

Item #8: Hospital Equity Reporting Qualitative Data Analysis

Approaches to strengthen the interpretation and context of findings

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Consulting (or designees)

What did we **learn** from initial Hospital Equity Reports and how can we **improve** for the next round?



Our Sample

- Formal review: 34 hospital HEM reports
 - 1 Psychiatric facility
 - 2 Children's hospitals
 - 4 County Hospitals
 - 2 Critical Access Hospitals
 - 3 Academic Medical Centers
 - 1 Predominantly Maternal
 - 1 Predominantly Rehabilitation
- Informal review: 6 hospitals



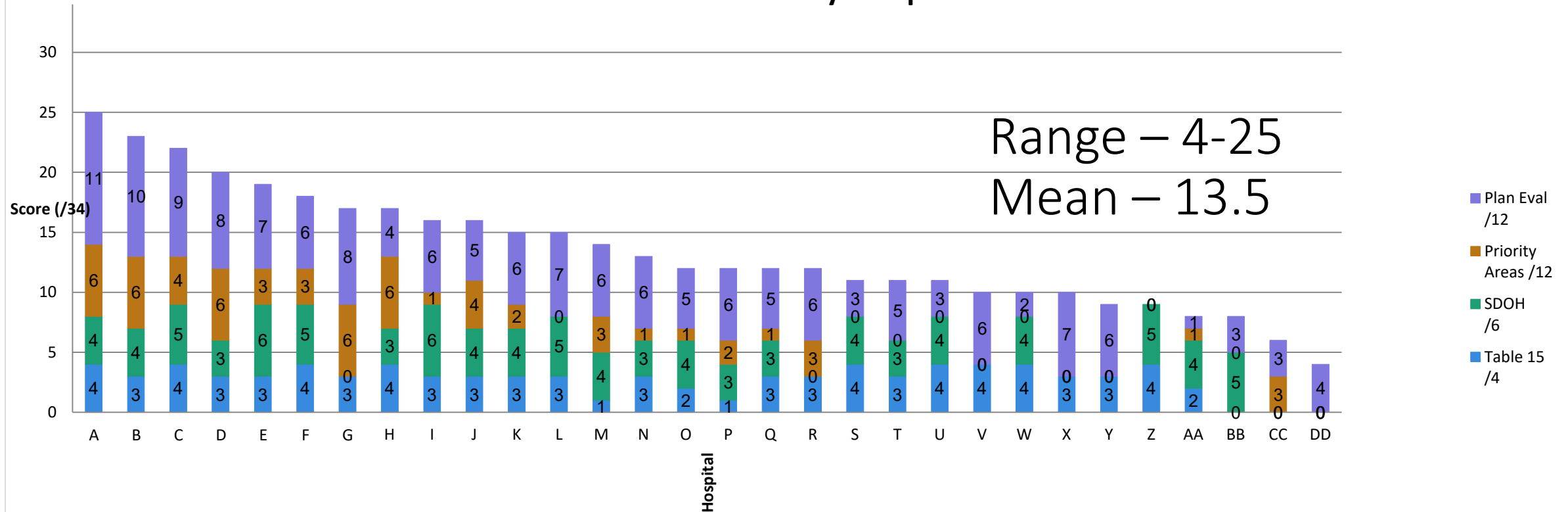
Establishing a Framework – *how did Convergence Health Consulting review reports?*

- **Systematic, more objective analysis** – consistency and fairness
- **Creates clear criteria** – transparency
- **Can distinguish better plans** – discrimination
- **Creates a framework for improvement** - actionable
- **Operationalizes high-performance** – shows exemplar hospitals to learn from

Results – Sample Hospitals

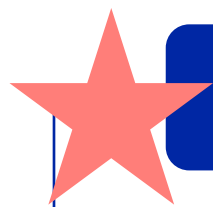
Total points possible = 34
22 of 30 hospitals scored below 17 (50% threshold)

Score Breakdown by Component



*Convergence reviewed and scored reports to identify lessons learned and high performers. These results are not a formal evaluation.

Hospital Equity Plan Review Components



SDOH Screening

Top 10 Disparities Table



Health Equity Plan

SDOH Screening and Plan
Evaluation have the most
differentiated components

Performance in the Priority Areas

Hospital Equity Plan Review Components

SDOH Screening

Top 10 Disparities Table

Performance relatively uniform. Most hospitals completed according to instructions.

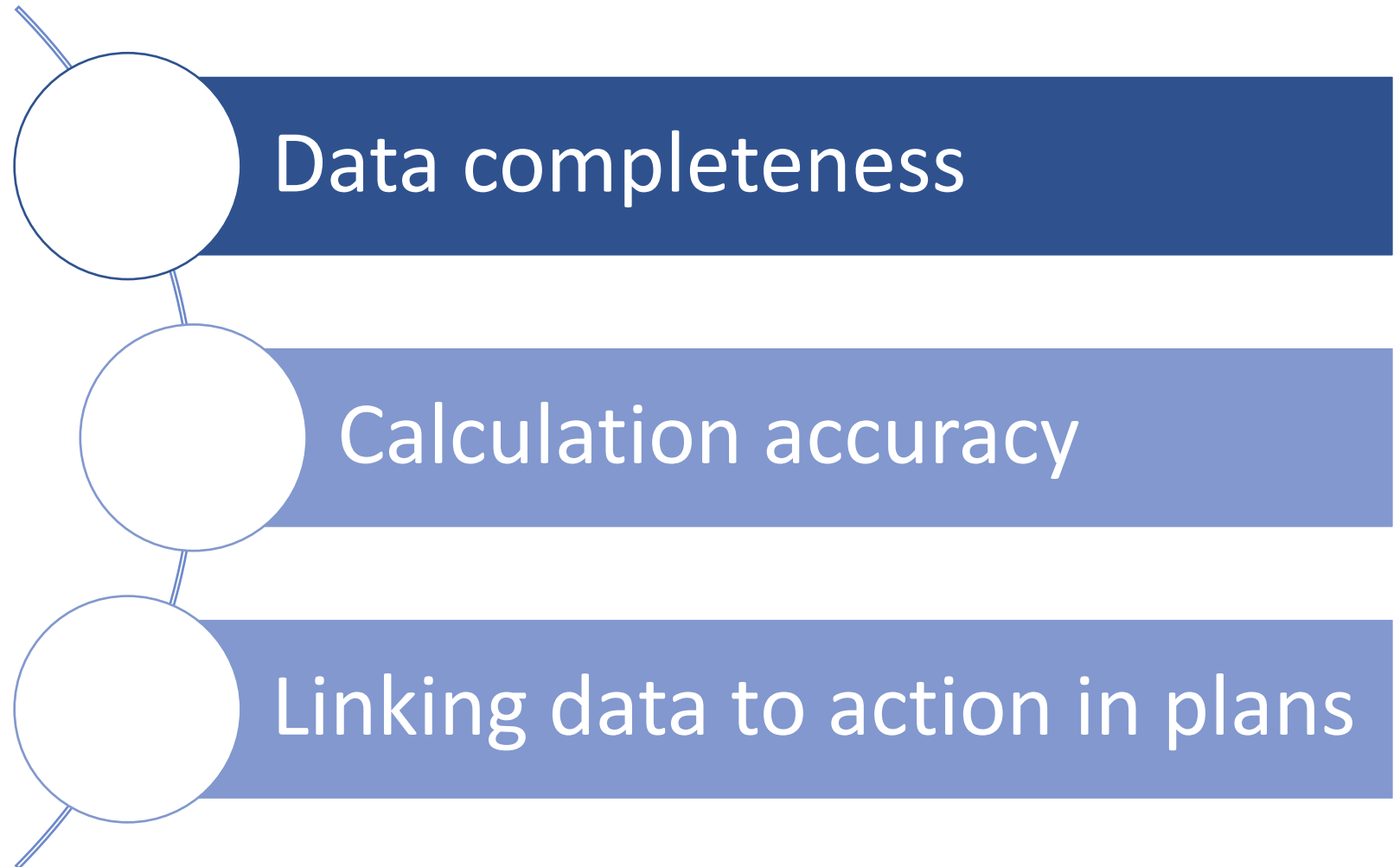
Health Equity Plan

Performance in the Priority Areas

Performance in priority areas is greatest opportunity for improvement.

How Can Hospitals Improve?

*Opportunities for
Technical Assistance*



Data Completeness

Findings

- Identification of disparities is limited by inconsistent demographic data collection
- Some hospitals consistently collect SOGI and disability status (e.g., Sutter Health)
- For HCAHPS – approximately 1/3 of hospitals (in our sample) work with their vendor to include demographic information for stratification

TA Recommendations

- Highlight best practices from hospitals that are consistently collecting various demographic data
- Provide examples of how to collaborate with HCAHPS vendor to stratify results by demographic categories

Accurate Calculation and Interpretation

Findings

- Common error types (e.g., rate ratio errors, self-referencing entries, systematic incorrect ratios)*

TA Recommendations

- Do not include suppressed values (e.g., assume median) or zero values in calculations*
- Develop a mechanism to determine the “absolute impact” of the disparity

*Updates to HQI reports underway to address common error types

Linking Data to Action (in Plan & Priority Areas)

Findings

- Priority area plans infrequently address specific disparities or actions
- References to vague future analysis and action
- Equity efforts exist that are not captured in the framework of this report

TA Recommendations

- Coach hospitals to avoid referencing only existing programs not designated for disparity reduction (e.g., Age-Friendly programs or PFACs without specific agenda items/projects related to disparity reduction)
- Provide examples of how to include open-ended response to describe other equity-focused initiatives
- Encourage hospitals to link SDOH screening results with actions

Considerations for Analysis & Interpretation

Acknowledge limitations in data quality

Define a reference group

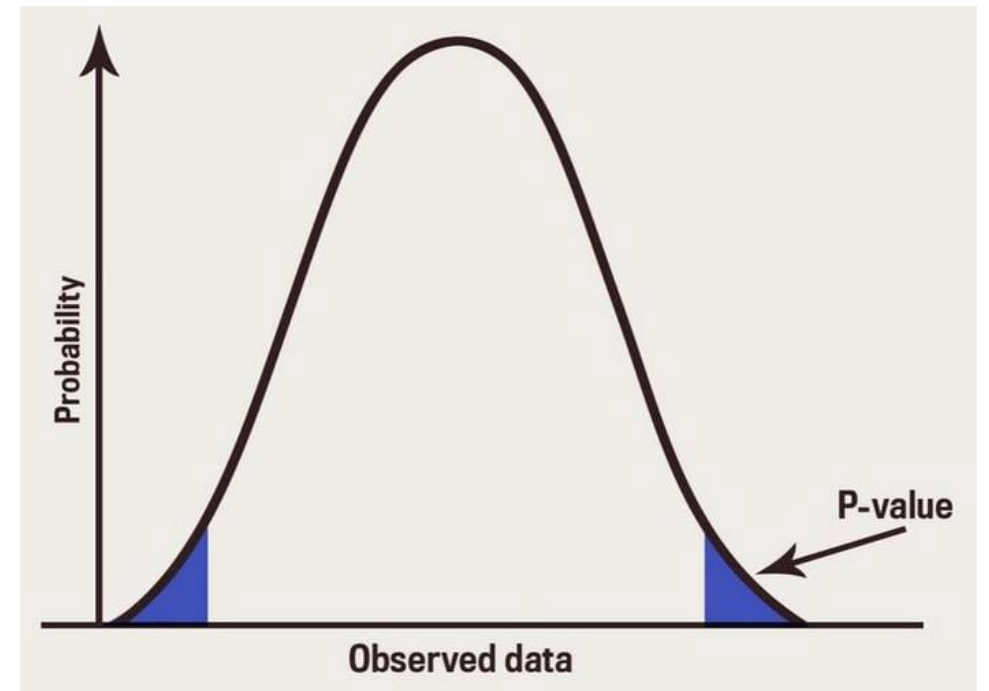
Consider relative vs. absolute differences

Explore statistical and public health significance

Determine actionability

Opportunity to refine
prioritization strategy

Step 3. Explore statistical and public health significance



Determining statistical vs public health impact (HCAI)

- Statistical significance is usually determined by a p-value of less than .05 but could be different based on the data
 - This is affected by both sample size and the size of the disparity
 - Some disparities may be very small but there may be statistical significance because of a large sample size
 - Statistical significance for a specific measure may not be considered a public health impact
- A disparity may not reach statistical significance but **may still affect a large enough group of people that it has a public health impact**

Magnitude of Impact

	Total	Medi-Cal	Medicare	Private	Other	Self-pay
Numerator [total readmissions]	726	523	82	55	38	28
Denominator [total discharges]	5000	3250	650	550	350	200
Rate	14.52%	16.09%	12.62%	10.00%	10.86%	14.00%
Potentially preventable events [reference group = private]	--	198	17	--	3	8

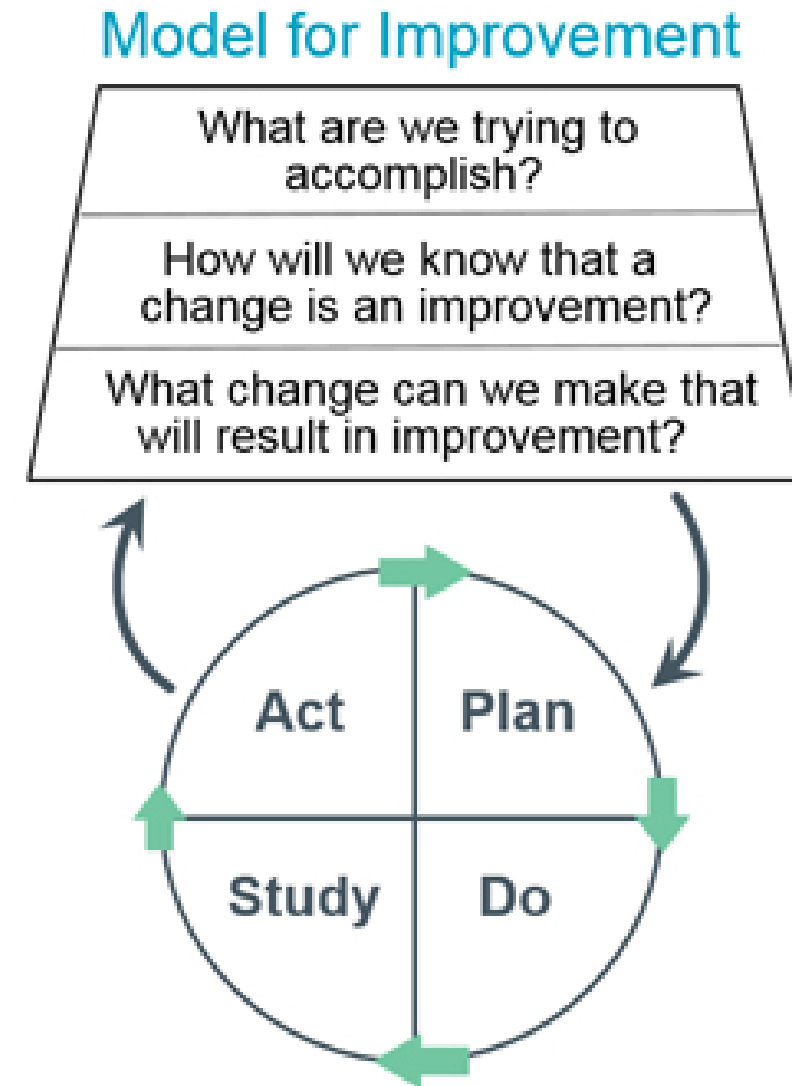
Rate difference multiplied by the denominator shows ***magnitude of impact.***

Magnitude of Impact, Example 2

	Total	Medi-Cal	Medicare	Private	Other	Self-pay
Numerator [total readmissions]	726	513	82	55	38	38
Denominator [total discharges]	5000	3250	650	550	350	200
Rate	14.52%	15.78%	12.62%	10.00%	10.86%	19.00%
Potentially preventable events [reference group = private]	--	188	17	--	3	18

Readmission rate for individuals with no insurance is highest (19%)....but the magnitude of impact is much smaller (18 vs 188 for Medicaid)

Step 4. Determine actionability



Considerations for Actionability



ARE THERE PROVEN
APPROACHES?



WHAT PARTNERSHIPS
DO YOU HAVE?



WHAT LOCAL CONTEXT
MIGHT INFORM
PRIORITIZATION?



IS THIS A SHORT- OR
LONG-TERM
ENDEAVOR?



HOW MUCH IS DRIVEN
BY FACTORS WITHIN THE
HOSPITAL'S CONTROL?

Future TA Considerations

- Highlight and spread best practices from hospitals with more advanced data completeness and stratification
- Offer a rubric and/or guidance for what to include in open-ended hospital equity plans, for example emphasis on specific disparities-related actions
- Provide guidance on how to prioritize disparities reduction efforts, such as by considering magnitude of impact and actionability