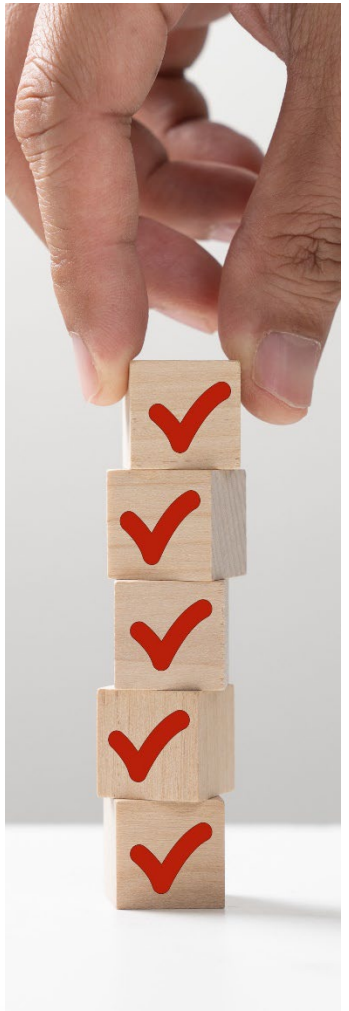
HHA = home health agency
PFAC = patient and family advisory council
PFE = patient and family engagement
SNF = skilled nursing facility

Domain 2: Data Collection

- Collects demographic information including race/ethnicity **and/or** SDOH information on **majority** of patients
- Trains staff in culturally sensitive collection of demographic **and/or** SDOH information
- Inputs demographic **and/or** SDOH information into structured, interoperable data elements using certified electronic health record (EHR)

Collection of REaL Data

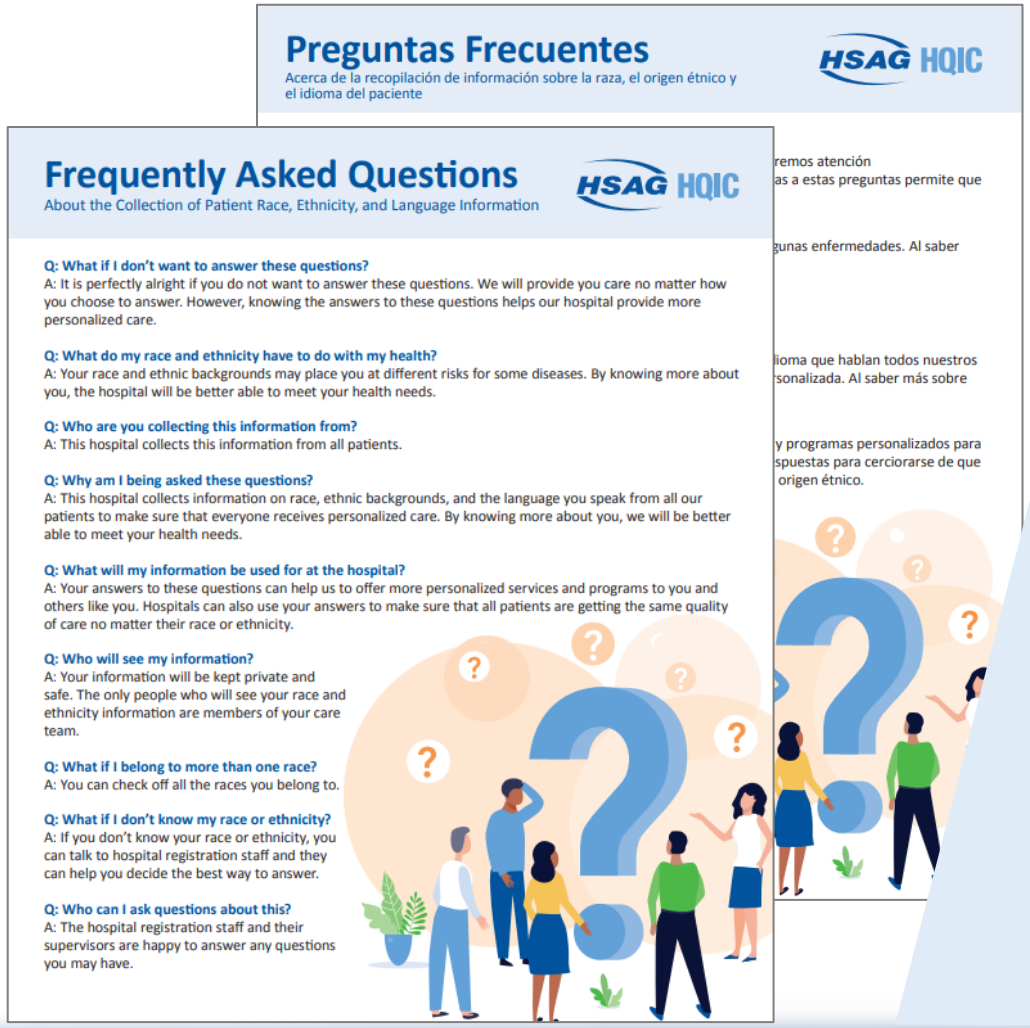
- Self-reported REaL data
  - Patients should be given opportunity to self-disclose
  - Staff should be trained to collect REaL data
- Multiple collection methods can be used
  - Paper forms, tablets, kiosks, or verbal discussion with patients are options
  - Remember health literacy and language barriers
- Multiple staff members involved
  - Typically initial collection during registration
  - Can include bedside/frontline staff
  - Staff with existing relationships with patients and families
- Demographic and SDOH data must be collected in the EHR
  - Can use Z-codes to standardize collection of SDOH



Culturally-Sensitive Data Collection

- Patients can be hesitant or have difficulty sharing information
  - May not understand purpose of REaL data collection
  - May lack trust in hospitals
  - Patients with low literacy or intellectual disabilities may be unable to share the information themselves
- Staff should be trained to collect data in a sensitive, culturally-competent manner
  - HSAG HQIC's Health Equity Quickinar session #7 will focus on culturally-competent data collection

Key Resource: Why Collect REaL Data? Handout



Preguntas Frecuentes

Acerca de la recopilación de información sobre la raza, el origen étnico y el idioma del paciente

HSAG HQIC

Frequently Asked Questions

About the Collection of Patient Race, Ethnicity, and Language Information

HSAG HQIC

Q: What if I don't want to answer these questions?
A: It is perfectly alright if you do not want to answer these questions. We will provide you care no matter how you choose to answer. However, knowing the answers to these questions helps our hospital provide more personalized care.

Q: What do my race and ethnicity have to do with my health?
A: Your race and ethnic backgrounds may place you at different risks for some diseases. By knowing more about you, the hospital will be better able to meet your health needs.

Q: Who are you collecting this information from?
A: This hospital collects this information from all patients.

Q: Why am I being asked these questions?
A: This hospital collects information on race, ethnic backgrounds, and the language you speak from all our patients to make sure that everyone receives personalized care. By knowing more about you, we will be better able to meet your health needs.

Q: What will my information be used for at the hospital?
A: Your answers to these questions can help us to offer more personalized services and programs to you and others like you. Hospitals can also use your answers to make sure that all patients are getting the same quality of care no matter their race or ethnicity.

Q: Who will see my information?
A: Your information will be kept private and safe. The only people who will see your race and ethnicity information are members of your care team.

Q: What if I belong to more than one race?
A: You can check off all the races you belong to.

Q: What if I don't know my race or ethnicity?
A: If you don't know your race or ethnicity, you can talk to hospital registration staff and they can help you decide the best way to answer.

Q: Who can I ask questions about this?
A: The hospital registration staff and their supervisors are happy to answer any questions you may have.

HSAG's Patient and Family Advisory Council (PFAC) developed an FAQ handout for patient education about collection of REaL data

www.hsag.com/hqic/tools-resources/pfe-health-equity

REaL Data Validation

- Valid and reliable data are essential for quality improvement
- REaL data should be assessed for quality and accuracy
  - Examples of REaL data validation include:
    - Validation sampling
    - Observation of patients and staff
    - Checking alignment of REaL data categories when switching EHR systems
    - Comparison of patient demographic data to community demographic data

Domain 3: Data Analysis

Stratifies key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and includes this information on **hospital performance dashboards**

Data Stratification

- Data stratification can be defined as "the process of partitioning data into distinct or nonoverlapping groups."
  - Allows for identification of potential relationships between variables and outcomes
  - Stratified analysis can also be used to identify confounding variables

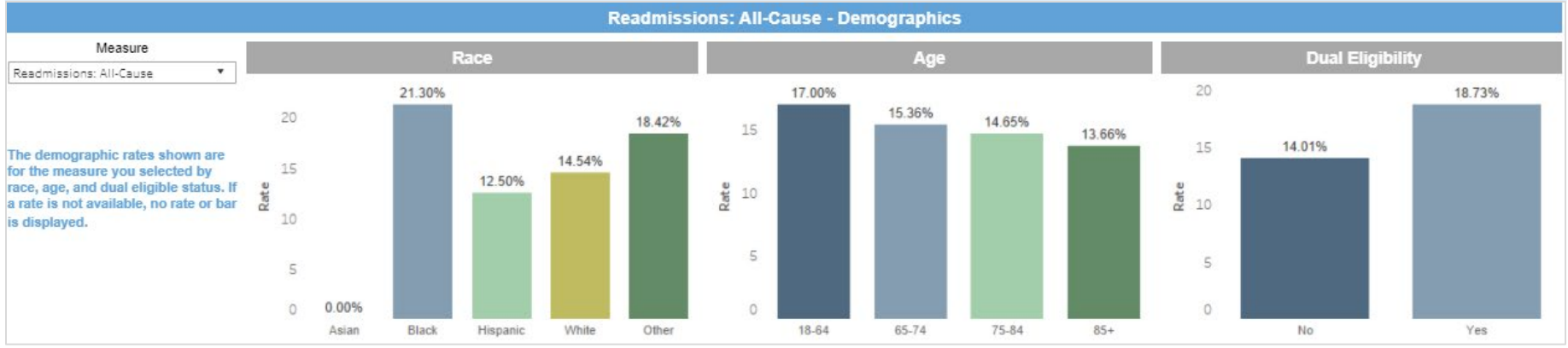
Encyclopedia.com. Stratification of Data. Available at www.encyclopedia.com/education/encyclopedias-almanacs-transcripts-and-maps/stratification-data.

Data Stratification (cont.)

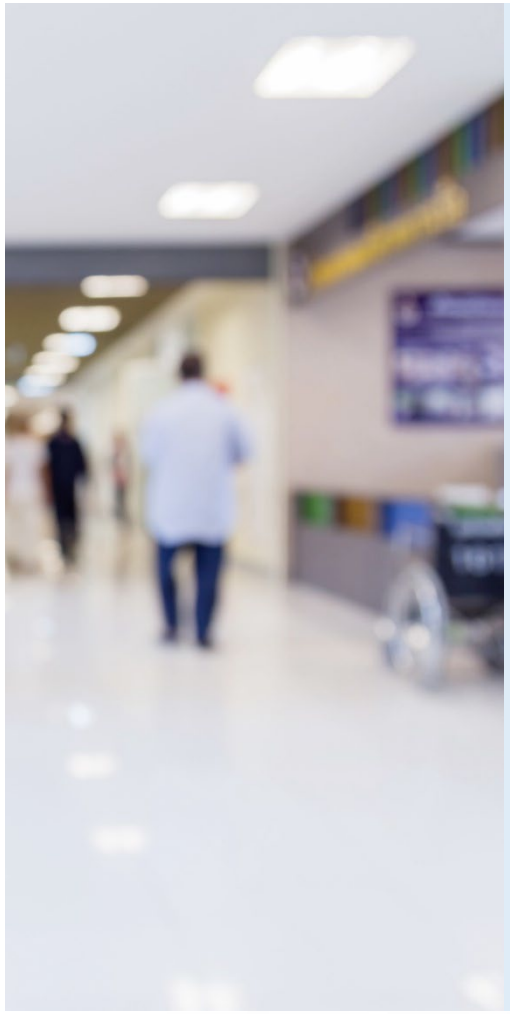
- Hospital quality data can be stratified by multiple groups
  - Race/ethnicity
  - Dual-eligibility status
  - Area Deprivation Index (ADI) census block group
  - Gender
  - Age
- Stratified outcomes data can used to identify trends and potential disparities

HSAG HQIC Performance Dashboard

- Stratifies outcome metrics by demographic and geographic categories
  - Race/ethnicity
  - Age
  - Dual-eligibility (proxy measure for SDOH)
- Allows facilities to identify potential heath disparities in their outcomes



Organizational Transparency

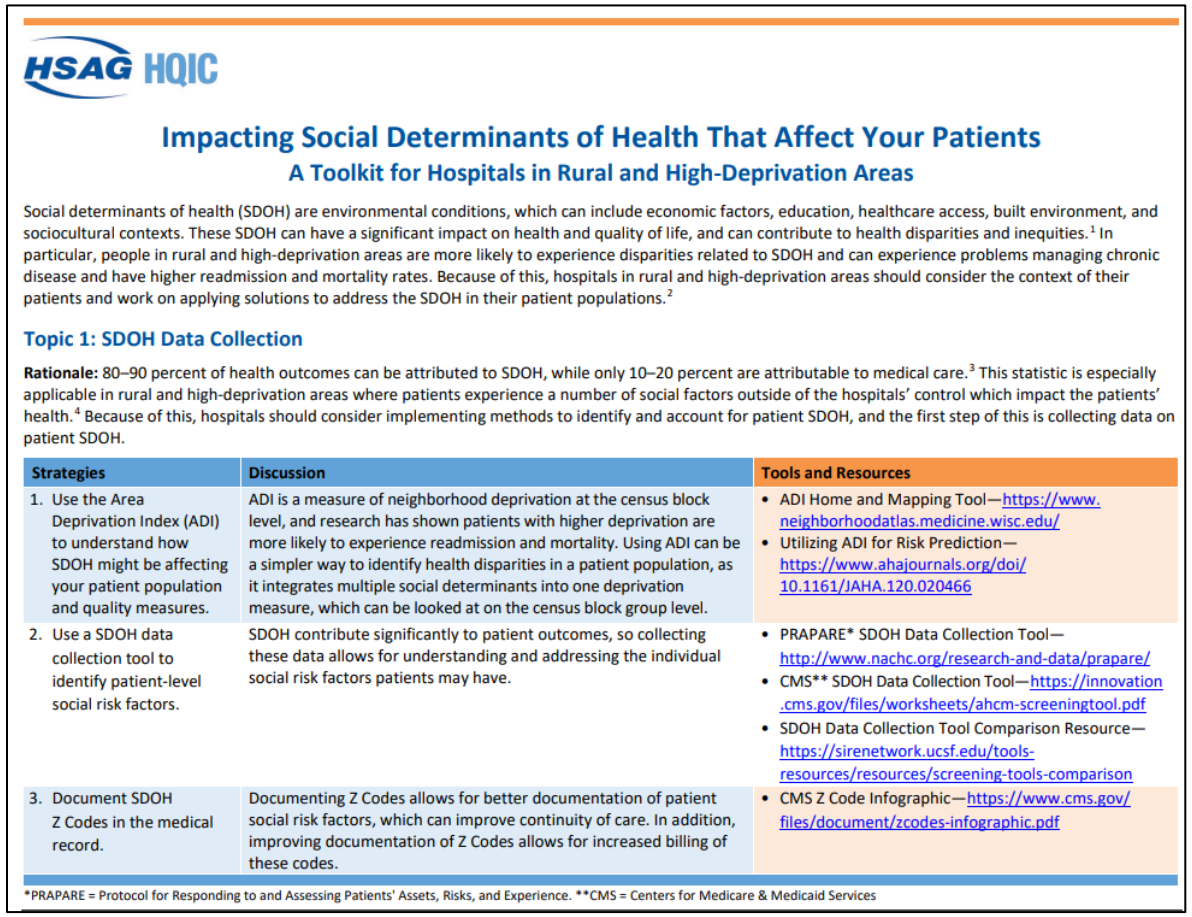


- If hospitals identify disparities, they should be transparent at all applicable organizational levels
  - Hospitals should implement interventions to address each disparity
  - Transparency allows for staff buy-in and understanding of why these interventions are occurring
- It helps to facilitate a culture of equality
  - It also raises awareness

Domain 4: Quality Improvement

Participates in local, regional, or national quality improvement activities focused on reducing health disparities.

Key Resource:
HSAG Toolkit for Social Determinants of Health



HSAG HQIC

Impacting Social Determinants of Health That Affect Your Patients
A Toolkit for Hospitals in Rural and High-Deprivation Areas

Social determinants of health (SDOH) are environmental conditions, which can include economic factors, education, healthcare access, built environment, and sociocultural contexts. These SDOH can have a significant impact on health and quality of life, and can contribute to health disparities and inequities.[1] In particular, people in rural and high-deprivation areas are more likely to experience disparities related to SDOH and can experience problems managing chronic disease and have higher readmission and mortality rates. Because of this, hospitals in rural and high-deprivation areas should consider the context of their patients and work on applying solutions to address the SDOH in their patient populations.[2]

Topic 1: SDOH Data Collection

Rationale: 80–90 percent of health outcomes can be attributed to SDOH, while only 10–20 percent are attributable to medical care.[3] This statistic is especially applicable in rural and high-deprivation areas where patients experience a number of social factors outside of the hospitals' control which impact the patients' health.[4] Because of this, hospitals should consider implementing methods to identify and account for patient SDOH, and the first step of this is collecting data on patient SDOH.

Strategies	Discussion	Tools and Resources
1. Use the Area Deprivation Index (ADI) to understand how SDOH might be affecting your patient population and quality measures.	ADI is a measure of neighborhood deprivation at the census block level, and research has shown patients with higher deprivation are more likely to experience readmission and mortality. Using ADI can be a simpler way to identify health disparities in a patient population, as it integrates multiple social determinants into one deprivation measure, which can be looked at on the census block group level.	• ADI Home and Mapping Tool—https://www.neighborhoodatlas.medicine.wisc.edu/ • Utilizing ADI for Risk Prediction—https://www.ahajournals.org/doi/10.1161/JAHA.120.020466
2. Use a SDOH data collection tool to identify patient-level social risk factors.	SDOH contribute significantly to patient outcomes, so collecting these data allows for understanding and addressing the individual social risk factors patients may have.	• PRAPARE* SDOH Data Collection Tool—http://www.nachc.org/research-and-data/prapare/ • CMS** SDOH Data Collection Tool—https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf • SDOH Data Collection Tool Comparison Resource—https://sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison
3. Document SDOH Z Codes in the medical record.	Documenting Z Codes allows for better documentation of patient social risk factors, which can improve continuity of care. In addition, improving documentation of Z Codes allows for increased billing of these codes.	• CMS Z Code Infographic—https://www.cms.gov/files/document/zcodes-infographic.pdf

*PRAPARE = Protocol for Responding to and Assessing Patients' Assets, Risks, and Experience. **CMS = Centers for Medicare & Medicaid Services

Six topic areas with interventions, strategies, and resources to address SDOH in rural and high deprivation areas

HSAG HQIC. Impacting Social Determinants of Health That Affect Your Patients. Available at https://www.hsag.com/globalassets/hqic/hqic_sdoh_toolkit_508.pdf.

Key Resource:
HSAG Health Equity Roadmap To Success

Comprehensive, step-by-step resource to build your health equity program

HSAG HQIC. The Roadmap to Success. Available at https://www.hsag.com/globalassets/hqic/hsaghqic_heoaroadmap_final.pdf.

Domain 5: Leadership Engagement

- Annually reviews, by senior leadership (including chief executives and the entire hospital board of trustees), the strategic plan for achieving health equity
- Annually reviews, by senior leadership (including chief executives and the entire hospital board of trustees), key performance indicators stratified by demographic and/or social factors

Leadership Support in Health Equity

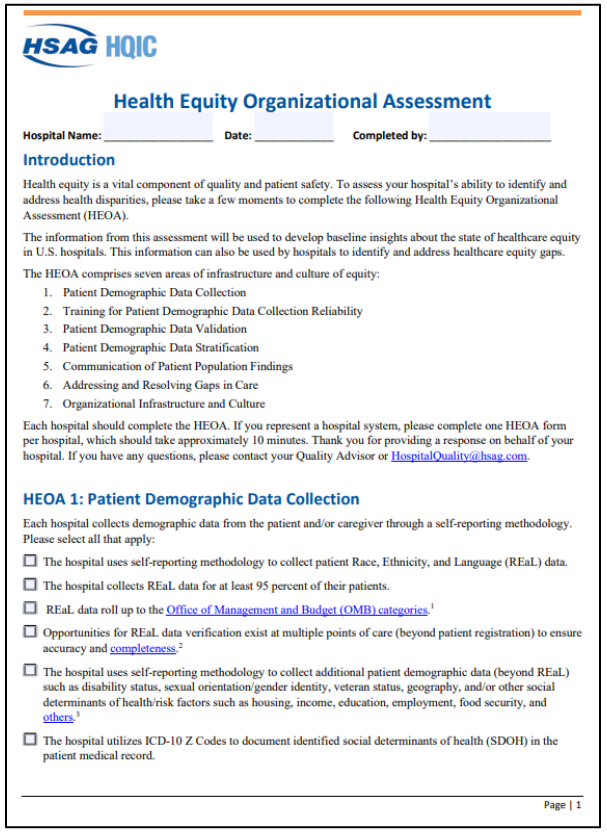
Health Equity

- Needs to be a strategic priority
- Is a shared vision
- Engages the community
  - CHNA
  - Collaboration and participation in community advocacy and projects
- Is a commitment of resources
  - Time
  - People
  - Monetary

Key Resource: Health Equity Organizational Assessment

Health Equity Organization Assessment (HEOA)

HEOA 1: Patient Demographic Data Collection
HEOA 2: Patient Demographic Data Collection Training
HEOA 3: Patient Demographic Data Validation
HEOA 4: Data Stratification
HEOA 5: Communication Patient Demographic Findings
HEOA 6: Addressing and Resolving Gaps in Care
HEOA 7: Organizational Infrastructure and Culture



HSAG HQIC

Health Equity Organizational Assessment

Hospital Name: _____ Date: _____ Completed by: _____

Introduction

Health equity is a vital component of quality and patient safety. To assess your hospital's ability to identify and address health disparities, please take a few moments to complete the following Health Equity Organizational Assessment (HEOA).

The information from this assessment will be used to develop baseline insights about the state of healthcare equity in U.S. hospitals. This information can also be used by hospitals to identify and address healthcare equity gaps.

The HEOA comprises seven areas of infrastructure and culture of equity:

1. Patient Demographic Data Collection
2. Training for Patient Demographic Data Collection Reliability
3. Patient Demographic Data Validation
4. Patient Demographic Data Stratification
5. Communication of Patient Population Findings
6. Addressing and Resolving Gaps in Care
7. Organizational Infrastructure and Culture

Each hospital should complete the HEOA. If you represent a hospital system, please complete one HEOA form per hospital, which should take approximately 10 minutes. Thank you for providing a response on behalf of your hospital. If you have any questions, please contact your Quality Advisor or HospitalQuality@hsag.com.

HEOA 1: Patient Demographic Data Collection

Each hospital collects demographic data from the patient and/or caregiver through a self-reporting methodology. Please select all that apply:

- ☐ The hospital uses self-reporting methodology to collect patient Race, Ethnicity, and Language (REaL) data.
- ☐ The hospital collects REaL data for at least 95 percent of their patients.
- ☐ REaL data roll up to the Office of Management and Budget (OMB) categories.[1]
- ☐ Opportunities for REaL data verification exist at multiple points of care (beyond patient registration) to ensure accuracy and completeness.[2]
- ☐ The hospital uses self-reporting methodology to collect additional patient demographic data (beyond REaL) such as disability status, sexual orientation/gender identity, veteran status, geography, and/or other social determinants of health/risk factors such as housing, income, education, employment, food security, and others.[3]
- ☐ The hospital utilizes ICD-10 Z Codes to document identified social determinants of health (SDOH) in the patient medical record.

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HSAG HQIC. Health Equity Organizational Assessment. Available at https://www.hsag.com/globalassets/hqic/hqic_healthequityorgassessment.pdf.

Social Drivers of Health—Two Measures

Screening for Social Drivers of Health Measure		Screen Positive Rate for Social Drivers of Health Measure	
• Food insecurity • Housing instability • Transportation needs • Utilities difficulties • Interpersonal safety		• Food insecurity • Housing instability • Transportation needs • Utility difficulties • Interpersonal safety	
Numerator	Number of patients who were screened for **one or all** social drivers	Numerator	Number of patients who screened positive for each driver
Denominator	Number of patients 18 or older admitted as an inpatient	Denominator	Number of patients 18 or older admitted as an inpatient and screened for social drivers

CMS. Screening for Social Drivers of Health Measure and the Screen Positive to Social Drivers of Health Measure. Available at https://qualitynet.cms.gov/files/6269ba5b5e40610016f30237?filename=ScrnSocDrvrs_%20Scrn_Pos_Specs.pdf.

Screening for Social Drivers of Health

- Report annually
- Structural measure
- Report 6 separate rates
  - Number screened for Social Drivers
  - Screened positive:
    - Food Insecurity
    - Housing Instability
    - Transportation Needs
    - Utility Difficulties
    - Interpersonal Safety
- CY 2023—Voluntary Reporting (May 15, 2024)
- CY 2024—Mandatory Reporting (May 15, 2025)

CMS. IQR Important Dates and Deadlines. October 2022. Available at https://qualitynet.cms.gov/files/633d7b34a90aef001784784b?filename=IQR_ImpDatesDdlns_Oct2022.pdf.
CMS. FY2023 IPPS/LTCH PPS Final Rule Overview for Hospital Quality Programs. Available at https://www.qualityreportingcenter.com/globalassets/iqr2022events/iqr9122/fy2023_ipps-final-rule-overview-for-hospital-quality-programs-_vfinal508.pdf.

Social Needs Screening

- Social needs screening requires individual assessments
  - Dependent on patient circumstances
  - Can be impacted by community factors
  - Social needs are fluid, so regular screening can be helpful
- Multiple options for screening tools are available
  - PRAPARE tool (prapare.org)
  - CMS tool (innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf)
  - HSAG Social Work Assessment (www.hsag.com/globalassets/hqic/hqic_socialworkassessment.pdf)
  - Screening tool comparison (sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison)

PRARARE = Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

CHAMP Software. Social Needs vs. SDOH: What Is the Difference and How to Document Them at the Local Level. Available at https://www.champsoftware.com/2021/02/03/social-needs-vs-social-determinants-of-health-what-is-the-difference-and-how-to-document-them-at-the-local-level.

Key Resource:
HSAG Health Equity Quickinar Series

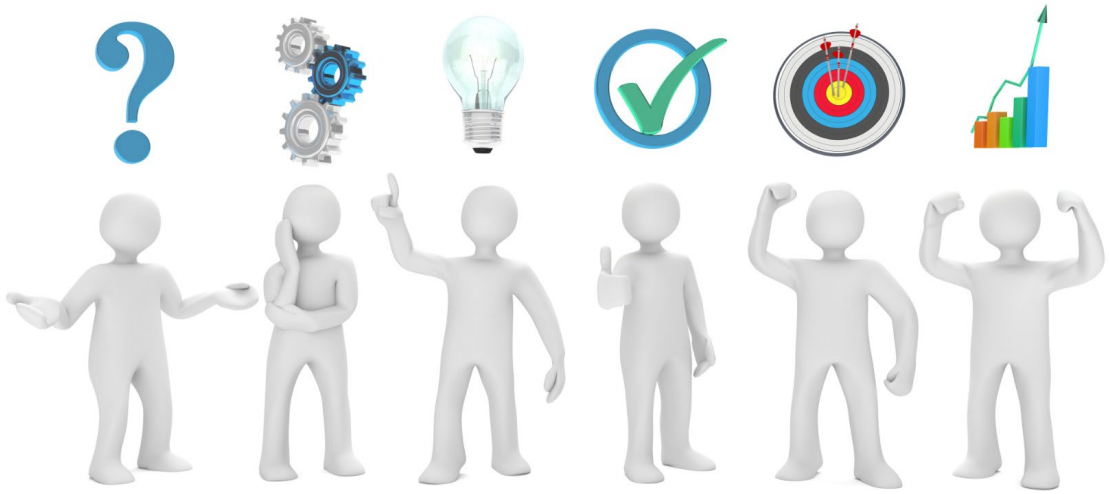
Health Equity Quickinar Series

Achieving equitable care for all patients is a key priority for the Centers for Medicare & Medicaid (CMS), which is reflected in the new Hospital Commitment to Health Equity Structural Measure and Social Drivers Screening Measures in the Final Rule. These short, 30-minute presentations will address the many facets and criteria hospitals will need to meet for these measures, and will assist your hospital in advancing health equity initiatives in alignment with CMS priorities.

- 1. Health Equity, Hospitals, and CMS Reporting
- 2. Engaging Leadership in Health Equity
- 3. Health Equity as a Strategic Priority
- 4. Collecting and Validating REaL Data
- 5. Social Determinants and Social Drivers of Health
- 6. Screening for Social Drivers
- 7. Culturally Competent Data Training
- 8. Analysis and Stratification of Health Equity Data
- 9. Health Equity Interventions
- 10. Health Equity FAQs Answered
- 11. Community Paramedicine
- 12. Identifying Community Health Disparities
- 13. Community Engagement—Health Equity

HSAG HQIC. Health Equity Quickinar Series. Available at https://www.hsag.com/en/hqic/health-equity-quickinar-series/.

Achieving Success



Interventions: Upstream vs. Downstream

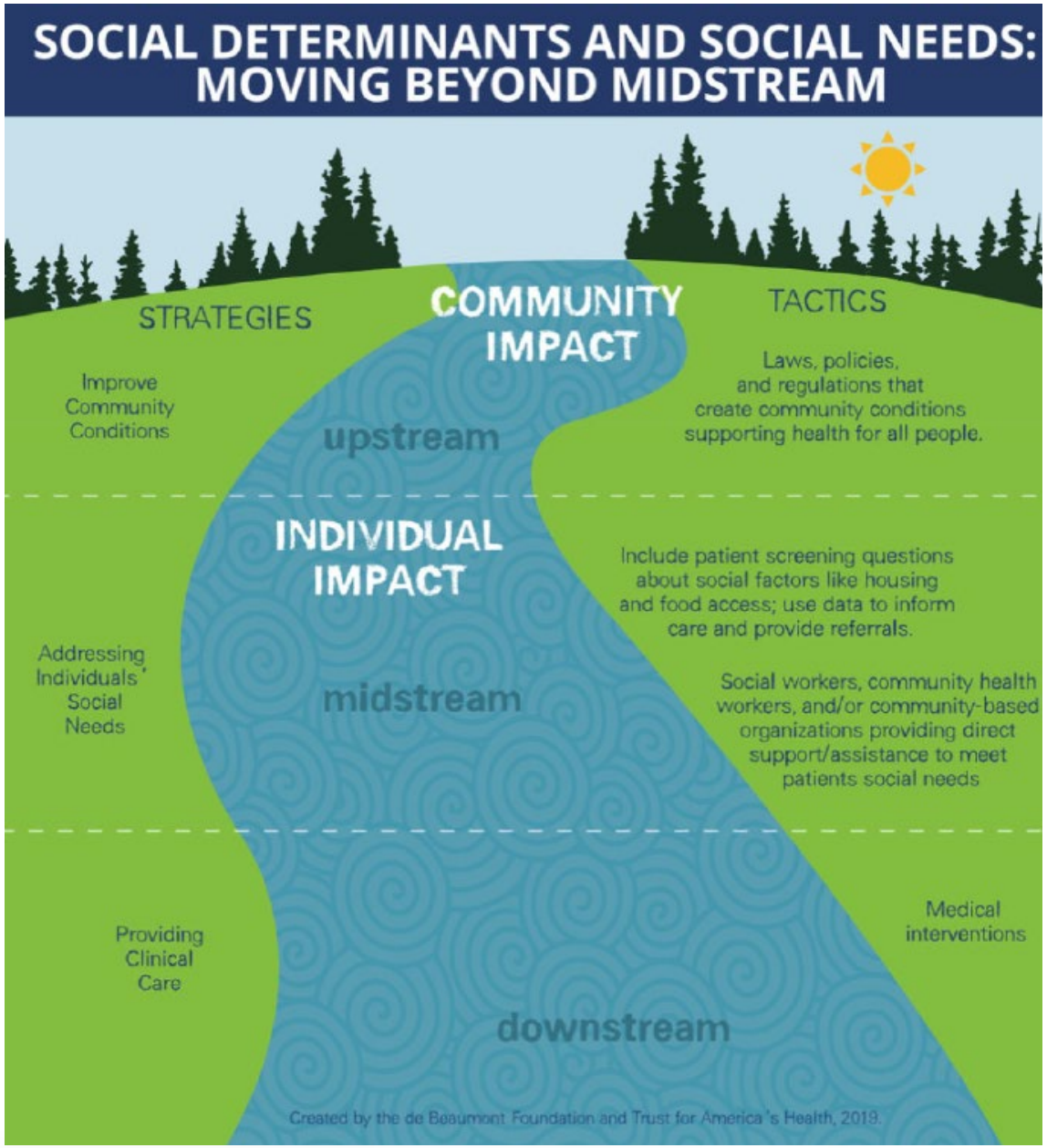
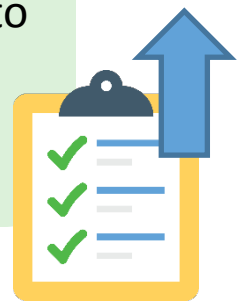


Image used with permission from the de Beaumont Foundation and Trust for America's Health. Available at https://debeaumont.org/news/2019/meeting-individual-social-needs-falls-short-of-addressing-social-determinants-of-health

Promoting The Use of Z-Codes

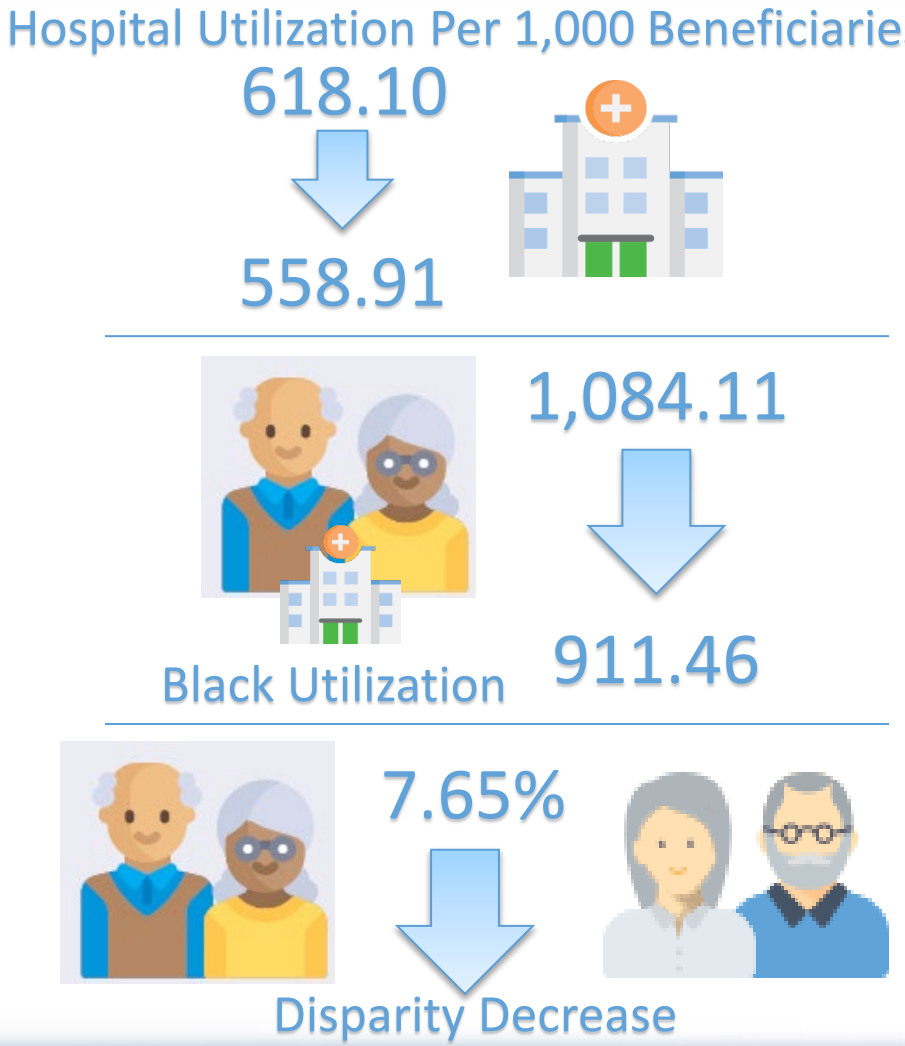
HSAG HQIC has promoted the use of Z Codes for the documentation of social needs in the medical record with its hospitals. We also have shared information on Z Codes and their growing emphasis with CMS on numerous coaching calls. This promotion and coaching from HSAG HQIC has resulted in a steady increase in the reporting of these codes by its hospitals.

Increase in Z-Code reporting for HQIC hospitals from 1.67% in September 2020 to 2.92% in April 2023, an increase of 1.25%



Reducing Disparities in Hospital Utilization and Readmissions, Pt.1

The outcome with the most significant disparity based on the CMS Medicare FFS Claims Data was identified by the HSAG analytics team as All Cause Readmissions. HSAG used the data to identify: (1) which diagnosis was driving the largest percentage readmissions; (2) use the readmissions discharge distribution data to identify the setting of discharge disposition and timeframe resulting in the most readmissions (i.e., readmissions from SNF at 0 to 7 days); (3) the readmission rates based on race, age, and dual eligibility; and (4) identification of high utilizers. Using this approach, HSAG was able to share tools, resources, and best practices to design interventions focused not just reducing readmissions but improving disparities.



Reducing Disparities in Hospital Utilization and Readmissions, Pt.2

The outcome with the most significant disparity based on the CMS Medicare FFS Claims Data was identified by the HSAG analytics team as All Cause Readmissions. HSAG used the data to identify: (1) which diagnosis was driving the largest percentage readmissions; (2) use the readmissions discharge distribution data to identify the setting of discharge disposition and timeframe resulting in the most readmissions (i.e., readmissions from SNF at 0 to 7 days); (3) the readmission rates based on race, age, and dual eligibility; and (4) identification of high utilizers. Using this approach, HSAG was able to share tools, resources, and best practices to design interventions focused not just reducing readmissions but improving disparities.

30-Day Hospital Readmissions per 1,000 Beneficiaries

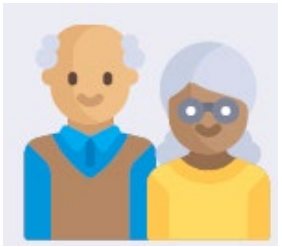
34.92

28.92

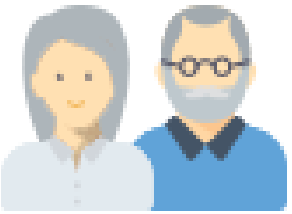
72.23

Black Readmissions

54.44



9.19%



Disparity Decrease

Questions

Thank you!

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