Health Equity Gap Analysis

The following checklist assesses a hospital's incorporation of health equity best practices as part of its overall operations.

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

Hospital name: _____

Date: _____

ELEMENT	BEST PRACTICE RECOMMENDATION	IMPLEMENTATION STATUS			ACTION PLAN/ NEXT STEPS List specific activities your team will seek to accomplish to fully implement each practice recommendation
		FULLY	PARTIALLY	NONE	
ORGANIZATIONAL LEADERSHIP					
Health equity is a key strategic priority with established structures and processes in place to eliminate disparities and ensure equitable healthcare is prioritized and delivered to all patient populations.	Health equity is articulated as a key organization-wide priority (e.g., goals and objectives, strategic plan, policy, protocol, pledges, mission/vision/values, data transparency, leadership buy-in, community partnerships, diverse workforce) supported by a clear business case and plan for operationalizing health equity strategies and interventions that address multiple determinants of health, decrease institutional racism and strengthen community partnerships to improve health and equity.	○	○	○	
Hospital has designated a leader(s) or functional area (i.e., health equity committee) responsible for advancing health equity and who actively engages in strategic and action planning activities to reduce disparities.	Health equity leaders are designated and held accountable for disparities reduction with established roles and responsibilities to champion equity and improve quality of care. Designated leaders actively engage hospital staff, patients and families and create linkages with community stakeholders to support health equity improvement activities.	○	○	○	
WORKFORCE TRAINING					
Hospital workforce training is provided to staff who collect self-reported race, ethnicity and language data.	Training must be provided during orientation to staff who collect demographic data. Effectiveness of training should be periodically evaluated using the self-reporting methodology to remove guesswork and ensure accurate data is collected. Training updates are recommended. At a minimum, training is provided to registration/admission staff. Training may include role-playing scripts, didactic methods or take place online.	○	○	○	
Hospital workforce training is provided to clinicians involved in the care of the patient regarding the standardized collection of SDOH data.	Training to ensure a standardized approach to screening for and documenting social needs enables hospitals to track and aggregate data across patients, target social determinants strategies, identify population health trends and guide community partnerships. Accurate documentation of social determinants also supports Z code utilization and is key to understanding how to support patients at greatest risk and ensuring patient social support, home and community-based services are enabled to manage their conditions and improve coordination of healthcare delivery.	○	○	○	

HQIC Hospital Quality Improvement Contractors
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QUALITY IMPROVEMENT & INNOVATION GROUP

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WORKFORCE TRAINING					
Hospital provides cultural competency education and training to all hospital employees and clinicians.	Implementing and monitoring a cultural competency training program helps to ensure culturally responsive clinical care and services, including within operations/ strategic planning efforts. Successful programs include a cultural assessment, multiple training methods, ongoing education and measurement and tracking.	◯	◯	◯	
DATA COLLECTION AND UTILIZATION					
Hospital uses a self-reporting methodology to collect REaL data from the patient, family member and/or care partner	State/national requirements and federal policies include collecting and reporting REaL data. Self-reported patient data is preferred. All race and ethnicity categories collected should, at a minimum, roll up to the OMB categories in separate fields in addition to collecting granular ethnicity data beyond the OMB categories. Hospital staff should receive data collection training.	◯	◯	◯	
Hospital has standardized processes in place to collect REaL data for at least 95% of its patients with an opportunity for verification at multiple points of care beyond registration.	Although most hospitals collect patient REaL data, these data are not collected in a systematic or standard manner leading to missing, incomplete or inaccurate data. Establishing data integrity checks, processes and protocols (e.g., hard stop) for self-reported REaL data collection and verification at multiple points of care beyond registration prevents missed opportunities to collect data (e.g., during pre-registration process, registration/admission process, inpatient units, prior to discharge, etc.). The timely, accurate and consistent collection of patient information allows hospitals to provide appropriate and tailored patient education, language assistance services and track quality indicators and health outcomes to improve quality and equity of care.	◯	◯	◯	
Hospital uses a self-reporting methodology to collect SDOH data (i.e., transportation, food insecurity, housing, etc.) from the patient, family member or care partner.	Best practice recommendations include collection of SDOH/social risk factors to mitigate health disparities, which can drive as much as 80% of health outcomes. Collecting these data helps organizations identify existing disparities, address health-related social needs and connect patients with resources to address unmet needs.	◯	◯	◯	
Hospital uses self-reporting methodology to collect sexual orientation and gender identity data.	Implementing SOGI data collection improves quality of care for LGBTQ+ patients and provides healthcare institutions information to identify and close quality of care gaps, improve patient satisfaction and expand patient population. Research has shown SOGI questions are widely understood and accepted by diverse patient populations across the country.	◯	◯	◯	
Hospital data demonstrating health equity gaps are shared broadly (i.e., use of equity dashboards or other reporting mechanism) with key stakeholders.	Transparently sharing health equity data (i.e., REaL stratified, patient experiences, outcomes and quality data) helps to identify clinical areas where potential inequities exist, analyze root causes, set aims to address gaps and target/implement interventions to close gaps and improve quality of care. Reporting: Adding REaL, SDOH and other patient demographic data to reports can inform value-based care opportunities to advance health equity.	◯	◯	◯	

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DATA COLLECTION AND UTILIZATION					
Hospital collects and utilizes data about the demographic and socioeconomic status of patient population(s) served and the surrounding community (social determinants) to target interventions and address health-related needs.	Collection and utilization of needs assessments can help your program determine where and how resources may best be targeted. Collecting data by demographic and socioeconomic subgroups of patients allows hospitals to identify gaps in care delivery and other factors that may influence health outcomes to improve quality, patient safety and communication between providers and patients, care partners and families. Examples: surveys, questionnaires, focus groups and secondary data sources, i.e., demographic data, vital statistics, hospital records and M&M reports. Combining quantitative and qualitative data can help to explain community trends.	◯	◯	◯	
Hospital analyzes SDOH "Z code" data to improve quality, care coordination and experience of care.	SDOH health-related Z codes ranging from Z55-Z65 are the ICD-10-CM encounter reason codes used to document SDOH data (e.g., housing, food insecurity, transportation, etc.). Coders can assign SDOH Z codes based on self-reported data and/or information documented in an individual's healthcare record, and data analysis of SDOH Z code data can be used to identify individual's social risk factors and unmet needs, inform healthcare and services and trigger referrals to social services and between providers and social service organizations.	◯	◯	◯	
DATA VALIDATION					
Hospital verifies the accuracy and completeness of patient self-reported demographic data to improve reliability and identification of disparities in care and target quality interventions [Goal >90%].	Standardized processes are in place to both evaluate the accuracy and completeness (percent of fields completed) of self-reported REaL data, including petcent of 'unknown' 'refused/declined' or 'unavailable' with a cumulative goal of <5%. Analysis of these percentages is a valuable tool for identifying and improving issues within data collection systems and processes. Increasing the accuracy and completeness of self-reported REaL data allows hospitals to better identify disparities in patient populations and implement programs to improve outcomes.	◯	◯	◯	
DATA STRATIFICATION					
Hospital stratifies patient safety, quality/and or outcome measures (e.g., 30-day readmission rates) by race, ethnicity and language to examine differences and equity of care provided.	Stratifying patient safety, quality and/or outcome measure(s) using patient self-reported REaL data helps to identify differences in patient outcomes, areas of opportunity and target interventions. Information can be gathered routinely at registration, updated at regular intervals and used, for example, to do predictive modeling to address factors that influence readmissions.	◯	◯	◯	

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HEALTH LITERACY, CULTURAL COMPETENCE AND LANGUAGE					
Health literacy level screened and documented within 24hrs of admission.	Patients with low health literacy are at risk for readmission. Assessing patients' ability to understand health information and responding appropriately to patients' level of health literacy is essential.	◯	◯	◯	
Patients are screened for language access/assistance services.	Patients with limited English proficiency are at higher risk for preventable readmission than English-speaking patients. Collect data on language by asking the patient's preferred spoken language for care, as well as preferred written language.	◯	◯	◯	
Patient cultural preferences documented to individualize care/treatment plan.	Effective clinician-patient communication is directly linked to improved patient satisfaction, adherence and health outcomes. Best practices include documenting and tailoring care in alignment with patients' cultural practice and beliefs when planning, providing and evaluating care.	◯	◯	◯	
Patient disability status/ assessment documented.	People with disabilities have more complex admissions. Collecting patient disability status can help ensure necessary information is gathered to provide appropriate care, interventions, services and a smooth transition after hospitalization.	◯	◯	◯	
COMMUNITY PARTNERSHIPS					
Hospital partners with community-based organizations to maximize cross-sector partnerships and meet patients' and communities' needs.	Effective, sustainable partnerships between healthcare organizations and CBOs (e.g., providing direct assistance to address health-related social needs, use of Bridge Model of transitional care, use of innovative models to enhance integration processes and improve scalability) are key to addressing social needs, optimizing patient navigation strategies and improving overall health and well-being of individuals and communities served.	◯	◯	◯	

