HQIC Community of Practice Call

Reducing the Health Disparities Gap: A Practical Framework for Promoting Health Equity in Your Hospital

April 14, 2022

This material was prepared by The Bizzell Group (Bizzell), the Data Validation and Administrative (DVA) contractor, 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. 12SOW/Bizzell/DVA-0735-3/10/22

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Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

Introduction

Welcome!

Who’s in the Room?

Shaterra Smith
Social Science Research Analyst - Division of Quality Improvement Innovation Models Testing
iQuality Improvement and Innovations Group
Center for Clinical Standards and Quality
Centers for Medicare & Medicaid Services (CMS)

Agenda

- Introduction
- Today's Topic
  - Reducing the Health Disparities Gap: A Practical Framework for Promoting Health Equity in Your Hospital

    Presentations by Priya Bathija and Julia Resnick, Strategic Initiatives, American Hospital Association

    Leticia Rodriguez and Brandy Jean Wolf, Ward Memorial Hospital
- Open Discussion/Q&A
- Closing Remarks

As You Listen, Ponder…

- What excites you the most about the information provided? What information can you leverage to help expand opportunities in your communities?
- What actions will you take as a result of the call?
- Where can you begin with your facility to continue to ensure safety, and a true patient-centered approach as you engage collaboratively with others?
- Which activities do you have underway that will allow for you to expand and push forward to build on action in the next 30 days? 90 days?

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Meet Your Speakers

Priya Bathija
Vice President, Strategic Initiatives, American Hospital Association
Vice President, Operations, Institute for Diversity & Health Equity

Julia J. Resnick, MPH
Director, Strategic Initiatives
American Hospital Association

Leticia C. Rodriguez
CEO, Ward Memorial Hospital

Brandy Jean Wolf
Clinical Informatics, Pharmacy Manager, LVN, LIC-P
Ward Memorial Hospital

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Alliant Speakers

Karen Holtz, Medical Technologist-American Society for Clinical Pathology (ASCP), MS, CPHQ
Training and Education Lead

Rosa Abraha, MPH
Health Equity Lead

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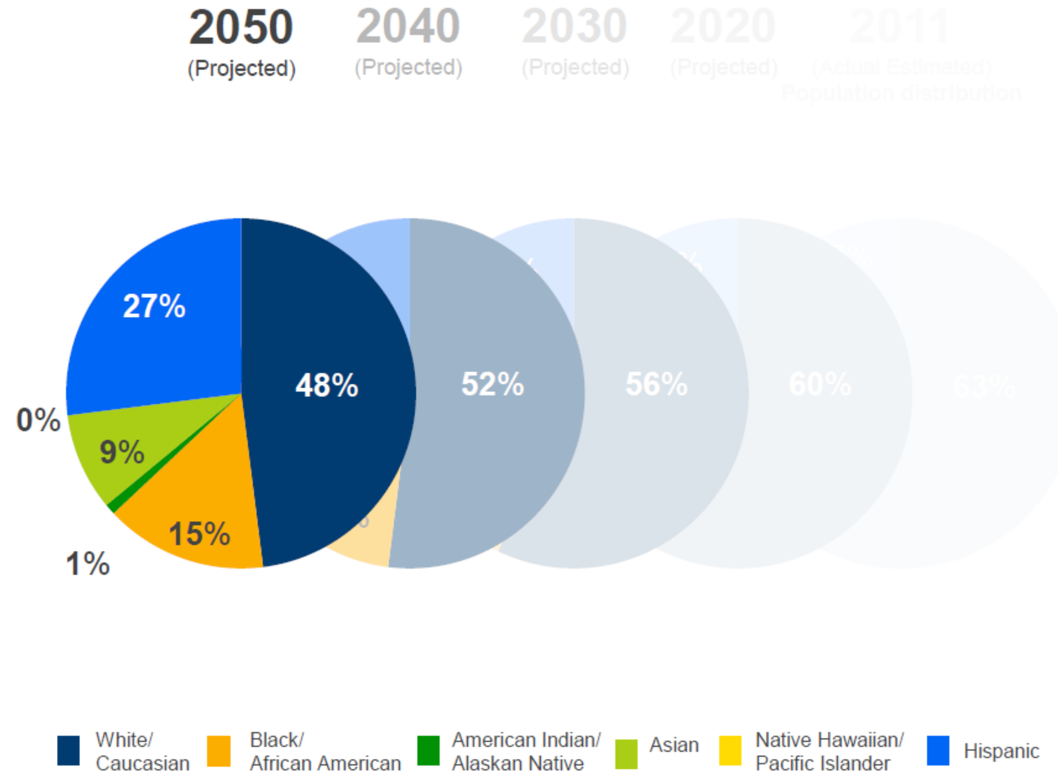
Projected U.S. Population Distribution

- By 2050, "Minorities" will comprise the majority of the U.S. population.[1]
- Minority births now comprise the majority according to recent Census data.[2]
- Hispanics, Asians and Blacks/ African American populations will grow at faster rates than other racial/ethnic groups.[1]



[1] *U.S. Census Bureau*, Current Estimates Data (v2012) and 2012 National Projections (Updated May 2013). Note: Charts depict non-Hispanic race (includes race alone or in combination) compared to all Hispanics.
[2] Most Children Younger than Age 1 are Minorities, Census Bureau Reports, U.S. Census Bureau. 17 May 2012.

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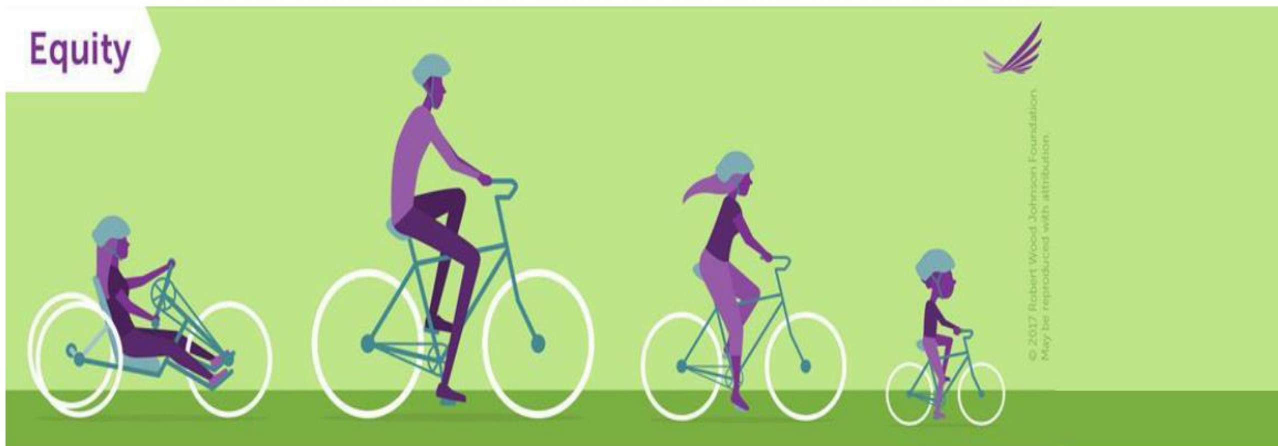
Health Equity is getting rid of inequalities or unfair differences in how people are given health care

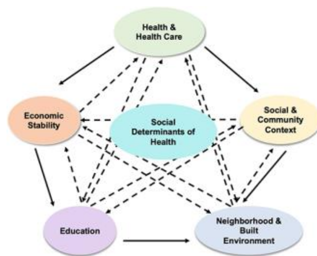
Equality means treating everyone the same to achieve the same result. However, this approach only works if everyone is starting from the same status. Not all of our members start from the same status. In fact, they experience ***health inequities***, or avoidable differences in health outcomes.



Equity, on the other hand, is giving people what they *need* in order to achieve the same result. It's commonly referred to as 'leveling the playing field.' Equity is needed before attaining true equality.

National Trends – Financial Implications

- Health disparities have amounted to $93 billion in excess costs annually
- Health outcome contributors:



80% - 90%
social determinants

10% - 20%
medical care

- Yet, an estimated 95% of health expenditures are medical costs

1. Healthy People 2030
2. O'Neill, Hayes (2018) Understanding Social Determinants of Health

National Trends – Social Determinants of Health

- 1 in 10 Americans live in poverty with the inability to afford health care, healthy food and housing
- Social determinants of health (SDOH) include:
  - Safe housing, transportation, and neighborhoods
  - Income, education level, job opportunities
  - Access to nutritious foods and physical activity
  - Language and literacy skills

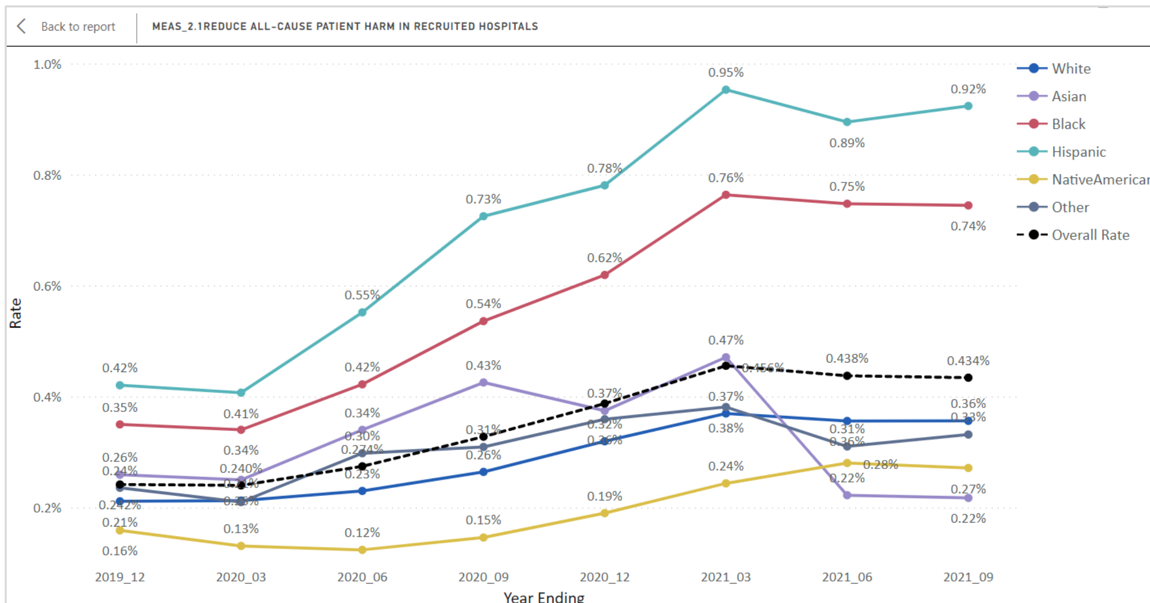
Social Determinants of Health

Social Determinants of Health | Healthy People 2030

1. Healthy People 2030
2. O'Neill, Hayes (2018) Understanding Social Determinants of Health

Alliant HQIC Trends – Quality Implications

SAMPLE



Reduce All-Cause Harm

- Harm includes Catheter-associated Urinary Tract Infections (CAUTI), Central Line-associated Bloodstream Infection CLABSI, C diff infections, pressure injuries, sepsis
- Hispanic is highest followed by Black population

Alliant HQIC: 150 hospitals in 13 states
Source: CMS Medicare Claims, NHSN data

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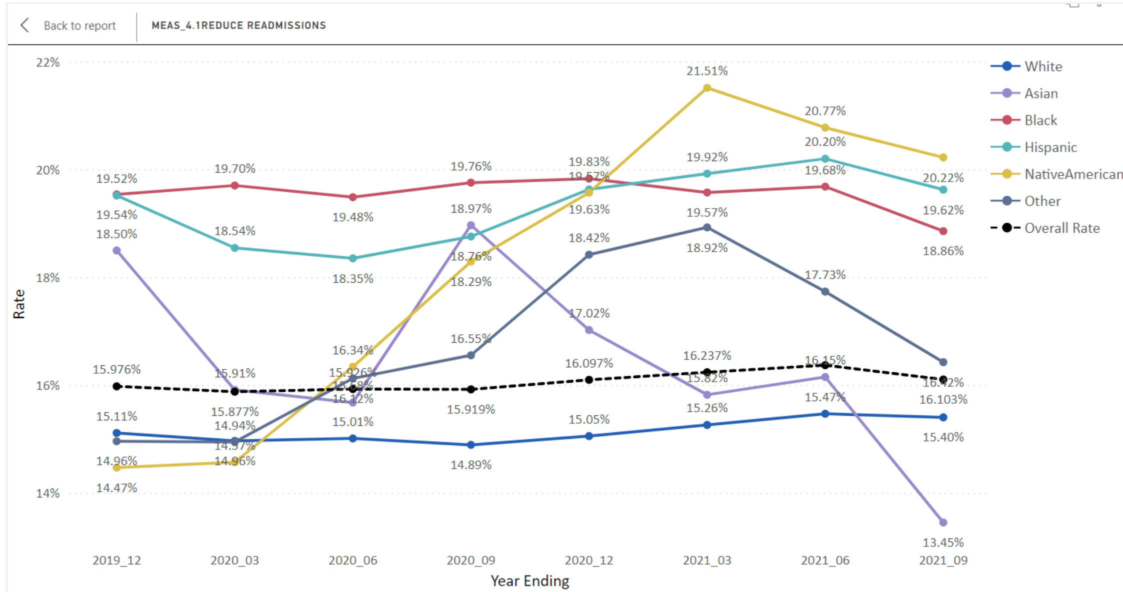
Alliant HQIC Trends – Quality Implications

SAMPLE



Reduce 30 Day Readmissions

- Increase in Native American
- Followed by Hispanic population

Alliant HQIC: 150 hospitals in 13 states
Source: CMS Medicare Claims

National Trends – COVID 19

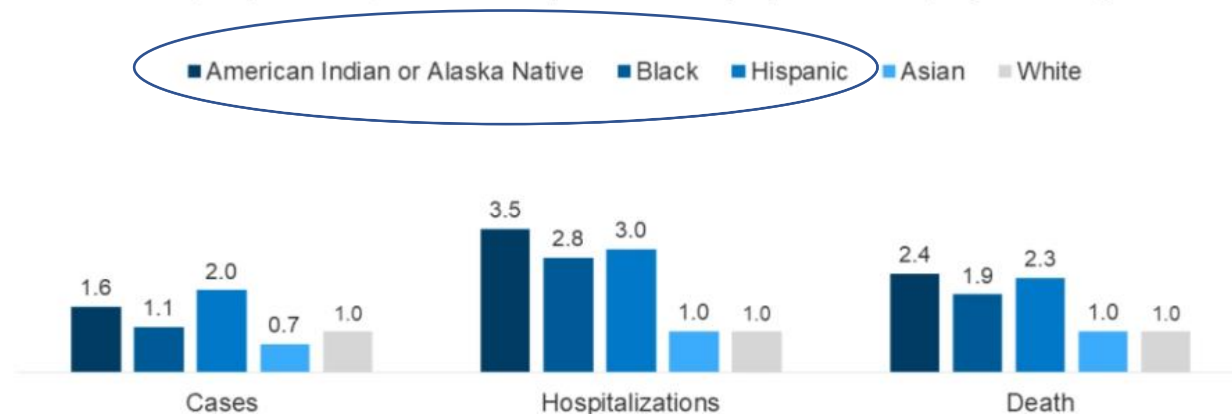


Figure 4: People of color have had higher rates of infection, hospitalization, and death due to COVID-19.

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Strategies for Hospitals to Address Health Equity

Priya Bathija, Vice President, Strategic Initiatives

Julia Resnick, Director, Strategic Initiatives

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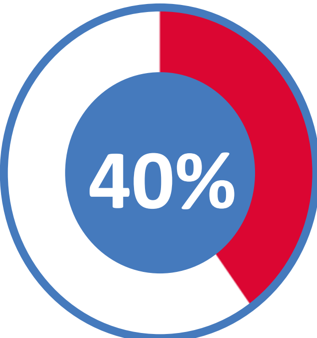
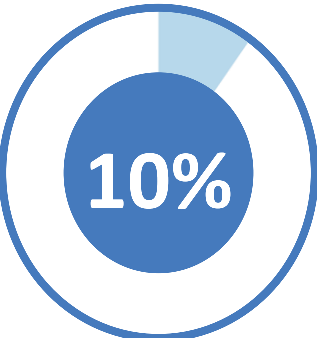
Health is More Than Health Care

80 percent of our health is determined by societal factors



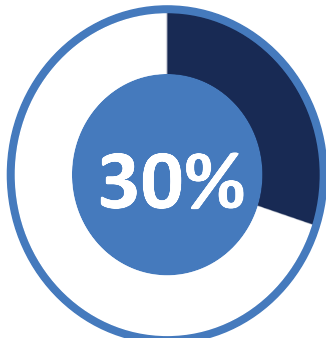
Socioeconomic Factors

Education, Job Status, Family/Social Support, Income, Community Safety



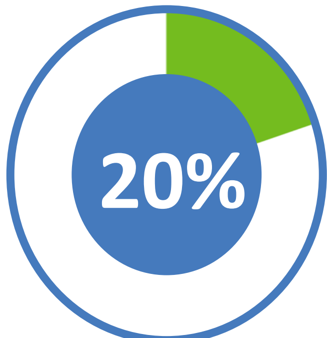
Physical Environment

Environment



Health Behaviors

Tobacco Use, Diet & Exercise, Alcohol Use, Sexual Activity



Health Care

Access to Quality Care

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Source: http://www.countyhealthrankings.org/county-health-rankings-model

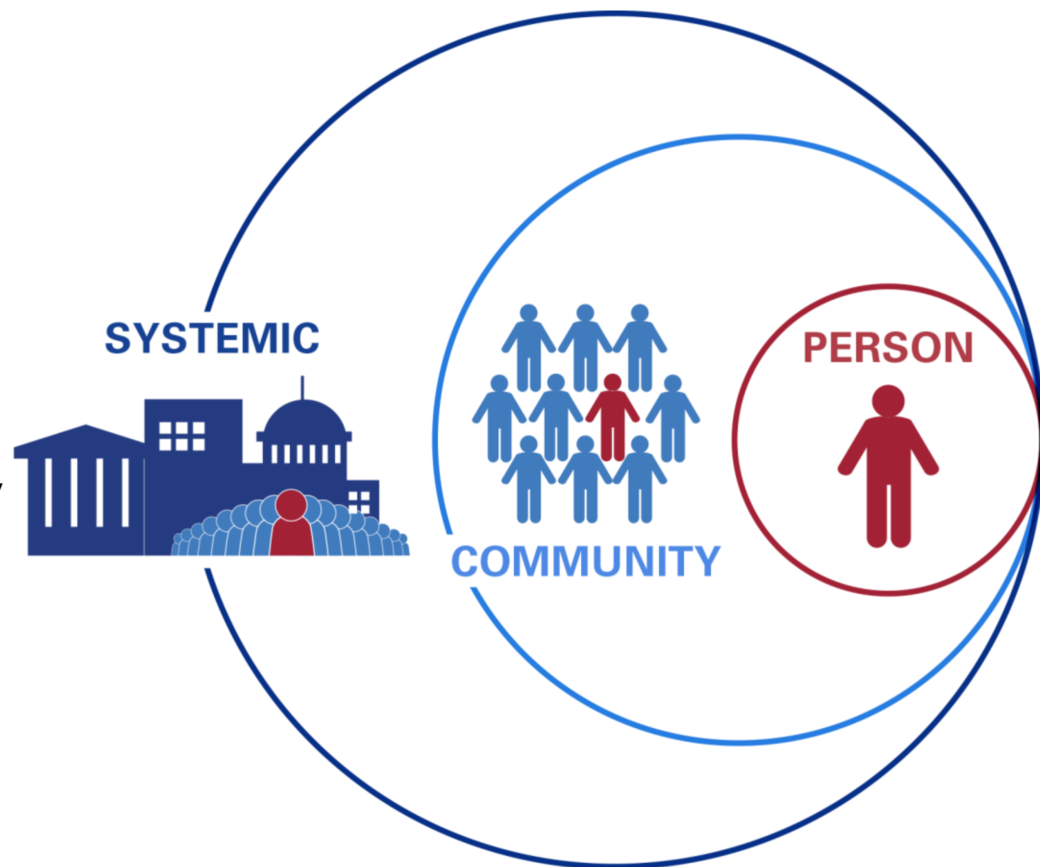
Societal Factors that Influence Health

A Framework for Hospitals

Social Needs
Individuals' non-medical, social or economic circumstances that hinder their ability to stay healthy and/or recover from illness.

Social Determinants of Health
Underlying social and economic conditions that influence people's ability to be healthy.

Systemic Causes
The fundamental causes of the social inequities that lead to poor health.



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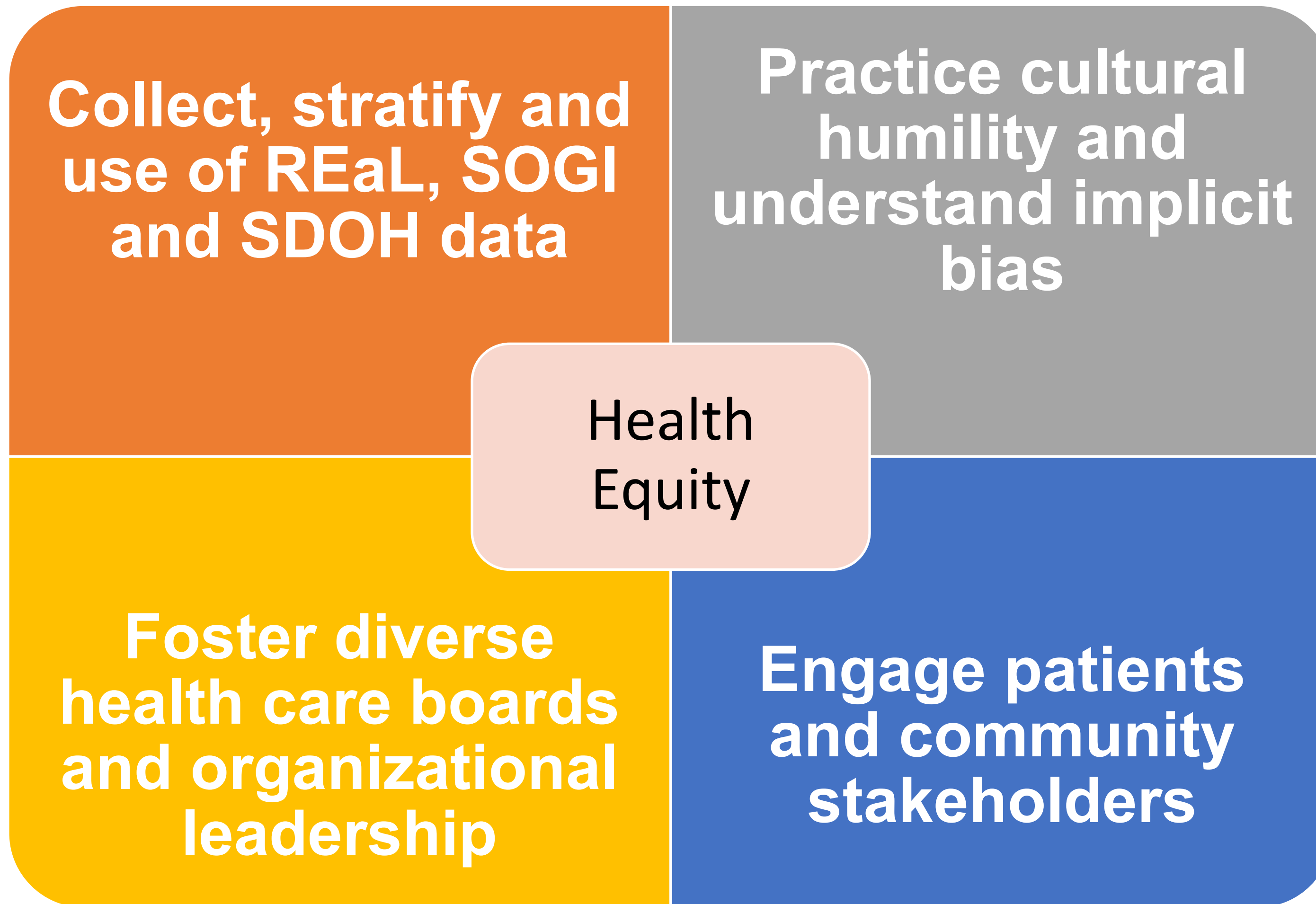
Source: www.aha.org/societalfactors

Key Strategies for Health Equity



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1

Data Collection & Use

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Data Guides a Health Equity Strategy

Understand the problem in order to address it:

- Is it a problem of inequitable care or access?
- Does this patient have social needs that they cannot meet that are prohibiting health?
- Community-level factors: e.g., food or housing insecurity?
- Are certain communities/populations at particular risk?

% of hospitals that collect
RACE, LANGUAGE AND ETHNICITY DATA

95%

% of hospitals that use the data in their **DECISION MAKING**

22%

SOURCE: Health Research & Educational Trust. (2014, June). 2013 Diversity and disparities survey: A benchmark study of the U.S. hospitals. Chicago, IL: Health Research & Educational Trust.

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Patient Demographic and Social Needs Data

- Race, Ethnicity and Language (REaL) data
- Sexual Orientation and Gender Identity (SOGI) data
- Patient Experience data
- Social Needs data including:
  - Food insecurity
  - Housing, neighborhood, built environment
  - Transportation access
  - Education
  - Social isolation
  - Healthy behaviors
  - Safety
- CHNA Data

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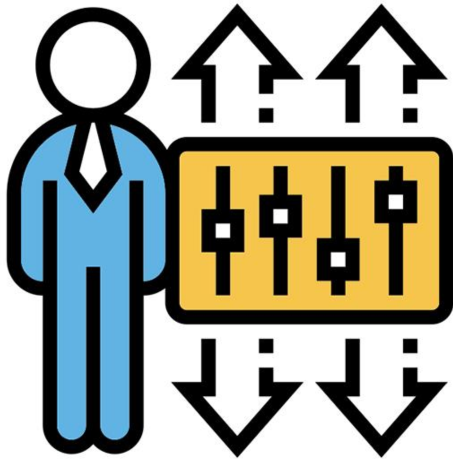
Making Data Useful with Stratification



1. Assemble a working group that is focused on health inequities
2. Validate the data
3. Identify priority metrics
4. Determine if stratification is possible on the selected metrics
5. Stratify the data

SOURCE: American Hospital Association. March 2021. Data-Driven Care Delivery: Data Collection, Stratification and Use.

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Identify Priority Metrics

QUALITY METRICS

Clinical
- Hospital inpatient quality reporting (IQR) measures
- 30-day readmissions
- Outcomes

Patient Satisfaction
- HCAHPS scores

Cost and Efficiency
- Medicare Spending per Beneficiary

PATIENT DATA

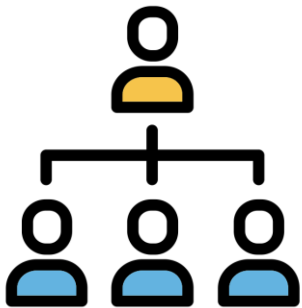
Demographic Data
- Age
- Gender
- Race
- Ethnicity
- Language preference
- Language proficiency
- Sexual orientation
- Gender identity

Social Needs Data
- Food security
- Housing security
- Community safety

Get Buy In by Telling the Story

Tell a story with the data.

- These data represent people – what is the story you're trying to tell?
- How does that inform your next steps?



Get organizational buy in.

- Who do you need to get buy in from for an intervention?
- How does your equity initiative tie to other strategic goals (e.g., readmissions, value, quality, reducing cost, etc.)?
- How does your organizational culture support this work?

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Data Collection and Use

Henry Ford Health System

We Ask Because We Care Campaign

- REaL data is collected for more than 90% of patients
- Data collection includes questions that reflect the population HFHS serves
- Built into electronic health record and data is gathered at multiple touch points
- HFHS stratifies quality and service metrics by REaL data and uses it to inform equity- and quality-related goals

Strategic Questions

- What health inequities do you know exist in your health care organization and community? What might you not know about?
- What REaL or SOGI metrics are the strongest indicators of inequities?
- What social needs metrics are the strongest indicators of inequities?
- What demographic factors have the greatest impact on readmission rates or health status?
- How do REaL, SOGI and social needs metrics relate to each other?

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2 Cultural Humility

Cultural Humility

- **Ability to provide care to patients with diverse values, beliefs and behaviors**
- **Increases understanding of factors that are important to patients, and:**
  - » Improves health outcomes and quality of care
  - » Contributes to elimination of racial and ethnic disparities
  - » Increases respect, mutual understanding and participation from the local community

Source: 2019 AHA Institute For Diversity and Health Equity Survey

Benefits of Cultural Humility for Health Care Organizations

Social Benefits	Health Benefits	Business Benefits
• Increases mutual respect and understanding between patient and organization • Increases trust • Promotes inclusion of all community members • Increases community participation and involvement in health issues • Assists patients and families in their care • Promotes patient and family responsibilities for health	• Improves patient data collection • Increases preventive care by patients • Reduces care disparities in the patient population • Increases cost savings from a reduction in medical errors, number of treatments and legal costs • Reduces the number of missed medical visits	• Incorporates different perspectives, ideas and strategies into the decision-making process • Decreases barriers that slow progress • Moves toward meeting legal and regulatory guidelines • Improves efficiency of care services • Increases the market share of the organization

Source: American Hospital Association, 2013.

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Cultural Humility

Advocate Lutheran

Cultural Competency Training

- Analysis of local demographics
- Education on the importance of cultural competence and it's implications included in new-employee education
- Diverse group of staff arrange cultural awareness events
- South Asian Cardiovascular Center aimed at educating, screening, preventing and treating South Asian Americans who are at high risk for cardiac disease
- Patients requesting accommodation for their beliefs or practices are identified more quickly

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3

Diversity & Inclusion

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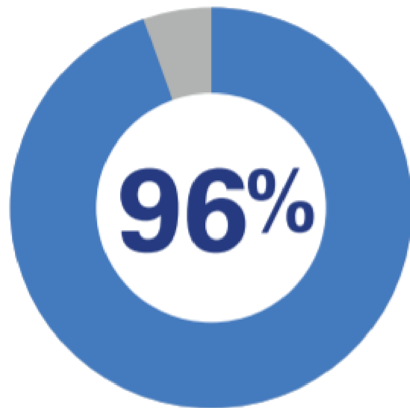
Diversity & Inclusion within Leadership and Governance

COMMITMENT



Report moderate- to high-priority commitments for fostering diversity and inclusion strategies within their organization.

- Strong commitment to eliminating health inequities and improving diversity and inclusion
- 2019 survey respondents show increases in diverse board representation and moderate increases in diverse executive leadership compared to previous surveys

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Source: 2019 AHA Institute For Diversity and Health Equity Survey

Trustees’ Role in Advancing Health Equity

Establish Strategic Intent

Mission, values and strategic priorities should reflect a strong commitment to health equity and addressing disparities. Use existing strategic initiatives as "touchstones" for moving forward.

Lead through Collaboration

Collaboration is essential to effectively addressing health equity. Move beyond the "four walls of the hospital" for greater impact. Engage trustees as ambassadors for building relationships with public health and community-based organizations.

Reflect, Understand and Learn

Look both internally and externally to better understand inequities. Establish a culture of equity in which all staff and providers are motivated to address disparities. Learn from best practices and other organizations pursuing health equity.

Ensure Meaningful, Measurable Goals

Unless specifically measured, disparities in health care may go unnoticed. Equity should be a key part of quality improvement efforts and community outreach programs.

Source: governWell™

Source: 2021 Diversity and Inclusion in Leadership and Governance.

Diversity & Inclusion

Cone Health

Creative Steps for Advancing Diversity and Inclusion

- Set diversity and inclusion hiring goals for leadership team
  - 30% of leadership hires to be people of color
  - Leadership team passed the goal at 35% in 2014 and 2015; Expanded the goal each year and reached over 50% in 2018 and 2019
- Strategies included:
  - a diverse selection committee and pool of applicants
  - a formal succession planning initiative
  - pipeline development
  - training on bias for the leadership team
  - connecting the importance of leadership diversity with the community's health outcomes

4 Community Partnerships

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Collaborating for Health

Governmental Organizations

Public Health Organizations

Faith-based Organizations

Service Organizations

Local Businesses

Housing & Transportation Services

Community Organizations

Educational Organizations

SOURCE: HRET, 2017. Accessed at: www.hpoe.org/partnershipplaybook.

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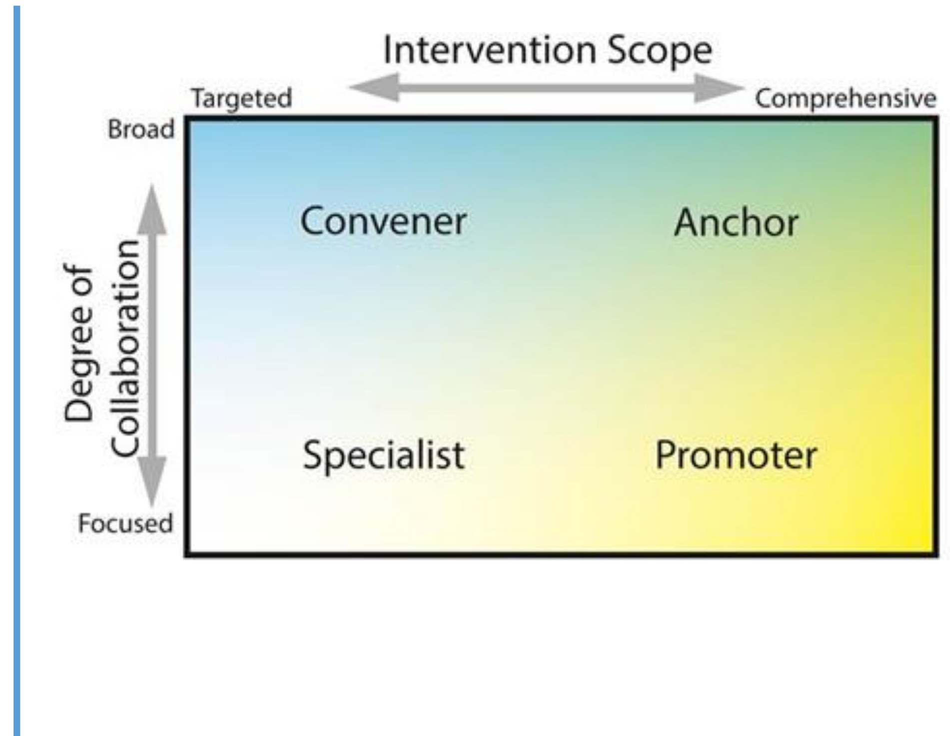
Health Care Organization's Roles in Community Partnerships

SPECIALIST
Focus on a few specific issues

PROMOTER
Supports other organizations' initiatives

CONVENER
Brings together hospital and community stakeholders to work toward shared goals

ANCHOR
Leads community health initiatives



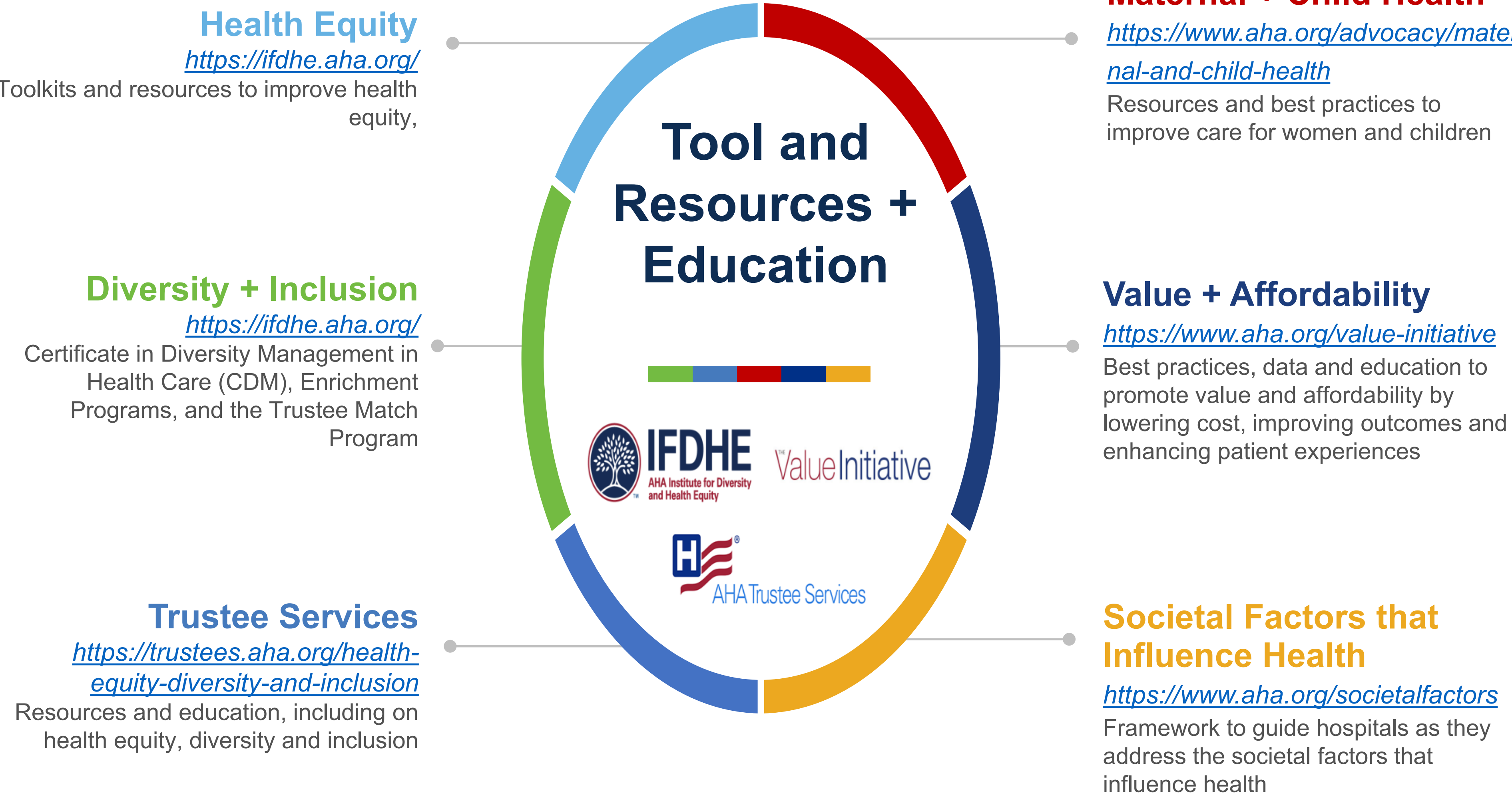
Source: Health Research & Education Trust, 2014.

Community Partnerships

Sharp Healthcare
Care Transitions Interventions

- Team of nurses, social workers, and financial service advisors provide care transition coaching and community resources for vulnerable patients
- Team includes those from community organizations, including 2-1-1 San Diego
- Reduced readmission to under 10%, health care costs by 30% and length of stay

Health Equity Strategies at AHA



AHA Health Equity Roadmap

The Six Levers of Transformation

Research and experience show that leading health equity strategies cut across six levers of transformation within health care organizational structures.

The Health Equity Roadmap

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

The Health Equity Roadmap is a framework to help hospitals and health care systems chart their own paths toward transformation — thus becoming more equitable and inclusive organizations.

Learn more at www.equity.aha.org

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Questions? Email healthequity@aha.org

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TMF Health Quality Institute

HOSPITAL QUALITY IMPROVEMENT CONTRACTOR

One Hospital’s Covid-19 Health Equity Journey: Lessons Learned from a Rural Community

Leticia Rodriquez, CEO

Brandy Wolf, Clinical Informatics

TMF®
Health Quality Institute

Ward Memorial in Monahans, Texas

- Located six miles from Monahans Sandhills State Park, a 3,840-acre state park
- 25-bed Critical Access Hospital (CAH)
  - Emergency & Same Day
  - Cardiac Rehab
  - Radiology
  - Pharmacy
  - Physical Therapy
  - Sleep Wellness
  - Swing Bed Program

Covid-19 Challenges

- Increasing skill sets
- Bed shortages
- Equipment demands
- Low provider-to-patient ratio
- Staffing shortages
- Staff burnout

Success Story

Covid-19 Health Equity Journey

Population

- Majority female and Hispanic, with total of 5,182 vaccinated

Purpose

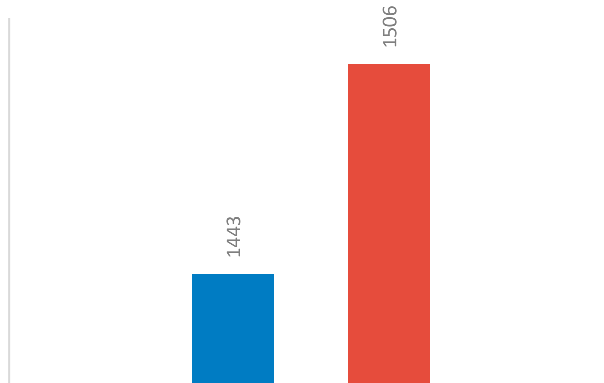
- Created Covid-19 preparedness committee to ensure continued health of community, increase vaccination rates at community vaccine events and educate community on Covid-19 transmission and side effects

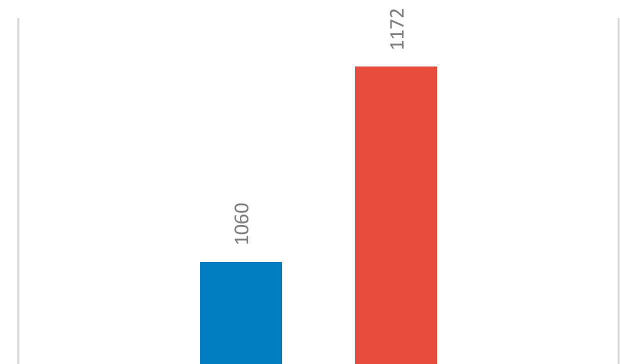
Partners

- Ward County and Monahans Chamber of Commerce

In Their Own Words

Covid-19 Equity





Covid-19 Equity Journey

- Increase availability and accessibility of Covid-19 testing and vaccination for populations that are disproportionately affected (e.g., racial and ethnic minority populations)
- Provide telehealth options
- Include materials in Spanish
- Ensure providers show awareness of, and respect for, culture when providing Covid-19 testing and care
- Help build vaccine confidence within minority populations
- Share clear and accurate information to educate about Covid-19
- Raise awareness about the benefits of vaccination and address common questions and concerns

Keys to Success

- Leadership support and vision is vital
- Involve patients, staff and community
- Teamwork

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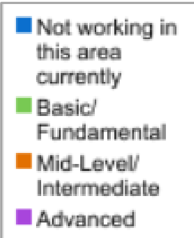
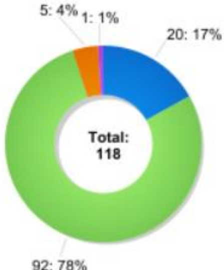
Baseline Assessment of Health Equity
Level of Hospital Implementation by Category

SAMPLE

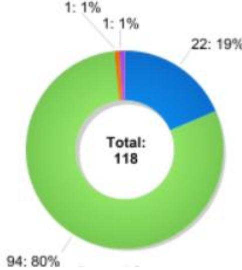
Legend



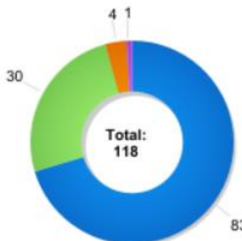
Data Collection
Self-Reporting Methodology



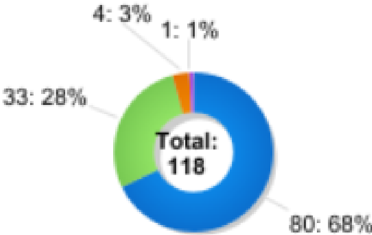
Data Collection Training
Workforce Training



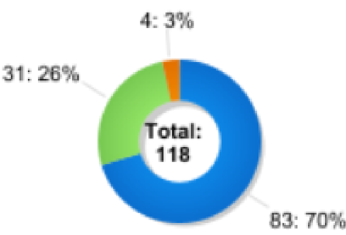
Data Validation
Verifies Data Accuracy



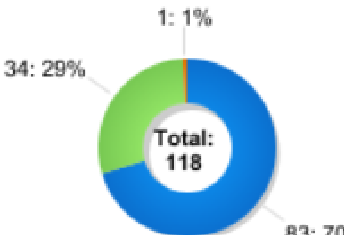
Data Stratification
Stratifies Data



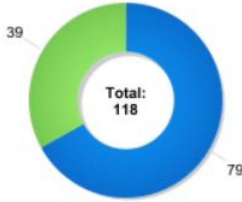
Communicate Findings
Reporting Mechanism



Address Gaps in Care
Interventions to Resolve Differences



Infrastructure and Culture
Culture of Health Equity



N = 118 hospitals

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Resources

1. Health Equity Resource Package (on Alliant website)
2. Two-hour online course on how to identify and eliminate health disparities in organizations Achieving Health Equity (CMS/Medicare Learning Network)
3. AHA Institute for Diversity and Health Equity https://ifdhe.aha.org/
4. Building an Organizational Response to Health Equity https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Health-Disparities-Guide.pdf
5. Rural Health Information Hub – Tools to Assess SDOH in the Rural Health setting. Types of Social Determinants of Health - RHIhub Toolkit (ruralhealthinfo.org)
6. Agency for Healthcare Research and Quality – Tools, resources, and information on SDOH Social Determinants of Health (SDOH) | Agency for Healthcare Research and Quality (ahrq.gov)
7. Protocols for Responding to and Assessing Patient's Assets, Risks, and Experiences PRAPARE

Ideas to Begin Your Team and Plan-Do-Study-Act

- Identify a project leader or champion to manage activities
- Create a team with appropriate members, include community
- Analyze patient Race, Ethnicity and Language (REaL) data
- Locate Community Health Needs Assessment results
- Provide Race, Ethnicity, and Language (REaL) data collection training
- Ask PFAC member to assist with data collection/self questionnaire
- Stratify data by REaL or Social Determinants of Health (SDOH)
- Engage in AHA's Health Equity Roadmap and #123 for Equity pledge https://equity.aha.org/

Moving Forward

Beginner	Intermediate	Expert
Identify a leader or champion and create a team, include community	Analyze data Collection and Use of Race, Ethnicity and Language (REaL) Data Using Data to Reduce Health Disparities (AHA)	Write health equity goals into critical documents such as mission statements and strategic plans
Complete Health Equity Organizational Assessment (HEOA)	Using SDOH Data to Reduce Breast Cancer (Parkland Health Case Study)	Chief Diversity, Equity and Inclusion Officer WellStar Health System
Involve Quality Improvement/ Accreditation professionals Sentinel Event Alert 64: Addressing health care disparities by improving quality and safety (TJC, 2021)	Provide staff training AHA Disparities Toolkit - Staff Training	Reporting mechanism (e.g., equity dashboard) or Diversity, Inclusion and Equity Report (Novant Health, 2020)
Locate and review your hospital's Community Health Needs Assessment (CHNA)	Engage in AHA's Health Equity Roadmap and #123forEquity pledge https://equity.aha.org/	Investigate research grants and funding opportunities Robert Wood Johnson Foundation

Discussion

- What excites you the most about the information provided? What information can you leverage to help expand opportunities in your communities?
- What actions will you take as a result of the call?
- Where can you begin with your facility to continue to ensure safety, and a true patient-centered approach as you engage collaboratively with others?
- Which activities do you have underway that will allow for you to expand and push forward to build on action in the next 30 days? 90 days?

Final Thoughts

Join Us for the Next Community of Practice Call!

Join us for the next
Community of Practice Call on May 12, 2022
from 1:00 – 2:00 PM ET

We invite you to register at the following link:

https://zoom.us/webinar/register/WN_ASl_l3p_TEyx_VY_YYFFeA

You will receive a confirmation email with login details.

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Thank You!

Your opinion is valuable to us. Please take 4 minutes to complete the post event assessment here: post assessment_4.14.22

We will use the information you provide to improve future events.