
# Welcome!

*We will get started promptly at 12 noon*

*Today's session is being recorded*

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# Health Equity Organizational Assessment (HEOA) Knowledge Builder Series

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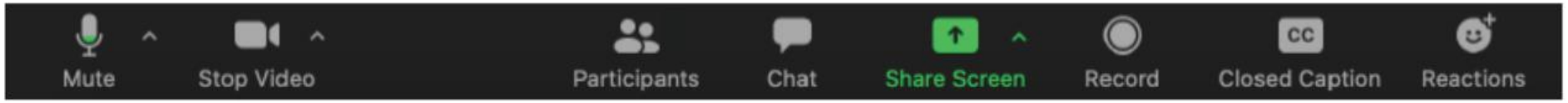
# Use Chat to introduce yourself & ask questions

## How to use Zoom

At the bottom of your screen, you will see a black bar with icons:




Chat **Everyone** for general comments or questions

# The IPRO QIN-QIO

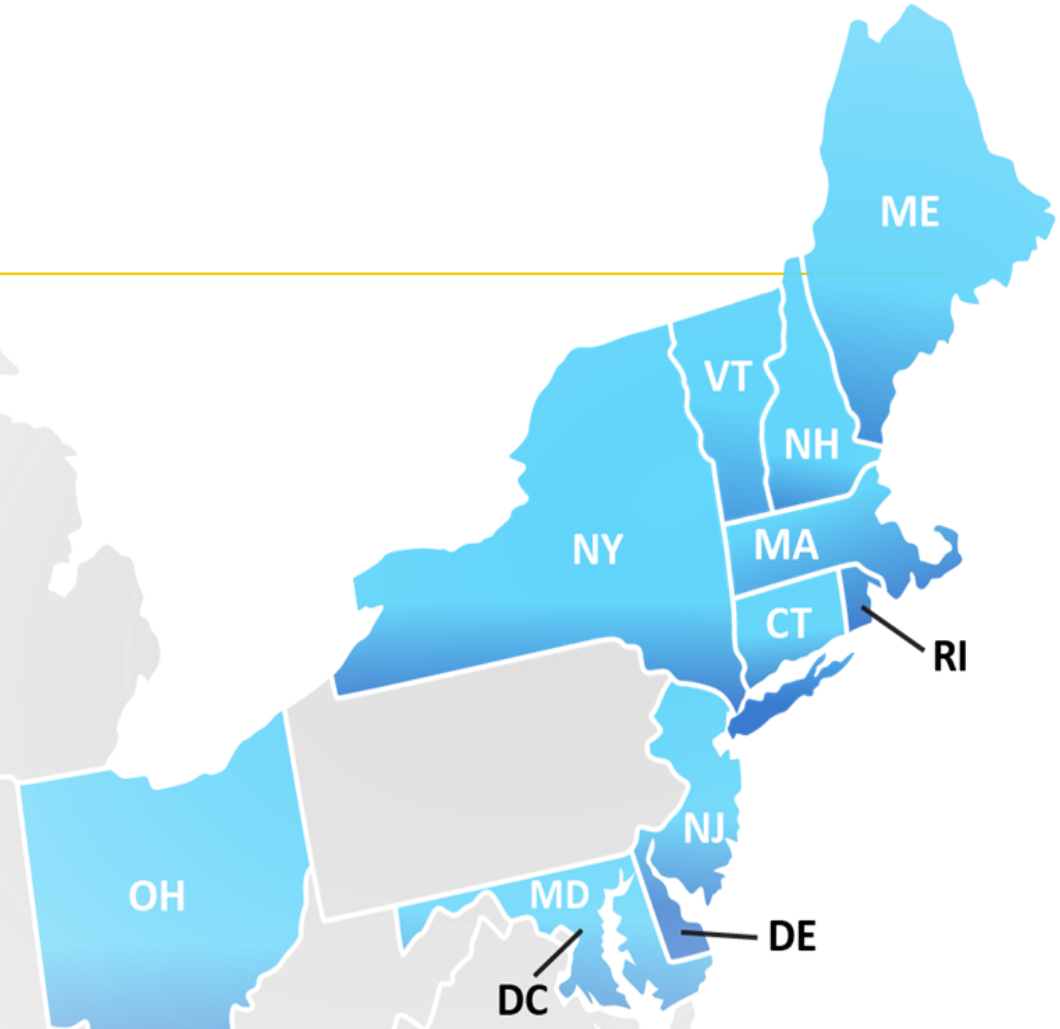
## The IPRO QIN-QIO

- A federally-funded Medicare Quality Innovation Network – Quality Improvement Organization (QIN-QIO) in contract with the Centers for Medicare & Medicaid Services (CMS)
- 12 regional CMS QIN-QIOs nationally

**IPRO:**
New York, New Jersey, and Ohio

**Healthcentric Advisors:**
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

**Qlarant:**
Maryland, Delaware, and the District of Columbia




Working to ensure high-quality, safe healthcare for
**20% of the nation's Medicare FFS beneficiaries**

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Healthcentric Advisors
Qlarant
QIN–QIO
Quality Innovation Network - Quality Improvement Organizations
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# The IPRO HQIC

## The IPRO HQIC

- A federally funded Medicare Hospital Quality Improvement
  Contractor (HQIC) in 12 states
- IPRO collaborates with several organizations to reach hospitals.

- IPRO
- Healthcentric Advisors
- Kentucky Hospital Association
- Qlarant
- Q3 Health Innovation Partners
- Superior Health Quality Alliance

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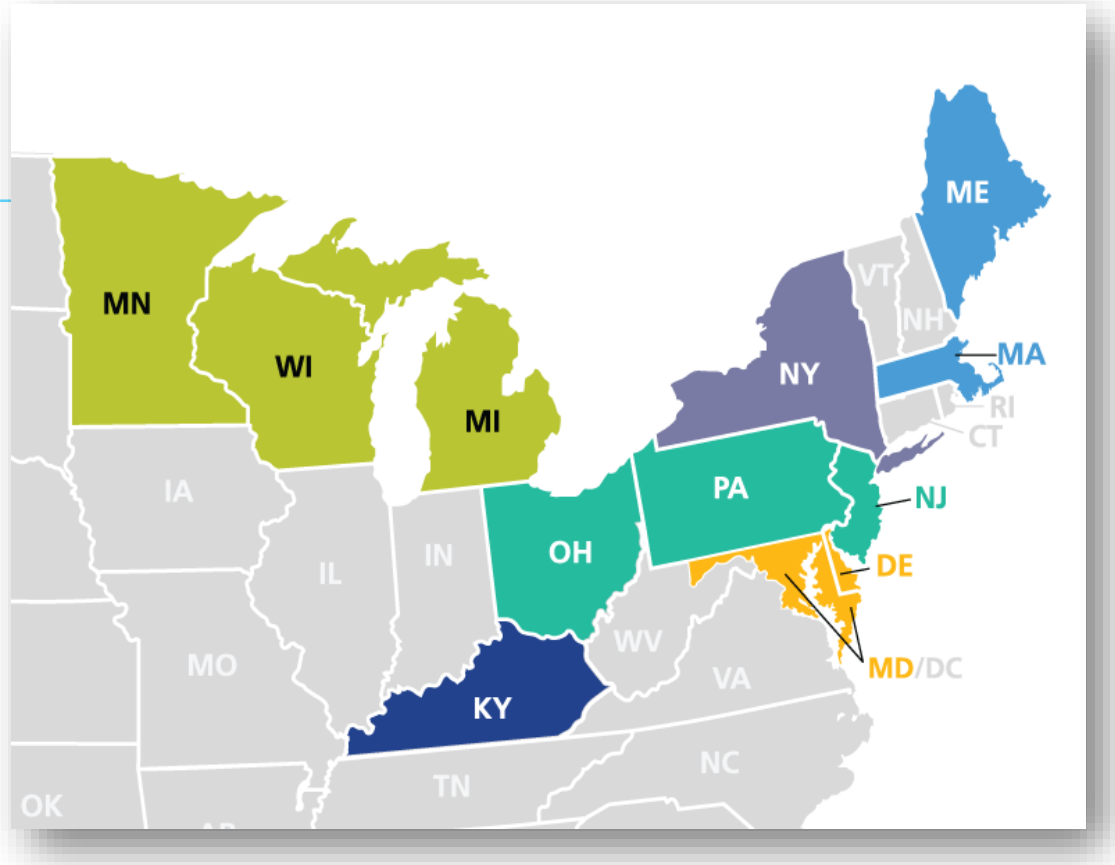
American Institutes for Research (AIR)

QSource Health Equity Subject Matter Experts

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# Health Equity Organizational Assessment (HEOA) Category 6: Addressing & Resolving Gaps in Care

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# Overview of this Series

1. **CHALLENGE:** Eliminating health disparities requires a commitment to collecting meaningful patient demographic data that healthcare organizations can use to identify and address disparities.

2. **ACTION:** Use the HEOA Assessment to identify opportunities for improvement in your organization's ability to collect, validate, stratify, and analyze patient demographic data to identify and address disparities.

3. **Result:** Develop and implement an action plan to address opportunities for improvement based on the seven HEOA categories with a goal of providing more equitable care.

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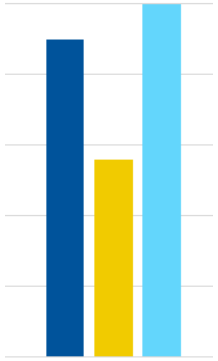
# HEOA Categories

| | |
|---|---|
| Data Collection | Hospital uses a self-reporting methodology to collect demographic data from the patient and/or caregiver. |
| Data Collection Training | Hospital provides workforce training regarding the collection of self-reported patient demographic data. |
| Data Validation | Hospital verifies the accuracy and completeness of patient self-reported demographic data. |
| Data Stratification | Hospital stratifies patient safety, quality and/or outcome measures using patient demographic data. |
| Communicate Findings | Hospital uses a reporting mechanism (e.g., equity dashboard) to communicate outcomes for various patient populations. |
| Addressing Resolve Gaps in Care | Hospital implements interventions to resolve difference in patient outcomes. |
| Organizational Infrastructure & Culture | Hospital has organizational culture and infrastructure to support the delivery of care that is equitable for all patient populations. |

Graphic by Michigan Health and Hospital Association

# Polling Question



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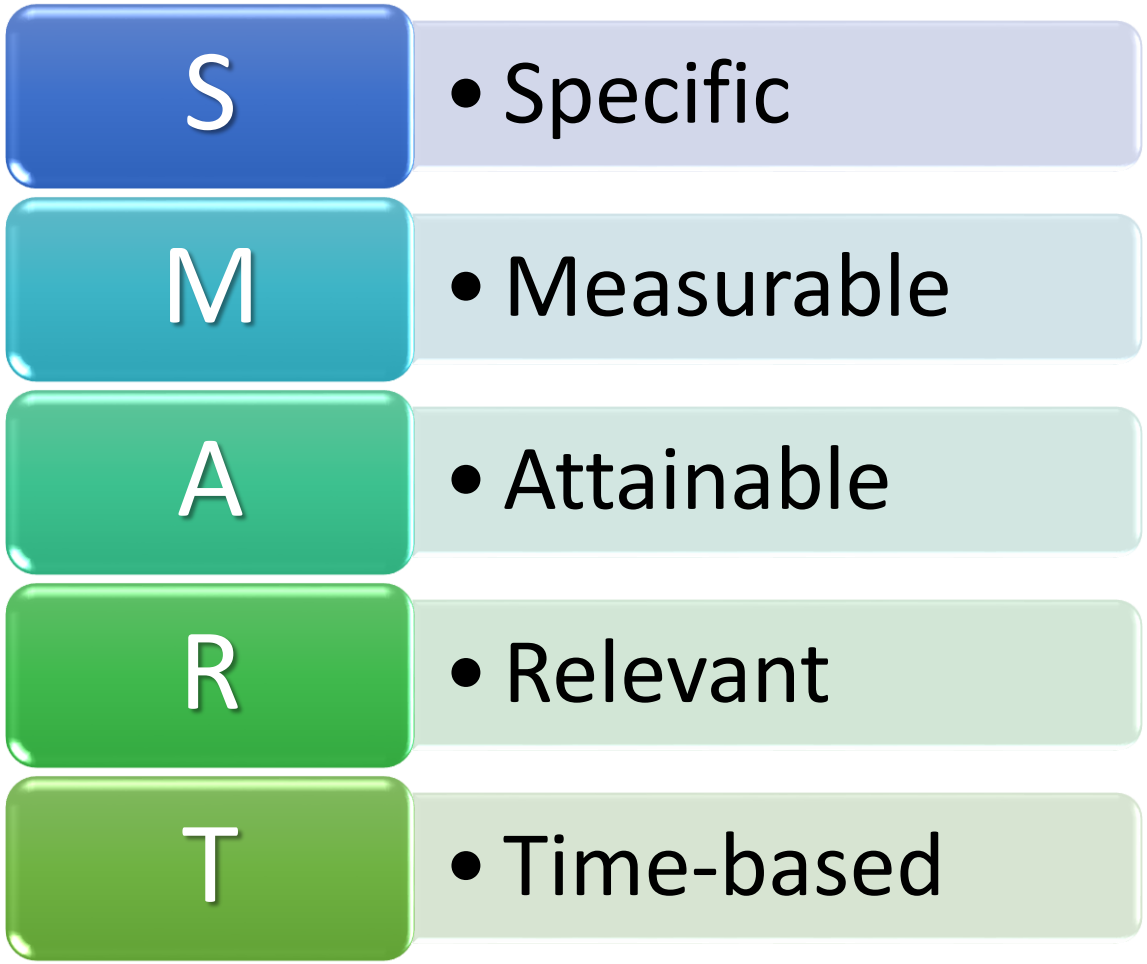
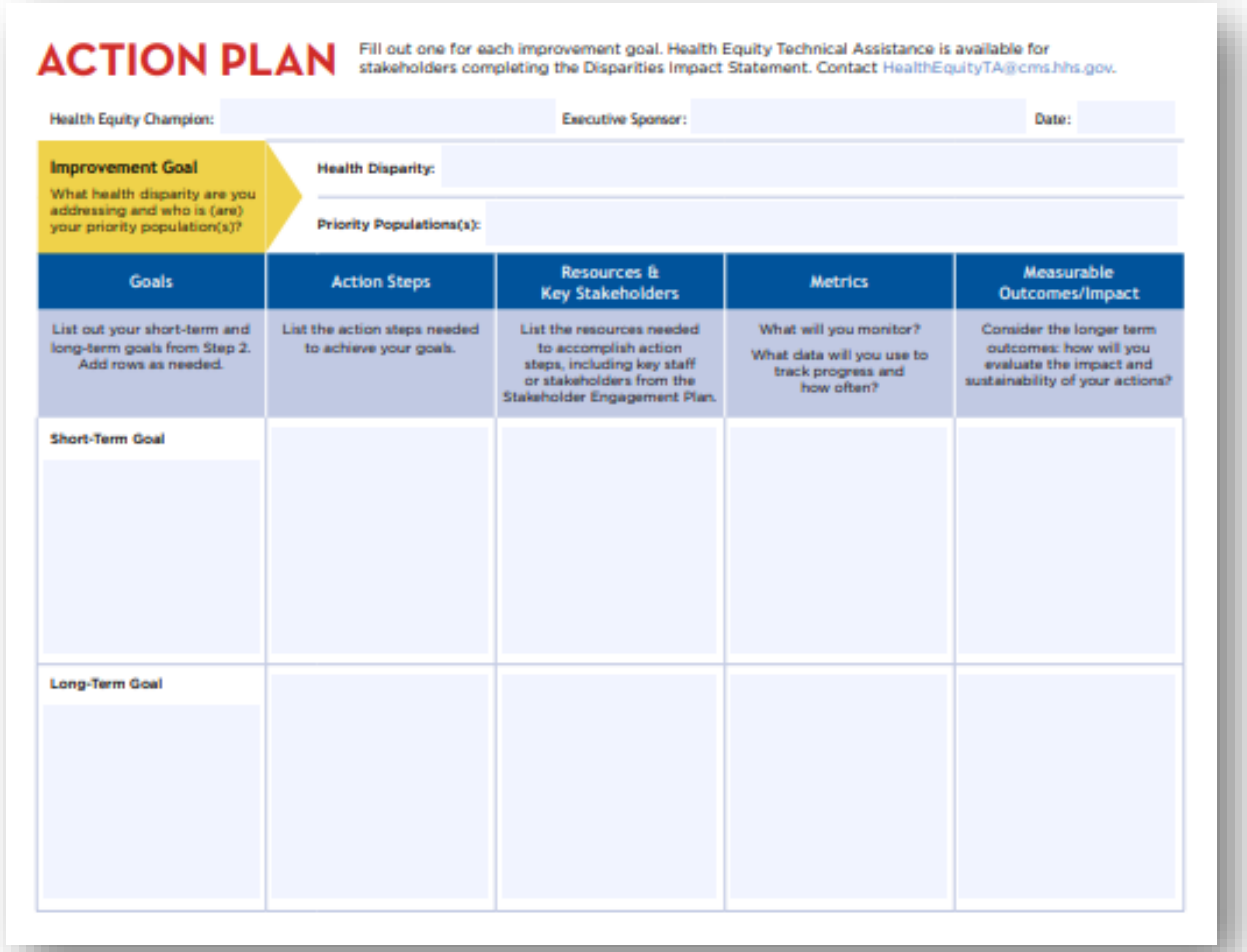
# Addressing & Resolving Gaps in Care

- Use data stratification and analysis to help identify gaps in care
- Once a disparity is identified, create SMART goals and an Action Plan
- Do a pilot test of the intervention using a PDSA methodology
- Regularly communicate the goal(s) of the intervention throughout the organization
- Keep front-line staff informed and working toward the same goal(s)
- If the pilot is successful, create a plan for spread

# SMART Goals


S
• Specific
M
• Measurable
A
• Attainable
R
• Relevant
T
• Time-based

# CMS OMH Disparities Impact Statement

## ACTION PLAN

Fill out one for each improvement goal. Health Equity Technical Assistance is available for stakeholders completing the Disparities Impact Statement. Contact HealthEquityTA@cms.hhs.gov.

Health Equity Champion: | Executive Sponsor: | Date:

**Improvement Goal**
What health disparity are you addressing and who is (are) your priority population(s)?

Health Disparity:

Priority Populations(s):

| Goals | Action Steps | Resources & Key Stakeholders | Metrics | Measurable Outcomes/Impact |
|---|---|---|---|---|
| List out your short-term and long-term goals from Step 2. Add rows as needed. | List the action steps needed to achieve your goals. | List the resources needed to accomplish action steps, including key staff or stakeholders from the Stakeholder Engagement Plan. | What will you monitor? What data will you use to track progress and how often? | Consider the longer term outcomes: how will you evaluate the impact and sustainability of your actions? |
| Short-Term Goal | | | | |
| Long-Term Goal | | | | |

https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Disparities-Impact-Statement-508-rev102018.pdf

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Health Equity Champion (Disparities Impact Statement Lead): Organization: Date:

Program, Model, or Demonstration(s): Projected Timeline (e.g., 6 months to plan, begin implementation on XX/XX):

| SMART Aim<br>What are you trying to improve for the populaton you identified? | Primary Drivers<br>What is needed to achieve your aim?<br>You may have more drivers. Print a second page to add rows. | Secondary Drivers<br>List interventions that will help you achieve the primary drivers. | Key Individuals & Organizations<br>Key staff, partners, stakeholders, or members of the community accountable for the secondary drivers. | Metrics<br>What will you monitor?<br>What data will you use to track progress toward your aim and how often? | Measurable Outcomes/ Impact<br>Should align with aim. |
|---|---|---|---|---|---|
| AIM | Primary Driver #1 | | | | |
| | Primary Driver #2 | | | | |
| | Primary Driver #3 | | | | |

# Model for Improvement – PDSA Cycles


https://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx

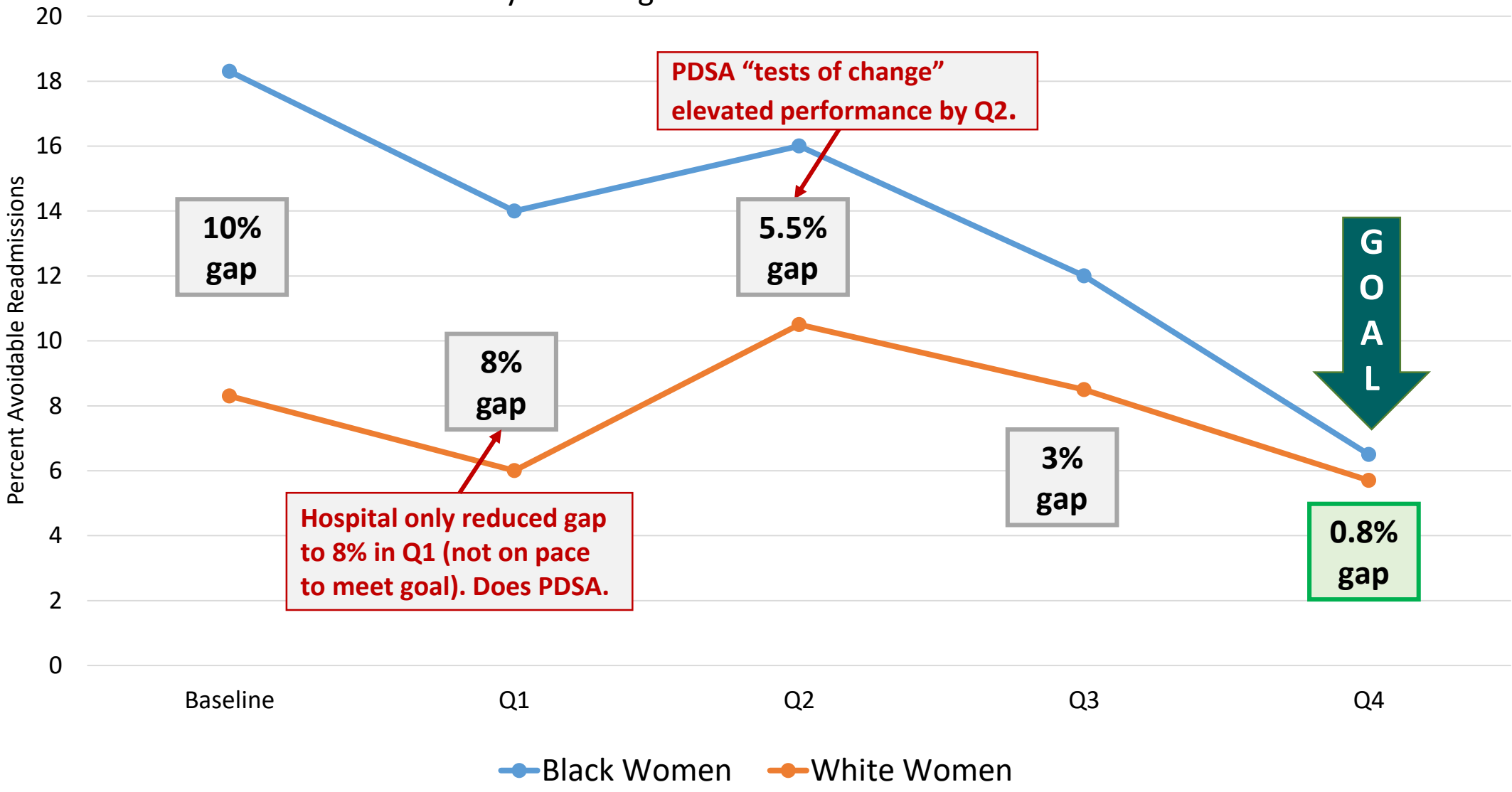
| SMART Aim<br>What you are trying to improve for the population you identified? | Primary Drivers<br>What is needed to achieve your aim?<br><br>You may have more drivers. Print a second page to add rows. | Secondary Drivers<br>List interventions that will help you achieve the primary drivers. | Key Individuals & Organizations<br>Key staff, partners, stakeholders, or members of the community accountable for the secondary drivers. |
|---|---|---|---|
| Our hospital will close the gap on avoidable readmissions for females 65 years of age and older who have had a heart attack so there is less than 1% difference in rates between Black females and their white counterparts within 12 months. | Appropriate Cardiac Rehab Referrals for Black females 65 years of age and older who have had a heart attack. | Automatically trigger a cardiac rehab referral using the electronic health record (EHR) for the target population prior to discharge. | • IT and Coding Dept.<br>• EHR Vendor |
| | | Provide an automated or manual communication to cardiologists and primary care physicians about their patients in the target population prior to discharge. | • Cardiologists & primary care physicians<br>• EHR vendor<br>• Administrative staff of primary care physicians & cardiologists<br>• State Health Information Exchange |
| | | Deliver provider education on cardiac rehab benefits and identified disparities in the target population. | • Cardiology Champion<br>• Chief Medical Officer<br>• Director of Education |
| | | Deliver culturally competent patient, family and caregiver engagement training and education on the benefits of participation in a cardiac rehab program. | • Patients, family members, caregivers<br>• Director of Education<br>• Heart Failure Center Health Educators |

| SMART Aim<br>What you are trying to improve for the population you identified? | Primary Drivers<br>What is needed to achieve your aim?<br><br>You may have more drivers. Print a second page to add rows. | Secondary Drivers<br>List interventions that will help you achieve the primary drivers. | Key Individuals & Organizations<br>Key staff, partners, stakeholders, or members of the community accountable for the secondary drivers. |
|---|---|---|---|
| Our hospital will close the gap on avoidable readmissions for women 65 years of age and older who have had a heart attack so there is less than 1% difference in rates between Black females and their white counterparts within 12 months. | Sustained participation (minimum 36 sessions) in a cardiac rehab program for Black females 65 years of age and older who have had a heart attack. | Coordinator in Heart Failure Center makes first cardiac rehab appointment for the target population. | • Heart Failure Center Coordinator<br>• Cardiac Rehab Facility Coordinator |
| | | Complete a Social Risk Factor screening for the target population to identify and mitigate transportation issues. | • Case Manager<br>• Social Worker<br>• Community Health Worker |
| | | Implement a hospital-supported transportation program that provides free transportation to/from cardiac rehab for the target population. | • Local volunteer driver non-profit organization<br>• Chief Experience Officer<br>• Community Health Outreach Coordinator |
| | | Implement a reward program to motivate patients in the target population to complete a cardiac rehab program. | • Chief Financial Officer<br>• Director of Education<br>• Cardiac Rehab Patients<br>• Cardiac Rehab Facility Coordinator |

# Review – Monitor – Recalibrate

- Define metrics and measures to monitor and track progress toward achieving goals (continuous quality improvement (CQI))
- Define how often monitoring will take place
- Decide who will be responsible for monitoring progress and ensuring continuous feedback
- Report progress to leadership on a regular basis

**GOAL**: Close the gap in avoidable readmissions to less than 1% between Black and White females 65 years of age and older who have had a heart attack.



| Category VI. Addressing and Resolving Gaps in Care | |
|---|---|
| Level of Implementation | Best Practices |
| Basic | Develop and pilot tests interventions to address identified healthcare disparities. |
| Intermediate | Implement interventions to resolve identified disparities, continuously informing and involving staff/workforce in support of the process. |
| Advanced | Have a process in place for ongoing review, monitoring, and recalibrating interventions to ensure changes are sustainable. |

| Best Practice Strategies for Organizational Health Equity | | |
|---|---|---|
| **Strategy** | **Tasks** | **Helpful Tools** |
| **Addressing and Resolving Gaps in Care (HEOA 6)** | | |
| Develop and pilot test interventions to address identified healthcare disparities. | ✓ Use data stratification results to identify specific populations and outcomes for intervention.<br>✓ Once a possible disparity is identified, create SMART (specific, measurable, attainable, relevant, time-based) aims/goals. Be realistic in what is achievable.<br>✓ Develop an action plan and pilot test using a PDSA methodology.<br>✓ Communicate the goal throughout the organization. Regularly communicate it during meetings to stay focused.<br>✓ Remind front-line staff members that all staff are working toward the same goal. | • CMS SMART Worksheet<br>• CMS Driver Diagram Guide<br>• CMS OMH Disparities Impact Statement<br>• IHI PDSA Worksheet |
| Implement interventions to resolve identified healthcare disparities, continuously inform and involve staff members/ workforce in support of the process. | ✓ If the pilot program is successful, create a plan for spread. | • IHI Spread Planner<br>• SDOH Toolkit for Rural Hospitals |
| Develop a process for ongoing review, monitoring, and recalibrating interventions to ensure changes are sustainable. | ✓ Create a process/policy to ensure continuous quality improvement (CQI).<br>✓ Decide who will report progress to whom and how often the progress will be reviewed.<br>✓ Report progress to leadership on a regular basis.<br>✓ Review outcomes to identify further opportunities for healthcare disparity interventions. | • CMS OMH Disparities Impact Statement |

# Chat In

Please feel free to unmute yourself or use the chat feature to share questions, ideas, success strategies, and/or lessons learned

**Improvement is a Team Support**

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# Leaving in Action

## Tips for Success

- Small Steps of Change:
  - After identifying a disparity based on data stratification and analysis:
    - Develop SMART Goals
    - Create an Action Plan
    - Implement the intervention on a small scale (i.e. one department/clinic/provider office) using the PDSA model of improvement
    - Review – Monitor – Recalibrate
    - After meeting goal(s), develop a plan for spread

# Next Week's Session

## Category 7: Organizational Infrastructure & Culture

**GUEST SPEAKERS**:

**Athena G. Minor**, MSN, RN, CNCO
Chief Nursing & Clinical Officer
Ohio County HealthCare
Hartford, KY

**Charles Redd,** MS, RN
Quality Director
Fairview Hospital
Great Barrington, MA

# Resource Recap

- Health Equity Roadmap
- HEOA FAQs
- HEOA Executive Audience One-Pager
- REaL Data Collection Toolbox
- Collecting REaL Data – Examples of How to Ask for REaL Data
- **Best Practice Strategies for Organizational Health Equity**

**Access All HEOA Resources:**

https://qi-library.ipro.org/2022/05/12/health-equity-organizational-assessment-heoa-resources/

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# HEOA Knowledge Builder Educational Series

| HEOA Knowledge Builders<br>12:00 – 12:30 PM ET | |
|---|---|
| May 19th & May 25th (repeat session) | Overview of the HEOA |
| June 16th | Category I: Data Collection |
| June 23rd | Category II: Training on Data Collection |
| June 30th | Category III: Data Validation |
| July 7th | Category IV: Data Stratification |
| July 14th | Category V: Communicating Patient Demographic Findings |
| July 21st | Category VI: Addressing & Resolving Gaps in Care |
| July 28th | Organizational Infrastructure & Culture |
| August 6th | Recap/Q&A |

**Information & Registration**

https://qi.ipro.org/2022/05/11/health-equity-organizational-assessment-heoa-knowledge-builders-series/

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## CONTACT INFORMATION

1. Your IPRO HQIC or
   IPRO QIN-QIO QI Advisor

2. HQIC
   Stacy Dorris
   sdorris@qsource.org

3. QIO
   Laura Benzel
   benzell@qlarant.com

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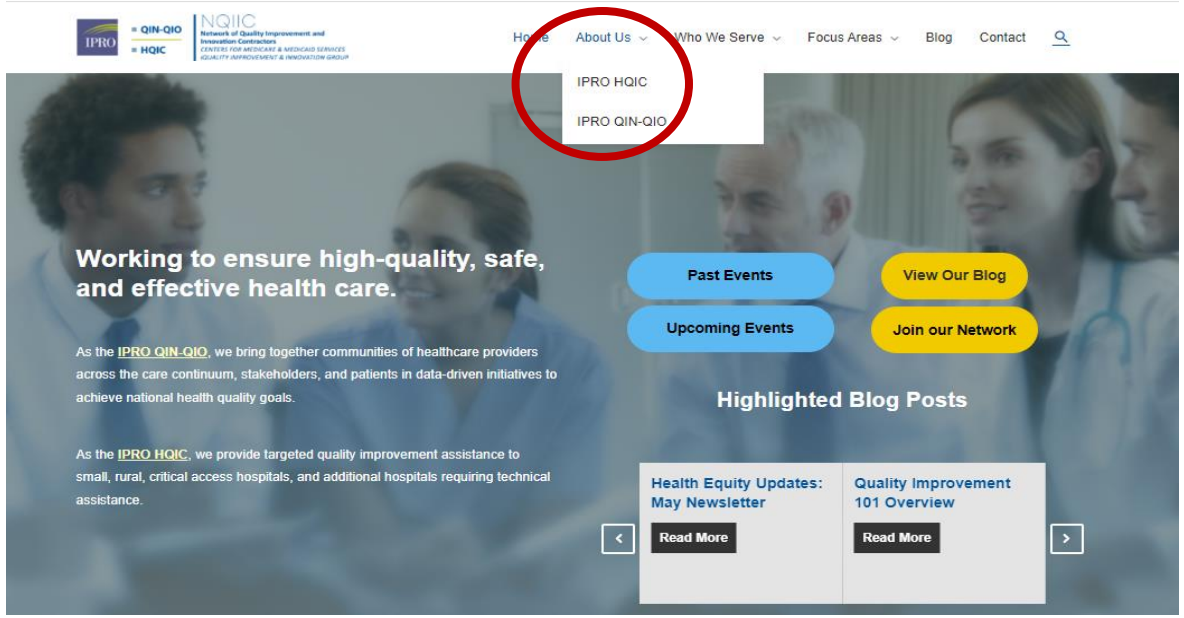
# Learn More & Stay Connected


https://qi.ipro.org/




## Follow IPRO QIN-QIO

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# Let Us Know More…


Your feedback is critically important and will help guide us as we prepare future Small Talks and other educational events.

Please take just a few minutes to complete our session evaluation.

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# Thank You

**Thank you for your continued partnership and commitment to health equity.**