HRET
HEALTH RESEARCH & EDUCATIONAL TRUST

Washington State Hospital Association

HRET HIIN HEALTH EQUITY ORGANIZATIONAL ASSESSMENT

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FOR QUESTIONS, PLEASE CONTACT HIIN@AHA.ORG.

BACKGROUND AND INSTRUCTIONS

The quality of health care has been, and continues to be, a focal point of both past and current U.S. health care policy, particularly as it relates to the hospital setting, where nearly 30 percent of personal health care spending is directed. However, recent reports indicate that significant disparities in health care quality between race, age, language, ethnic and socio-demographic categories exist and have not been reduced over the last several years. One critical insight into the quality of inpatient care is the number of complications or harms that patients experience as a result of exposure to hospital care. An important first step in developing interventions to reduce disparities and achieve high quality care for all patients is identifying which types of patient safety problems exist for different sub-groups of patients.

To support the reduction of disparities in care, HRET HIIN provided guidance for hospitals to collect seven key assessment categories, outlined below, where each identifies the level of hospital implementation to reduce disparities. The seven assessment categories align with research in the field on how and where hospitals have the most impact to reduce disparities. Assessment categories include: 1) data collection, 2) data collection training, 3) data validation, 4) data stratification, 5) communicate findings, 6) address and resolve gaps in care, and 7) organizational infrastructure and culture. Please use this guide to determine the appropriate level of implementation for each of the seven HRET HIIN health equity organizational assessment. Upon completing the survey, HRET HIIN advises reviewing the results with a cross-functional and multi-disciplinary team to develop an action plan and transition strategies to improve health equity and patient safety, as well as quality of care. As you identify gaps in a hospital's level of implementation, please refer to the resources toward the end of the document to support the hospital in transitioning between levels.

For questions on HRET HIIN Health Equity Organizational Assessment, please contact HIIN@aha.org.

HEALTH EQUITY ORGANIZATIONAL ASSESSMENT	INTENT	LEVEL OF HOSPITAL IMPLEMENTATION
1 DATA COLLECTION Hospital uses a self-reporting methodology to collect demographic data from the patient and/or caregiver.	• Best practice recommendations include the collection of patient demographic data to help hospitals and healthcare systems understand their patient populations and measure patient outcomes to ensure health equity. • National/State reporting requirements emphasize the need for obtaining REAL and disability information. • Federal policies govern racial, ethnic, and primary language data collection and reporting. • Meaningful Use Certification Criteria requires the recoding of demographic information including Race and Ethnicity in accordance with the OMB Standards. • Using a self-reporting methodology to collect patient demographic data removes "guesswork" and ensures accurate data is being collected.	**Basic/Fundamental** Hospital uses self-reporting methodology to collect race, ethnicity and language Race, Ethnicity, Age and Language (REAL) data for all patients. *All race and ethnicity categories collected should, at a minimum, roll up to the OMB categories and should be collected in separate fields. Engage Patient/Family Advisors in the collection of REAL data to gain their insights and feedback.* **Mid-Level/Intermediate** *Hospital meets the above basic/fundamental level of implementation **plus**:* Hospital collects REAL data for at least 95% of their patients with opportunity for verification at **multiple points of care (beyond just registration)** to ensure accuracy of the data and to prevent any missed opportunities for data collection (e.g., pre-registration process, registration/admission process, inpatient units, etc.). Resource, here. **Advanced** *Hospital meets the above basic/fundamental and mid/intermediate levels of implementation plus:* Hospital uses self-reporting methodology to collect **additional demographic data (beyond REAL)** for patients such as disability status, sexual orientation/gender identity (SOGI), veteran status, geography and/or other social determinants of health (SDOH) or social risk factors. *SDOH/social risk factors may include education level, access to housing, food availability, migrant status, income, incarceration history, access to healthcare, and employment status, etc. For additional details, click here* **Not Applicable** Does not meet basic level.

HEALTH EQUITY ORGANIZATIONAL ASSESSMENT	INTENT	LEVEL OF HOSPITAL IMPLEMENTATION
2 DATA COLLECTION Hospital provides workforce training regarding the collection of self-reported patient demographic data.	• Training must be provided during orientation for staff who collect patient demographic data and the effectiveness of training should be periodically evaluated. • Annual training updates for staff are highly recommended. • At a minimum, training is provided to registration/admission staff. Training additional staff in patient self-reported demographic data collection should be completed as needed. • Standardized procedures are in place to train staff to use patient self-reporting methodologies to collect demographic data, ensuring this data is accurately and consistently collected.	**Basic/Fundamental** Workforce training is provided to staff regarding the collection of **patient self-reported REAL data**. *Examples of training may include: role playing, scripts, didactic, manuals, on-line modules, or other tools/ job aids. Patient/Family Advisors should be included in the development and delivery of workforce training to collect REAL data.* **Mid-Level/Intermediate** *Hospital meets the above basic/fundamental level of implementation **plus**:* Hospital **evaluates the effectiveness** of workforce training on an annual basis to ensure staff demonstrate competency in patient self-reporting data collection methodology (e.g., observations, teach back, post-test, etc.). **Advanced** *Hospital meets the above basic/fundamental and mid/intermediate levels of implementation **plus**:* Workforce training is provided to staff regarding the collection of **additional patient self-reported demographic data (beyond REAL)** such as disability status, sexual orientation/gender identity (SOGI), veteran status, geography and/or other social determinants of health (SDOH) or social risk factors. *SDOH/social risk factors may include education level, access to housing, food availability, migrant status, income, incarceration history, access to healthcare, and employment status, etc. For additional details, click here* **Not Applicable** Does not meet basic level.

HEALTH EQUITY ORGANIZATIONAL ASSESSMENT		INTENT	LEVEL OF HOSPITAL IMPLEMENTATION
3 DATA VALIDATION	Hospital verifies the accuracy and completeness of patient self-reported demographic data.	• Hospital has a standardized process in place to evaluate and validate the accuracy of patient self-reported demographic data including percent of "unknown", "unavailable", or "declined" for REAL data (aiming for a cumulative goal of <5%). • Resource on <5% recommendation. • Hospital evaluates and addresses system-level issues throughout evaluation processes to continually improve the collection of self-reported patient demographic data.	**Basic/Fundamental** Hospital has a standardized process in place to both **evaluate the accuracy and completeness** (percent of fields completed) for **REAL data and** a process to **evaluate and compare** hospital collected REAL data to local demographic community data. **Mid-Level/Intermediate** *Hospital meets the above basic/fundamental level of implementation **plus**:* Hospital **addresses any system-level issues** (e.g., changes in patient registration screens/fields, data flow, workforce training, etc.) to improve the collection of self-reported REAL data. *Patient/Family Advisors can provide invaluable insights and feedback to address system-level issues regarding the collection of REAL data.* **Advanced** *Hospital meets the above basic/fundamental and mid/intermediate levels of implementation **plus**:* Hospital has a standardized process in place to evaluate the accuracy and completeness (percent of fields completed) for **additional demographic data (beyond REAL)** such as disability status, sexual orientation/ gender identity (SOGI), veteran status, geography and/ or other social determinants of health (SDOH) or social risk factors — and has a process in place to evaluate and compare hospital collected patient demographic data to local demographic community data. *SDOH/social risk factors may include education level, access to housing, food availability, migrant status, income, incarceration history, access to healthcare, and employment status, etc. For additional details, click here* **Not Applicable** Does not meet basic level.

HEALTH EQUITY ORGANIZATIONAL ASSESSMENT		INTENT	LEVEL OF HOSPITAL IMPLEMENTATION
4 DATA STRATIFICATION	Hospital stratifies patient safety, quality and/or outcome measures using patient demographic data.	• Examine patient safety, quality or outcome measures with an equity lens to determine if differences in patient outcomes exist, identify areas in need of quality improvement and targeted interventions.	**Basic/Fundamental** Hospital stratifies **at least one** patient safety, quality and or outcome measure by REAL. **Mid-Level/Intermediate** *Hospital meets the above basic/fundamental level of implementation **plus**:* Hospital stratifies **more than one (or many)** patient safety, quality and or outcome measure by REAL. **Advanced** *Hospital meets the above basic/fundamental and mid/intermediate levels of implementation **plus**:* Hospital stratifies **more than one (or many)** patient safety, quality and/or outcome measure by REAL and **other demographic data (beyond REAL)** such as disability status, sexual orientation/gender identity (SOGI), veteran status, geography and/or other social determinants of health (SDOH) or social risk factors. *SDOH/social risk factors may include education level, access to housing, food availability, migrant status, income, incarceration history, access to healthcare, and employment status, etc. For additional details, click here.* **Not Applicable** Does not meet basic level.

HEALTH EQUITY ORGANIZATIONAL ASSESSMENT		INTENT	LEVEL OF HOSPITAL IMPLEMENTATION
5 COMMUNICATE FINDINGS	Hospital uses a reporting mechanism (e.g., equity dashboard) to communicate outcomes for various patient populations.	• Hospital communicates identified gaps in disparities with the intent to create organization- and community-wide awareness of potential differences in patient outcomes and promotes understanding of patient population needs. • A regular reporting mechanism (e.g. quarterly, semi-annually, etc.) is in place that leadership can visually assess for potential differences in patient outcomes. This may include equity dashboards, scorecards or reports.	**Basic/Fundamental** Hospital uses a reporting mechanism (e.g., equity dashboard) to routinely communicate patient population outcomes to **hospital senior executive leadership (including medical staff leadership) and the Board**. **Mid-Level/ Intermediate** *Hospital meets the above basic/fundamental level of implementation **plus**:* Hospital uses a **reporting mechanism** (e.g., equity dashboard) to routinely communicate patient population outcomes **widely within the organization** (e.g., quality staff, front line staff, managers, directors, providers, committees and departments or service lines). **Advanced** *Hospital meets the above basic/fundamental and mid/ intermediate levels of implementation **plus**:* Hospital uses a **reporting mechanism** (e.g., equity dashboard) to share/communicate patient population outcomes with **patients and families** (e.g., PFAC members) **and/or other community partners or stakeholders**. **Not Applicable** Does not meet basic level.

HEALTH EQUITY ORGANIZATIONAL ASSESSMENT	INTENT	LEVEL OF HOSPITAL IMPLEMENTATION
6 ADDRESS AND RESOLVE GAPS IN CARE Hospital implements interventions to resolve differences in patient outcomes.	• Ensure proper provision of resources to resolve differences in patient outcomes • Tailor interventions to resolve differences in patient outcomes and educate staff about gaps in care. • To every extent possible, existing teams should be utilized to address gaps in care.	**Basic/Fundamental** Hospital engages multidisciplinary team(s) to **develop and test pilot interventions** to address identified disparities in patient outcomes. *Multidisciplinary teams can include: diversity & inclusion committee, data/analytics, Patient and Family Advisory Councils (PFACs), patient safety committee, information technology, quality/ performance improvement, patient experience, corporate auditing and finance, etc.* **PRACTICAL EXAMPLE:** Hospital organized a team [nursing, linguistic services, case management, providers and Patient and Family Advisory Council (PFAC) member] to pilot test the mandatory use of in-person interpreters at the point of discharge for all patients/families with limited English proficiency (LEP) for 3 months and monitor readmissions rates.
		Mid-Level/Intermediate *Hospital meets the above basic/fundamental level of implementation **plus**:* Hospital **implements interventions (e.g., redesigns processes, conducts system improvement projects and/or develops new services)** to resolve identified disparities and educates staff/workforce regarding findings. **PRACTICAL EXAMPLE:** Pilot data shows reduction in readmissions in LEP patients. Due to positive results, linguistic resources were broadened, policy was changed to make in-person interpreter mandatory at discharge and triggers were built in the EHR to alert staff to use in-person interpreters at the point of discharge.
		Advanced *Hospital meets the above basic/fundamental and mid/intermediate levels of implementation **plus**:* Hospital has a **process in place for ongoing review, monitoring, recalibrating interventions (as needed) to ensure changes are sustainable.** **PRACTICAL EXAMPLE:** Linguistic services and case management keep dashboards to monitor LEP related readmissions, in person interpreter utilization with EHR triggers and report this to leadership on a monthly basis.
		Not Applicable Does not meet basic level.

PRACTICAL EXAMPLE BACKGROUND/EXPLANATION

Hospital identified a disparity in Readmission rates between patients with limited English proficiency (LEP), compared to English speaking counterparts.

- Limited English proficiency (LEP) contributes to readmissions due to factors such as (but not limited to) inadequate understanding of discharge diagnosis and instructions, lower rates of outpatient follow-up and use of preventative services and lack of medication adherence.[1,2]

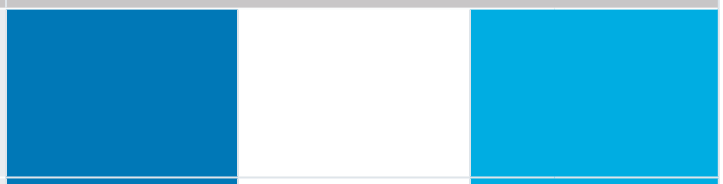
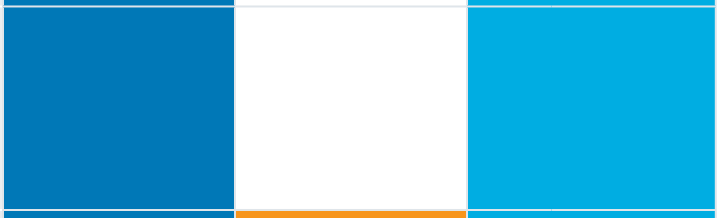
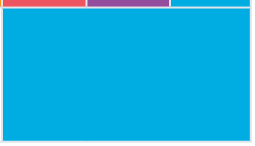
HEALTH EQUITY ORGANIZATIONAL ASSESSMENT	INTENT	LEVEL OF HOSPITAL IMPLEMENTATION
7 ORGANIZATIONAL INFRASTRUCTURE AND CULTURE Hospital has organizational culture and infrastructure to support the delivery of care that is equitable for all patient populations.	• Hospital has a commitment to effectively deliver services that meet the cultural and linguistic diversity of the population served (according to CLAS standards). • Hospital has designated an individual (or individuals) with leadership responsibility and accountability for health equity efforts (this person or team may wear more than one hat, be full-time or dedicate a portion of their time to equity efforts). • Hospital actively involves key stakeholders including patients and families and/or community partners in the planning, development and implementation of health equity efforts. • Hospital explicitly prioritizes equity in organization mission and goals.	**Basic/Fundamental** Hospital has a standardized process to train its workforce to deliver culturally competent care and linguistically appropriate services (according to the CLAS standards). *Training should routinely involve patient and family input (e.g., Patient and Family Advisory Councils (PFACs)) and can include cultural competency/ intelligence regarding racial and ethnic minorities, patients with physical and mental disabilities, veterans, limited English proficient patients, lesbian, gay, bisexual and transgender (LGBT) patients, elderly patients, etc.* **Mid-Level/ Intermediate** *Hospital meets the above basic/fundamental level of implementation **plus**:* Hospital has named an individual (or individuals) who has leadership responsibility and accountability for health equity efforts (e.g., manager, director or Chief Equity, Inclusion and Diversity Officer/Council/ Committee) who engages with clinical champions, patients and families (e.g., Patient and Family Advisory Councils (PFACs)) and/or community partners in strategic and action planning activities to reduce disparities in health outcomes for all patient populations. Note: This doesn't have to be a member of the C-Suite. **Advanced** *Hospital meets the above basic/fundamental and mid/intermediate levels of implementation **plus**:* Hospital has made a commitment to ensure equitable health care is prioritized and delivered to all persons through written policies, protocols, pledges or strategic planning documents by organizational leadership and Board of Directors (e.g. mission/vision/values reflect commitment to equity and is demonstrated in organizational goals and objectives). Example: #123forEquity Pledge **Not Applicable** Does not meet basic level.

RESOURCES TO SUPPORT PROGRESS ON HEALTH EQUITY ORGANIZATIONAL ASSESSMENT

RESOURCE	APPLICABLE TO HEALTH EQUITY ORGANIZATIONAL ASSESSMENT
Building and Organizational Response to Health Equity CMS Office of Minority Health	
Disparities Action Statement CMS Office of Minority Health	
Compendium of Resources for Standardized Demographic and Language Data Collection CMS Office of Minority Health	
A Practical Guide to Implementing the National CLAS Standards CMS Office Minority Health	
Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries CMS Office of Minority Health	
Mapping Medicare Disparities CMS Office of Minority Health	
Providing Language Services to Diverse Populations: Lessons from the Field CMS Office of Minority Health	
Guide to Developing a Language Access Plan CMS Office of Minority Health	
Sexual and Gender Minority Clearinghouse CMS Office of Minority Health	
OMB Categories for Data Collection HHS Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status	
7 Best Practices for Collecting REAL Data Using Patient Self-Reporting Methods Vizient & Multimedia in Healthcare, 2017	
8 Health Information Technology Best Practices for REAL Data Collection Vizient & Multimedia in Healthcare, 2017	

RESOURCES TO SUPPORT PROGRESS ON HEALTH EQUITY ORGANIZATIONAL ASSESSMENT

DATA COLLECTION AND TRAINING
DATA VALIDATION
DATA STRATIFICATION
COMMUNICATE
TAKE ACTION
INFRASTRUCTURE

RESOURCE	APPLICABLE TO HEALTH EQUITY ORGANIZATIONAL ASSESSMENT
Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals The Joint Commission 2010	
Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community The Joint Commission 2014	
American Society of Healthcare Risk Management Equity of Care Assessment Tool ASHRM 2015	
Reducing Health Care Disparities: Collection and Use of Race, Ethnicity and Language Data Equity of Care AHA/HRET Aug 2013	
A Framework for Stratifying Race, Ethnicity and Language Data Equity of Care AHA/HRET 2014	
Equity of Care: A Toolkit for Eliminating Health Care Disparities Equity of Care AHA/HRET 2015	
#123forEquity Pledge to Act to Eliminate Health Care Disparities Equity of Care AHA/HRET	
Improving Health Equity Through Data Collection AND Use: A Guide for Hospital Leaders Equity of Care AHA/HRET 2011	
Becoming a Culturally Competent Health Care Organization Equity of Care AHA/HRET 2013	
Eliminating Health Care Disparities: Implementing the National Call to Action Using Lessons Learned Equity of Care AHA/HRET 2012	
The Role of the Chief Diversity Officer in Academic Health Centers Institute for Diversity in Health Management, HRET_2012	

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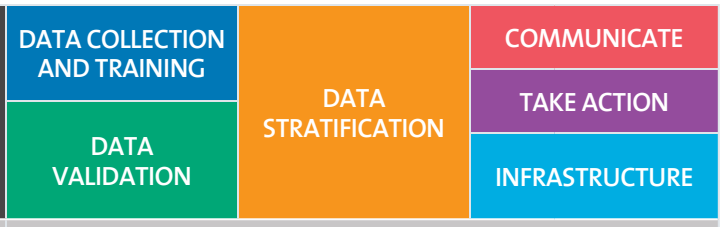

RESOURCE	APPLICABLE TO HEALTH EQUITY ORGANIZATIONAL ASSESSMENT
Health Equity and Race and Ethnicity Data: The Colorado Trust The Colorado Trust Sept 2013	
Building a Culturally Competent Organization: The Quest for Equity in Health Care Institute of Diversity in Health Management, HRET 2011	
Guide to Demographic Data Collection in Healthcare Settings Ontario Central Local Health Integrated Network-Sinai Health System, 2017	
New York State Toolkit to Reduce Health Care Disparities: Improving Race and Ethnicity Data NY State Department of Health 2014	
Collecting Sexual Orientation and Gender Identity Data in Electronic Health Records Taking the Next Steps Fenway Institute	
A Toolkit for Collecting Data on Sexual Orientation and Gender Identity in Clinical Settings Fenway Institute	
Improving Patient Safety Systems for Patients With Limited English Proficiency: A Guide for Hospitals AHRQ/Disparities Solution Center 2012	
Commissioned Paper: Healthcare Disparities Measurement Disparities Solution Center 2011	
Improving Quality and Achieving Equity: A Guide for Hospital Leaders Disparities Solution Center 2015	
How Person and Family Engagement Can Help Hospitals Achieve Equity in Health Care Quality and Safety A Supplemental Resource for Hospital Improvement Innovation Networks AIR: Person and Family Engagement Contractor for Partnership for Patients 3.0 2017	

RESOURCES TO SUPPORT PROGRESS ON HEALTH EQUITY ORGANIZATIONAL ASSESSMENT	DATA COLLECTION AND TRAINING	DATA VALIDATION	DATA STRATIFICATION	COMMUNICATE	TAKE ACTION	INFRASTRUCTURE
RESOURCE	**APPLICABLE TO HEALTH EQUITY ORGANIZATIONAL ASSESSMENT**					
Race, Ethnicity, Language Data Collection Best Practices Greater Cincinnati Health Council, 2012	■	■				
Sexual Orientation and Gender Identity Data Collection Demonstration Videos National LGBT Health Education Center (Fenway Institute)	■					
Ready, Set, Go! Guidelines and Tips For Collecting Patient Data on Sexual Orientation and Gender Identity (SO/GI) National LGBT Health Education Center (Fenway Institute) 2018	■					
PRAPARE Assessment Tool: Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (Social Determinants/Risk Factors). National Association of Community Health Centers	■					
AHCS: Accountable Health Communities Screening Tool (Health-Related Social Needs Screening Tool) Center for Medicare and Medicaid Innovation-Accountable Health Communities (AHC)	■					
Healthcare Equality Index LGBTQ Human Rights Campaign Foundation 2018	■	■	■	■	■	■

REFERENCES

[1]Rodriguez F, Joynt KE, Lopez L, Saldana F, Jha AK. Readmission rates for Hispanic Medicare beneficiaries with heart failure and acute myocardial infarction. Am Heart J. Aug 2011;162(2):254-261 e253.

[2] Karliner LS, Auerbach A, Napoles A, Schillinger D, Nickleach D, Perez-Stable EJ. Language barriers and understanding of hospital discharge instructions. Med Care. Apr 2012;50(4):283-289.