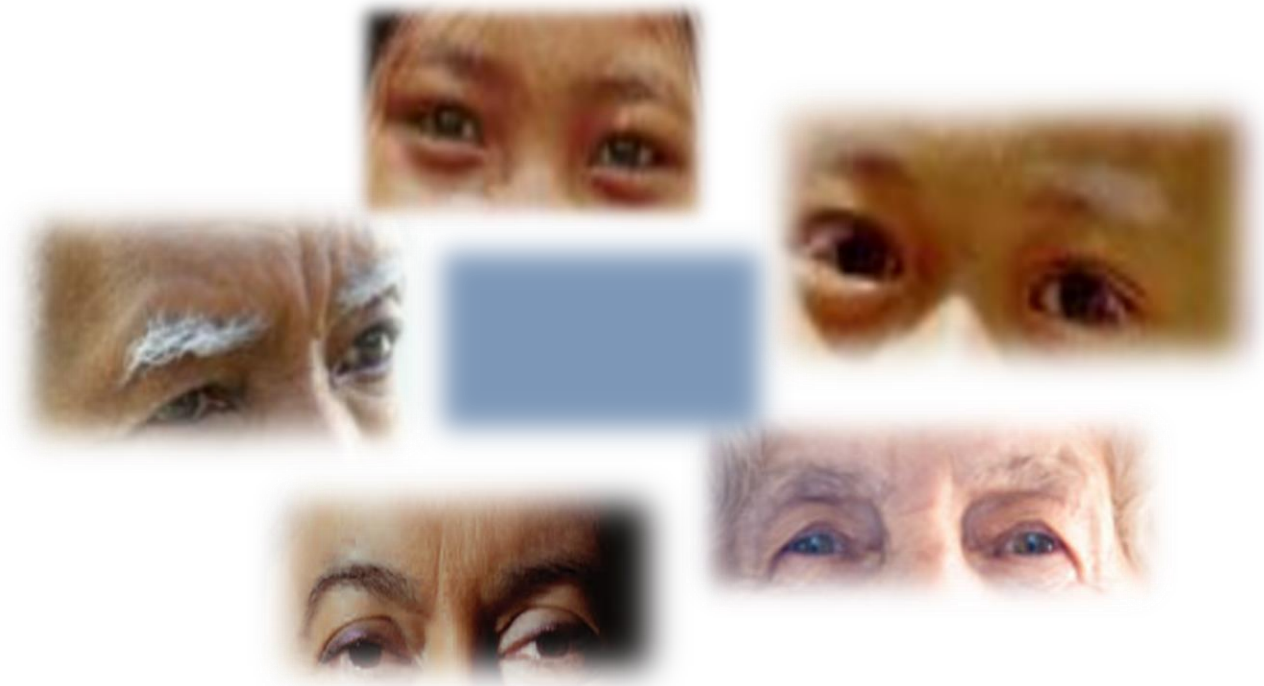
Addressing Health Equities

Outcomes

- Define key terms related to health equity

- Identify core components of addressing health equity

Through The Lens



“Health Equity”

Attainment of the highest level of health for ***all*** people

“Health Equity”

Steps to Achieving Health Equity

- Valuing everyone equally
- Focus on ongoing societal efforts to address avoidable inequalities, injustices, and elimination of health and health care disparities

Health Equity Goals

- Moving from “Awareness” to Triggering “Action”

- Better Performance and Outcomes – Closing Disparate Gaps

Health Equity Tools: HIIN Health Equity Assessment/Metrics

- **Data Collection**
- **Data Collection Training**
- **Data Validation**
- **Data Stratification**
- **Communication of Findings**
- **Address & Resolve Gaps in Care**
- **Organizational Infrastructure & Culture**

Health Equity Tools: HIIN Health Equity Assessment/Metrics

- **Data Collection:** Collection of patient demographics data to help hospitals and healthcare systems understand their patient populations
  - REaL data & additional data beyond (i.e. disability status, social determinants, social risk factors, etc.)

- **Data Collection Training:** Training must be provided during orientation and annual updates are highly recommended
  - Training is provided regarding collection of REaL data & for additional self-reported demographic data beyond REaL (i.e. socio-economic/SDOH)

- **Data Validation:** Hospital has a standardized process in place to evaluate and validate accuracy and completeness of patient self-reported demographics including percent of “unknown”, “unavailable”, and “declined”. Hospital addresses system level issues to continually improve

Health Equity Tools: HIIN Health Equity Assessment/Metrics

- **Data Stratification:** Examine patient safety, quality or outcome measures with an equity lens to determine if differences in patient outcomes exist, identify areas in need of improvement, and target interventions

- **Communication of Findings:** Hospital uses a reporting mechanism to communicate outcomes/gaps in disparities for various patient populations

- **Address & Resolve Gaps in Care:** Hospital implements interventions to resolve differences in patient outcomes and educate staff about gaps in care

- **Organizational Infrastructure & Culture:** Hospital has organizational culture and infrastructure to support the delivery of care that is equitable for all populations (i.e. services that meet cultural and linguistic diversity, designated leader accountable for health equity efforts, involved key stakeholders, equity prioritized in mission and goals)

Data Analysis

- Race/Ethnicity
- Language
- Age
- Gender
- Payer Status
- Poverty Quintile
- Length of Stay
- Admission/Discharge Type/Source/Status

OHA HIIN EXAMPLE

Sepsis Diagnosis

- Older groups and patients who live in areas with higher poverty were more likely to experience post-operative sepsis
- The average rate of sepsis readmission was 18.2%
  - Patients 53-83 years old with a discharge status to “other health care facility” or “home health care”
  - Patients discharged to other health care facility or home health care were much more likely to experience sepsis readmission than patients discharged to routine places (e.g., home or self-care)