Vermont Program for Quality in Health Care, Inc.

CARE TRANSITIONS DIRECTOR MEETING 9.27.2022

Topic: Aligning CMS and TJC Expectations for Health Equity Achievement

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WHAT IS HEALTH EQUITY AND HOW CAN CARE MANAGERS CONTRIBUTE?

Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. (CDC)

Health Disparity is defined as the difference (whether unjust or not) in health outcomes between groups within a population (IHI)

Care Managers are in a unique position to:

- Verify REaL data
- Collect and address SDOH data
- Strengthen community partnerships
- Analyze data to inform a written action plan that describes how it will address at least one of the health care disparities or unmet needs identified in its patient population

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POLLING QUESTION #1

Has your organization provided education and/or training regarding the collection of REaL data, sexual orientation and gender identity data?

CMS AND TJC REQUIREMENTS CROSSWALK

DATA COLLECTION

CMS	TJC
Hospital uses a self-reporting methodology to collect • REaL data from the patient, family member and/or care partner. (**race, ethnicity and language**) • **sexual orientation and gender identity data.** • **SDOH data** (i.e., transportation, food insecurity, housing, etc.) from the patient, family member or care partner. Hospital has standardized processes in place to collect REaL data for at least **95%** **of its patients with an opportunity for verification at multiple points of care beyond registration.**	**Standard LD.04.03.08**: Reducing health care disparities for the [organization's] [patients] is a quality and safety priority. **EP 3:** The [organization] identifies health care disparities in its [patient] population by stratifying quality and safety data using the sociodemographic characteristics of the [organization's] [patients]. Sociodemographic characteristics are defined as: **Age, Gender, Preferred Language, Race and Ethnicity.**

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POLLING QUESTION #2

Do you verify REaL data and sexual orientation and gender identity data?

CMS AND TJC REQUIREMENTS CROSSWALK

DATA VERIFICATION AND UTILIZATION

CMS	TJC
Hospital collects and utilizes data about the demographic and socioeconomic status of **patient population(s) served** and the surrounding community (social determinants) to target interventions and address health-related needs. Hospital analyzes SDOH "Z code" data to improve quality, care coordination and experience of care. (SDOH Z code data can be used to identify **individual's social risk factors and unmet needs, inform healthcare and services and trigger referrals to social services and between providers and social service organizations.)**	**Standard LD.04.03.08**: Reducing health care disparities for the [organization's] [patients] is a quality and safety priority. **EP 2:** The [organization] assesses the [patient's] **health-related social needs** and provides information about community resources and support services. Note 1: [Organizations] determine which health-related social needs to include in the [patient] assessment. Examples of a [patient's] health-related social needs may include the following: •**Access to transportation** •**Difficulty paying for prescriptions or medical bills** •**Education and literacy** •**Food insecurity** •**Housing insecurity**
Hospital verifies the accuracy and completeness of patient self-reported demographic data to improve reliability and identification of disparities in care and target quality interventions [Goal >90%].	**EP 4:** The [organization] develops a **written action plan** that describes how it will address at least one of the health care disparities identified in its [patient] population

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POLLING QUESTION #3

A. Is the collection of standardized SDOH data part of your initial admission assessment and addressed before discharge?

B. Does your organization collect SDOH data using an evidence based tool?

CMS AND TJC REQUIREMENTS CROSSWALK

DATA STRATIFICATION

CMS	TJC
Hospital stratifies patient safety, quality/and or outcome measures (e.g., 30-day readmission rates) by race, ethnicity and language to examine differences and equity of care provided.	**Standard LD 04.03.08 EP** 3: The [organization] identifies health care disparities in its [patient] population **by stratifying** quality and safety data using the sociodemographic characteristics of the [organization's] [patients]. Note 1: [Organizations] may focus on areas with known disparities identified in the scientific literature (for example, Hospital/Critical Access Hospital: organ transplantation, maternal care, diabetes management; kidney disease, treatment for substance abuse disorder, restraint use, suicide rates or select measures that affect all [patients] (for example, experience of care and communication).
HEALTH LITERACY, CULTURAL COMPETENCE AND LANGUAGE	
Health literacy level screened and documented within 24hrs of admission. Patients are screened for **language access/assistance services.** Patient **cultural preferences** documented to individualize care/treatment plan. Patient **disability status/ assessment** documented.	
Hospital **partners with community-based organizations** to maximize cross-sector partnerships and meet patients' and communities' needs.	**EP 6:** At least annually, the [organization] informs key stakeholders, including leaders, licensed practitioners, and staff, about its progress to reduce identified health care disparities.

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POLLING QUESTION #4

Are you involved in or aware of efforts to stratify quality and safety data outcome measures (e.g., 30-day readmission rates) by race, ethnicity and language to examine differences and equity of care provided?

REFERENCES

FY 2023 IPPS Final Rule Home Page | CMS

R3 Report | The Joint Commission