Addressing Health Equity in Rural Ohio

A Change Package to Advance Your Efforts

Ohio Rural Health Conference

August 1, 2022

Christine Bailey, MSN, RN, CSSGB
Executive Director
Health Services Advisory Group (HSAG)

OBJECTIVES

- Review the Centers for Medicare & Medicaid Services (CMS) focus on health equity.
- Identify how Z codes can provide a mechanism to code social determinants of health (SDOH) and stratify outcomes.
- Explore national mapping tools to identify areas of high disparities within a community.
- Identify tools, resources, and best practices that will assist rural communities in addressing disparities and SDOH.

HSAG

Who Are We?

HSAG

About

www.hsag.com

We Are on a Mission to Make Healthcare Better

Since our beginning in 1979, HSAG has been committed to improving the quality of healthcare services in order to achieve the best possible patient outcomes.

We provide:

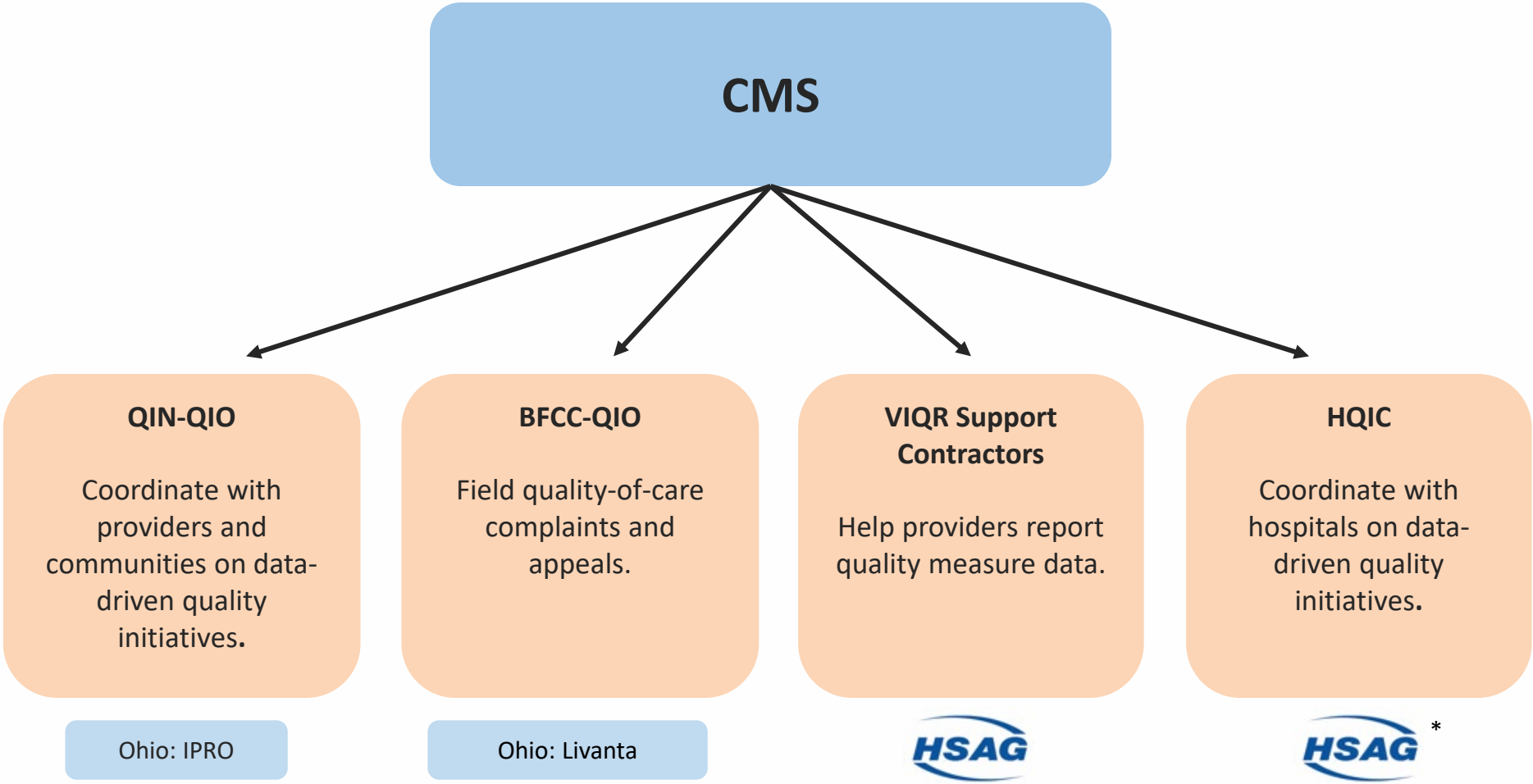
- **Healthcare quality expertise to those who deliver care and those who receive care.**
- **Tools and resources for patients, families, and caregivers to be advocates for their own health.**

Quality: It's Who We Are and What We Do

We embody quality in all we do: in the services we provide, in the knowledge we share, and in the relationships we build with providers, patients, families, and caregivers. Quality is our way of doing business, and directs all of our actions and work.

- CMS Quality Innovation Network-Quality Improvement Organization (QIN-QIO)—AZ and CA
- CMS Hospital Quality Improvement Contract (HQIC)
- End Stage Renal Disease (ESRD) Network Contractor
- ESRD National Support Contractor
- Medicaid External Quality Review Organization (EQRO)
- CMS Value, Incentives, and Quality Reporting Support Contractor (VIQR)
- Healthcare Policy and Quality Measurement Services
- Data Science and Advanced Analytics Services
- Audit and Validation Services
- HEDIS® Compliance Services
- Healthcare Survey Services—CAHPS®

The CMS Quality Contractors



BFCC-QIO = Beneficiary and Family-Centered Care Quality Improvement Organization
(*HSAG is one of nine contractors awarded HQIC contracts

Health Equity:
Identifying Patients of Need

HSAG HQIC

Does Health Equity Impact Rural Areas?

- Most rural communities tend to be less diverse than urban areas.
- Rural Ohio race demographics:
  - 94% White
  - 2.3% Black or African American
  - 0.2% Native American or Alaskan Native
  - 0.7% Asian
  - 2.7% Hispanic/Latino
- Noted increase in migrant population for farm workers and/or transient workers.

https://stacker.com/stories/4335/rural-demographics-every-state

Focus on Health Equity

- CMS National Quality Strategy Goal 2: Advance Health Equity
  - CMS Strategic Framework Pillar 1: Advance Equity
  - CMS Proposed Rules: Principles for Measuring Healthcare Quality Disparities

https://www.cms.gov/blog/cms-national-quality-strategy-person-centered-approach-improving-quality
https://www.cms.gov/files/document/2022-cms-strategic-framework.pdf
https://www.cms.gov/newsroom/fact-sheets/fy-2023-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospitals-ltch-pps

The Joint Commission: Sentinel Event Alert 64

Sentinel Event Alert

A complimentary publication of The Joint Commission — Issue 64, Nov. 10, 2021

Addressing health care disparities by improving quality and safety

The Joint Commission considers addressing health care disparities a quality and patient safety imperative, as well as a moral and ethical duty. Our enterprise's mission to continuously improve health care commits us to finding solutions to these inequities.

"Disparities in health care is one of the most studied and researched problems; there are overwhelming evidence and persistence of gaps in virtually all areas of health care," said Dr. Ana McKee, executive vice president, chief medical officer and chief diversity and inclusion officer, The Joint Commission. "This is a problem that is a major patient safety issue; it provides and introduces as much risk of harm as a central line infection or a fall. We encourage all organizations to address disparities as a patient safety concern."[1]

This *Sentinel Event Alert* summarizes strategies for health care and human services organizations in all settings as they begin to address health care disparities; it also provides examples of successful initiatives for organizations that are well on their way. This alert can guide organizations as they address disparities as a central part of performance and patient safety improvement hardwire the pursuit of health equity into their strategic planning.

The Henry J. Kaiser Family Foundation defines health care disparities a "differences between groups in health coverage, access to care, and care."[2] While these disparities are commonly viewed through the le ethnicity, they occur across many dimensions, including socioeco age, location, gender, disability status, and sexual orientation a

According to the Centers for Disease Control and Preventio women are three times more likely to die from a pregnanc white women.[3] The COVID-19 pandemic has widened di Hispanic Blacks and Hispanics with COVID-19 experie rate of hospitalization as whites,[4] and both demogr experienced more than half of COVID-19 deaths n only a third of the population, according to age-s

- *"The Joint Commission considers addressing healthcare disparities a quality and patient safety imperative…"*
- Defines healthcare disparities as *"The differences between groups in health coverage, access to care, and quality of care."*
- *"While these disparities are commonly viewed through the lens of race and ethnicity, they occur across many dimensions, including socioeconomic status, age, location, gender, disability status, and sexual orientation and expression."*

Joint Commission. https://www.jointcommission.org/resources/patient-safety-topics/sentinel-event/sentinel-event-alert-newsletters/sentinel-event-alert-64-addressing-health-care-disparities/#.Ys8Em3bMKUk

What Is Health Equity?

Defining Health Equity

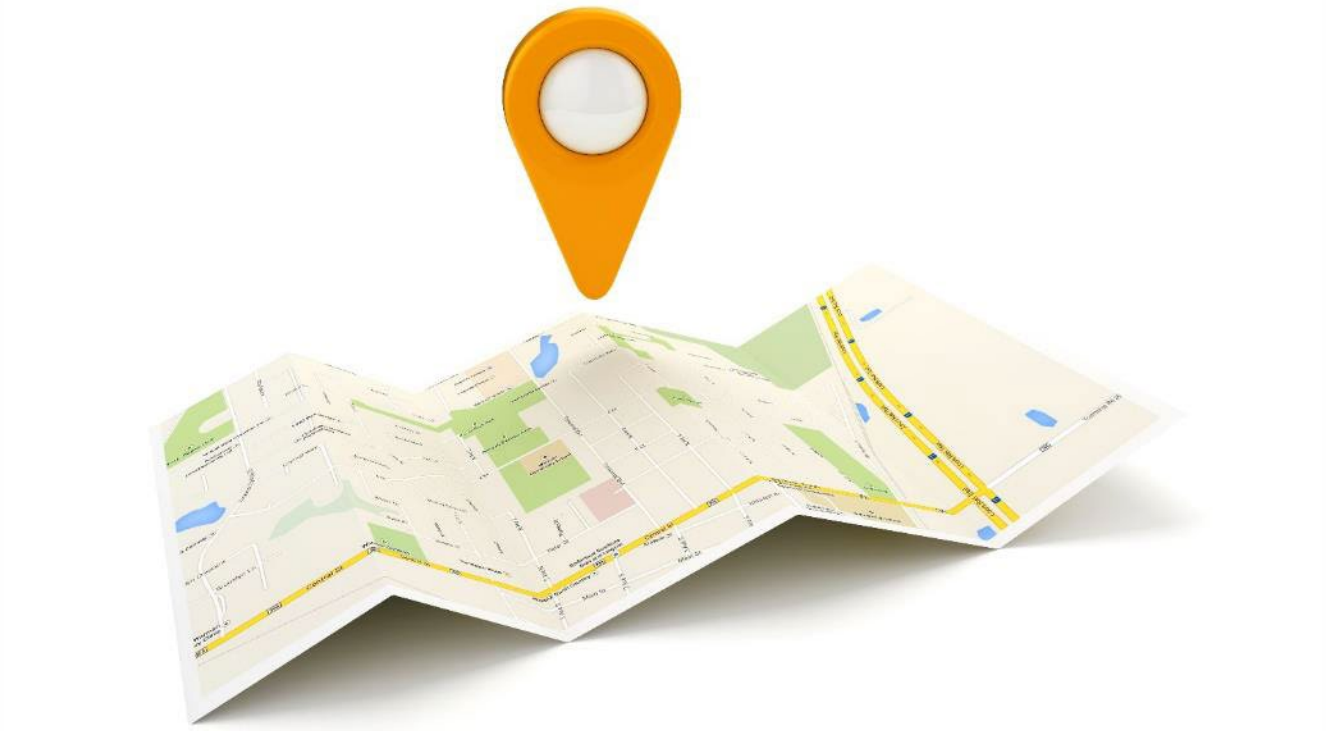
"Health equity is achieved when every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances." —*CDC*

- Length of life
- Rates of disease, disability, and death
- Severity of disease
- Access to treatment

Centers for Disease Control (CDC). https://www.cdc.gov/chronicdisease/healthequity/index.htm

Greatest Predictor of Life Expectancy

Your ***ZIP Code***



https://www.cdc.gov/nchs/data-visualization/life-expectancy/index.html

What Are SDOH?

"SDOH are the conditions in the environment where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." —*HHS*

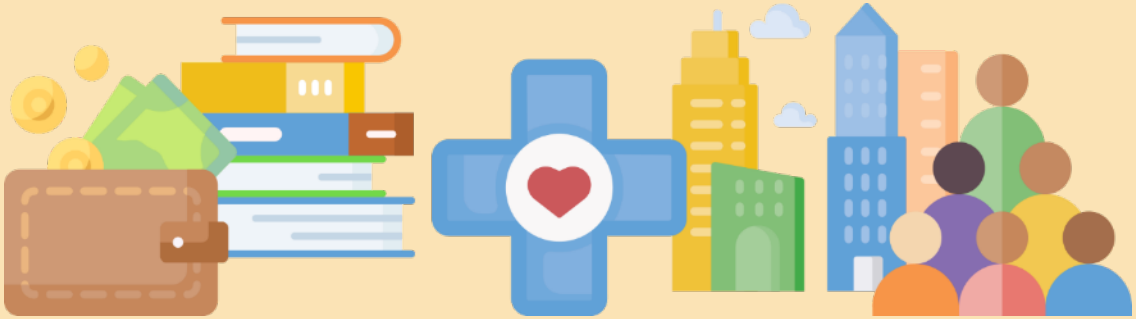
- Housing
- Transportation
- Violence/crime
- Education
- Job opportunities
- Income
- Nutrition
- Physical activity
- Pollution
- Health literacy
- Community resources
- Access to care
- Insurance coverage

HHS = U.S. Dept. of Health and Human Services

https://health.gov/healthypeople/priority-areas/social-determinants-health

Impact of SDOH

SDOH



Healthcare

80% to 90% of health outcome contributors are social determinants of health. *—National Academy of Medicine*

https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/

Who Does SDOH Impact?

1 in 10 Americans live in poverty with the inability to afford healthcare, healthy food, and housing.[1]

1.5 times higher hospital utilization*

70% higher prescribing of high-risk drugs*

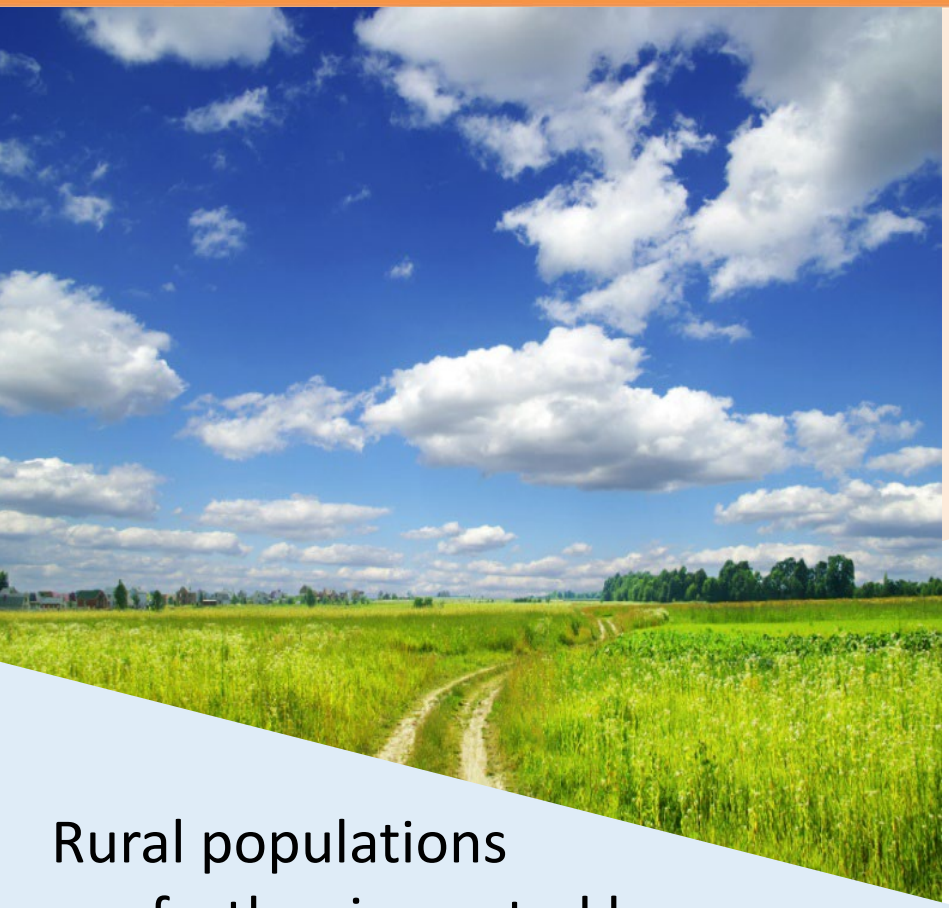
Anticoagulants, glycemic agents, opioids

18% higher avoidable readmissions*

1. Health People 2030, Economic Stability. https://health.gov/healthypeople/objectives-and-data/browse-objectives/economic-stability.

*Patients on Medicare and Medicaid

SDOH Impacts Rural Areas

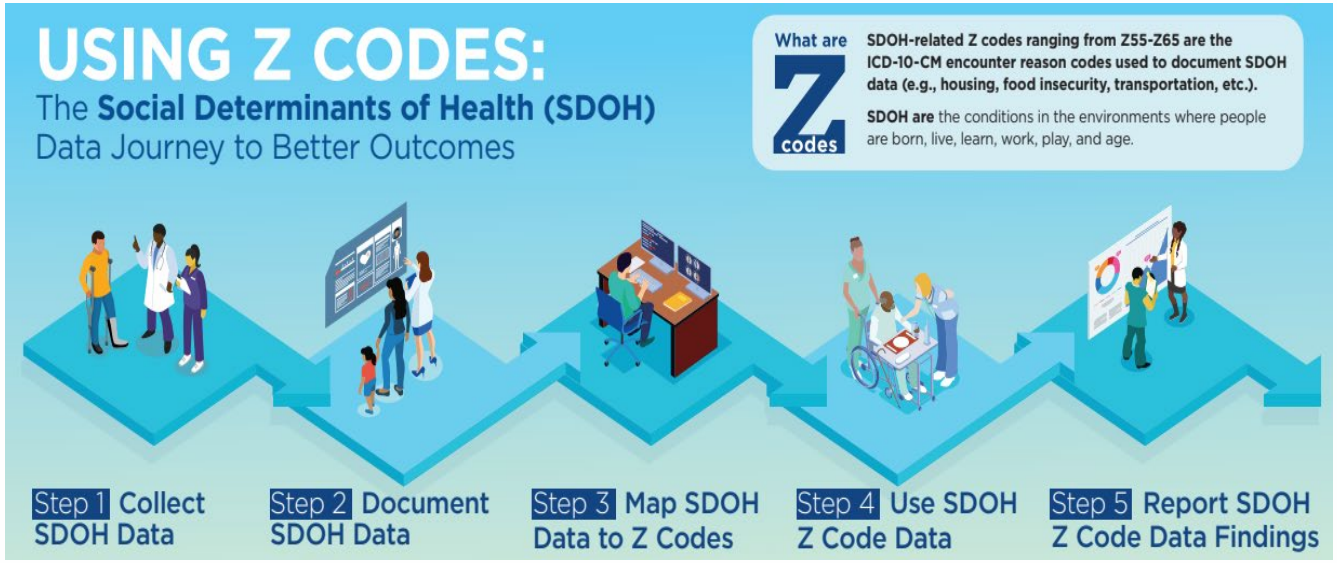


Rural populations are more likely to experience socioeconomic hardships.

Rural populations are further impacted by limited community resources.

https://www.ruralhealthinfo.org/topics/social-determinants-of-health

Measuring SDOH: Z Codes



Z codes are a special group of ICD-10 codes used to report factors influencing health status.

- Assist in capturing social needs of patients, such as SDOH.
- Can be used to enhance discharge planning.
- Can be used to stratify outcomes based on SDOH.

ICD = International Classification of Diseases
https://www.cms.gov/files/document/zcodes-infographic.pdf

SDOH ICD-10 Z Codes

SDOH ICD-10 Z-Codes	Description	Number of Sub-Codes
Z55	Problems related to education and literacy	7
Z56	Problems related to employment and unemployment	12
Z57	Occupational exposure to risk factors	12
Z59	Problems related to housing and economic circumstances	10
Z60	Problems related to social environment	7
Z62	Problems related to upbringing	24
Z63	Other problems related to primary support group, including family circumstances	14
Z64	Problems related to certain psychosocial circumstances	3
Z65	Problems related to other psychosocial circumstances	8

https://www.cms.gov/files/document/zcodes-infographic.pdf

Z Code Resource for You: PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)

- Standardized risk-assessment tool for SDOH
- Evidence-based
- Well-established
- Questionnaire
- Z code mapping tool
- Implementation and Action Tool Kit
- In partnership with the National Association of Community Health Centers

https://prapare.org/

PRAPARE Webinar

www.hsag.com/hqic-events

July 22, 2021

www.hsag.com/hqic/hqic-events/2021/july-2021/using-prapare-to-collect-sdoh-data/

PAST EVENT

Using PRAPARE to Collect SDOH Data

Thursday, July 22, 2021, 2:00 p.m. to 3:00 p.m. ET.

11:00 a.m. Pacific | 12 noon Mountain | 1:00 p.m. Central

Access the Recording

The Health Services Advisory Group (HSAG) Hospital Quality Improvement Contract (HQIC) Offers an overview on how to use the protocol for responding to and assessing patients' assets, risks, and experiences (PRAPARE) assessment tool to collect and document data on the social determinants of health (SDOH).

Objectives

- Discover how PRAPARE enables hospitals to better understand patient complexity, address social risks, and demonstrate value.
- Identify workflows, tips, and strategies for effectively implementing PRAPARE.
- Explore examples of how PRAPARE has led to changes at the patient, organization, and community levels.

Presenters

Nalani Tarrant, MPH, PMP, is the Deputy Director of Research projects at the NACHC, where she helps health centers build community-based and patient-centered research and data capacity. She focuses on helping health centers collect and use social determinants of health data to improve care delivery, inform policy, and accelerate community change by developing, testing, and implementing the standardized social determinants of health protocol known as PRAPARE. Previously, Ms. Tarrant was the Director of Quality Collaboratives, Data & Quality Measures at the American College of Emergency Physicians where she worked with physician leads on the Transforming Clinical Practice Initiative supported by CMS. She earned a bachelor's degree in behavioral science from Drew University, and a master of public health (MPH) in epidemiology from George Washington University. She also holds a Project Management Professional accreditation.

Sarah Halpin, MPH, is the Research Program Associate for NACHC, focusing on social determinants of health and health equity projects. In this role, Ms. Halpin supports health centers in developing strategies to assess and address social needs alongside community partners, and works to identify and elevate health centers working upstream to inform innovation and system transformation efforts. Passionate about the intersection of health and social justice, Ms. Halpin has previously conducted research on access to care, health literacy, and food insecurity in historically marginalized and underserved communities in the U.S. and abroad. She has a BA in anthropology & bioethics and an MPH with a concentration in health policy, law & ethics from the University of Virginia.

Leveraging the Area Deprivation Index (ADI)

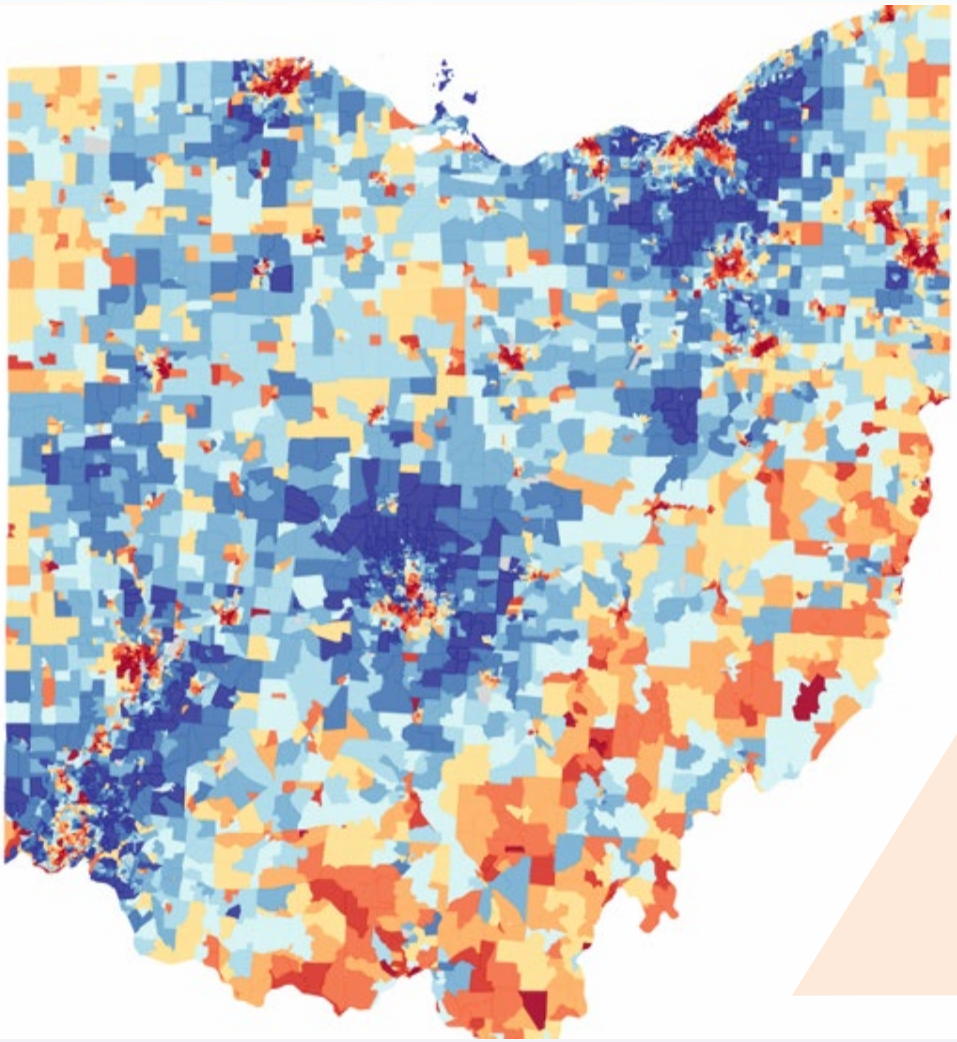
"An ADI is a multidimensional evaluation of a region's socioeconomic conditions, which have been linked to outcomes."

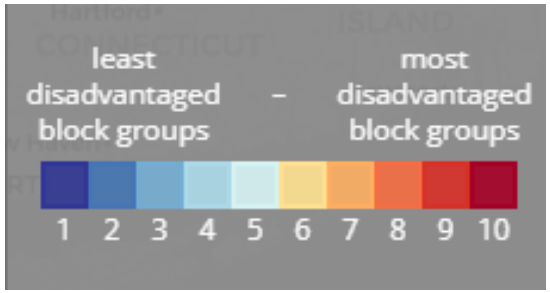
—Maroko, et. al.

- Neighborhood Atlas®
- Created by Health Resources & Services Administration (HRSA)
- Through University of Wisconsin
- In existence for 30-plus years
- Uses census block groups to define neighborhoods
- Identifies most disadvantaged neighborhoods
- Factors in:
  - Income
  - Education
  - Employment
  - Housing

https://www.cdc.gov/pcd/issues/2016/16_0221.htm

Ohio—ADI Mapping Function

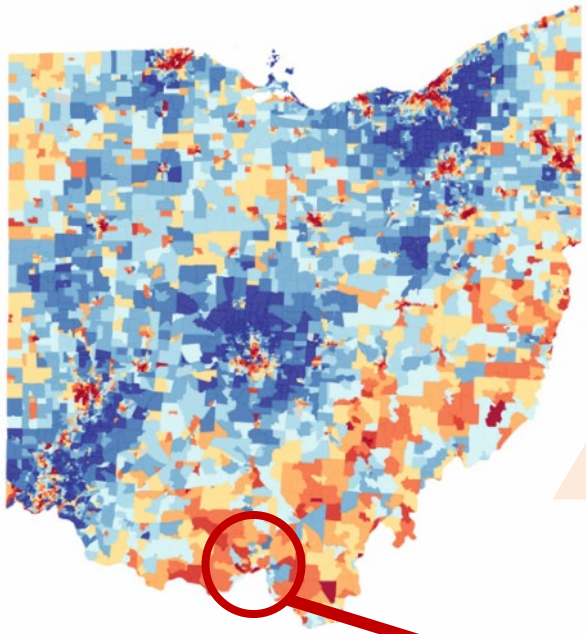


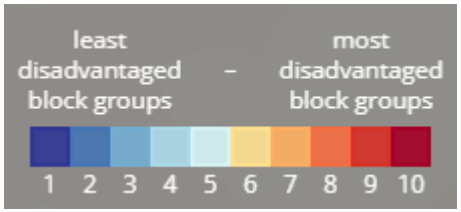


Many of Ohio's rural areas have a high density of disadvantaged block groups.

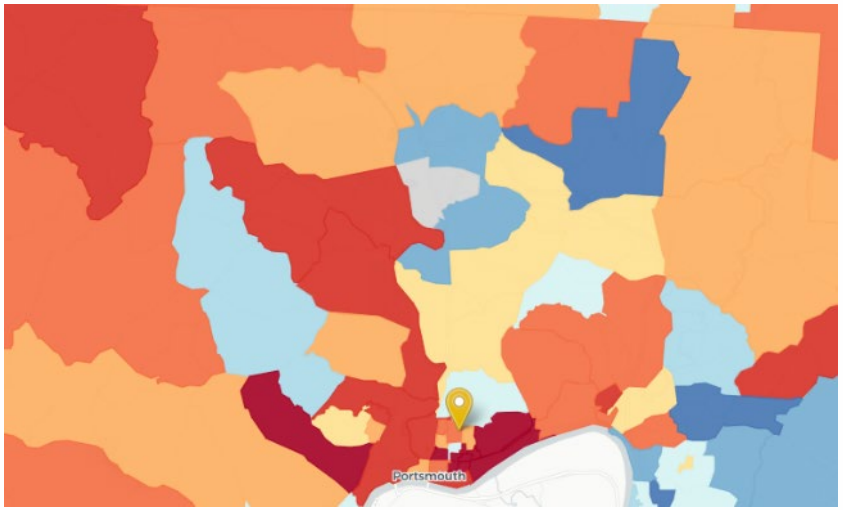
https://www.neighborhoodatlas.medicine.wisc.edu/mapping

ADI Community Example





- The mapping tool can assist hospitals by focusing on areas with the most disadvantaged census blocks.
- Patients coming from these areas will most likely experience more SDOH that will impact their care and clinical outcomes.



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HSAG ADI Patient Stratification:
Analyze Deprivation Level in Your Patient Population

				Beneficiaries with ADI National Ranking Assigned		Numerator: Beneficiaries Fall in the ADI Bucket Denominator: Beneficiaries with ADI National Ranking Assigned										Beneficiaries with ADI National Ranking Not Available		Numerator: Beneficiaries with Specific Reason that ADI is Not Available Denominator: Beneficiaries with ADI National Ranking Not Available					
						ADI Ranking: 85 +		ADI Ranking: 76 - 84		ADI Ranking: 51 - 75		ADI Ranking: 26 - 50		ADI Ranking: 0 - 25				ADI Ranking is Suppressed in the Crosswalk		Beneficiary's 9-Digit ZIP Code is Not Available in BIC		Beneficiary's 9-Digit ZIP Code Cannot be Found in the ADI Crosswalk	
Stat	CCN	Hospital Name	Total Beneficiari	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
SC	100001	Hospital A	1,597	1,534	96.1%	823	53.7%	320	20.9%	298	19.4%	80	5.2%	13	0.8%	63	3.9%	27	42.9%	34	54.0%	2	3.2%
SC	100002	Hospital B	2,603	2,469	94.9%	915	37.1%	452	18.3%	749	30.3%	342	13.9%	11	0.4%	134	5.1%	46	34.3%	78	58.2%	10	7.5%
SC	100003	Hospital C	200	192	96.0%	148	77.1%	25	13.0%	9	4.7%	9	4.7%	1	0.5%	8	4.0%	2	25.0%	5	62.5%	1	12.5%

Stat	CCN	Hospital Name	Total Beneficiari	N	%
SC	100001	Hospital A	1,597	1,534	96.1%
SC	100002	Hospital B	2,603	2,469	94.9%
SC	100003	Hospital C	200	192	96.0%

Numerator: Beneficiaries Fall in the ADI Bucket Denominator: Beneficiaries with ADI National Ranking Assigned									
ADI Ranking: 85 +		ADI Ranking: 76 - 84		ADI Ranking: 51 - 75		ADI Ranking: 26 - 50		ADI Ranking: 0 - 25	
N	%	N	%	N	%	N	%	N	%
823	53.7%	320	20.9%	298	19.4%	80	5.2%	13	0.8%
915	37.1%	452	18.3%	749	30.3%	342	13.9%	11	0.4%
148	77.1%	25	13.0%	9	4.7%	9	4.7%	1	0.5%

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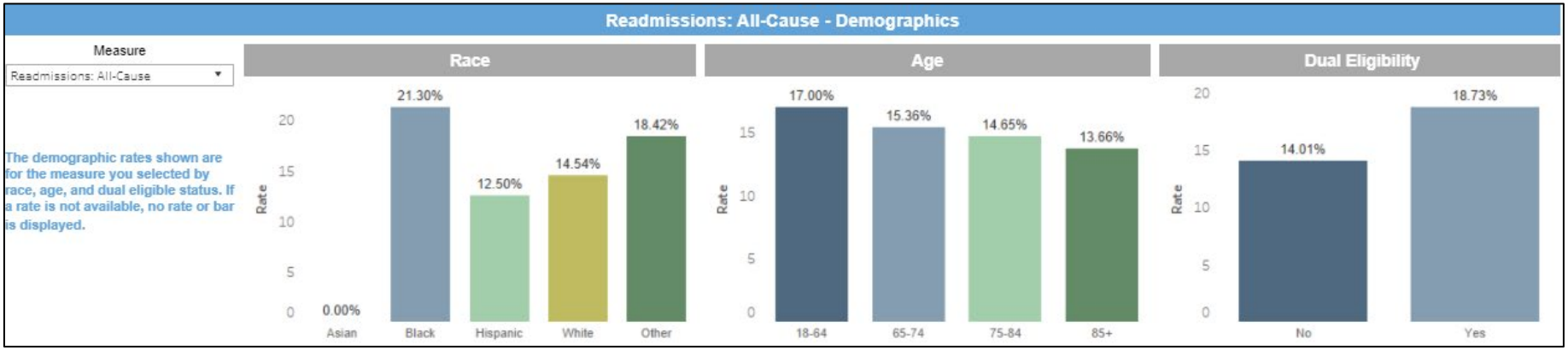
HSAG HQIC Performance Dashboard

- Stratifies outcome metrics by demographic and geographic categories.
  - Race/ethnicity
  - Age
  - Dual eligibility (proxy measure for SDOH)
- Allows facilities to identify potential health disparities in their outcomes.



Using Tools to Improve Health Equity

Data for Action

- Develop a methodology to collect and validate health equity and community demographic data.
- Stratify data outcome(s) by demographic and/or SDOH data.
- Communicate the disparities and engage patients, families, caregivers, staff, and the community in solutions.
- Design interventions to address the identified disparities.
- Evaluate impacts, scale, and spread of successful interventions.

Start small but start somewhere!

HSAG HQIC
Health Equity Change Package

www.hsag.com/hqic-tools

HSAG HQIC

HSAG HQIC Health Equity Change Package

A Guide to Support You Through Your Health Equity Journey

Health Equity

Health Equity Change Package

Organizational Assessments and Culture

Health Equity: A Business Case. What is the impact of health disparities? Health disparities can lead to poor patient outcomes and significant excess financial loss. A single-page handout from HSAG.

Buidling an Organization Response to Health Disparities. A toolkit from the Centers for Medicare & Medicaid Services (CMS).

Health Equity Organizational Assessment (HEOA). A downloadable form that assesses your hospital's ability to identify and address health disparities. From HSAG.

Implementing Health Equity Roadmap to Success

Data Collection, Training, Validation, and Stratification

Improving Health Equity: Building Infrastructure to Support Health Equity. Institute for Healthcar

Reducing Health Care Disparities: Collection and Use of Race, Ethnicity, and Language. Americ

Achieving Health Equity. Centers for Medicare & Medicaid Services (CMS) online course.

ICD-10 Z Codes for Disparities. From CMS, this PDF outlines the steps in using Z Codes.

Social Work Assessment. From HSAG, a checklist form.

HSAG HQIC can assist you in navigating to the tools that are right for you.

Interventions and Quality Outcomes

Strategies for Equitable Care. From HSAG, this downloadable strategy tree of tactics, tasks, and tools, offers numerous options that coordinate with the Health Equity Organization Assessment (HEOA).

Impacting Social Determinants of Health (SDOH) Toolkit. This downloadable HSAG document is designed for hospitals in rural and high-deprivation areas, where people are more likly to experience disparities related to SDOH. It includes strategies and links to resources.

Examples of Healthcare Systems and Addressing Health Equity:

- Building an Organizational Response to Health Disparities: 5 Pioneers from the Field. From CMS, the report includes several business cases.

Tools for Patients

Why Collect REaL Data. From HSAG, this downloadable flyer for patients answers frequently asked questions about why hospitals collect information on patient race, ethnicity, and language.

Why Collect REaL Data. (Spanish)

Zone Tools. Downloadable tools to assist discharging patients in managing a number of common health conditions.

Medicare and You Handbook. (English)

Medicare and You Handbook. (Other languages)

www.hsag.com/hqic-equity

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Health Equity Business Case

Organizational Assessments and Culture

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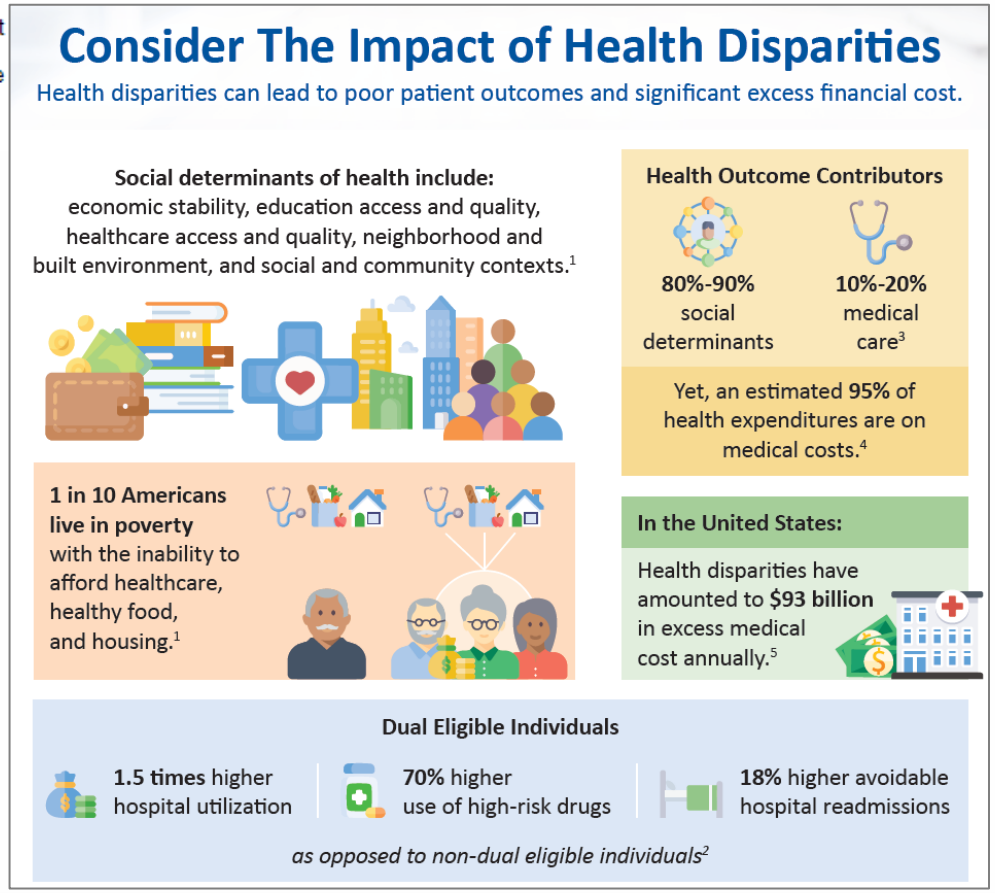

www.hsag.com/globalassets/hqic/hqic-healthequity-bizcase.pdf

Social Work Assessment

Data Collection, Training, Validation, and Stratification

Improving Health Equity: Building Infrastructure to Support Health Equity. Institute for Healthcare Improvement (IHI) webpage.

Reducing Health Care Disparities: Collection and Use of Race, Ethnicity, and Language. American Hospital A

Achieving Health Equity. Centers for Medicare & Medicaid Services (CMS) online course.

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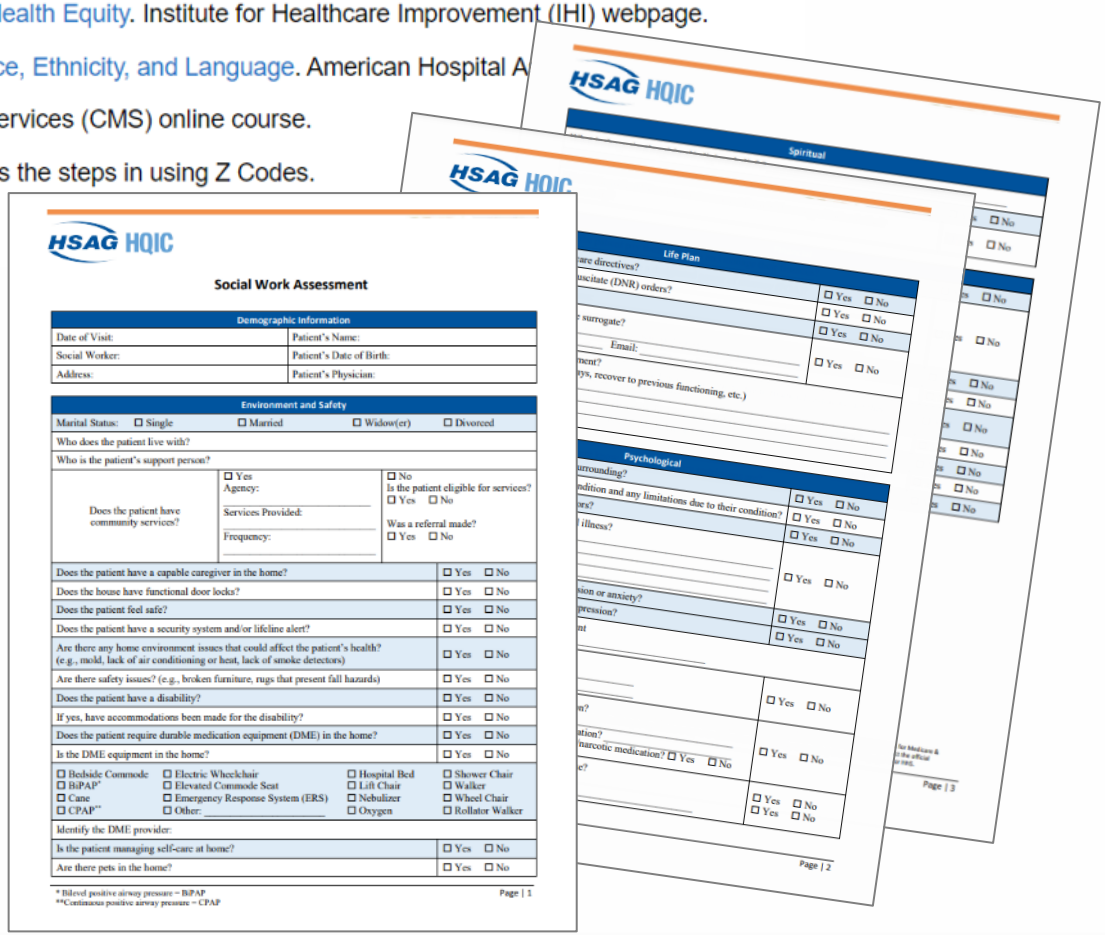

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Social Work Assessment

Demographic Information	
Date of Visit:	Patient's Name:
Social Worker:	Patient's Date of Birth:
Address:	Patient's Physician:

Environment and Safety			
Marital Status: ☐ Single	☐ Married	☐ Widow(er)	☐ Divorced
Who does the patient live with?			
Who is the patient's support person?			
Does the patient have community services?	☐ Yes Agency: Services Provided: Frequency:	☐ No Is the patient eligible for services? ☐ Yes ☐ No Was a referral made? ☐ Yes ☐ No	
Does the patient have a capable caregiver in the home?			☐ Yes ☐ No
Does the house have functional door locks?			☐ Yes ☐ No
Does the patient feel safe?			☐ Yes ☐ No
Does the patient have a security system and/or lifeline alert?			☐ Yes ☐ No
Are there any home environment issues that could affect the patient's health? (e.g., mold, lack of air conditioning or heat, lack of smoke detectors)			☐ Yes ☐ No
Are there safety issues? (e.g., broken furniture, rugs that present fall hazards)			☐ Yes ☐ No
Does the patient have a disability?			☐ Yes ☐ No
If yes, have accommodations been made for the disability?			☐ Yes ☐ No
Does the patient require durable medication equipment (DME) in the home?			☐ Yes ☐ No
Is the DME equipment in the home?			☐ Yes ☐ No
☐ Bedside Commode ☐ BiPAP* ☐ Cane ☐ CPAP**	☐ Electric Wheelchair ☐ Elevated Commode Seat ☐ Emergency Response System (ERS) ☐ Other:	☐ Hospital Bed ☐ Lift Chair ☐ Nebulizer ☐ Oxygen	☐ Shower Chair ☐ Walker ☐ Wheel Chair ☐ Rollator Walker
Identify the DME provider:			
Is the patient managing self-care at home?			☐ Yes ☐ No
Are there pets in the home?			☐ Yes ☐ No

* Bilevel positive airway pressure = BiPAP
**Continuous positive airway pressure = CPAP

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www.hsag.com/globalassets/hqic/hqic_socialworkassessment.pdf

SDOH Toolkit

Interventions and Quality Outcomes

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Impacting Social Determinants of Health (SDOH) Toolkit. This downloadable HSAG document is designed for hospitals in rural and high-deprivation areas, where people are more likly to experience disparities related to SDOH. It includes strategies and links to resources.

Examples of Healthcare Systems and Addressing Health Equity:

- Building an Organizational Response to Health Disparities: 5 Pioneers from the Field. From CMS, the report includes several business cases.

HSAG HQIC

Impacting Social Determinants of Health That Affect Your Patients

A Toolkit for Hospitals in Rural and High-Deprivation Areas

Social determinants of health (SDOH) are environmental conditions, which can include economic factors, education, healthcare access, built environment, and sociocultural contexts. These SDOH can have a significant impact on health and quality of life, and can contribute to health disparities and inequities.[1] In particular, people in rural and high-deprivation areas are more likely to experience disparities related to SDOH and can experience problems managing chronic disease and have higher readmission and mortality rates. Because of this, hospitals in rural and high-deprivation areas should consider the context of their patients and work on applying solutions to address the SDOH in their patient populations.[2]

Topic 1: SDOH Data Collection

Rationale: 80–90 percent of health outcomes can be attributed to SDOH, while only 10–20 percent are attributable to medical care.[3] This statistic is especially applicable in rural and high-deprivation areas where patients experience a number of social factors outside of the hospitals' control which impact the patients' health.[4] Because of this, hospitals should consider implementing methods to identify and account for patient SDOH, and the first step of this is collecting data on patient SDOH.

Strategies	Discussion	Tools and Resources
1. Use the Area Deprivation Index (ADI) to understand how SDOH might be affecting your patient population and quality measures.	ADI is a measure of neighborhood deprivation at the census block level, and research has shown patients with higher deprivation are more likely to experience readmission and mortality. Using ADI can be a simpler way to identify health disparities in a patient population, as it integrates multiple social determinants into one deprivation measure, which can be looked at on the census block group level.	• ADI Home and Mapping Tool—https://www.neighborhoodatlas.medicine.wisc.edu/ • Utilizing ADI for Risk Prediction—https://www.ahajournals.org/doi/10.1161/AHA.120.020466
2. Use a SDOH data collection tool to identify patient-level social risk factors.	SDOH contribute significantly to patient outcomes, so collecting these data allows for understanding and addressing the individual social risk factors patients may have.	• PRAPARE* SDOH Data Collection Tool—http://www.nachc.org/research-and-data/prapare/ • CMS** SDOH Data Collection Tool—https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf • SDOH Data Collection Tool Comparison Resource—https://sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison
3. Document SDOH Z Codes in the medical record.	Documenting Z Codes allows for better documentation of patient social risk factors, which can improve continuity of care. In addition, improving documentation of Z Codes allows for increased billing of these codes.	• CMS Z Code Infographic—https://www.cms.gov/files/document/zcodes-infographic.pdf

*PRAPARE = Protocol for Responding to and Assessing Patients' Assets, Risks, and Experience. **CMS = Centers for Medicare & Medicaid Services

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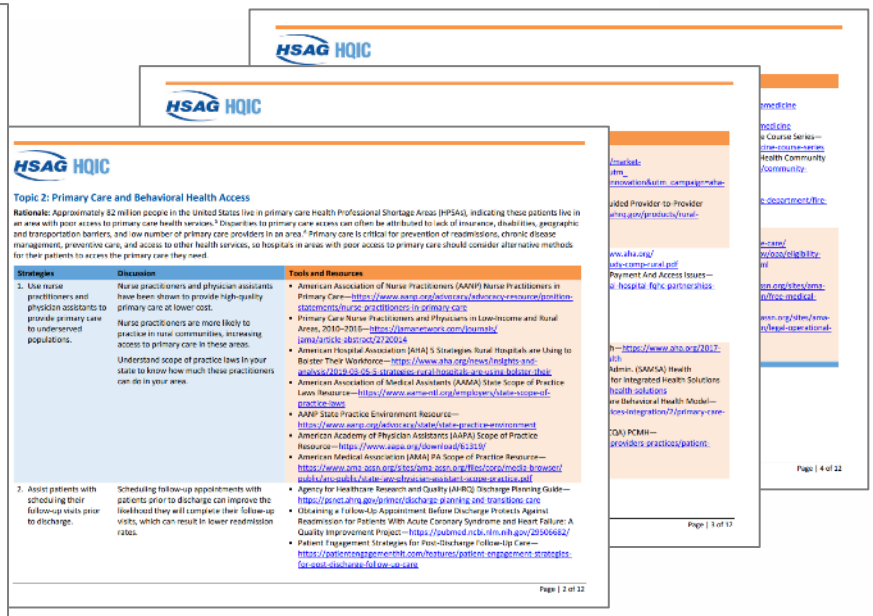

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Topic 2: Primary Care and Behavioral Health Access

Rationale: Approximately 82 million people in the United States live in primary care Health Professional Shortage Areas (HPSAs), indicating these patients live in an area with poor access to primary care health services.[1] Disparities to primary care access can often be attributed to lack of insurance, disabilities, geographic and transportation barriers, and low number of primary care providers in an area.[2] Primary care is critical for prevention of readmissions, chronic disease management, preventive care, and access to other health services, so hospitals in areas with poor access to primary care should consider alternative methods for their patients to access the primary care they need.

Strategies	Discussion	Tools and Resources
1. Use nurse practitioners and physician assistants to provide primary care to underserved populations.	Nurse practitioners and physician assistants have been shown to provide high-quality primary care at lower cost. Nurse practitioners are more likely to practice in rural communities, increasing access to primary care in these areas. Understand scope of practice laws in your state to know how much these practitioners can do in your area.	• American Association of Nurse Practitioners (AANP) Nurse Practitioners in Primary Care—https://www.aanp.org/advocacy/advocacy-resource/position-statements/nurse-practitioners-in-primary-care • Primary Care Nurse Practitioners and Physicians in Low-Income and Rural Areas, 2010–2016—https://jamanetwork.com/journals/jama/article-abstract/2720014 • American Hospital Association (AHA) 5 Strategies Rural Hospitals are Using to Bolster Their Workforce—https://www.aha.org/news/insights-and-analysis/2019-08-05-5-strategies-rural-hospitals-are-using-bolster-their • American Association of Medical Assistants (AAMA) State Scope of Practice Laws Resource—https://www.aamanet.org/employers/state-scope-of-practice-laws • AANP State Practice Environment Resource—https://www.aanp.org/advocacy/state/state-practice-environment • American Academy of Physician Assistants (AAPA) Scope of Practice Resource—https://www.aapa.org/download/61819/ • American Medical Association (AMA) PA Scope of Practice Resource—https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/state-law-physician-assistant-scope-practice.pdf
2. Assist patients with scheduling their follow-up visits prior to discharge.	Scheduling follow-up appointments with patients prior to discharge can improve the likelihood they will complete their follow-up visits, which can result in lower readmission rates.	• Agency for Healthcare Research and Quality (AHRQ) Discharge Planning Guide—https://psnet.ahrq.gov/primer/discharge-planning-and-transitions-care • Obtaining a Follow-Up Appointment Before Discharge Protects Against Readmission for Patients With Acute Coronary Syndrome and Heart Failure: A Quality Improvement Project—https://pubmed.ncbi.nlm.nih.gov/29506682/ • Patient Engagement Strategies for Post-Discharge Follow-Up Care—https://patientengagementhit.com/features/patient-engagement-strategies-for-post-discharge-follow-up-care

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www.hsag.com/globalassets/hqic/hqic_sdoh_toolkit_508.pdf

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Race, Ethnicity, and Language (REaL) Data

Tools for Patients

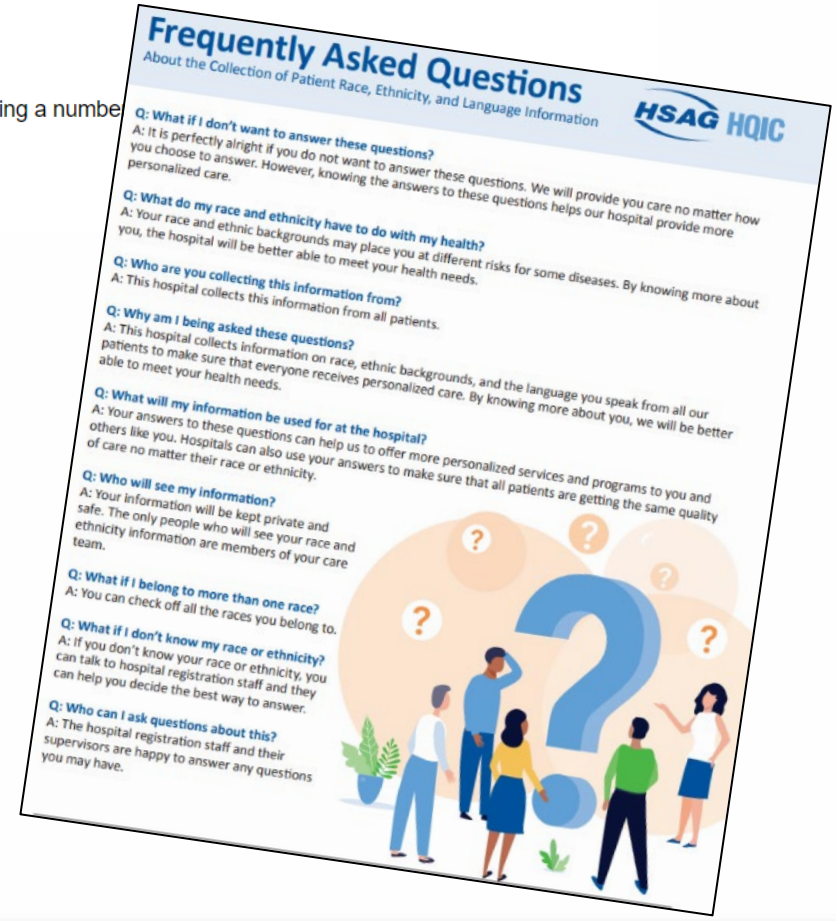
Why Collect REaL Data. From HSAG, this downloadable flyer for patients answers frequently asked questions about why hospitals collect information on patient race, ethnicity, and language.

Why Collect REaL Data. (Spanish)

Zone Tools. Downloadable tools to assist discharging patients in managing a numbe

Medicare and You Handbook. (English)

Medicare and You Handbook. (Other languages)



Frequently Asked Questions

About the Collection of Patient Race, Ethnicity, and Language Information

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Q: What if I don't want to answer these questions?
A: It is perfectly alright if you do not want to answer these questions. We will provide you care no matter how you choose to answer. However, knowing the answers to these questions helps our hospital provide more personalized care.

Q: What do my race and ethnicity have to do with my health?
A: Your race and ethnic backgrounds may place you at different risks for some diseases. By knowing more about you, the hospital will be better able to meet your health needs.

Q: Who are you collecting this information from?
A: This hospital collects this information from all patients.

Q: Why am I being asked these questions?
A: This hospital collects information on race, ethnic backgrounds, and the language you speak from all our patients to make sure that everyone receives personalized care. By knowing more about you, we will be better able to meet your health needs.

Q: What will my information be used for at the hospital?
A: Your answers to these questions can help us to offer more personalized services and programs to you and others like you. Hospitals can also use your answers to make sure that all patients are getting the same quality of care no matter their race or ethnicity.

Q: Who will see my information?
A: Your information will be kept private and safe. The only people who will see your race and ethnicity information are members of your care team.

Q: What if I belong to more than one race?
A: You can check off all the races you belong to.

Q: What if I don't know my race or ethnicity?
A: If you don't know your race or ethnicity, you can talk to hospital registration staff and they can help you decide the best way to answer.

Q: Who can I ask questions about this?
A: The hospital registration staff and their supervisors are happy to answer any questions you may have.

www.hsag.com/globalassets/hqic/hqic-ptedwhycollectrealdata.pdf

Zone Tools

Tools for Patients

Why Collect REaL Data. From HSAG, this downloadable flyer for patients answers frequently asked questions about why hospitals collect information on patient race, ethnicity, and language.

Why Collect REaL Data. (Spanish)

Zone Tools Downloadable tools to assist discharging patients in managing a number of common health conditions.

Medicare

Medicare

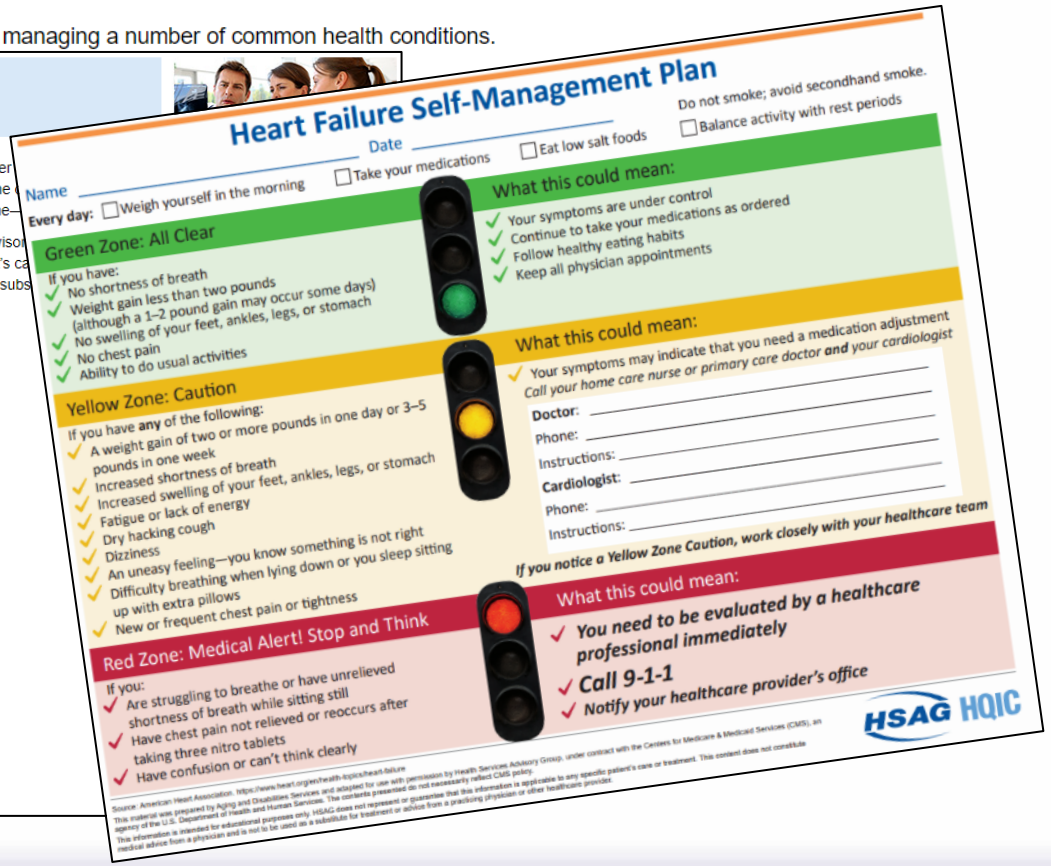
Zone Tools

These downloadable tools were created to assist patients in managing a number
Better self-management can lead to improved overall health and help reduce the
The tools include: Green Zone—All Clear; Yellow Zone—Caution; and Red Zone—

This information is intended for educational purposes only. Health Services Advisor
represent or guarantee that this information is applicable to any specific patient's ca
does not constitute medical advice from a physician and is not to be used as a subs
from a practicing physician or other healthcare provider.

Zone Tools

Asthma: English | Spanish
Blood Thinner: English | Spanish
COPD: English | Spanish
COVID-19: English | Spanish
Diabetes: English | Spanish
Heart Disease: English | Spanish
Heart Failure: English | Spanish
Hip (Total): English | Spanish
Knee (Total): English | Spanish
Medications: English | Spanish
Pneumonia: English | Spanish
Sepsis: English | Spanish
Stroke: English | Spanish
Urinary: English | Spanish



www.hsag.com/hqic-zone-tools

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Another Valuable Resource

Quality and Safety Series

Find resources to assist your quality improvement journey, from planning and preparation to sustaining your organization's gains. Topic areas contain short video presentations (a.k.a., "quickinars") and associated tools and resources to support your organization. Sign up for future live quickinars by visiting the HSAG HQIC event calendar at: www.hsag.com/hqic-events, or you can register for all future quality and safety quickinars at once here.

- 1. Team Forming
- 2. Buy-In
- 3. Organizational Readiness
- 4. Quality Improvement Models
- 5. Rapid-Cycle Improvement
- 6. SMART Goals
- 7. Fishbone Diagramming
- 8. SWOT Analysis
- 9. Voice of the Customer
- 10. Process Mapping
- 11. Reliable Processes
- 12. 5 Whys
- 13. Prioritization Matrix
- 14. Data Plan
- 15. Action Hierarchy
- 16. Action Planning
- 17. FMEA
- 18. Communication Plan
- 19. Kamishibai
- 20. A3 Thinking
- 21. Data Visualization
- 22. Variation, Monitoring, Course Correction
- 23. Process Observation
- 24. Control Plan

On demand, bite-size quality improvement learning series!

1. Team Forming

Quality Series: Team Forming

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View the Team Forming Quickinar Recording

Team Forming Tools to Download

- Forming a Team Template (PDF)
- Forming a Team Template (Microsoft Word)
- Team Meeting Schedule Template (PDF)
- Team Meeting Schedule Template (Microsoft Word)
- Team Meeting Agenda Template (PDF)
- Team Meeting Agenda Template (Microsoft Word)
- Team Meeting Notes Template (PDF)
- Team Meeting Notes Template (Microsoft Word)

www.hsag.com/hqic-quality-series

Questions?

Thank you!

Christine Bailey, MSN, RN, CSSGB
Executive Director
HSAG
cbailey@hsag.com
614.307.2936

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