Equitable Care Measures Review

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Learning Objectives

- Identify the goals and differences of the three new measures
- Review the timeline for these measure requirements
- Understand how these new measures will be scored
- Learn our top tips for collecting and reporting these measures

Health Equity

AHA - Health Equity is where all individuals reach their highest potential for health.

*American Hospital Association. (2020). Health Equity, Diversity & Inclusion Measures for Hospitals and Health System Dashboards. December 2020. Accessed: January 18, 2022. Available at: https://ifdhe.aha.org/system/files/media/file/2020/ 12/ifdhe_inclusion_dashboard.pdf.

CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs.

https://www.cms.gov/pillar/health-equity

The Joint Commission's vision is that "all people always experience safe, high quality health care."

https://www.jointcommission.org/our-priorities/health-care-equity/

Health Equity Measures

Health Equity Measures

1

Hospital Commitment to Health Equity
HCHE

Required 2023

Publicly Reported

2

3

Health Equity Measures

1

Hospital Commitment to Health Equity
HCHE

Required 2023

Publicly Reported

2

Screening for Social Drivers of Health
SDOH-1

Available 2023
Required 2024

3

Health Equity Measures

1

Hospital Commitment to Health Equity
HCHE

Required 2023

Publicly Reported

2

Screening for Social Drivers of Health
SDOH-1

Available 2023
Required 2024

3

Screen Positive Rate for Social Drivers of Health
SDOH-2

Available 2023
Required 2024

Three Health Equity Measures

Structural Measures				
Short Name	**Measure Name**	**Discharge Dates**	**Submission Window**	**Submission Method**
HCHE	Hospital Commitment to Health Equity	January 1, 2023 – December 31, 2023	April 1, 2024 – May 15, 2024	HQR web-based data collection tool
SDOH-1	Screening for Social Drivers of Health	January 1, 2023 – December 31, 2023	April 1, 2024 – May 15, 2024	HQR web-based data collection tool
SDOH-2	Screen Positive Rate for Social Drivers of Health	January 1, 2023 – December 31, 2023	April 1, 2024 – May 15, 2024	HQR web-based data collection tool

Hospital Commitment to Health Equity (HCHE)

HCHE

“While many factors contribute to health equity, we believe this measure is an important step toward assessing *hospital leadership commitment*, and a fundamental step toward closing the gap in equitable care for all populations”

-CMS

HCHE

1. **The HCHE measure assesses hospital commitment to health equity across five domains**
2. **Uses organizational competencies to achieve health equity for:**
   - Racial and ethnic minority groups
   - People with disabilities
   - Members of the LGBTQ+ community
   - Individuals with limited English proficiency
   - Rural populations
   - Religious minorities
   - People facing socioeconomic challenges
3. **Actionable focus areas**
4. **Assesses of hospital leadership commitment to the focus areas**
5. **Incentivizes hospitals & providers to:**
   - Collect and evaluate data to identify equity gaps
   - Implement plans to address gaps
   - Dedicate resources to healthcare equity initiatives

HCHE

- Required in 2023
- Hospitals must meet the requirements of *all* 5 domains
- To receive a point for that domain, hospitals must affirmatively attest to each element within the domain
- 1 point per domain for a total of 5 points

HCHE
Domains & Elements

Domains	Elements
Equity is a Strategic Priority (4 elements met = 1 point)	Our hospital strategic plan: • Identifies priority populations who currently experience health disparities. • Identifies healthcare equity goals and discrete action steps to achieving these goals. • Outlines specific resources which have been dedicated to achieving our equity goals. • Describes our approach for engaging key stakeholders, such as community-based organizations.
Data Collection (3 elements met = 1 point)	Our hospital: • Collects demographic information, including self-reported race and ethnicity and/or social determinant of health information on the majority of our patients. • Has training for staff in culturally sensitive collection of demographic and/or social determinant of health information. • **Inputs demographic and/or social determinant of health information collected from patients into structured, interoperable data elements using a certified EHR technology.**
Data Analysis (1 element met = 1 point)	• **Our hospital 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.**
Quality Improvement (1 element met = 1 point)	• Our hospital participates in local, regional, or national quality improvement activities focused on reducing health disparities.
Leadership Engagement (2 elements met = 1 point)	Our hospital senior leadership, including chief executives and the entire hospital board of trustees annually reviews: • Our strategic plan for achieving health equity. • Key performance indicators stratified by demographic and/or social factors.

Social Drivers of Health (SDOH)

Social Drivers of Health

- **Social Drivers of Health (SDOH) are 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.**
- **SDOH can be grouped into 5 domains.**

Social Determinants of Health
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Healthy People 2030

SDOH

- Identify patients with Health-Related Social Needs (HRSNs)
- HRSNs are “individual-level, adverse social conditions that negatively impact a person’s health or healthcare”
- *These patients have the greatest risk of poor health outcomes*
- U.S. Department of Health and Human Services

SDOH

Identifying HRSNs in patients has significant benefits:

1. Serves as evidence-based building blocks for supporting hospitals and health systems in actualizing commitment to address disparities, improve health equity through addressing the social needs with community partners, and implement associated equity measures to track progress.
2. Support ongoing quality improvement initiatives by providing data with which to stratify patient risk and organizational performance
3. Encourages collaboration between healthcare providers and community-based organizations and in implementing and evaluating related innovations in health and social care delivery
4. Enables systematic collection of Health-Related Social Needs data

SDOH

Rationale for SDOH Measures:

- 92% of hospitals screen for one or more of the five HRSNs
- Only 24% of hospitals screen for all five HRSNs

Evidence shows that social risk factors are directly associated with:

- Patient outcomes
- Healthcare utilization
- Costs
- Performance in quality-based payment programs

Widespread hospital/provider support for addressing HRSNs

SDOH

Goals:

- Identify high-risk patients with improved accuracy
- Reduce healthcare access barriers
- Address the disproportionate expenditures attributed to high-risk population groups
- **Improve quality of care**

SDOH-1

Screening for Social Drivers of Health

SDOH-1: Screening for Social Drivers of Health

Measure Specification

Evaluates whether a hospital is screening *all* patients for *all* 5 Health Related Social Needs (HRSNs):

- Food Insecurity
- Housing Instability
- Transportation Needs
- Utility Difficulties
- Interpersonal Safety

Performance Measure Name: Screening for Social Drivers of Health

Description: The Screening for Social Drivers of Health Measure assesses whether a hospital implements screening for all patients that are 18 years or older at time of admission for food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety. To report on this measure, hospitals will provide: (1) The number of patients admitted to the hospital who are 18 years or older at time of admission and who are screened for each of the five HRSNs: Food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety; and (2) the total number of patients who are admitted to the hospital who are 18 years or older on the date they are admitted.

Measure Numerator: The numerator consists of the number of patients admitted to an inpatient hospital stay who are 18 years or older on the date of admission and are screened for all of the following five HRSNs: Food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety during their hospital inpatient stay.

Measure Denominator: The denominator consists of the number of patients who are admitted to a hospital inpatient stay and who are 18 years or older on the date of admission.

Exclusions: The following patients will be excluded from the denominator: (1) Patients who opt- out of screening; and (2) patients who are themselves unable to complete the screening during their inpatient stay and have no legal guardian or caregiver able to do so on the patient's behalf during their inpatient stay.

Clarifying Information: The Screening for Social Drivers of Health measure will be calculated as the number of patients admitted to an inpatient hospital stay who are 18 years or older on the date of admission screened for all five HRSNs (food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety) divided by the total number of patients 18 years or older on the date of admission admitted to the hospital. Hospitals would report using their CCN through the Hospital Quality Reporting (HQR) System.

SDOH-1: Screening for Social Drivers of Health

IPP/Denominator -

- Admitted Inpatients
- ≥18 years

Denominator Exclusions -

- Opt-out of screening or
- Unable to complete the screening and no legal guardian/caregiver able to do so on the patient's behalf

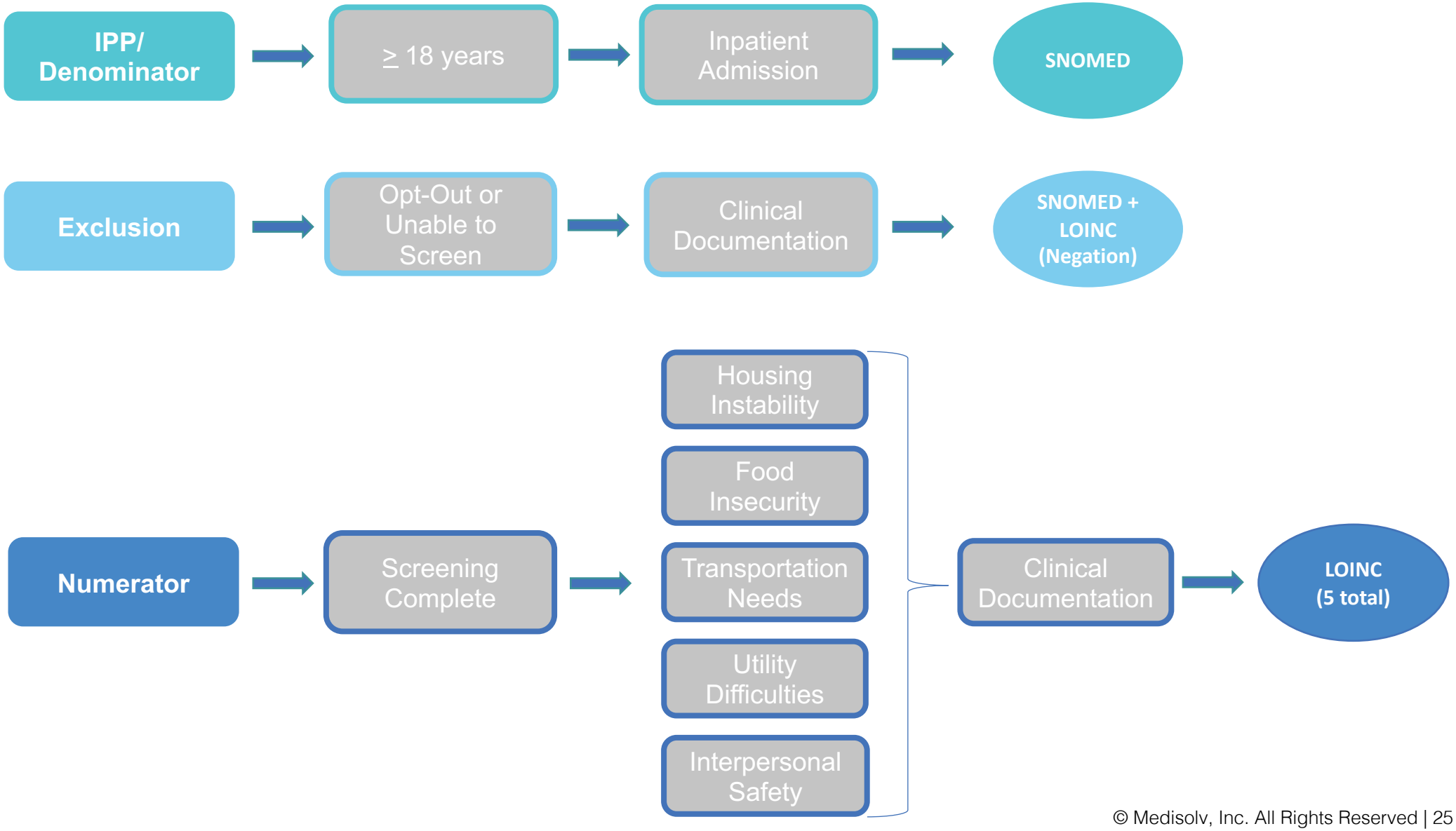
Numerator - Screening completed on all HRSNs

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

SDOH-1: Screening for Social Drivers of Health

Measure ID	Measure Name	Denominator	Exclusion	Numerator	In Denominator Only	Result
SDOH-1	Screening for Social Drivers of Health	All Admitted Inpatients who are ≥18 years	Total unique encounters with at least 1 opt-out or unable to complete screening response for any of the 5 HRSNs	Total encounters where screening is completed on all 5 HRSNs	Any encounter without screening on all 5 HSRNs	Numerator div by (Denominator minus Exclusions) %
Strata 1	Food Insecurity	All Admitted Inpatients Encounters, ≥18 years	Opt-out or Unable to complete food insecurity screening	Total encounters NOT screened for food insecurity		Numerator div by (Denominator minus Exclusions) %
Strata 2	Housing Instability	All Admitted Inpatients Encounters, ≥18 years	Opt-out or Unable to complete housing instability screening	Total encounters NOT screened for housing instability		Numerator div by (Denominator minus Exclusions) %
Strata 3	Transportation needs	All Admitted Inpatients Encounters, ≥18 years	Opt-out or Unable to complete transportation needs screening	Total encounters NOT screened for transportation needs		Numerator div by (Denominator minus Exclusions) %
Strata 4	Utility Difficulties	All Admitted Inpatients Encounters, ≥18 years	Opt-out or Unable to complete utility difficulties screening	Total encounters NOT screened for utility difficulty		Numerator div by (Denominator minus Exclusions) %
Strata 5	Interpersonal Safety	All Admitted Inpatients Encounters, ≥18 years	Opt-out or Unable to complete safety screening	Total encounters NOT screened for safety		Numerator div by (Denominator minus Exclusions) %

SDOH-1: Screening for Social Drivers of Health



SDOH-2

Screen Positive Rate for Social Drivers of Health

SDOH-2: Screen Positive Rate for Social Drivers of Health

Measure Specification

- **Evaluates the number of patients who were screened and screened positive for one or more of the 5 HRSNs**
- **Calculated as 5 separate rates**

Performance Measure Name: Screen Positive Rate for Social Drivers of Health

Description: The Screen Positive Rate for Social Drivers of Health Measure provides information on the percent of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, were screened for an HSRN, and who screen positive for one or more of the following five HRSNs: Food insecurity, housing instability, transportation problems, utility difficulties, or interpersonal safety.

Measure Numerator: The numerator consists of the number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, who were screened for all five HSRN, and who *screen positive* for having a need in one or more of the following five HRSNs (calculated separately): Food insecurity, housing instability, transportation needs, utility difficulties or interpersonal safety.

Measure Denominator: The denominator consists of the number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission and are screened for all of the following five HSRN (food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety) during their hospital inpatient stay.

Exclusions: The following patients would be excluded from the denominator: 1) Patients who opt-out of screening; and 2) patients who are themselves unable to complete the screening during their inpatient stay and have no caregiver able to do so on the patient's behalf during their inpatient stay.

Clarifying Information: The result of this measure would be calculated as *five separate rates*. Each rate is derived from the number of patients admitted for an inpatient hospital stay and who are 18 years or older on the date of admission, screened for an HRSN, and who screen positive for each of the five HRSNs—food insecurity, housing instability, transportation needs, utility difficulties, or interpersonal safety—divided by the total number of patients 18 years or older on the date of admission screened for all five HRSNs.

SDOH-2: Screen Positive Rate for Social Drivers of Health

IPP/Denominator -

1. Admitted Inpatients
2. ≥18 years
3. Screened for all HRSNs (overall Numerator from measure 1)

Denominator Exclusions -

1. Opt-out of screening
2. Unable to complete the screening and no legal guardian/caregiver able to do so on the patient's behalf

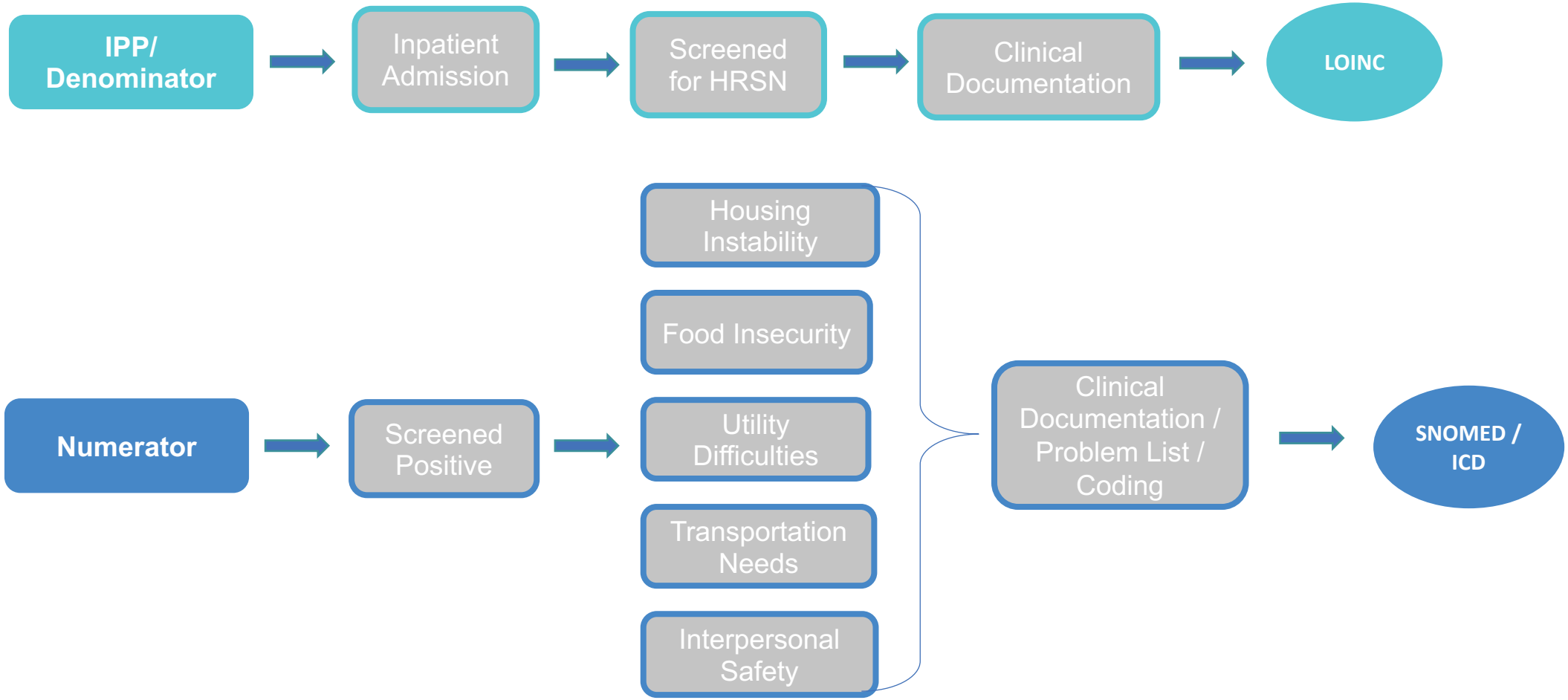
Numerator - Total patients screened positive for each unique HRSN (reported as 5 separate rates)

1. Food insecurity
2. Housing instability
3. Transportation needs
4. Utility difficulties
5. Interpersonal safety

SDOH-2: Screen Positive Rate for Social Drivers of Health

Measure ID	Measure Name	Denominator	Exclusion	Numerator	Result
	Screen Positive for Social Drivers of Health	Admitted Inpatients who are ≥18 years and have screening completed on all 5 HRSNs (equivalent to the numerator from SDOH-1)		Total encounters with a positive screen on 1 or more of the five HRSNs	Numerator div by (Denominator) %
SDOH-2	Food Insecurity	Admitted Inpatients who are ≥18 years and have screening completed on all 5 HRSNs	Opt-out or Unable to complete	Total encounters screened positive for food insecurity	Numerator div by (Denominator minus Exclusions) %
SDOH-2	Housing Instability	Admitted Inpatients who are ≥18 years and have screening completed on all 5 HRSNs	Opt-out or Unable to complete	Total encounters screened positive for housing instability	Numerator div by (Denominator minus Exclusions) %
SDOH-2	Transportation needs	Admitted Inpatients who are ≥18 years and have screening completed on all 5 HRSNs	Opt-out or Unable to complete	Total encounters screened positive for transportation needs	Numerator div by (Denominator minus Exclusions) %
SDOH-2	Utility Difficulties	Admitted Inpatients who are ≥18 years and have screening completed on all 5 HRSNs	Opt-out or Unable to complete	Total encounters screened positive for utility difficulties	Numerator div by (Denominator minus Exclusions) %
SDOH-2	Interpersonal Safety	Admitted Inpatients who are ≥18 years and have screening completed on all 5 HRSNs	Opt-out or Unable to complete	Total encounters screened positive for safety	Numerator div by (Denominator minus Exclusions) %

SDOH-2: Screen Positive Rate for Social Drivers of Health



Top Tips:

Implementation, Tracking, Analysis & Improvement

Implementation

- Identify stakeholders and determine role/responsibilities
- Understand and review HCHE domains and elements & SDOH specifications
- Identify resources
- Document current state and gaps
- Project plan to meet HCHE domain requirements
- Review and select SDOH screening tool
- Build workflow & educate end-users
- Implement screening and reports
- Tracking results
- Improvement planning

Implementation

SDOH Screening:

Can use any self-selected screening tool but AHC Health-Related Social Needs Screening Tool is recommended resource/reference in set-up: https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

Additional tools:

https://sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison

Consider needs and populations in decision making

Tracking & Analysis

Domains	Elements
Equity is a Strategic Priority (4 elements met = 1 point)	Our hospital strategic plan: • Identifies priority populations who currently experience health disparities. • Identifies healthcare equity goals and discrete action steps to achieving these goals. • Outlines specific resources which have been dedicated to achieving our equity goals. • Describes our approach for engaging key stakeholders, such as community-based organizations.
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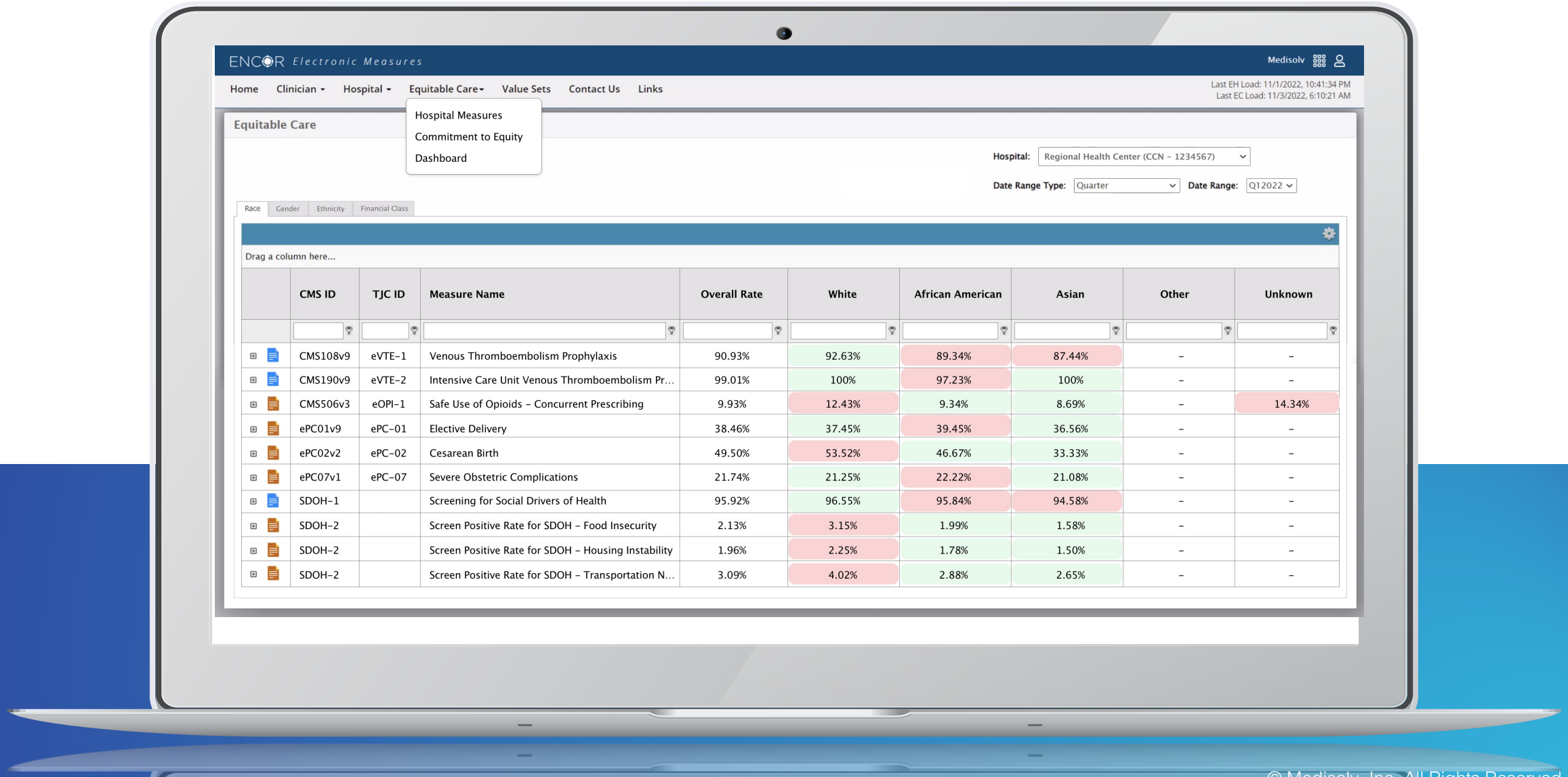
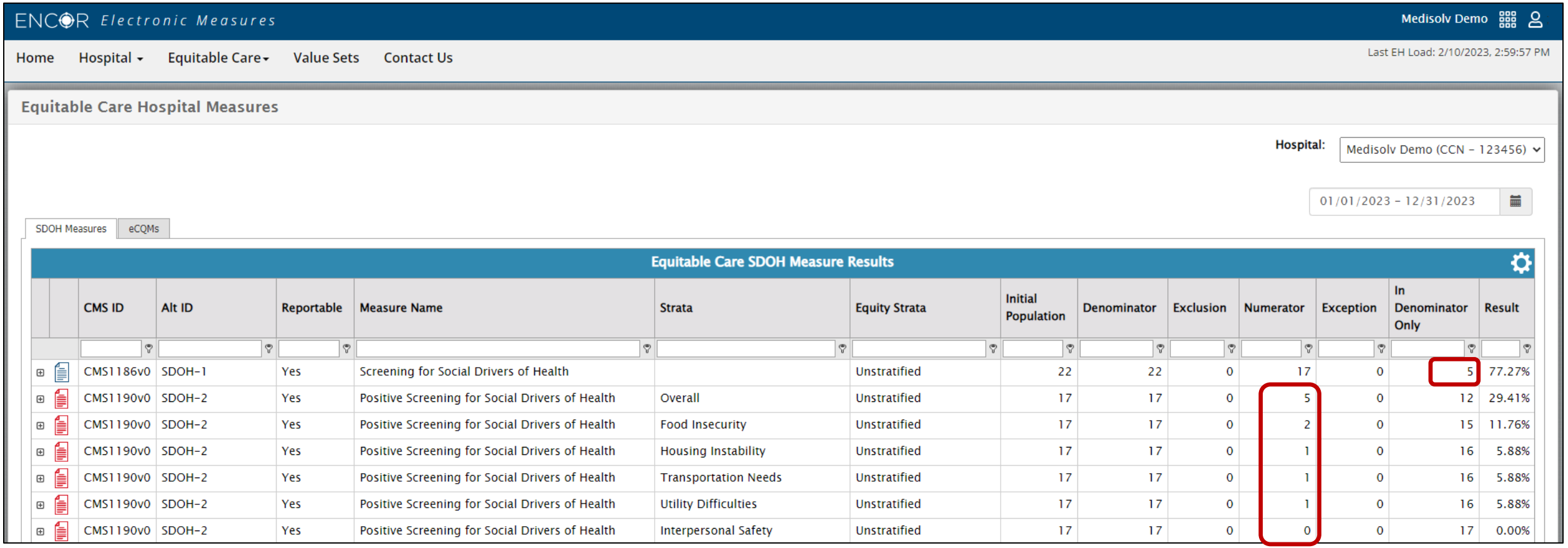
Leadership Engagement (2 elements met = 1 point)	Our hospital senior leadership, including chief executives and the entire hospital board of trustees annually reviews: • Our strategic plan for achieving health equity. • Key performance indicators stratified by demographic and/or social factors.

Tracking & Analysis: Dashboard

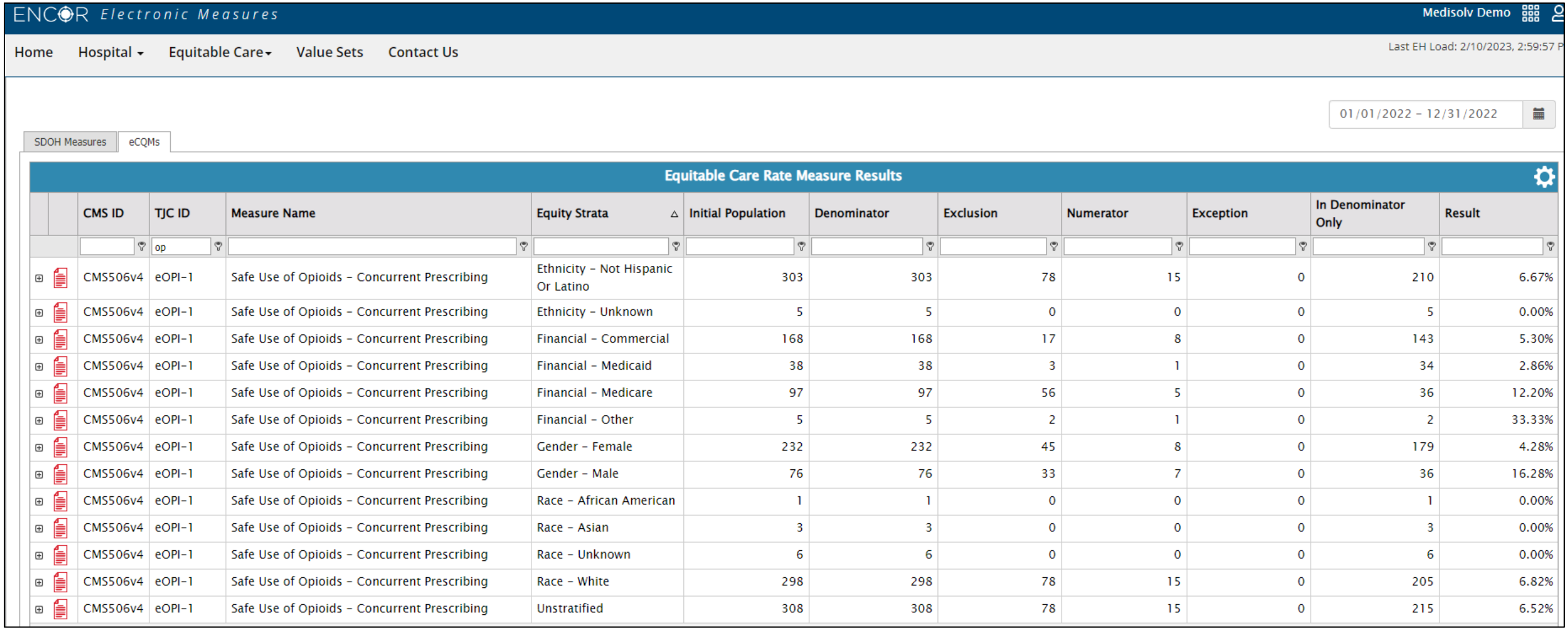


Tracking & Analysis: SDOH-1 & SDOH-2



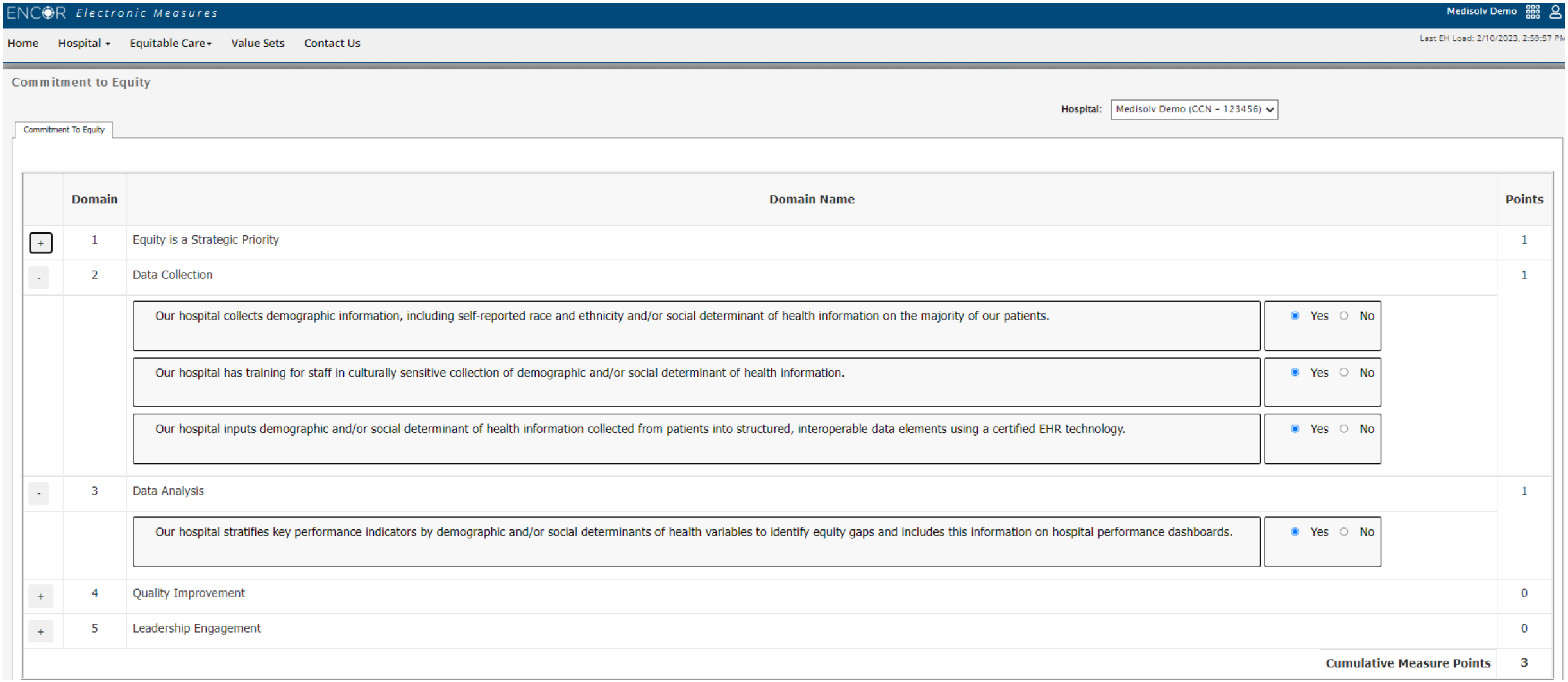
CMS ID	Alt ID	Reportable	Measure Name	Strata	Equity Strata	Initial Population	Denominator	Exclusion	Numerator	Exception	In Denominator Only	Result
CMS1186v0	SDOH-1	Yes	Screening for Social Drivers of Health		Unstratified	22	22	0	17	0	5	77.27%
CMS1190v0	SDOH-2	Yes	Positive Screening for Social Drivers of Health	Overall	Unstratified	17	17	0	5	0	12	29.41%
CMS1190v0	SDOH-2	Yes	Positive Screening for Social Drivers of Health	Food Insecurity	Unstratified	17	17	0	2	0	15	11.76%
CMS1190v0	SDOH-2	Yes	Positive Screening for Social Drivers of Health	Housing Instability	Unstratified	17	17	0	1	0	16	5.88%
CMS1190v0	SDOH-2	Yes	Positive Screening for Social Drivers of Health	Transportation Needs	Unstratified	17	17	0	1	0	16	5.88%
CMS1190v0	SDOH-2	Yes	Positive Screening for Social Drivers of Health	Utility Difficulties	Unstratified	17	17	0	1	0	16	5.88%
CMS1190v0	SDOH-2	Yes	Positive Screening for Social Drivers of Health	Interpersonal Safety	Unstratified	17	17	0	0	0	17	0.00%

Tracking & Analysis: Measure Stratification



CMS ID	TJC ID	Measure Name	Equity Strata	Initial Population	Denominator	Exclusion	Numerator	Exception	In Denominator Only	Result
CMS506v4	eOPI-1	Safe Use of Opioids – Concurrent Prescribing	Ethnicity – Not Hispanic Or Latino	303	303	78	15	0	210	6.67%
CMS506v4	eOPI-1	Safe Use of Opioids – Concurrent Prescribing	Ethnicity – Unknown	5	5	0	0	0	5	0.00%
CMS506v4	eOPI-1	Safe Use of Opioids – Concurrent Prescribing	Financial – Commercial	168	168	17	8	0	143	5.30%
CMS506v4	eOPI-1	Safe Use of Opioids – Concurrent Prescribing	Financial – Medicaid	38	38	3	1	0	34	2.86%
CMS506v4	eOPI-1	Safe Use of Opioids – Concurrent Prescribing	Financial – Medicare	97	97	56	5	0	36	12.20%
CMS506v4	eOPI-1	Safe Use of Opioids – Concurrent Prescribing	Financial – Other	5	5	2	1	0	2	33.33%
CMS506v4	eOPI-1	Safe Use of Opioids – Concurrent Prescribing	Gender – Female	232	232	45	8	0	179	4.28%
CMS506v4	eOPI-1	Safe Use of Opioids – Concurrent Prescribing	Gender – Male	76	76	33	7	0	36	16.28%
CMS506v4	eOPI-1	Safe Use of Opioids – Concurrent Prescribing	Race – African American	1	1	0	0	0	1	0.00%
CMS506v4	eOPI-1	Safe Use of Opioids – Concurrent Prescribing	Race – Asian	3	3	0	0	0	3	0.00%
CMS506v4	eOPI-1	Safe Use of Opioids – Concurrent Prescribing	Race – Unknown	6	6	0	0	0	6	0.00%
CMS506v4	eOPI-1	Safe Use of Opioids – Concurrent Prescribing	Race – White	298	298	78	15	0	205	6.82%
CMS506v4	eOPI-1	Safe Use of Opioids – Concurrent Prescribing	Unstratified	308	308	78	15	0	215	6.52%

Tracking & Analysis: HCHE



Measure Improvement

- Consistent workflow and data capture
- Data accuracy
- Standards / Consistency across organization
- Tracking and analysis of results
- Transparency / Feedback

Improvement

Requires an **interdisciplinary, team-based** approach to ensure everyone can achieve optimal health that is fair and just, especially for individuals who have the greatest need. (AHA)

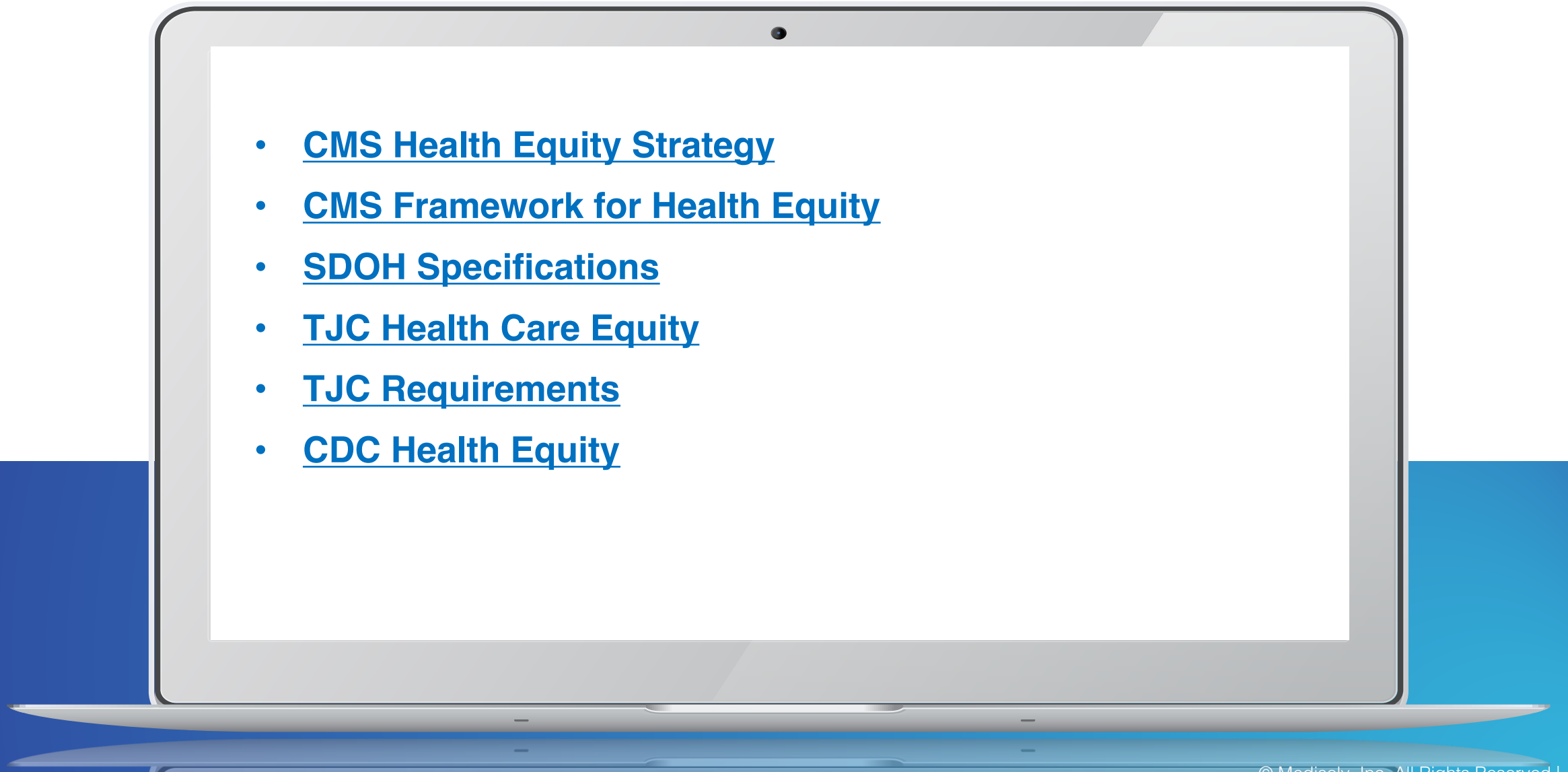
Eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our enrollees need to thrive. (CMS)

To achieve sustainable improvement, we need to approach health care equity in the same way we approach other crucial patient safety priorities — by **understanding the root causes and implementing targeted standards of care**. (TJC)

Lessons Learned

- Keep up with communications and updates from CMS
- Standardize data collection across health system
- Determine how and when data will be collected
- Plan for connecting to resources
- Establish relationships with community organizations
- Share results

Resources



- CMS Health Equity Strategy
- CMS Framework for Health Equity
- SDOH Specifications
- TJC Health Care Equity
- TJC Requirements
- CDC Health Equity

**“If not us,
then who?
If not now,
then when?”**

-John Lewis

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