Health Equity Quickinar Series
Session 1

Health Equity, Hospitals, and CMS* Reporting
Health Equity Quickinar Series Overview

• 12 sessions
• Live and on-demand
• 2nd and 4th Thursdays
• 30 minutes or less
• Support to advance health equity in your facility
• Assistance in meeting new CMS health equity measures
HSAG Health Equity Series Website

Recordings, slides, and resource links will be posted for on-demand access after every session.

1. Health Equity, Hospitals, and CMS Reporting
2. Engaging Leadership in Health Equity
3. Health Equity as a Strategic Priority
4. Collection 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. Best Practices in Health Equity Interventions
11. Community Paramedicine
12. Identifying Community Health Disparities
13. Community Engagement—Health Equity

www.hsag.com/health-equity-quickinars
Health Equity Video

- Short video—1:21
- Importance of health equity
- Your “elevator speech”
- Assists with getting buy-in

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The Health Equity Quickinar Series will also assist hospitals participating in the CMS HQIC.*

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*HEOA = Health Equity Organizational Assessment
HQIC = Hospital Quality Improvement Contract
• Identify health equity and the role that social determinants of health play.
• Discuss how health equity impacts your facility.
• Review the current CMS health equity measures and how the HSAG HQIC Change Package can assist you in meeting that criteria.
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 exist even when adjusted for demographics and socioeconomic factors.
Race is defined as “a group sharing some outward physical characteristics and some commonalities of culture and history.”

Ethnicity “refers to markers acquired from the group with which one shares cultural, traditional, and familial bonds.”

https://www.merriam-webster.com/words-at-play/difference-between-race-and-ethnicity
Populations Experiencing Disparities

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

https://www.cdc.gov/healthequity/whatis/index.html
What Is 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.” —CDC

- Length of life
- Rates of disease, disability, and death
- Severity of disease
- Access to treatment
The Impact of Health Equity
Greatest Predictor of Life Expectancy

Your ZIP Code

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

Social Determinants as a Healthcare Driver

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

—National Academy of Medicine

https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/
Why Address Health Disparities

- Part of a hospital’s mission, vision, values
- To serve the underserved
- Part of community health needs assessment
- Human toll

- High resource utilization
- Increased readmission rate
- Increased non-compliance
- Increased emergency department utilization
- Increased chronic conditions

- $93 billion in excess medical costs annually\(^1\)
- Expected to rise to $1 trillion by 2040\(^2\)
- Increase in unreimbursed care
- Value-based payment penalties due to increases in adverse outcomes

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

<table>
<thead>
<tr>
<th>5 Health Equity Commitment Domains¹</th>
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<tbody>
<tr>
<td>Domain 1: Equity is a Strategic Priority</td>
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<tr>
<td>Domain 2: Data Collection</td>
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<tr>
<td>Domain 3: Data Analysis</td>
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<td>Domain 4: Quality Improvement</td>
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<td>Domain 5: Leadership Engagement</td>
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- 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 2024²
- Annual submission

Domain 1: Equity as a Strategic Priority

Must have a strategic plan that:

- Identifies priority populations currently experiencing health disparities.
- Identifies healthcare 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.
Domain 2: Data Collection

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

*EHR = electronic health record
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.
Domain 4: Quality Improvement

Participates in local, regional, or national quality improvement activities focused on reducing health disparities.
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.
## Social Drivers of Health—Two Measures

### Screening for Social Drivers of Health Measure

- Food insecurity
- Housing instability
- Transportation needs
- Utilities difficulties
- Interpersonal safety

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of patients who were screened for <strong>one or all</strong> social drivers</th>
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</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Number of patients 18 or older admitted as an inpatient</td>
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</table>

### Screen Positive Rate for Social Drivers of Health Measure

- Food insecurity
- Housing instability
- Transportation needs
- Utilities difficulties
- Interpersonal safety

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<thead>
<tr>
<th>Numerator</th>
<th>Number of patients who screened positive for each driver</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Number of patients 18 or older admitted as an inpatient and screened for social drivers</td>
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</tbody>
</table>

Screening for Social Drivers of Health

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

• Start now!
• Identify your team.
• Attend the HSAG Health Equity Quickinar Series.
• Discover how to recognize and advance health equity.
• HSAG will help you meet the metrics!
Thank you!