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Hospital Equity Measures Advisory Committee (HEMAC)

Draft Meeting Minutes for October 2, 2024

Members Attending In-Person: Dr. Ash Amarnath, California Association of Public Hospitals and Health Systems; Joan Allen, Service Employees International Union; Elia Gallardo, Department of Health Care Access and Information (HCAI); Dr. Amy Sitapati, University of California San Diego.

Members Attending Remotely: Dr. Amy Adome, Sharp Healthcare; Dannie Ceseña, California LGBTQ Health and Human Services Network; Denny Chan, Justice, and Aging; Dr. Neil Maizlish, Public Health Alliance of Southern California; Cary Sanders, California Pan-Ethnic Health Network; Kristine Toppe, National Committee for Quality Assurance; Silvia Yee, Disability Rights Education & Defense Fund.

State Partners Attending Remotely: Peg Carpenter, Covered California; Julie Nagasako, California Department of Public Health (CDPH).

Members Absent: Sarah Lahidji, California Department of Health Care Services (DHCS); Nathan Nau, California Department of Managed Health Care (DMHC).

Presenters: Michael Valle, Deputy Director of Information Services, HCAI; Elia Gallardo, Deputy Director of Legislative and Government Affairs and Chief Equity Officer, HCAI; Tara Zimonjic, Chief Planning Officer, HCAI; Christopher Krawczyk, PhD, Chief Analytics Officer, HCAI; Dr. Bruce Spurlock, Hospital Quality Measures Subject Matter Expert, HCAI Consultant, Natalie Graves Hospital Quality Measures Subject Matter Expert, HCAI Consultant; Leslie Kowaleski, California Maternal Quality Care Collaborative (CMQCC); Melinda Kent, CMQCC; Moojan Rezvan, MBA, Mission Providence Hospital; Kopitzee Parra-Thornton, PhD, Mission Providence Hospital; Scott V. Masten, PhD, Hospital Quality Institute (HQI).

Public Attendance: *66*

Agenda Item #1: Call to Order, Welcome, and Meeting Minutes

Elia Gallardo, Committee Facilitator, welcomed everyone and called the meeting to order with roll call of committee members and state partners.

The committee reviewed and approved the meeting minutes from the April 10, 2024, Hospital Equity Measures Advisory Committee (HEMAC) Meeting. The motion was made by Neil Maizlish and seconded by Ash Amarnath.

The following members voted to approve the minutes: Amy Adome, Ash Amarnath, Dannie Ceseña, Denny Chan, Neil Maizlish, Cary Sanders, Kristine Toppe.

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Silvia Yee abstained from voting.

The motion to approve the minutes was carried by a vote of seven in favor and one abstention.

Questions/Comments from the Committee:

The committee asked about a statement in the April minutes regarding United States Core Data for Interoperability (USCDI) Version 3 access and the resolution of the license agreement issue, as the state moves toward interoperability and standardization. HCAI confirmed the issue has been resolved and may be addressed later in the meeting or through a written response if needed.

Public Comment:

There were no public comments received for this agenda item.

Agenda Item #2: Hospital Equity Measures Advisory Committee Updates

Michael Valle, HCAI Deputy Director of Information Services, introduced new committee members Joan Allen and Dr. Amy Sitapati, and administered the oath of office on behalf of Director Landsberg. He announced Peg Carpenter had replaced Taylor Priestly as the invited state partner from Covered California. He announced Dr. Ash Amarnath as the new committee chair, who will co-facilitate meetings with Elia Gallardo, Committee Facilitator.

Questions/Comments from the Committee:

There were no questions or comments from the committee received for this agenda item.

Public Comment:

There were no public comments received for this agenda item.

Agenda Item #3: April 10, 2024, Meeting Recap

Elia Gallardo, Committee Facilitator, reviewed April's discussions and current meeting goals. Michael Valle also introduced HCAI's technical assistance partners— CMQCC, HQI, Convergence Health—and Providence Mission Hospital, who shared best practices.

Questions/Comments from the Committee:

There were no questions or comments from the committee received for this agenda item.

Public Comment:

There were no public comments received for this agenda item.

Agenda Item #4: Hospital Equity Measures Program Updates

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Administrative Procedure Act - Regulations Process

Chris Krawczyk, HCAI, Chief Analytics Officer, outlined the rulemaking timeline, which included a 45-day public comment period and revisions, with a subsequent 15-day comment period planned. Once complete, the regulations will be finalized and submitted to the Office of Administrative Law for review.

Questions/Comments from the Committee:

The committee inquired about how the 120-day revision period for the regulatory changes affects the timeline for public reporting. HCAI explained that the timeline depends on how frequently the full 120-day period is used. The committee suggested releasing preliminary data, similar to hospital financial data, for public access before the final submission is accepted. HCAI noted that data will be released as it is verified, though initially this may be on a staggered basis. The committee also emphasized the need for clarity on whether hospitals must post their equity reports on their website by the original deadline or can use the extra 120 days.

Public Comment:

There were no public comments received for this agenda item.

Hospital Equity Toolkit Webpage

Tara Zimonjic, Chief Planning Officer at HCAI, outlined the development of the Hospital Equity Toolkit, designed to help hospitals improve their health equity efforts. Feedback has led to improvements, such as organizing resources by type. Tara Zimonjic also mentioned that HCAI is refining the toolkit and seeking member feedback.

Questions/Comments from the Committee:

The committee recommended clarifying the intended audience, organizing resources by type (e.g., webinars, toolkits), and adding context on race, ethnicity, and language data, including new Office of Management and Budget (OMB) categories like Middle Eastern and North African. The committee recommended creating a fact sheet on these categories for improved relevance.

To improve navigation, the committee proposed using symbols to distinguish resource types or adding metadata on each resource's purpose. They also recommended tracking resource usage to ensure effectiveness and engaging health equity officers through targeted sharing methods like webinars or health system meetings.

The committee emphasized mapping screening tools (e.g., Centers for Medicare & Medicaid Services (CMS) The National Committee for Quality Assurance (NCQA)) to existing measures like UCSF's social needs inventory. They also suggested linking the website to broader healthcare equity discussions, such as those at the Census Bureau, NCQA, or OMB, for context. Additionally, they endorsed a short, five-minute video to guide users through the toolkit.

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Public Comment:

There were no public comments received for this agenda item.

Agenda Item #5: Discussion on Data Analysis Technical Assistance (TA) for Hospitals

Hospital Quality Measures Subject Matter Experts from Convergence Health Consulting, Bruce Spurlock, MD, President & CEO, and Natalie Graves, Director Research & Implementation, highlighted the need for ongoing TA to help hospitals develop and implement health equity plans to address disparities. The TA will focus on regulatory understanding, data collection and submission, and peer-to-peer learning through webinars, help desks, and website resources.

Questions/Comments from the Committee:

[…] Regarding the presentation slide illustrating potential opportunities to provide technical assistance in the implementation process, the committee recommended adding “patient registration” to the Quality/Improvement - Demographics components. The committee emphasized that patient registration is the most common workflow for acquiring data and recommended considering a dedicated section for community members or patients. The committee also highlighted the importance of including training resources for frontline workers as an “Implementation” component within the Quality/Improvement section. Additionally, the committee agreed on the necessity of establishing strong technical assistance (TA) relationships to build trust and align community priorities.

The committee also emphasized applying the “structure-process-outcome” framework to data analysis, emphasizing systematic approaches to analyzing disparities. They recommended incorporating existing literature and applying epidemiologic reasoning to ensure data quality. Additionally, they highlighted the value of engaging internal stakeholders in data interpretation to identify underlying clinical or administrative processes, rather than just publishing results. While the committee suggested methodological rigor, they also recommended the TA be accessible and understandable by hospital staff.

The committee agreed on including patients' self-reports and appreciated the mention of community resources and local coalitions. The committee also discussed community advisory councils gathering input from local health jurisdictions into their plans and implementation.

The committee voiced understanding that implementation and quality improvement is iterative and suggested a process by which the learnings and best practices that hospitals gain could be shared with external stakeholders.

The committee pointed out, regarding the Quality Improvement demographics components of the presentation, the need to understand the data sources as hospitals submit data. They acknowledged the challenge of conflicting data and the importance of capturing this information

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for iterative data quality improvement. The committee suggested that HCAI track whether data is primarily coming from the Electronic Health Record (EHR) or other sources, using this information to improve data quality. If a hospital's data submission path differs from others, it could present an opportunity for technical assistance to align them with their peers. The committee mentioned that, while this isn't a task for the first year, starting early is crucial to ensure this information is available for future use.

The committee pointed out regarding goal three of the presentation – facilitating peer-to-peer learning to drive improvements in equity across the state – that some consumer and patient voices are missing.

The committee raised concerns about how hospitals with varying circumstances (e.g., small rural hospitals vs. those owned by private equity) fit into the framework and were concerned that private equity involvement could hinder hospital participation in TA, data reporting, and accountability, potentially creating barriers to effective implementation and accurate data collection.

The committee also highlighted opportunities for collaboration in demographic data collection across healthcare settings, including health insurance enrollment and Health Information Exchanges (HIEs). They suggested encouraging data exchange between these sources to improve demographic data collection.

Public Comment:

The public discussed challenges in identifying disparities when stratifying hospital data by quality metrics and demographics, noting that raw data analysis often misses factors like insurance or socioeconomic status. They sought guidance on how hospitals can address these disparities through multivariate analysis, and how to differentiate between factors within their control versus those requiring collaboration with community partners.

Agenda Item #6: California Maternal Quality Care Collaborative (CMQCC) Presentation

Leslie Kowaleski and Melinda Kent of CMQCC outlined their work to reduce preventable maternal morbidity, mortality, and racial disparities in maternity care. Through the Maternal Data Center, they provide data support to over 99% of California's maternity hospitals, focusing on quality improvement. CMQCC is working to enhance healthcare equity by helping hospitals analyze stratified race and ethnicity data. They are committed to improving data transparency, aligning data systems, and providing training to enhance data quality and reporting.

Questions/Comments from the Committee:

The committee expressed appreciation for the CMQCC's recommendation to implement a five-year plan focused on educating stakeholders about the goals of aligning with the new OMB

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standard for race and ethnicity categories, as well as identifying early adopters and champions for progress. The committee expressed gratitude to CMQCC for its role in reducing data redundancy and improving data quality through collaboration with multiple partners. They agreed that gradual alignment with the new OMB standard for race and ethnicity categories is needed, noting that the transition will be significant. The members emphasized the importance of consistency in reporting and noted that NCQA supports a phased implementation. They clarified that NCQA is not prescriptive about how organizations or states should stratify data but emphasized the importance of mapping to the highest-level OMB categories for The Healthcare Effectiveness Data and Information Set (HEDIS) reporting and related activities. Additionally, the committee mentioned that the Quality Improvement Plan (QIP) program for public hospitals and health systems will also align with NCQA and HEDIS changes, including the OMB updates, requiring similar reporting adjustments when HEDIS measures are revised.

The committee highlighted the importance of hospitals' electronic data systems and suggested using The Centers for Disease Control and Prevention (CDC's) staged data collection framework to adapt as data grows over time. The committee highlighted interoperability importance, particularly with Heath Level 7 Fast Healthcare Interoperability Resources (HL7 FHIR) for facilitating healthcare data sharing.

The committee expressed interest about partnerships with community birth centers due to growing access issues in California. Leslie Kowalewski explained they are analyzing birth centers to understand their role in the broader perinatal care system, beyond just their locations. She also mentioned DHCS' interest in developing maternal levels of care and suggested involving midwives in the Data Advisory Committee for their insights on data dashboards.

The committee noted the incredible connections with CDPH and the access to valuable data on births and hospital outcomes. They also noted that social determinants of health aren't adequately incorporated into the HCAI measures and suggested leveraging geocoded birth record data to conduct small area socioeconomic analysis, offering a cost-effective method to better understand health outcomes and address social determinants of health. They emphasized that social class is often overlooked despite its significant impact on health outcomes and advocated for incorporating both race and social class into health interventions.

The committee emphasized the need to consider disability stratification in maternal health data, noting that people with disabilities face higher risks but lack sufficient data. Leslie Kowalewski, CMQCC, noted inconsistent use of ICD-10 disability coding in hospitals and emphasized the importance of proper coding and educational efforts.

Public Comment:

There were no public comments received for this agenda item.

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Agenda Item #7: Mission Providence Hospital Presentation

Moojan Rezvan, MBA, Project Lead, and Kopitzee Parra-Thornton, PhD, Project Sponsor, presented best practices from Providence Mission Hospital's health equity project aimed at reducing disparities in Limited English Proficiency (LEP) patients with sepsis. Using basic statistical analysis, they successfully reduced length of stay by 25% and readmission rates by 28%. They found language to be a more effective factor than race and ethnicity alone for improving care outcomes.

Questions/Comments from the Committee:

The committee inquired about the language access intervention used, such as bilingual providers, phone interpreters, and other bilingual staff. They also asked whether the project examined the impact of different types of language access interventions. Moojan Rezvan explained that their hospital used a combination of bilingual staff and interpreters. The main intervention involved nurse navigators fluent in Spanish, ensuring their clinical Spanish was sufficient for patient communication. For other languages, vendors provided video or phone interpretation services, ensuring every patient received interpreter services. Educational materials, including brochures and videos, were also created in the top four languages (Spanish, Farsi, Arabic, and Mandarin) to ensure patients received information in their preferred language.

The committee inquired about the disaggregation within the LEP group, asking whether the data for major language groups (like Asian languages or Spanish) was uniform. Kopitzee Parra-Thornton noted they did not find significant differences between language groups but identified cultural factors affecting healthcare access and self-advocacy behaviors.

The committee also inquired about statistical outliers, particularly in the English-speaking group, where there were approximately 20 outliers with long lengths of stay. Moojan Rezvan explained they investigated cases with extended stays, finding medical complications in LEP patients and insurance and discharge issues in English-speaking patients.

The committee asked whether focusing on the LEP population improved data collection and integrity. Moojan Rezvan explained that language data was collected through their Epic EHR system. Initially, some patients had language listed as "unknown" or "other," prompting training for admitting staff to emphasize the importance of collecting this information. This training helped raise awareness about LEP patients and reinforced interpreter use. Kopitzee Parra-Thornton added that the project highlighted the importance of using interpreters to ensure proper understanding and shifted the hospital's perspective on language as a tool for understanding patient needs.

The committee praised the project's simple design, regarding it as suitable for hospitals with limited data analysis tools and suggested it could benefit patients with communication disabilities. They emphasized the importance of raising awareness about the accommodations needed for effective communication and how communication disabilities can affect clinical decisions, like the Sequential Organ Failure Assessment (SOFA) scores. Moojan Rezvan confirmed their program

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included such individuals, citing an example of a deaf-blind patient who received the necessary interpreter services to ensure proper care.

Public Comment:

There were no public comments received for this agenda item.

Agenda Item #8: Hospital Quality Institute (HQI) Presentation

Scott Masten, Vice President of Measurement Science Performance Analytics at the Hospital Quality Institute (HQI), presented their work supporting California's 391 member hospitals through the Hospital Quality Improvement Platform (H-QuIP), offering data comparisons on over 300 metrics. HQI is also developing pre-filled equity reports for hospitals to meet regulatory reporting requirements for the implementation of the Hospital Equity Measures Reporting Program. These reports will include stratified data on various measures and customizable templates. HQI aims to support hospitals with equity through hospital-wide data and stratified insights. The platform will eventually include pediatric, psychiatric, and general acute reports.

Questions/Comments from the Committee:

The committee inquired about further stratification mixed-race categories showing skewed data. Scott Masten, HQI, explained that the reports follow existing regulations, with additional stratification available upon request.

The committee inquired whether it is possible to stratify data by language, specifically using American Sign Language (ASL), to identify any potential interrelated issues within that category. Scott Masten explained this depends on available data, using a three-digit code for the language and the actual reported language. If additional information, such as a write-in, is provided, further stratification can be done. The ability to stratify depends on the data available, with the general answer being "yes" if the information is present, and "no" if it is not.

The committee asked about tracking hospitals' discrimination policies documentation. Scott Masten, HQI, explained that while hospitals submit this data in spreadsheet exports, it may not be easily aggregated. While he anticipates being able to track other items, like the clean air and water requirements, he clarifies that the "yes/no" responses on discrimination policies would not be automatically processed. The committee expressed interest in tracking this information and suggested it may be worth discussing with other agencies, like HCAI, to ensure hospitals are consistently sharing their discrimination policies. Michael Valle, Deputy Director, HCAI, clarified that by 2026, the HEM reports will include a structural measure where hospitals will be required to provide documentation that they have a policy prohibiting discrimination, which will allow for tracking of statewide trends.

The committee raised questions about health plans and payers accessing aggregated, how geospatial representation to help identify regional differences in outcomes, using census block data to examine structural variance, particularly with the Healthy Places Index, and tracking demographic data completeness and quality as a progress marker.

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The committee also raised several questions regarding data quality checks, how feedback is given to hospitals when data appears incorrect or has missing values, and whether there is a data quality report card. They also asked if logical checks are conducted between data points, such as ensuring there are not more readmissions than admissions. Finally, the committee asked if the tool is capable of bivariate and univariate stratification. Scott Masten, HQI, explained that hospitals upload their data to HCAI, which conducts extensive data checks and edits before the data is sent to their platform. The team performs basic checks to ensure the data is accurate but mainly relies on HCAI's thorough data cleaning. Hospitals can upload data at various frequencies, and the system ensures that the most recent, cleaned data is used by overwriting older versions if errors are corrected. He confirmed that multi-level stratification is possible within the system and was initially available but removed for simplicity in the presentation. He further mentioned that the team continuously checks data accuracy by comparing it with external reports, such as those published by HCAI, and that they collaborate with hospitals to address discrepancies. Hospitals also help identify errors by reporting issues, such as abnormal PSI values, creating a partnership to maintain data quality.

The committee expressed concern about hospitals choosing the easier Patient Discharge Data reporting over comprehensive internal systems to collect better quality race and ethnicity data. They emphasized the need for HCAI to encourage hospitals to exceed the minimum data submission requirements. HCAI reflected on the challenges and opportunities hospitals will face in the first few years of the program and acknowledged that while larger hospitals may have advanced systems already in place, smaller and rural hospitals may lack the resources to develop similar systems, and efforts should be made to support them.

The committee highlighted concerns regarding alcohol and drug use disorder treatment of vulnerable groups within hospital systems, referencing a recent case involving Acadia Hospital and its settlement with the Department of Justice. The committee stressed the need to analyze this data carefully, considering factors like hospital payment sources, race, ethnicity, and potential inequities.

The committee inquired about the potential interaction with health plans regarding the dashboard, suggesting it might be a topic for a separate discussion. Scott Masten, HQI, explained that their role involves helping hospitals calculate measures for various hospital Pay-for-Performance programs, such as providing feedback to Inland Empire hospitals throughout the year. Scott Masten clarified that while the rules and algorithms are set by the program administrators, their focus is on providing hospitals with real-time, quarterly feedback rather than waiting for biannual reports. The goal is to offer quicker data to help hospitals improve the quality of care.

The committee warned against health equity plans becoming bureaucratic exercises without meaningful engagement and that over time, it might become difficult to assess how seriously hospitals are addressing health equity if their plans are vague or lack positive outcomes. They also expressed concern about AI-generated equity plans, suggesting that HCAI should consider the legal and transparency issues this could raise. The committee noted that AI-generated plans might lack human oversight and interpretation, leading to reliability and quality issues.

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The committee agreed with previous comments about using data effectively to create meaningful plans and look to HCAI to guide the process and ensure the plans achieve their intended purpose. HCAI clarified that the regulations require the registered contact person from the hospital to certify, under penalty of perjury, that the equity plans submitted to HCAI are accurate and truthful. The committee emphasized that the community will play a crucial role in holding hospitals accountable once equity plans are publicly reported.

Public Comment:

There were no public comments received for this agenda item.

Agenda Item #9: Committee Wrap Up

Questions/Comments from the Committee:

Dr. Ash Amarnath, HEMAC Chair, provided a recap of the meeting. Action items for the next advisory meeting includes providing an update on hospital equity regulations and developing a 2025 meeting approach, with input from the committee to be gathered before the end of the year.

Agenda Item #10: Public Comment

There were no public comments.

Agenda Item #11: Adjournment

Dr. Ash Amarnath, HEMAC Chair, adjourned the meeting at 12:57 p.m.