

# Item #5: Review of the Equity Report Evaluation Framework

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What can we learn about how hospitals are **understanding** and **addressing** identified disparities?



# Establishing a Framework – *what is the purpose of a scoring rubric?*

- **Systematic, more objective evaluation** – 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

# Other Considerations

- Does a similar rubric **already exist**?
  - SIREN Review, Community Benefit Plan research, discuss with experts
  - Can you evaluate/predict impact?
- **Simple rubric is easier** to understand, implement and use for improvement, but **may not generalize** to every setting
  - Critical Access Hospitals, Children's Hospitals
- Regulations specify more about process, components and less about determining impact – rubric needs to **align with regulations**
  - Example – interventions for SDOH screen positive patients

# Our Sample

- Formal Evaluation: 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 Evaluation: 6 hospitals



# Hospital Equity Plan Evaluation Rubric

SDOH Screening

Top 10 Disparities Table

Health Equity Plan

Performance in the Priority Areas

# Hospital Equity Plan Evaluation Rubric: SDOH Screening (Max = 6)

	<b>2 POINTS</b>	<b>1 POINT</b>	<b>0 POINTS</b>
Report SDOH rates?	>70%	1-69%	0 rates
Report screen positive rates for all 5 SDOH domains?	All 5 domains	1-4 domains	0 screen positive
Report intervention for positive screens?	>50% positive with interventions	1-49% positive with interventions	0 interventions

# Hospital Equity Plan Evaluation Rubric: Top 10 Disparities Table (Max = 4)

	<b>2 POINTS</b>	<b>1 POINT</b>	<b>0 POINTS</b>
Report accurate disparities data and rate ratios?	All rate ratios correct and all Top 10 listed	1-3 errors	More than 3 errors
Provides complete stratification and reference group Top 10 list?	All cells complete	1-3 cells missing	More than 3 missing cells

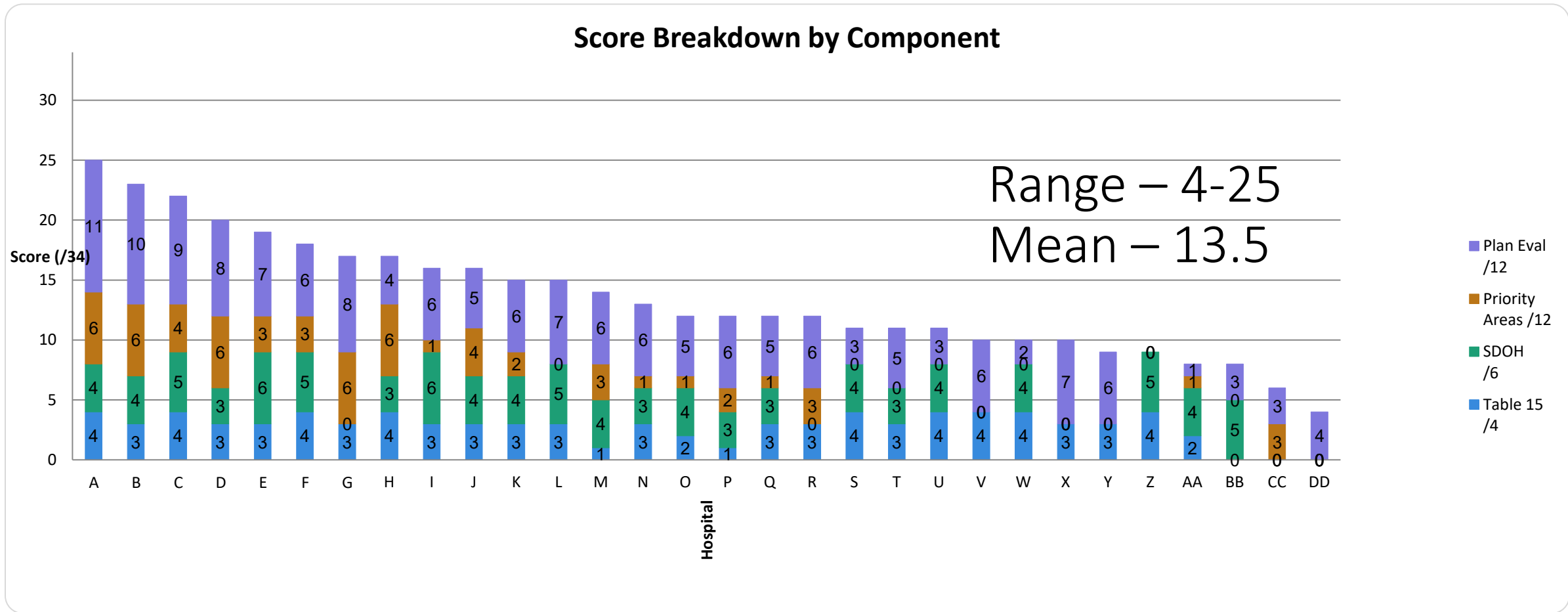
# Hospital Equity Plan Evaluation Rubric: Health Equity Plan (Max = 12)

	2 POINTS	1 POINT	0 POINTS
Propose potential <b>drivers and/or root causes</b> to investigate?	Explicitly investigates/identifies specific root causes for ALL Top 10 disparity group	Done for some	Not done
Propose <b>additional analyses</b> to further understand the drivers of disparities?	Proposes new data analyses to understand drivers for ALL Top 10 groups	Done for some	Not done
Propose interventions (policies, programs, processes) <b>specific</b> to disparities groups?	Specific policies/programs/processes proposed for ALL Top 10 groups individually	Done for some	Not done
Propose <b>general</b> interventions for all populations?	General interventions proposed for ALL patients addressing the type of disparity found	Done for some	Not done
Identify ways to <b>engage patients and/or family caregivers</b> in improvement efforts?	Patient and/or family caregivers are explicitly engaged in improvement efforts for ALL Top 10 disparity groups	Done for some	Not done
Allocate <b>resources</b> for the proposed interventions?	Resources (staff, budget, committees, programs, partnerships) explicitly allocated for ALL proposed interventions	Done for some	Not done

# Hospital Equity Plan Evaluation Rubric: Performance in the Priority Areas (Max=12)

	<b>2 POINTS</b>	<b>1 POINT</b>	<b>0 POINTS</b>
Top 10 disparities addressed in each priority area (6)?	Yes for all	Done for some	Not done (General terms only)

# Results – Sample Hospitals



# Plan to Address Disparities Themes (1 of 3)

## Transitional Care and Discharge Planning (19)

*“Key actions included targeted education for providers and nursing staff in partnership with case management team to strengthen transitional care services...including follow up instruction at discharge, provision of discharge medications, accurate medication reconciliation, and education using teach back to confirm understanding.”*

## SDOH Screening and Community Resource Referrals (18)

*“Contracted with Cardea Health...operates a medically supported shelter to serve patients who would benefit from a safe environment for recuperation and continued access to medical and social support services.”*

## Readmissions Review and Multidisciplinary Task Force (17)

*“...dedicated Readmission Reduction Task Force that has met monthly over the past two years to systematically analyze and address 30-day readmissions...efforts have traditionally been disease-specific”*

## Language Access and Culturally Responsive Care (16)

*“Avoid family interpretation for medical info. Translate key documents (instructions, medications, appointments. Recruit Armenian-speaking staff/providers”*

# Plan to Address Disparities Themes (2 of 3)

## Patient and Family Education (Teach Back, Condition Specific) (13)

*“...language interpreters and make every effort to provide concordant instructions and culturally informed patient engagement”*

## Community and Health Plan Partnerships (11)

*“...strengthening our relationship with Alameda Alliance and the Community Health Center Network to bolster care coordination for patients who receive follow up care externally”*

## Medication Management (9)

*“We track and report on the timeliness of medication consent and initiations of Riese petitions to prevent treatment delays, as well, appropriate use of long-acting injectables through enhanced education and coordinated post-discharge follow-up”*

## Governance, Equity Infrastructure and Strategic Planning (9)

*“Quality Council is reviewing disparities...hospital leadership has designated our Chief Equity and Engagement Officer, Chief Quality Officer, and Associate Medical Director for Outpatient Services to co-lead these efforts.”*

# Plan to Address Disparities Themes (3 of 3)

## Age-Friendly and Geriatric Initiatives (7)

*“SNF collaborative...goal is to strengthen relationship between community SNF partners and facilities to address readmission disparities, provide palliative care, initiate advanced care planning, and ensure patient preferences are honored”*

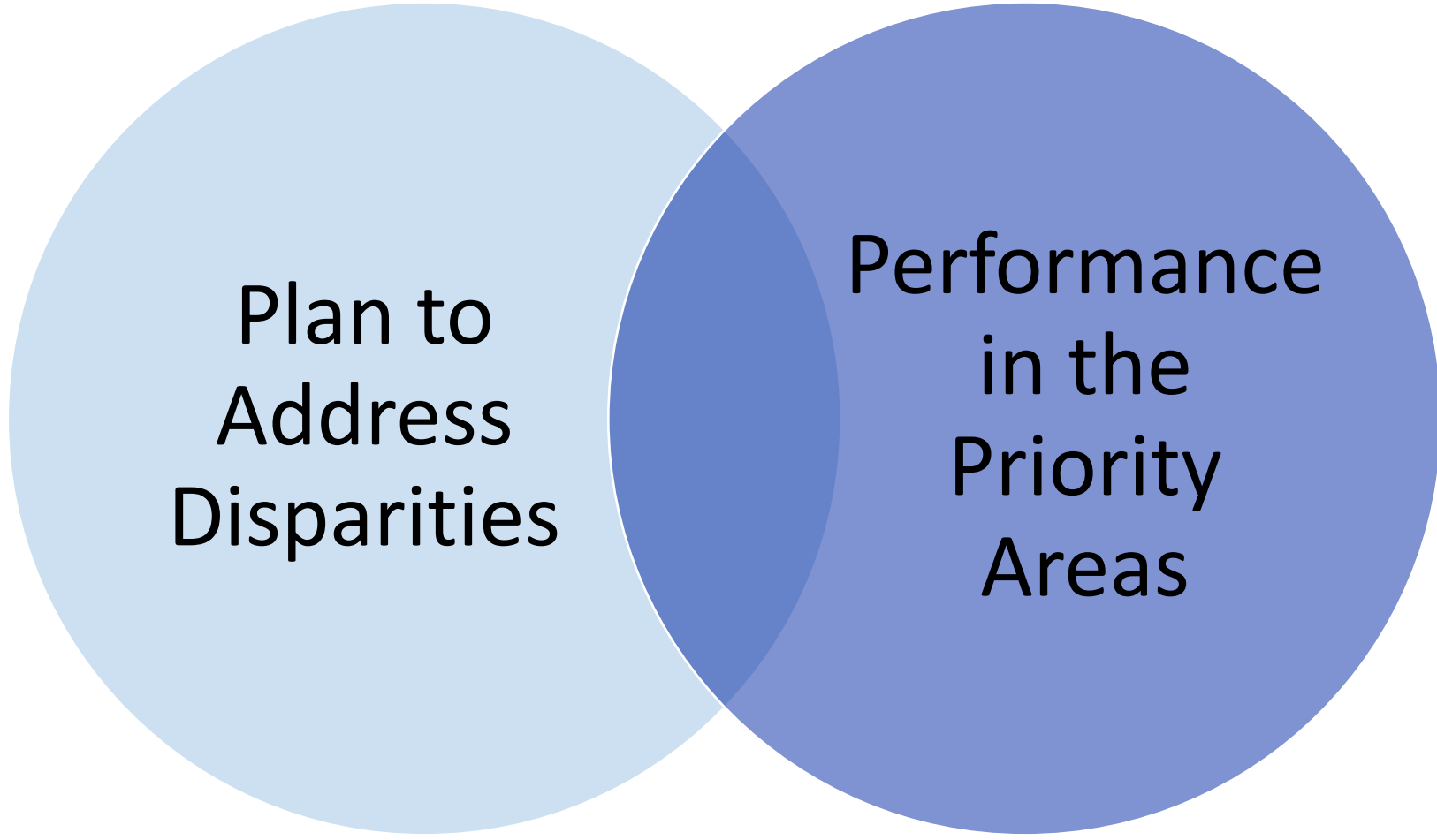
## Behavioral Health Support (6)

*“...coordinated, multidisciplinary approach that includes risk identification, transitional care and housing, medication management, and next level of care treatment referrals( psychiatrist, psychologist, therapist, mental health clinics)*

## Maternal Health and Obstetric Equity (9)

*“Creation of a Patient Family Advisory Council will enable us to address culturally responsive care (related to exclusive breastfeeding)”*

## No Disparities Identified (4)



# Future Considerations

- “Performance in the Priority Areas” – consider language to clarify whether hospitals should describe how work in these areas will affect identified disparities
- Provide rubric as guidance for what to include in open-ended hospital equity plans
- Consider a hospital attestation that disparities data is validated