

# Importance of HQIC Health Equity Metrics



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



An important component of high-quality, safe, and patient-centered care is the ability to understand the unique characteristics of the patients, families, and caregivers that are serviced by a provider. This encompasses language, culture, race, ethnicity, and other aspects of diversity that are just as essential to providing quality and equitable care. It is difficult to assess whether your organization is

providing equitable care without collecting and analyzing demographic data and information from patients and their families/caregivers.

The table below identifies the five HQIC health equity metrics, explains why they are important, and identifies some strategies and resources to make meaningful progress on reducing healthcare disparities

Health Equity Metric	Purpose of the Metric	Strategies and Resources
<b>Successfully collect (Race Ethnicity and Language) REaL</b>	Understand the patient’s race, ethnicity, and language and consider the needs, perspectives, interests, values and beliefs of patients and families/caregivers when providing care.	<ul style="list-style-type: none"> <li>● Create a systematic process for collecting and recording REaL data.</li> <li>● Train staff to collect the data accurately and respectfully.</li> <li>● Assess completeness and accuracy of data collection.</li> </ul> <b>Resources:</b> <ul style="list-style-type: none"> <li>● IPRO QIN/QIO: Collecting REaL Data: Examples of How to Ask for REaL Data</li> <li>● AHRQ: <a href="#">Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement</a></li> <li>● AHA: <a href="#">Disparities Toolkit</a></li> <li>● CMS: <a href="#">Inventory of Resources for Standardized Demographic and Language Data Collection</a></li> </ul>
<b>Successfully collect social determinants of health (SDOH)</b>	Explore how factors such as socioeconomic status, education, neighborhood, employment, social support networks, and other factors are impacting the patient’s health, and engage the patient and family/caregivers to address these factors.	<ul style="list-style-type: none"> <li>● Use a SDOH screening tool.</li> <li>● Train staff on using Z codes to capture data on social needs.</li> <li>● Aggregate data across patients to identify strategies for social determinants.</li> <li>● Identify community partners to help address social needs.</li> </ul> <b>Resources:</b> <ul style="list-style-type: none"> <li>● CMS: <a href="#">Accountable Health Communities Health-Related Social Needs Screening Tool</a></li> <li>● IPRO QIN/QIO: Webinar: <a href="#">Optimal Z Code Utilization &amp; Reimbursement Opportunities</a></li> <li>● CMS: <a href="#">Using Z Codes: The SDOH Journey to Better Outcomes</a></li> <li>● AHA: <a href="#">ICD-10-CM Coding for SDOH</a></li> </ul>

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## Importance of HQIC Health Equity Metrics (continued)

Health Equity Metric	Purpose of the Metric	Strategies and Resources
<p><b>Use data to identify gaps in care by REaL or SDOH</b></p>	<p>Analyze gaps in treatment and outcomes by race, ethnicity, gender, and other subgroups and social determinants of health to provide patient-centered care and reduce disparities in care.</p>	<ul style="list-style-type: none"> <li>• Displayed data on dashboards and include in summary reports.</li> <li>• Stratify quality metrics.</li> <li>• Use data in quality improvement projects.</li> <li>• Explore gaps during Root Cause Analysis.</li> </ul> <p><b>Resources:</b></p> <ul style="list-style-type: none"> <li>• AHA: <a href="#">Data-Driven Care Delivery</a></li> <li>• HRET: <a href="#">A Framework for Stratifying Race, Ethnicity and Language Data</a></li> <li>• AHE: <a href="#">Diagnosing the Disparity</a></li> </ul>
<p><b>Establish goals to reduce healthcare disparities</b></p>	<p>Develop an organizational plan and establish goals for addressing disparities in care.</p>	<ul style="list-style-type: none"> <li>• Use data to help determine organizational and departmental goals.</li> <li>• Assess whether use of REaL and SDOH data is improving outcomes</li> </ul> <p><b>Resources:</b></p> <ul style="list-style-type: none"> <li>• AHE: <a href="#">Best Practices to Reduce Disparities</a></li> <li>• CMS: <a href="#">Building an Organizational Response to Health Disparities: Five Pioneers from the Field</a></li> </ul>
<p><b>Use boards/PFE councils to address disparities</b></p>	<p>Partner with persons and their families/caregivers to highlight areas of disparities, respond to patient and family-identified needs and desired outcomes, to ultimately impact quality and safety.</p>	<ul style="list-style-type: none"> <li>• Assess representation on the PFE councils and ensure that where disparities exist, the communities are represented.</li> <li>• Involve boards/PFE councils in the quality improvement cycles and program planning.</li> </ul> <p><b>Resources:</b></p> <ul style="list-style-type: none"> <li>• IPRO HQIC: <a href="#">Partnering with Representative Patient and Family Advisors to Achieve Health Equity</a></li> </ul>