Equitable Care Measures Review

Getting Started with Equitable Care Initiatives

Presented at the HLTH 2022 Conference (Removing barriers to equitable healthcare)

Dr. Shantanu Nundy, Accolade & Dr. Jay Bhatt, Deloitte

BUILD

Build a business case for investment.

COLLECT

Collect data to understand the problem.

IDENTIFY

Identify an initial population to focus on.

INVOLVE

Involve a broad group of stakeholders to design solutions.

IDENTIFY

Identify progress to drive accountability and build momentum.

COMMIT

Commit to advancing health equity.

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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

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Health Equity

AHA Definition:

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

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.

*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.

Health Equity

NIH:

The root causes of health inequity begin with historical and contemporary inequities that have been shaped by institutional and societal structures, policies, and norms in the United States.

These deeply rooted inequities have shaped inequitable experiences of the social and other determinants of health: education, income and wealth, employment, health systems and services, housing, the physical environment, transportation, the social environment, and public safety.

*National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States; Baciu A, Negussie Y, Geller A, et al., editors. Communities in Action: Pathways to Health Equity. Washington (DC): National Academies Press (US); 2017 Jan 11. 3, The Root Causes of Health Inequity. Available from: https://www.ncbi.nlm.nih.gov/books/NBK425845/

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Health Equity

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, 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.

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

Equitable Care Measures

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Three Equitable Care 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

Health Equity Measures

1

2

3

Hospital Commitment to Health Equity
HCHE

Required 2023

Publicly Reported

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

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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

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Hospital Commitment to Health Equity (HCHE)

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HCHE

The first pillar of CMS's strategic priorities reflects their commitment to improving healthcare equity by addressing underlying health disparities

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

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HCHE

1. **Actionable focus areas**
2. **Assessment of hospital leadership commitment to the focus areas**
3. **Incentivizes hospitals & providers to:**
   - Collect and evaluate data to identify equity gaps
   - Implement plans to address gaps
   - Dedicate resources to healthcare equity initiatives.

"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

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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

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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.

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Social Drivers of Health

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SDOH

Intent: Identify patients with Health-Related Social Needs (HRSNs). "Individual-level, adverse social conditions that negatively impact a person's health or healthcare"

These patients have the greatest risk of poor health outcomes.

Identifying HRSNs in patients has significant benefits:

1. Serves 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

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SDOH

Rationale for SDOH Measures:

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

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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

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SDOH-1

Screening for Social Drivers of Health

SDOH 1 - Screening for Social Drivers of Health

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: If finalized, this measure would assess 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 would provide: (1) The number of inpatients admitted to 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 one or 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 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 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 would 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 one or 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.

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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

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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) %

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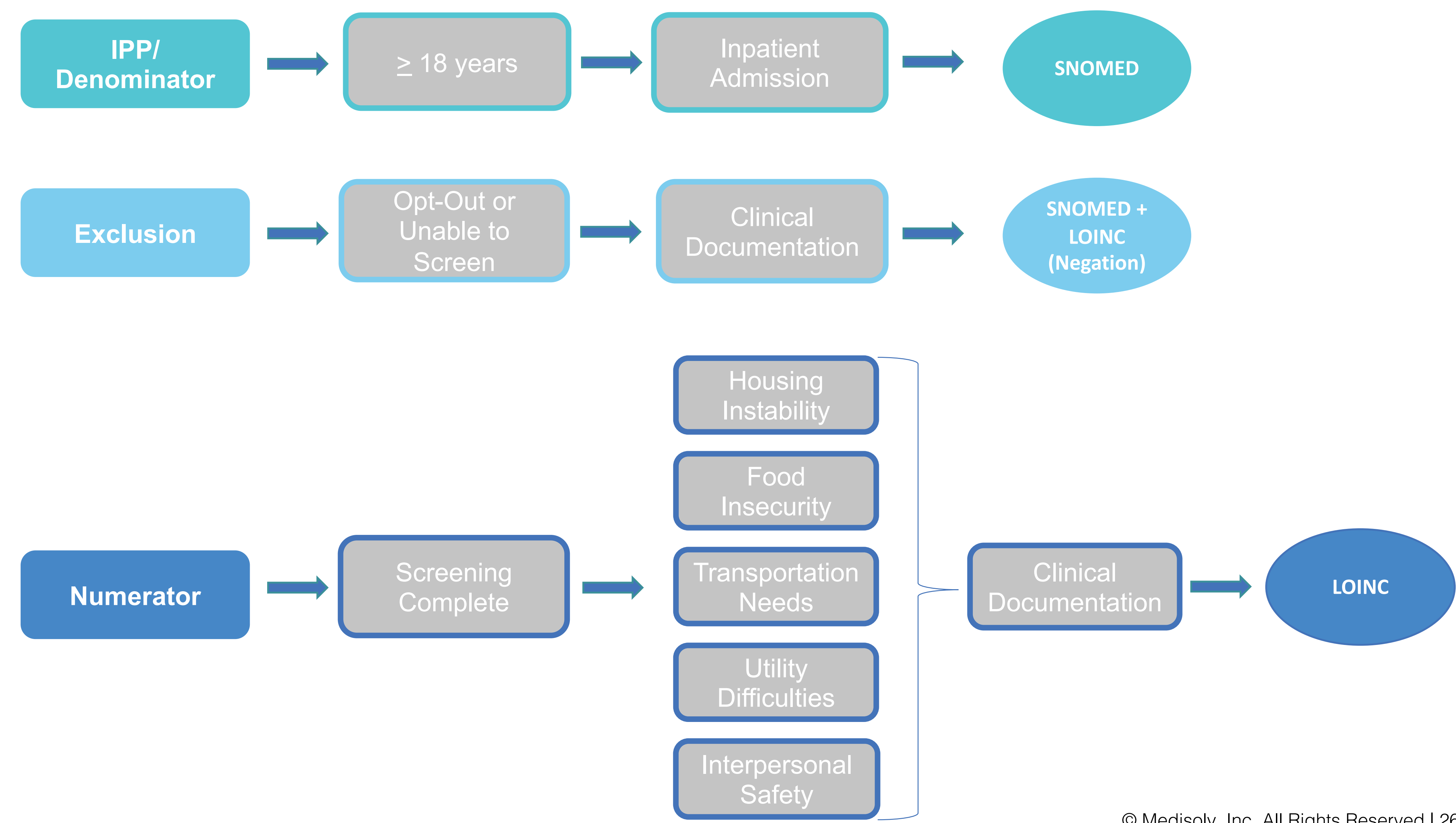
SDOH 1- Screening for Social Drivers of Health



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SDOH-2

Screen Positive Rate for Social Drivers of Health

SDOH 2- Screen Positive Rate for Social Drivers of Health

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: If finalized, the Screen Positive Rate for Social Drivers of Health would provide information on the percent of patients admitted for an inpatient hospital stay and 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 an 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 an 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 HSRN, 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.

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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

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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) %

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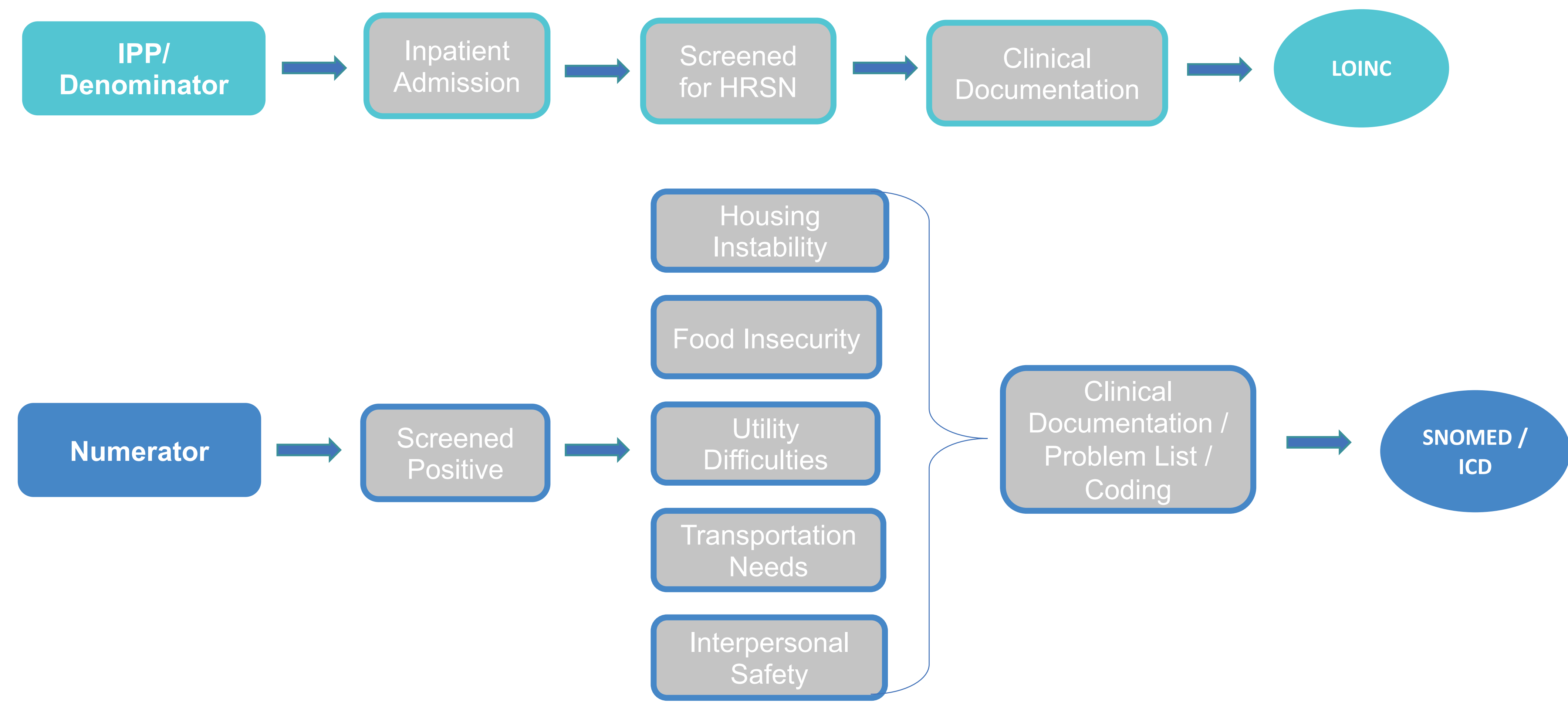
SDOH 2- Screen Positive Rate for Social Drivers of Health



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Our Top Tips:

Implementation, Tracking & Improvement

Implementation, Tracking & Improvement

1. **Identification**
   - Identify stakeholders and determine role/responsibilities
2. **Education**
   - Review HCHE domains and elements
   - Review SDOH requirements and data elements

HCHE

- Identify current state and gaps
- Plan and document process to meet each required element

SDOH

1. **Screening tool evaluation and selection**
   - Use any self-selected screening tool but AHC Health-Related Social Needs Screening Tool https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf recommended as resource/reference
   - Consider needs and populations in decision making
2. **Plan for tracking and improvement**
3. **Implement screening and reports**
4. **On-going communication**

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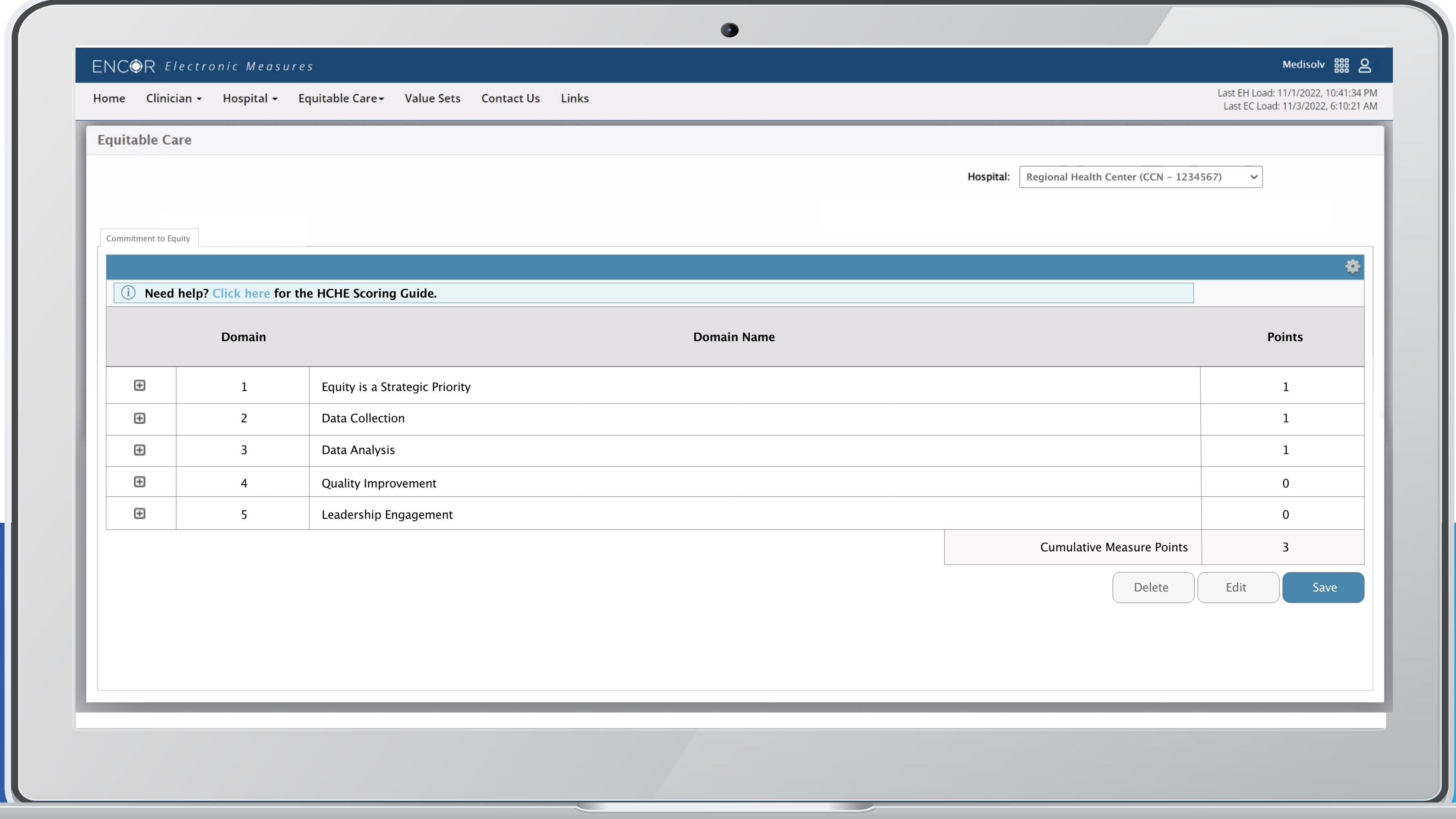
Hospital Commitment to Health Equity (HCHE)



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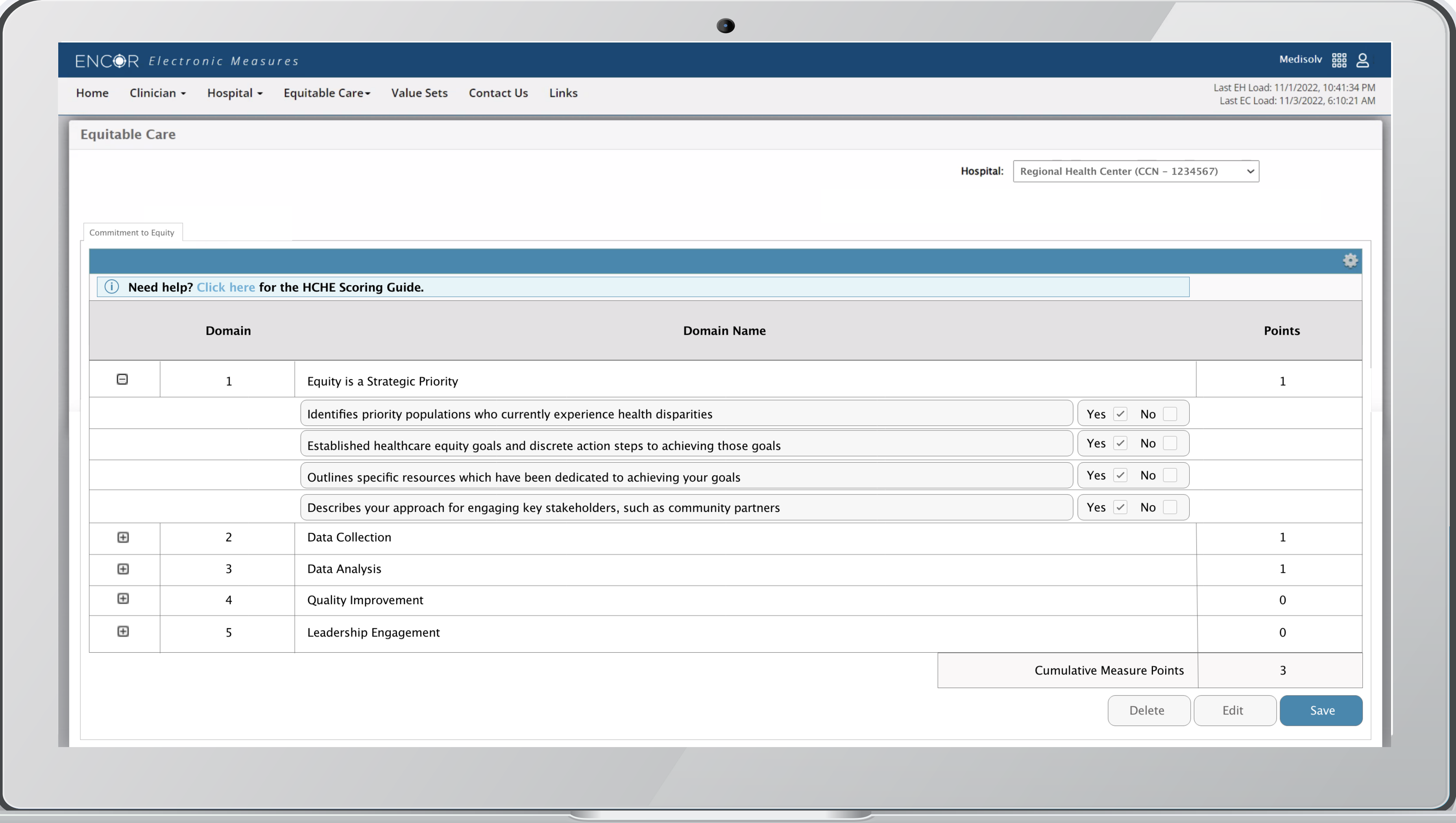
Hospital Commitment to Health Equity (HCHE)



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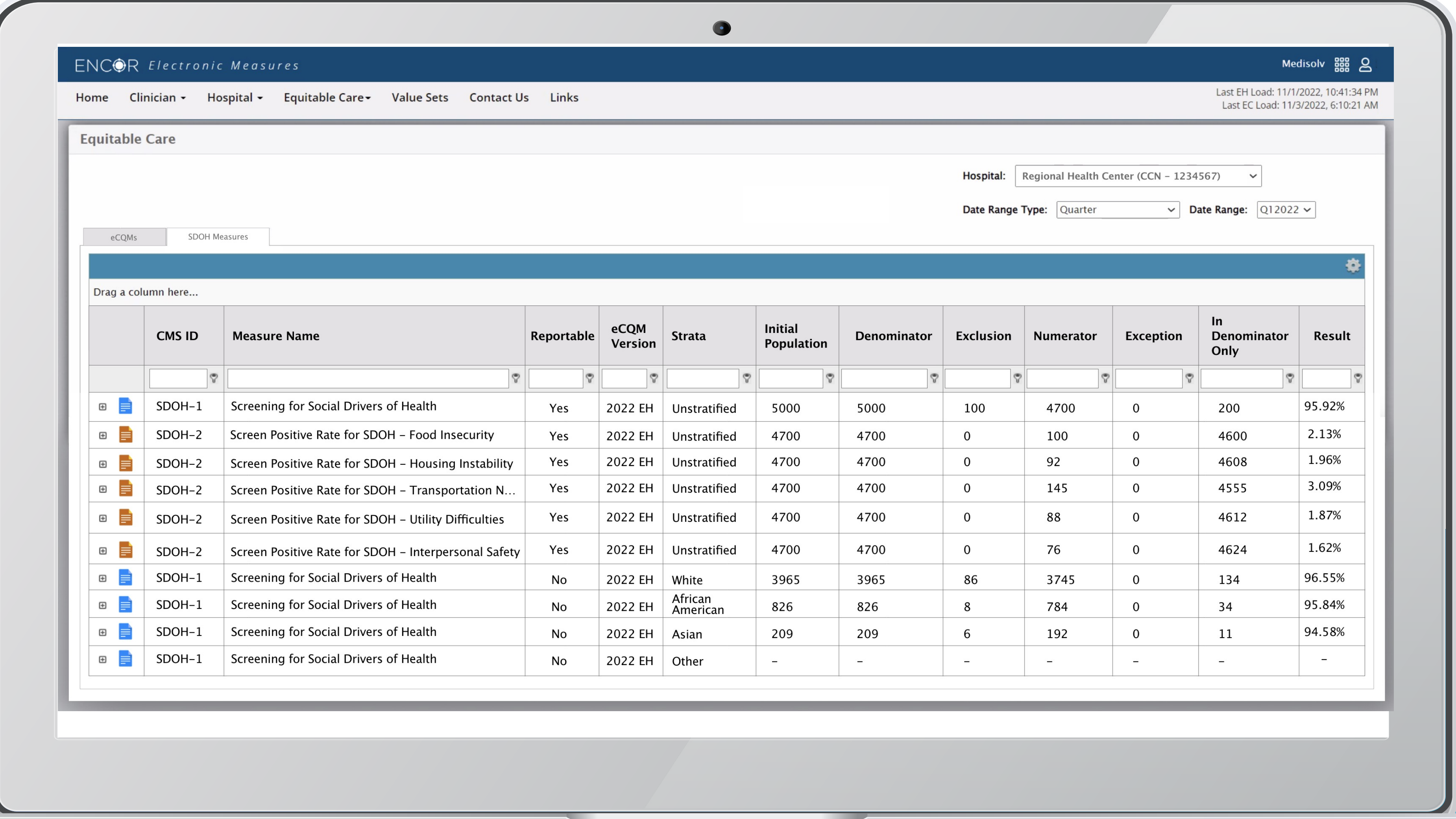
SDOH-1 & SDOH-2



CMS ID	Measure Name	Reportable	eCQM Version	Strata	Initial Population	Denominator	Exclusion	Numerator	Exception	In Denominator Only	Result
SDOH-1	Screening for Social Drivers of Health	Yes	2022 EH	Unstratified	5000	5000	100	4700	0	200	95.92%
SDOH-2	Screen Positive Rate for SDOH – Food Insecurity	Yes	2022 EH	Unstratified	4700	4700	0	100	0	4600	2.13%
SDOH-2	Screen Positive Rate for SDOH – Housing Instability	Yes	2022 EH	Unstratified	4700	4700	0	92	0	4608	1.96%
SDOH-2	Screen Positive Rate for SDOH – Transportation N...	Yes	2022 EH	Unstratified	4700	4700	0	145	0	4555	3.09%
SDOH-2	Screen Positive Rate for SDOH – Utility Difficulties	Yes	2022 EH	Unstratified	4700	4700	0	88	0	4612	1.87%
SDOH-2	Screen Positive Rate for SDOH – Interpersonal Safety	Yes	2022 EH	Unstratified	4700	4700	0	76	0	4624	1.62%
SDOH-1	Screening for Social Drivers of Health	No	2022 EH	White	3965	3965	86	3745	0	134	96.55%
SDOH-1	Screening for Social Drivers of Health	No	2022 EH	African American	826	826	8	784	0	34	95.84%
SDOH-1	Screening for Social Drivers of Health	No	2022 EH	Asian	209	209	6	192	0	11	94.58%
SDOH-1	Screening for Social Drivers of Health	No	2022 EH	Other	–	–	–	–	–	–	–

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Implementation, Tracking & Improvement

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.

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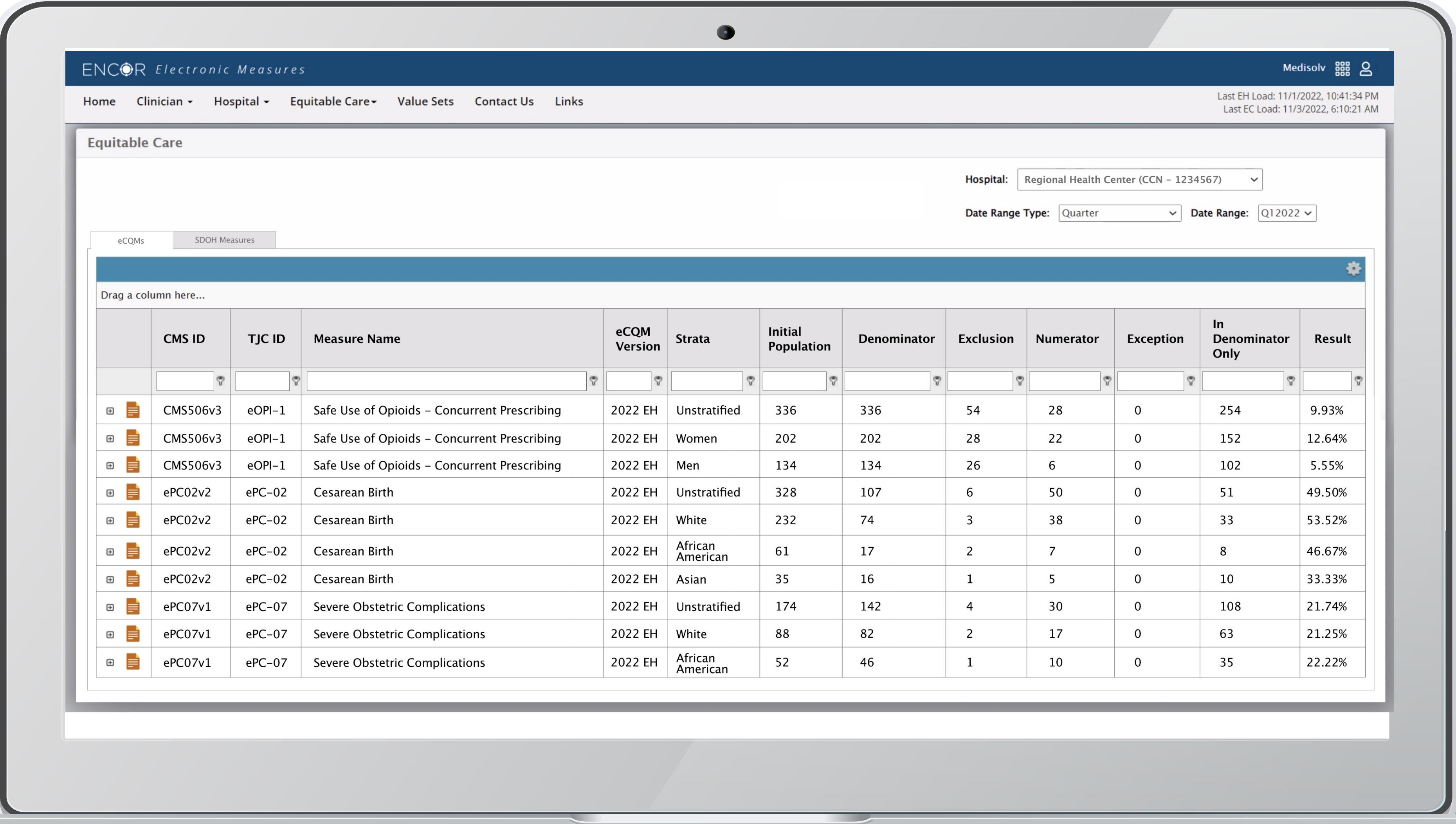
Implementation, Tracking & Improvement



CMS ID	TJC ID	Measure Name	eCQM Version	Strata	Initial Population	Denominator	Exclusion	Numerator	Exception	In Denominator Only	Result
CMS506v3	eOPI-1	Safe Use of Opioids – Concurrent Prescribing	2022 EH	Unstratified	336	336	54	28	0	254	9.93%
CMS506v3	eOPI-1	Safe Use of Opioids – Concurrent Prescribing	2022 EH	Women	202	202	28	22	0	152	12.64%
CMS506v3	eOPI-1	Safe Use of Opioids – Concurrent Prescribing	2022 EH	Men	134	134	26	6	0	102	5.55%
ePC02v2	ePC-02	Cesarean Birth	2022 EH	Unstratified	328	107	6	50	0	51	49.50%
ePC02v2	ePC-02	Cesarean Birth	2022 EH	White	232	74	3	38	0	33	53.52%
ePC02v2	ePC-02	Cesarean Birth	2022 EH	African American	61	17	2	7	0	8	46.67%
ePC02v2	ePC-02	Cesarean Birth	2022 EH	Asian	35	16	1	5	0	10	33.33%
ePC07v1	ePC-07	Severe Obstetric Complications	2022 EH	Unstratified	174	142	4	30	0	108	21.74%
ePC07v1	ePC-07	Severe Obstetric Complications	2022 EH	White	88	82	2	17	0	63	21.25%
ePC07v1	ePC-07	Severe Obstetric Complications	2022 EH	African American	52	46	1	10	0	35	22.22%

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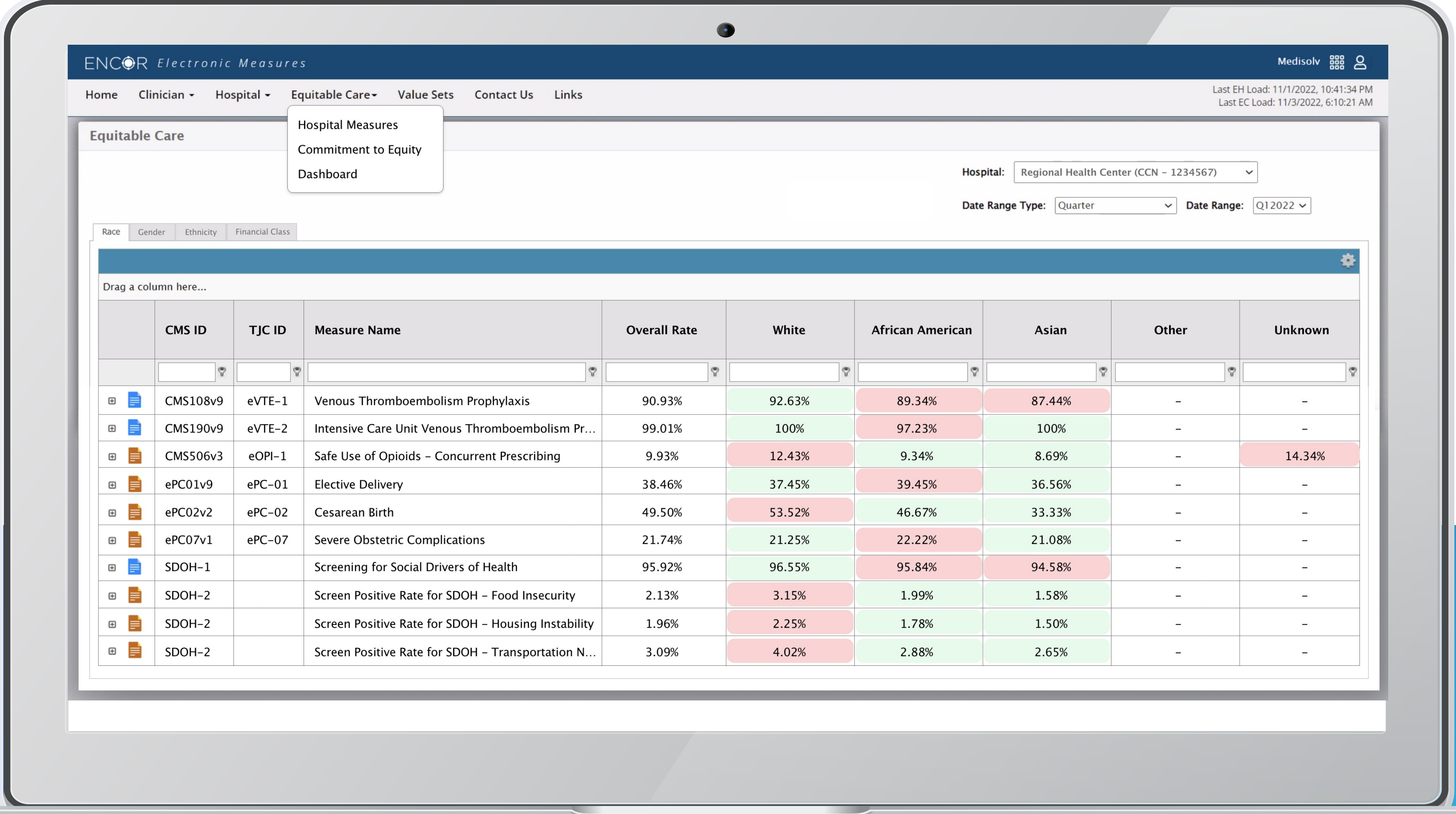
Dashboard



CMS ID	TJC ID	Measure Name	Overall Rate	White	African American	Asian	Other	Unknown
CMS108v9	eVTE-1	Venous Thromboembolism Prophylaxis	90.93%	92.63%	89.34%	87.44%	–	–
CMS190v9	eVTE-2	Intensive Care Unit Venous Thromboembolism Pr...	99.01%	100%	97.23%	100%	–	–
CMS506v3	eOPI-1	Safe Use of Opioids – Concurrent Prescribing	9.93%	12.43%	9.34%	8.69%	–	14.34%
ePC01v9	ePC-01	Elective Delivery	38.46%	37.45%	39.45%	36.56%	–	–
ePC02v2	ePC-02	Cesarean Birth	49.50%	53.52%	46.67%	33.33%	–	–
ePC07v1	ePC-07	Severe Obstetric Complications	21.74%	21.25%	22.22%	21.08%	–	–
SDOH-1		Screening for Social Drivers of Health	95.92%	96.55%	95.84%	94.58%	–	–
SDOH-2		Screen Positive Rate for SDOH – Food Insecurity	2.13%	3.15%	1.99%	1.58%	–	–
SDOH-2		Screen Positive Rate for SDOH – Housing Instability	1.96%	2.25%	1.78%	1.50%	–	–
SDOH-2		Screen Positive Rate for SDOH – Transportation N...	3.09%	4.02%	2.88%	2.65%	–	–

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Implementation, Tracking, & Improvement

Consistency and accuracy of processes and documentation, across all areas of your facility, is key to meeting requirements

SDOH

- Timeline for submission
- Not published as an eCQM but significant encouragement in Final Rule to collect electronically
- Reference to including additional data elements in the future

HCHE

- Timing
- Significant number of elements across the domains
- Who will be responsible for executing and maintaining each element
- How will you support positive attestation if audited?

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Things to Note

Numerator

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 one or all of the following five HRSNs: Food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety during their hospital inpatient stay.

(d) 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 [561] of the following five HRSNs: Food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety during their hospital inpatient stay.

Clarity

Lack of clarity in specifications vs IPPS rule

HRSNs

[561] In the FY 2023 IPPS/LTCH PPS proposed rule (87 FR 28502), we stated ''one or all of the following five HRSNs.'' We have updated the preamble of the final rule in this instance to state ''all five HRSNs'' as per the measure specifications and in alignment with the language throughout the preamble.

Measure Calculation

(f) Measure Calculation

The result of this measure will 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.

Versions

Current version of specification is based on proposed rule

Denominator

(e) 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 an HRSN (food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety) during their hospital inpatient stay. The following

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

-John Lewis

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