Strategies for Equitable Care

HEOA 1: Patient Demographic Data Collection

Tactics	Tasks	Linked Tools
1. Use self-reporting methodology to collect patient Race, Ethnicity, and Language (REAL) data.	• Allow patients to self-report their REAL data—never assume based on observations alone. Data can be self-identified by the patient or by the registration staff members. Provide options: — Paper format (provides privacy). — Electronic kiosks/tablets (auto-entry to electronic medical record [EMR]). — Verbal discussion (patients with limited literacy or English proficiency). • Refine race and ethnicity category descriptions to help members of minority populations self-identify appropriate category for themselves.	• New York State Partnership for Patients (NYSPFP): e-Learning REAL Data Collection: How and Why We Ask • Vizient: 8 Health Information Technology Best Practices for REAL Data Collection
2. Collect REAL data for at least 95% of patients.	Calculate the following: • Percentage of patients who have all three REAL data elements documented. Set goal at 95%. • Percentage of patients who were documented as Declined, Unavailable, and/or Unknown. Set goal < 5% for each element/field.	
3. Roll up REAL data to the Office of Management and Budget (OMB) categories.	• Ensure health information technology (HIT) is set-up to align with OMB standards. • Add “Declined” or “Unavailable” or “Unknown” categories to ethnicity and race fields. • Ensure an aggregation method does not lead to double counting.	• U.S. Department of Health and Human Services (DHHS): Data Standards for Granularity on Race and Ethnicity That Roll up to OMB Categories
4. Examine opportunities for REAL data verification at multiple points of care (beyond patient registration) to ensure accuracy and completeness.	• Design multiple REAL data collection process entry points: at time of check-in, pre-visit, over the phone, pre-exam, at time of discharge, and post-discharge (evaluation). • Engage staff members across all roles in cultural sensitivity, data collection training, and processes.	
5. Use self-reporting methodology to collect additional patient data (beyond REAL).	Collect other demographic data such as disability status, sexual orientation/gender identity, veteran status, geography and/or data on other social determinants of health/social risk factors—housing, income, education, employment, food security, and others.	• Accountable Health Communities Screening (AHCS) Tool (Health-Related Social Needs [HRSN] Screening Tool) • Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences (PRAPARE) Assessment Tool

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HEOA 2: Patient Demographic Data Collection and Training

Tactics	Tasks	Linked Tools
1. Provide training regarding collection of patient self-reported REAL data.	• Train staff members to understand that REAL data are collected to reduce healthcare disparities. Include all front-line registration staff members (inpatient, ambulatory, and primary care). • Adopt an interactive training program. Incorporate scripts or role playing to help staff members become accustomed to patient self-reporting and to practice challenging questions they may receive from patients. • Require training at orientation and annually to maintain your data collection program.	• Health Research & Education Trust (HRET) toolkit for collecting REAL and additional demographic data on disability • HRET: Scripts and PowerPoint for addressing concerns from patients • New York State Partnership for Patients (NYSPFP): e-Learning REAL Data Collection: How and Why We Ask
2. Evaluate training for effectiveness on at least an annual basis to ensure staff member competency in collecting patient demographic data.	• Analyze REAL data before and after the training program has been implemented. • Evaluate data once per quarter to determine if you have met your measurable objectives. • If the hospital has not met objectives, additional interventions: — Conduct supplementary training. — Coach staff members or managers as needed. • Evaluation can include methods like tests, role playing, and observations.	
3. Provide training regarding collection of additional patient self-reported demographic data (beyond REAL).	Incorporate additional demographic variables beyond REAL into your self-reported data collection training programs. This could include: • Disability status, sexual orientation/gender identity, veteran status, geography and/or data on other social determinants of health/social risk factors—housing, income, education, employment, food security, and others.	• Health Research & Education Trust (HRET) toolkit for collecting REAL and additional demographic data on disability

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HEOA 3: Patient Demographic Data Validation

Tactics	Tasks	Linked Tools
1. Evaluate accuracy and completeness (percent of fields completed) of REAL data.	Examine data for: • Accuracy—Are the data self-identified and correctly recorded? Are there differences in categorization among data sources? • Completeness—Are REAL data captured across all service areas? What is the percentage of unknown, other, unavailable, or declined data? Consider also examining data for: • Uniqueness—Are individual patients represented only once? • Timeliness—Are data kept up to date? How often is the data updated? • Consistency—Are data internally consistent? Do the data reflect the patient population served?	• HRET: A Framework for Stratifying REAL Data
2. Evaluate and compare hospital-collected REAL data to local community demographic data.	Compare internally collected REAL data to other demographic data sources: • Federal data sources (e.g., U.S. Census Bureau) • State data sources (e.g., local schools and counties) • City and district data sources	• U.S. Census Bureau: American Fact Finder • University of Missouri Extension: Community Commons, Community Health Needs Assessment Report • Los Angeles County: City and Community Health Profiles
3. Address system-level issues to improve the collection of self-reported REAL data.	• Regularly interview patients and staff members to assess efficiency and accuracy of the process. Use results to improve collection methods. • Examples are changes in patient registration screens/fields, data flow, workforce training, etc.	
4. Evaluate accuracy and completeness of additional demographic data (beyond REAL).	• Incorporate additional demographic variables beyond REAL into your data validation process.	
5. Compare hospital-collected additional demographic data (beyond REAL) to local community demographic data.	Compare other hospital-collected demographic data to local community demographic data such as disability status, sexual orientation/gender identity, veteran status, geography and/or data on other social determinants of health/social risk factors—housing, income, education, employment, food security, and others.	• U.S. Census Bureau: American Fact Finder • California Deptartment of Education: DataQuest *(also applies to HEOA 3, tactic 2)*

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HEOA 4: Data Stratification

Tactics	Tasks	Linked Tools
1. Stratify at least one patient safety, quality, and or outcome measure by REAL.	Determine what outcome measures to review: • Focus on: • Healthcare disparities-sensitive measures — Care with high degree of discretion. — Communication-sensitive services. — Social determinant dependent measures. • High prevalence conditions among minority populations. • Conditions/outcomes with a large gap in quality between the disparity population and the highest quality group. • Common measures: inpatient quality reporting (IQR) measures, 30-day readmissions, Hospital CAHPS® (Hospital Consumer Assessment of Healthcare Providers and Systems) scores. Determine what group to use as a reference point: • Best practice: choose the historically advantaged group. Determine what sample size to use: • To increase power, combine smaller groups into broader categories and/or years of data together (e.g., using OMB categories instead of measures of greater granularity. This may increase risk of masking disparities). • Analyze smaller sample sizes to identify areas for improvement; they are unlikely to be statistically significant. Small groups may represent "low-hanging fruit" for quality improvement.	• Disparities Solutions Center: Healthcare Disparities Measurement • HRET: Reducing Health Care Disparities: Collection and Use of REAL Data • HRET: A Framework for Stratifying REAL Data
2. Stratify more than one patient safety, quality, and/or outcome measure by REAL.	Stratify groups further to examine differences in quality by racial/ethnic substrata. Highlight areas of the greatest potential for intervention. • There may be interaction effects initially unapparent (ex: race-sex interaction may be driving result, not just race or sex alone)	• Disparities Solutions Center: Healthcare Disparities Measurement • HRET: Reducing Health Care Disparities: Collection and Use of REAL Data
3. Stratify more than one patient safety, quality, and/or outcome measure by additional demographic data (beyond REAL).	Stratify outcomes by other demographic data such as disability status, sexual orientation/gender identity, veteran status, geography and/or data on other social determinants of health/social risk factors—housing, income, education, employment, food security, and others.	• Disparities Solutions Center: Healthcare Disparities Measurement • HRET: Reducing Health Care Disparities: Collection and Use of REAL Data

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HEOA 5: Communicating Patient Demographic Findings

Tactics	Tasks	Linked Tools
1. Use a HE dashboard to routinely communicate patient population outcomes to hospital executive leadership (including medical staff leadership) and the board.	• Create awareness through development and promotion of a HE dashboard/ scorecard/report composed of key quality measures stratified by race and ethnicity. • Create a standing agenda item for HE for hospital executive, board, and other leadership meetings.	• American Hospital Association (AHA): #123forEquity Pledge to Act • HRET: A Framework for Stratifying REAL Data
2. Use a HE dashboard to routinely communicate patient population outcomes within the organization.	• Create awareness among staff members by sharing the HE dashboard/scorecard/ report widely within the organization. • Create a standing agenda item for HE on all staff member meetings. • Communicate within the organization to front-line staff members, quality staff members, managers, directors, providers, committees, departments, service lines, etc.	
3. Use a HE dashboard to routinely communicate patient population outcomes to patients and families.	• Develop partnerships with community organizations providing insight into cultural differences in the community served to better inform strategies to reduce healthcare disparities. • Create awareness among patients and families, other community partners, and/ or stakeholders. — Identify a mechanism to share the HE dashboard to patients and families, to other community partners, and stakeholders. — Consider reviewing the HE dashboard in PFAC meetings. • Communicate to Patient and Family Advisory Council (PFAC) members and/or to other community partners or stakeholders.	

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HEOA 6: Addressing and Resolving Gaps in Care

Tactics	Tasks	Linked Tools
1. Develop and pilot test interventions to address identified healthcare disparities.	• Use data stratification results to identify specific populations and outcomes for intervention. • Once possible disparity is identified, create SMART (specific, measurable, attainable, relevant, time-based) aims/goals using the worksheet tool. Be realistic in what you can achieve. Stakeholder collaboration is the key when setting goals. • Develop an action plan and pilot test. • Post the written goal visible on your units. Regularly communicate the goal during meetings to stay focused. Remind front-line staff members that everyone is working toward the same goal.	• The Centers for Medicare & Medicaid Services (CMS) goal setting worksheet: SMART Goals • CMS Driver Diagram • Institute for Healthcare Improvement (IHI) Science of Improvement: Driver Diagram
2. 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 Science of Improvement: Spreading Change • IHI Spread Planner
3. 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). • Decide who will report progress to whom and how often will you review progress. • Report progress to leadership on a monthly basis. Remind leadership of the importance of this work. Allow the team to follow your progress. • Review outcomes to identify further opportunities for healthcare disparity interventions.	• IHI Project Planning Form

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HEOA 7: Organizational Infrastructure and Culture

Tactics	Tasks	Linked Tools
1. Train workforce in cultural and linguistic competence according to Culturally and Linguistically Appropriate Services (CLAS) Standards.	• Conduct a cultural and linguistic audit in the facility to assess organizational competence. • Create a written education plan to address gaps in CLAS using national CLAS standards. • Include CLAS standards concepts in educational curriculum for new and existing staff members.	• DHHS: National CLAS Standards Implementation Checklist • CMS: A Practical Guide to Implementing the National CLAS Standards
2. Name individual(s) with leadership responsibility and accountability for HE efforts.	• Build out a leadership role and title of the designated individual to spearhead HE efforts and be held accountable for efforts (e.g., Chief Diversity Officer). • Use various approaches to facilitate leadership buy-in: — Use REAL data and identified healthcare disparities for strategic planning and to help appropriately allocate resources. — Provide published data about how decreasing healthcare disparities can lower medical harm and hospital expense. — Build a business case for HE • Senior leaders serve as executive champions for the cultural competency work. • Tie senior management annual goals to equitable healthcare delivery.	
3. Identify a leader to engage clinical champions, patients and families, and/or community partners in strategic and action planning activities to reduce healthcare disparities.	• Conduct an environmental scan of community resources and develop an asset map for improving HE. • Work with community partners to gain insight into the cultural differences and diversity that exists between various ethnic groups. • Name a community board or advisors, establish regular check-ins with your community, and find opportunities to dialogue with patients. • Create formal and informal relationships. Convene and learn from each other. • Write out timelines or list key dates when planning to engage your community, patients, and local partners.	• Internal Revenue Services (IRS): CHNA • American Hospital Association (AHA): #123forEquity Pledge to Act
4. Ensure leadership and board commitment to equitable healthcare through written policies, protocols, pledges, or strategic planning.	• Use a multidisciplinary disparities committee to consolidate efforts and drive strategic plan. • Use senior-level champions to help lend support and push process forward. • Integrate disparities efforts with existing performance improvement infrastructure. • Document examples: mission/vision/values, organizational goals, and objectives.	• AHA: A Diversity, Equity and Cultural Competency Assessment Tool for Leaders

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