ACHC U
EDUCATIONAL RESOURCES

ACUTE CARE HOSPITAL   CRITICAL ACCESS HOSPITAL

Using Data to Make Informed Decisions About Your Disparity and Equity Initiatives

Christopher Pratt MS, BSN, RN, HACP-CMS, Senior Consultant

ACHCU IS A BRAND OF ACCREDITATION COMMISSION *for* HEALTH CARE

ACHC

First, a story……

Admission and Discharge Summary

I. Patient Information

Upon admission to and discharge from a healthcare facility, it is crucial to document comprehensive details about the patient's medical history and care. This section provides essential information regarding the patient's identity and pertinent medical details.

A. Admission Details

- **[Patient Name]:** [Insert patient's full name]
- **[Date of Birth]:** [Insert patient's date of birth]
- **[Gender]:** [Insert patient's gender]
- **[Address]:** [Insert patient's full address]
- **[Phone Number]:** [Insert patient's contact number]
- **[Medical Record Number]:** [Insert patient's unique medical record identifier]

B. Discharge Details

- **[Discharge Date]:** [Insert date of discharge]
- **[Reason for Admission]:** [Briefly describe the reason for the patient's admission]
- **[Reason for Discharge]:** [Specify the reason for the patient's discharge]

II. Medical History

This section outlines the patient's medical history, including relevant past illnesses, surgeries, and chronic conditions.

A. Past Medical History

- **[Chronic Conditions]:** [List any chronic medical conditions the patient has]
- **[Past Surgeries]:** [Specify any previous surgeries undergone by the patient]

Inequity, Disparity, and Data

It's All About Quality

CMS Framework for Health Equity

- 10-year plan to embed Health Equity across all CMS programs.

- Establishes their commitment to addressing disparities in healthcare.

CMS Framework for Health Equity 2022–2032

GO.CMS.GOV/OMH

The Centers for Medicare and Medicaid Services

Priorities

Priority 1:
Expand the Collection, Reporting, and Analysis of Standardized Data

Priority 2:
Assess Causes of Disparities Within CMS Programs, and Address Inequities in Policies and Operations to Close Gaps

CMS Framework for Health Equity Priorities

Priority 5:
Increase All Forms of Accessibility to Health Care Services and Coverage

Priority 3:
Build Capacity of Health Care Organizations and the Workforce to Reduce Health and Health Care Disparities

Priority 4:
Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services

The Centers for Medicare and Medicaid Services

CMS Health Equity Goals 2022

- Close the **gaps** in health care **access**, **quality**, and **outcomes**.

- Promote culturally and linguistically appropriate services.

- Build on outreach efforts.

- Expand and standardize the collection and use of data.

- Evaluate policies.

- Ensure engagement with and accountability to the communities CMS serves.

- Incorporate screening for and promote broader access to health-related social needs.

- Ensure CMS programs serve as a model and catalyst to advance health equity.

- Use the framework to promote the highest quality outcomes and safest care.

Where to Begin? Ask Ourselves…

- Are we delivering equitable care to everyone?

- Have we measured it?

Using Quality Data Allows Healthcare Organizations to:

- Discover and prioritize differences in care, outcomes, and/or experiences across patient groups.

- Plan equity-focused care transformations and measure impact.

- Tell the story of how patients experience health care.

"Without data, you're just another person with an opinion."

– W. Edwards Deming

The W. Edwards Deming Institute

ACHCU is a brand of ACHC.

Discovering Healthcare Disparities

Healthcare organizations must:

- Understand where disparities exist and who they affect.

- The magnitude of the disparities.

- Why these disparities are occurring within their patient population.

Identifying Health Disparities and Priority Populations

Use available data sources to help you identify and prioritize which population and health care disparities you want to address.

- Is your data accurate?

- What data will you use to identify disparities and/or your priority populations?

- What population will you prioritize?

- What disparities do you want to address?

Identifying Populations

Assess and stratify patient population based on sociodemographic data.

- Racial or ethnic group
- Religion
- Socioeconomic status
- Gender
- Age
- Mental health

- Cognitive, sensory, or physical disability
- Sexual orientation or gender identity
- Geographic location
- Language
- Other characteristics

Identifying Populations

Review current processes to determine if you are soliciting information to identify your patient populations.

- Admission/Assessment data

- Customer satisfaction surveys

- Customer complaints

- Patient Safety Events

- Patient/Family Advisory Committee

- Local special interest groups

- Social Media

Strategic Comparisons

- Identify how a chosen quality measure is distributed within each demographic group (rather than how the measure is distributed across the whole population).

- Compare the distribution in one group against the distribution in another.

Screening for Health-Related Social Needs

- Housing instability

- Safety needs

- Food insecurity

- Lack of education

- Utility needs

- Lack of access to transportation

Screening for Health-Related Social Needs

- Determine **which data** to collect and the **size of the population** to screen.

- Accrediting Organizations may allow organizations to assess HRSNs for a <u>representative sample</u> of their patients rather than all patients.

- Focus on the **social needs** that are most **practical** and **relevant** for your unique situation.

- Determine what information about interventions, services and resources <u>in the community</u> are needed to address the HRSNs of your patients.

Screening Tools

- **American Academy of Family Physicians (AAFP)** www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/hops19-physician-form-sdoh.pdf

- **Accountable Health Communities (AHC) Health-Related Social Needs Screening Tool.** https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

- **Boston Medical Thrive Screening.** https://sirenetwork.ucsf.edu/sites/default/files/2021-02/BMC-THRIVE.pdf

- **Health Leads Social Needs Screening Toolkit.** https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/

- **PRAPARE Screening Tool. National Association of Community Health Centers.** https://prapare.org/the-prapare-screening-tool/

What about Social Determinates of Health?

- Social determinants of health are non-medical factors affecting health, like socioeconomic status, and geographic location.

- Addressing SDOH can enhance health and lead to better outcomes.

- May be beyond scope of Healthcare Organizations to change.

The Centers for Disease Control and Prevention

Patient Safety Events

- Often overlooked for disparity opportunities

- Overlay disparity data with safety event analysis.

- <u>Consider the use of rate as a more accurate measure than incidence.</u>

- **Don't forget near misses!**

Problem Prone and High-Risk Issues

- Restraint use

- Suicide Screening

- Medication Errors

- Hospital Acquired Conditions
  - SSIs
  - CLABSI
  - CAUTI
  - HAPI
  - Obstetric Adverse Events
  - Adverse Drug Events

Benchmarks and Meaningful Differences

- Alternative to rigorous statistical analysis.

- Benchmark current data against historical data sources.

- Multiple measures may be necessary when a single measure doesn't make disparity apparent.

Sources of National Data

SAMPLE NQF- ENDORSED™ NATIONAL PERFORMANCE MEASURES TO ADDRESS HEALTHCARE DISPARITIES	
Condition Areas	**Measure Description**
Infant Mortality	• Adverse outcome index • Unplanned Maternal Admission to the ICU • Neonatal Intensive Care All-Condition Readmissions
Mental Illness	• Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment Child and Adolescent Major Depressive Disorder: Diagnostic Evaluation • Preventative Care and Screening: Screening for Depression and Follow Up Plan
Cardiovascular Disease	• Controlling High Blood Pressure for People with Serious Mental Illness Heart Failure Symptoms Assessed and Addressed • Median Time to ECG
Diabetes/Chronic Kidney Disease	• Adherence to ACEIs/ARBs for Individuals with Diabetes Mellitus Controlling High Blood Pressure • Patient Education Awareness—Physician Level

Center for Healthcare Strategies

Sources of Community Data

Sources	Primary Value
Regional newspapers, neighborhood (in libraries, community centers) and culturally-specific news media	• Identify local priorities and current events among minority communities
Digital storytelling archives or photo voice projects(often run by community-based organizations or public health campaigns)	• Hear first-hand accounts of community needs (potential causes of disparities), particularly among more vulnerable populations
Meet with local business leaders, cultural or religious figures, social services directors, school superintendents, consumer advocacy groups, and neighborhood coalition patients	• Promote equity efforts among diverse stakeholders, gain buy-in for future interventions, and access resources
Community needs assessments and health improvement plans	• Identify community priority issues that could affect clinical data. Collaborate with public health entities that can help support and spread effective interventions
RWFJ's County Health Rankings	• View health behavior and social determinants of health data by county and state. • Utilize tools, webinars, and learn from other communities
Community Catalyst	• Access a host of resources, tools, and policy briefs.

Center for Healthcare Strategies

Multiple Measures

- Used to identify disparities and their cause when they are not readily apparent.

- Trends can vary between different measures.

- Think of data in multiple dimensions

Designing Improvement Plans

- Keep the use of data as part of implementation **(You'll thank me later).**

- Define goals for improvement and identify appropriate measures.

- Develop a process for reviewing data over the course of the care transformation, including gathering a baseline prior to implementation.

Prioritizing Disparities

- **Prioritization Considerations:**
  - **Prevalence:** How prevalent is the disease or condition (targeted by the quality measure) in the disparate population?
  - **Size of Disparity:** How large is the gap in quality, access, and/or health outcome between the disparate population and the group with the highest quality for that measure?
  - **Strength of Evidence:** How strong is the evidence linking improvement in performance on the measure to improved outcomes in the disparate population?
  - **Ease and feasibility of improvement (actionable):** Is the measure actionable (e.g., by providers, clinicians, health plans, etc.) among the disparate population?

# Defining Goals for Improvement and Tracking Appropriate Measures

- **Intervention Process Measures:** Evaluate whether the care transformation was successfully implemented as planned.

- **Health Process Measures:** Refer to what is done to a patient.

- **Outcome Measures:** Refer to the actual results for the patient.

Example – How Many Patients Have Completed a HbA1C?

PATIENTS WITH COMPLETED HBA1C TESTS, BY RACE/ETHNICITY			
	Diabetic patients in each racial/ethnic group	Diabetic patients in each racial/ethnic group with completed test	%
White	300	100	33.3
Hispanic	50	12	24.0

White   Hispanic

■ No Test ■ Test   ■ No Test ■ Test
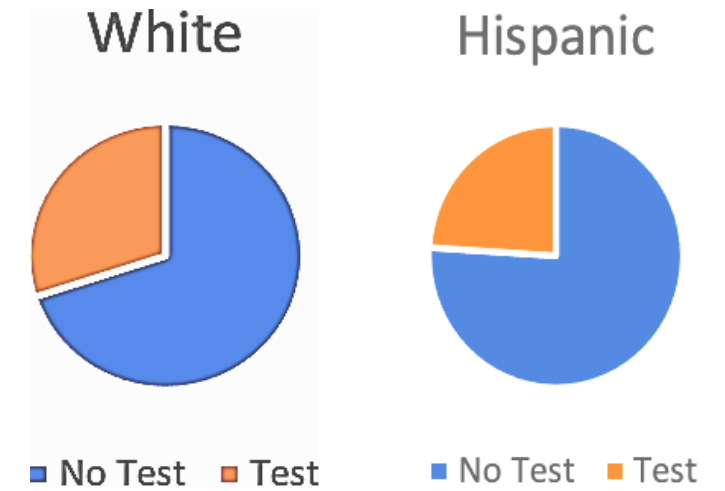
Center for Healthcare Strategies

Sample results statement:
- Only **24 percent of Hispanic patients** have completed requested HbA1C tests, whereas **30 percent of white patients** have completed tests. Though every individual has different barriers, <u>we would like to identify barriers that may affect a large portion of our Hispanic patients, causing them to miss needed tests more often than white patients.</u>

Intervention Process Measure Example

Health Priority	Intervention	Example Intervention Process Measure
Hard-to-reach patients with chronic health conditions were not being properly engaged leading to gaps in care, high utilization of preventable emergency department visits and hospitalizations, and low-quality outcomes	• The health plan implemented a community health worker program to target hard-to-reach patients. • Established an automated review and analysis of patient claims data to capture when a patient visited a provider different from their PCP or ED. • Patients were flagged based on analyses and followed-up with phone calls, targeted education, and referrals to resources to address high-risk and treatable conditions. • Staff also attended cultural competency training.	• Number of patients identified within claims data • Number of staff who attended cultural competency training • Number of patients engaged and connected to their PCP. • Barriers to care documented in EHR • Number of providers engaged

Center for Healthcare Strategies

Defining Goals and Measures

Goals:

- Compare the population before and after intervention
- Comparison to another group
- Comparison to an external benchmark

Measures:

- Absolute improvement
- Positive change in trends
- Flattening trends

Developing a Process for Reviewing Data Over the Course of Implementation.

- Determine frequency of data review over the course of the intervention to monitor outcomes and adjust intervention processes.

- Regularly review data to ensure that there are no new or worsening disparities.

- Consider a pilot test before a large-scale implementation.

- Account for lags in data availability that will impact project timelines.

Don't Simply Collect and Monitor Data – Share It

By sharing results within and outside of the organization, organizations can:

- Receive feedback and ideas for ways to improve health equity efforts.

- Celebrate progress to maintain momentum.

- Understand why results came out as they did.

- Create a culture of transparency with patients and communities.

- Lay the groundwork for future partnerships and encourage action from people not previously involved.

- Maintain health equity as a top priority.

Data Messaging for Different Stakeholders

Stakeholder	Likely Concern	Addressing the Concern
Leadership	• Return on investment	• Present data on potential positive financial impact or flattening of spending trend. Highlight how the initiative satisfies a contractual requirement.
Providers	• Office visit efficiency	• Describe patients' cultural background as information that, like family history, helps determine the best course of action with the patient. Give examples of how culturally tailored approaches enhance patient engagement and satisfaction, reducing redundancy or disconnect in visits and outreach.
Front-Line Staff	• Clinic flow	• Be honest about potential temporary impact but not how changes will ultimately improve flow (for example, reduce patient confusion). • Solicit input for improvement.
Patients	• How the clinic will use equity data (e.g. Privacy) Health status	• Ensure the patient that data are used to ensure everyone is getting high quality care and that all data will remain confidential.
Community	• Access to health care services and general wellness in the community	• Emphasize project outcomes that benefit the community and include community partners in developing strategies to reduce disparities.
Everyone	• Patient outcomes	• Explain health equity efforts and how activity should affect outcomes.

Center for Healthcare Strategies

Using Data to Support Sustainability

Health Equity data supports sustainability by:

- Maintaining a focus on the importance of reducing disparities and providing equitable care among competing priorities.

- Identifying how factors that drive disparities also drive overall quality.

- Demonstrating their success to external entities, such as CMS, and charitable foundations.

" You can't improve what you don't measure."

– Peter Drucker

ACHC U

ACHCU is a brand of ACHC.

ACHC

Thank you

chris@courtemanche-assocs.com

Office: 704-573-4535

www.Courtemanche-assocs.com

ACUTE CARE HOSPITAL   CRITICAL ACCESS HOSPITAL

References

- CMS Framework for Health Equity 2022-2032. Centers for Medicare & Medicaid Services. April 2022. https://www.cms.gov/files/document/cms-framework-health-equity.pdf.

- The Path Forward: Improving Data to Advance Health Equity Solutions. Centers for Medicare & Medicaid Services. November 2022. https://www.cms.gov/files/document/path-forwardhe-data-paper.pdf

- Using Data to Reduce Disparities and Improve Quality. Content last reviewed April 2021. Agency for Healthcare Research and Quality, Rockville, MD. https://www.chcs.org/media/Using-Data-to-Reduce-Disparities-2021_Final.pdf

Accreditation Commission for Health Care
We Offer a Better Accreditation Experience

About ACHC

- Founded in 1986.

- More than 25 healthcare accreditation programs.

- CMS Deeming Authority for Acute Care Hospital and Critical Access Hospital.

- 98% customer satisfaction rating.

- More than 25,000 locations accredited.

Find out how we can help at achc.org.

Accreditation Commission for Health Care
We Offer a Better Accreditation Experience

Why ACHC?

- Straightforward standards.

- Access to real clinical experts.

- Dedicated account advisors.

- Expert-developed resources.

- Customer care that puts you first.

- Monthly free education opportunities for hospital customers.