



ESRD Networks 7, 13, 15, 17, 18

# **How to Complete the *Looking at Quality Improvement Through a Health Equity Lens Worksheet***

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# Health Equity Definition

CMS defines health equity as “the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes.”

CMS = The Centers for Medicare & Medicaid Services

# Health-Related Social Needs & Social Determinants of Health

- According to CMS, health-related social needs (HRSN) are *“Individual-level, adverse social conditions that negatively affect an individual’s health or health care.”*<sup>1</sup>
- Social determinants of health (SDOH), also known as social drivers of health, are defined by the CDC as the *“Nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live and age. And the wider set of forces and systems shaping the conditions of daily life.”*<sup>2</sup>
- While both concepts are related to the social factors that influence health outcomes, they differ in their scope.
  - HRSN are more focused on the individual level and refer to specific circumstances that can impact a person’s health.
  - SDOH are broader in scope and encompass a wide range of environmental factors that can impact the health of entire populations.

CDC = The Centers for Disease Control and Prevention

1. CMS. A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool: Promising Practices and Key Insights. Available at <https://www.cms.gov/priorities/innovation/media/document/ahcm-screeningtool-companion>. Accessed on May 1, 2024.

2. CDC. Social Determinants of Health (SDOH) and PLACES Data | PLACES: Local Data for Better Health. Available at <https://www.cdc.gov/places/social-determinants-of-health-and-places-data/index.html>. Accessed on May 1, 2024.

# Looking at Quality Improvement Through a Health Equity Lens Worksheet (pages 1–3)



## Looking at Quality Improvement Through a Health Equity Lens

### Worksheet Instructions

Looking at quality improvement activities through a health equity lens helps us identify health-related social needs (HRSN). HRSNs are individual-level adverse social conditions that negatively affect an individual's health or healthcare.<sup>2</sup> Social determinants of health (SDOH) are defined by CDC as the "Nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live and age. And the wider set of forces and systems shaping the conditions of daily life."<sup>1</sup> HRSNs are frequently identified as root causes of disparities in health outcomes for individual patients, as opposed to SDOH, which is better suited for describing a population. It is important to identify and address SDOH, which often show up as HRSNs in dialysis settings. This worksheet can assist dialysis facilities with addressing HRSNs for a specific patient and SDOH for a diverse population of people at a facility level to improve health outcomes.

#### Action Steps for Facility Staff

Step 1. Choose the Quality Improvement Activity (QIA) or area of care you want to improve (hospitalizations/readmissions, transplant, home dialysis, or vaccinations). If you are a part of the PFE QIA, you can choose from one of three QIA choices (life planning, QAPI or peer mentoring). Then identify the patient population that would be focused on in the QIA (i.e., patients using the hospital for primary medical care or patients that are uninterested in kidney transplant).

Step 2. Choose one patient from the QIA population and complete a screening for HRSNs using the list provided in the table below or you can use this [Health-Related Social Needs Screening Tool](#). The idea is to identify any health-related social needs that appear to be preventing the patient from achieving optimal dialysis or other health outcomes. Choose the most impactful HRSN to work on with the patient.

Step 3. Discuss the QIA and health equity activities with the Interdisciplinary Team (IDT) during monthly QAPI meetings. Determine interventions and resources to use and complete the worksheet monthly or until the HRSN has been addressed.

Step 4. Discuss the QIA interventions and resources to address the HRSN with the patient. Apply interventions with the patient's approval. Monitor and check in frequently with the patient. Identify barriers along the way and assist where needed.

Step 5. Maintain the change. Check in monthly with the patient to identify any barriers or concerns. Update the IDT, monitor the QIA for improvements based on the applied interventions and update your worksheet during this activity.

**Important Note:** Addressing one HRSN can impact other HRSNs. For example, helping your patient find transportation could impact food insecurity, access to healthcare and job insecurity.

#### References:

1. [Social Determinants of Health at CDC | About | CDC](#)
2. [3 disparities July 2022-6-20-2022.pdf \(jointcommission.org\)](#)
3. [Healthy People 2030 | health.gov](#)

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### Identification of Health-Related Social Needs

Health-Related Social Need	Definition of Health-Related Social Need
Food Insecurity	Food insecurity is a household-level economic and social condition of limited or uncertain access to adequate food.
Housing Insecurity	Housing insecurity is an umbrella term that encompasses several dimensions of housing problems people may experience, including affordability, safety, quality, insecurity, and loss of housing.
Transportation Insecurity	A condition in which one is unable to regularly move from place to place in a safe and timely manner because one lacks the material, economic or social resources necessary for transportation.
Racism	Racism can be defined as organized systems within societies that cause avoidable and unfair inequalities in power, resources, capacities, and opportunities across racial or ethnic groups.
Environmental Factors	Environment includes factors such as air quality, water quality, climate change, exposure to hazards, and access to green spaces and parks.
Inadequate Access to Healthcare	The National Academies of Sciences, Engineering, and Medicine (formerly known as the Institute of Medicine) define access to health care as the "timely use of personal health services to achieve the best possible health outcomes."
Unsafe Neighborhood	Neighborhood safety is a social determinant of health that affects the physical and mental health of people who live in places with high rates of violence, crime, and other risks.
Job Insecurity	Job insecurity is powerlessness to assure desired continuity of one's job or job components when either the job or its components are threatened. The term job insecurity can refer not only to the potential loss of the job itself, but also to the threatened loss of key components of the job, such as supervisory activities or pay.
Economic Insecurity	Economic insecurity is living in a household with incomes below 200 percent of the federal poverty level. Today one out of every 3 people in the U.S are economically insecure.
Low Education Attainment	Education is a significant social determinant that influences health over the course of a lifetime. Levels of educational attainment have been directly linked with important health outcomes such as self-rated health, infant mortality, and life expectancy.
Inadequate Health Insurance	Inadequate health insurance coverage is one of the largest barriers to health care access, and the unequal distribution of coverage contributes to disparities in health.
Limited Health Literacy	Personal health literacy is the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.
Limited English Proficiency	LEP means being limited in ability or unable to speak, read and/or write the English language well enough to understand and be understood without the aid of an interpreter.

#### References:

- [Measuring Housing Insecurity in the American Housing Survey | HUD USER](#)  
 "Developing a New Measure of Transportation Insecurity: An Exploratory Factor Analysis." *Survey Practice* 11 <https://doi.org/10.28115/SP-2018-0024>. Understanding Communication and Language Needs of Beneficiaries, April 2017. [Understanding Communication and Language Needs of Medicare Beneficiaries \(cms.gov\)](#). [Racism as a Determinant of Health: A Systematic Review and Meta-Analysis - PMC \(nih.gov\)](#). [Job Security and Insecurity - IResearchNet](#). [SDOH-One-Page-EconomicStability.pdf \(cwis.org\)](#). [Social Determinants of Health: Education - America's Essential Hospitals](#)

### Worksheet

Date QI Activity Started:  Date Completed:

Facility Name:  CCN:

Quality Improvement Activity/Project: Hospitalizations/Readmissions

Identified Health-Related Social Need: Job Insecurity

Did you discuss this activity in your QAPI meeting this month?  Yes  No

1. Initial Plan: Describe the interventions or steps you plan to take this month to address your patient's HRSN.

2. Describe the patient's response to the initial interventions and any related outcome.

3. Monthly updates: What interventions were completed by the facility during the month to address the health-related social need. (Example: I used large-print materials with pictures to teach patient about the importance of missing treatments and reporting symptoms to avoid hospitalizations).

4. Describe any barriers experienced and the facility's plan to address them.

5. Please describe any impact the interventions have had on the patient and the QIA.



# HRSN Worksheet: How to Use With a Quality Improvement Activity (QIA)

- Assign a responsible party for the assessment and worksheet completion.
- Should the clinical or facility manager be in charge of overseeing and reporting the Quality Improvement Activity (QIA), they have the option to delegate the task of evaluating the patient and addressing the patient's HRSN to another person.
- Ensure delegated tasks are reported back monthly for Survey Monkey responses.
- Identify your QIA patient population/patient target group. For instance, should your QIA aim to boost home dialysis, you might concentrate on patients lacking caregiver support or those facing housing insecurity, or perhaps address a different pattern observed within your patient group. Similarly, if your QIA pertains to transplants, you could direct your efforts toward patients who consider age a barrier to transplantation or those who encounter difficulties with transportation. You will choose one patient from this target patient group to assess and address his/her HRSN.
- You can also use the [CMS HRSN Assessment Tool](#) to complete the screening or another HRSN screener tool.

# QIA Scenario: Identify QIA Topic and QIA Patient Population/Patient Target Group

- The facility identifies hospitalizations and readmissions to focus on for the QIA.
- Upon review of the QIA patient population or patient target group, you identify five patients in the facility that are without primary care physicians, resulting in emergency room reliance for their care.
- You then choose one patient to work with. You assess your patient and identify their HRSN utilizing the HRSN list that is on page 2 of the 3-page worksheet.
- Save the worksheet on your computer every month to include in QAPI meetings and for documentation. Saving this worksheet in the EMR is beneficial for efficiently completing the monthly Survey Monkey questionnaires distributed by Network. By scanning to your EMR, it ensures that others can readily consult the worksheet to answer the Survey Monkey questionnaires, providing convenient access.
- Print this worksheet and bring it to your monthly QAPI meeting for the QIA discussion.

QAPI = Quality Assurance and Performance Improvement  
EMR = Electronic medical record

# QIA Scenario: HRSN Screening

- During your assessment of the patient, it becomes evident that he is struggling to understand his medical condition. A brief assessment reveals the patient's limited health literacy.
- In addition to limited health literacy, you also identify that the patient lives rurally and there is a lack of primary care where he lives. You also identify that patient is experiencing some transportation insecurity, as the patient can no longer drive due to limited eyesight and depends on his spouse and family for transportation.
- You then must choose the most impactful HRSN to work on with the patient. The patient is using the ER for his health needs, so you decide to work on lack of access to healthcare because the patient needs a primary care physician. The realization of the patient having limited health literacy emphasizes the importance of delivering straightforward communication, supplying materials that are simple to comprehend, employing the teach-back technique, and thoroughly educating the patient about his health condition and the significance of having primary care.

# QIA Scenario: Patient Discussion

- At this point, it is helpful to reinforce with the patient that it is unknown what services are available, what he qualifies for, and if there are waitlists.
- Inform the patient that everyone will do their best to help him, but there is no guarantee that there will be available services.
- Let the patient know that if there are no available resources, someone will be meeting with him to discuss next steps.
  - This is a great team approach.
- In this scenario, patient (with assistance from the SW) was able to find a rural health clinic close to his home that can provide primary care. By assessing the patient's health literacy, the patient received education and resources that were easy to understand, which also reduced the patient's hospital usage.

SW = social worker

# QIA Scenario: QIA Follow-up

- It is recommended that you print out the worksheet during the evaluation process because everything recorded on it will have to be provided in the monthly Survey Monkey questionnaire sent by the Network. If you have access to a tablet or laptop, or if the patient is at your desk where you can directly input responses into the document, that would be ideal.
- This worksheet can be used monthly until you have addressed the HRSN of the patient. You may end up meeting once with the patient to assess and address all his/her needs or it may take a few months.
- It is suggested that you save your worksheets each month. You can also upload them to your EMR to ensure the continuum of care and to also assist with follow-up. Scanning the worksheet into the EMR will make it easy for you or your QIA Lead to access the information needed. This data is needed to complete the Survey Monkey questionnaires that the Network will send to you.

# HRSN Worksheet: How to Complete the Form

Worksheet  
Date QI Activity Started:  Date Completed:   
Facility Name:  CCN:   
Quality Improvement Activity/Project: Hospitalizations/Readmissions ▾  
Identified Health-Related Social Need: Job Insecurity ▾  
Did you discuss this activity in your QAPI meeting this month?  Yes  No

1. Initial Plan: Describe the interventions or steps you plan to take this month to address your patient's HRSN.

2. Describe the patient's response to the initial interventions and any related outcome.

3. Monthly updates: What interventions were completed by the facility during the month to address the health-related social need. (Example: I used large-print materials with pictures to teach patient about the importance of missing treatments and reporting symptoms to avoid hospitalizations).

4. Describe any barriers experienced and the facility's plan to address them.

5. Please describe any impact the interventions have had on the patient and the QIA.

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- **NOTE: Please open in the Google Chrome browser or download to your desktop to use the drop-down menus.**
- There are two dates at the top of the worksheet. One date is when the QIA or Network project started, and the other is the date completed. You may end up needing to work with your patient for several months to address his/her HRSN, and so having these dates will be helpful to keep track each month.
- Please be sure to accurately enter the name of your facility and your Certified CMS number (CCN) number. If you are unfamiliar with this number, please ask your manager for it.
- Choose your QIA and the HRSN you identified during the patient's assessment.
- Box #1 is where you will describe the proposed interventions or steps you and your team intend to take to address one of the HRSN that was identified during the patient's assessment .
- Box #2 is where you will describe your patient's reaction.
- Box #3 is where you will describe the actual interventions or steps you took each month while working with the patient.
- Box #4 discusses barriers experienced and your plan to address them. If there are no new barriers identified or no new impact on the patient, note "none identified."
- Box #5 is where you will describe the impact and success your interventions had on your patient and the QIA.

# References

- CMS. *CMS Framework for Health Equity*. October 2023: 2. Available at <https://www.cms.gov/priorities/health-equity/minority-health/equity-programs/framework>. Accessed on May 1, 2024.
- CMS. *A Guide to Using the Accountable Communities Health-Related Social Needs Screening Toolkit*. August 2022. Available at <https://www.cms.gov/priorities/innovation/media/document/ahcm-screeningtool-companion>.
- CDC. *Social Determinants of Health (SDOH) and PLACES Data*. May 2022: 27. Available at <https://www.cdc.gov/places/social-determinants-of-health-and-places-data/index.html>.



*ESRD Networks 7, 13, 15, 17, 18*

# Thank you!

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