Health Equity Organizational Assessment (HEOA) Compendium of Resources

Instructions for use:

This guide had been developed to provide guidance for hospitals who are interested in investigating resources in eight key HEOA assessment categories (outlined below), and to support the quality improvement efforts aimed at the reduction of disparities in care.

HEOA categories include: 1) data collection, 2) data collection training, 3) data validation, 4) data stratification, 5) communicate findings, 6) address and resolve gaps in care, 7) organizational infrastructure and culture, and 8) SDOH Z Code Collection.

Table 1 offers a brief description of each category and level of implementation (fundamental, intermediate, and advanced). As a hospital identifies gaps in a category and/or level of implementation, Table 2 provides resources that align with the category to support the hospital in transitioning between levels and develop interventions to reduce disparities and achieve high quality care for all patients.

Table 1: HEOA Categories and Level of Implementation Description Guide

Category	Fundamental Level of Implementation	Intermediate Level of Implementation	Advanced Level of Implementation
Data Collection Description: Hospital uses a self-reporting methodology to collect demographic data from the patient and/or caregiver	Hospital uses self-reporting methodology to collect race, ethnicity and language Race, Ethnicity, Age and Language (REAL) data for all patients. All race and ethnicity categories collected should, at a minimum, roll up to the OMB categories and should be collected in separate fields.	Hospital meets the above basic/ fundamental level of implementation plus: • Hospital collects REAL data for at least 95% of their patients with opportunity for verification at multiple points of care (beyond just registration) to ensure accuracy of the data and to prevent any missed opportunities for data collection (e.g., pre-registration process, registration/admission process, inpatient units, etc.).	Hospital meets the above basic/ fundamental and mid/intermediate levels of implementation plus: • Hospital uses self-reporting methodology to collect additional demographic data (beyond REAL) for patients such as disability status, sexual orientation/ gender identity (SOGI), veteran status, geography and/ or other social determinants of health (SDOH) or social risk factors.
Data Collection Training Description: Hospital provides workforce training regarding the collection of self-reported patient demographic data.	Hospital provides workforce training regarding the collection of patient self-reported data. Examples include role-playing, scripts, didactic, manuals, online modules, or other tools/job aids.	Training includes collection of REAL data (race, ethnicity, and language), SOGI data (disability status, sexual orientation/gender identity), SDOH/ social risk factors data (social determinants of health data may include veteran status, geography, education level, access to housing, food availability, migrant status, income, incarceration history, access to healthcare, employment status, etc.	Hospital evaluates the effectiveness of workforce training on an annual basis to ensure staff demonstrates competency in patient self-reporting data collection methodology (i.e., observations, teach back, post-test, etc.)?

Data Validation Description: Hospital verifies the accuracy and completeness of patient self-reported demographic data	Hospital has a standardized process in place to both evaluate the accuracy and completeness (percent of fields completed) for REAL data and a process to evaluate and compare hospital collected REAL data to local demographic community data.	Hospital meets the above basic/fundamental level of implementation plus: • Hospital addresses any system-level issues (e.g., changes in patient registration screens/fields, data flow, workforce training, etc.) to improve the collection of self-reported REAL data. Patient/Family Advisors can provide invaluable insights and feedback to address system-level issues regarding the collection of REAL data	Hospital meets the above basic/ fundamental and mid/intermediate levels of implementation plus: • Hospital has a standardized process in place to evaluate the accuracy and completeness (percent of fields completed) for additional demographic data (beyond REAL) such as disability status, sexual orientation/gender identity (SOGI), veteran status, geography and/ or other social determinants of health (SDOH) or social risk factors — and has a process in place to evaluate and compare hospital collected patient demographic data to local demographic community data.
Data Stratification Description: Hospital stratifies patient safety, quality and/or outcome measures using patient demographic data.	Hospital stratifies at least one patient safety, quality and or outcome measure by REAL.	Hospital meets the above basic/ fundamental level of implementation plus: • Hospital stratifies more than one (or many) patient safety, quality and or outcome measure by REAL.	Hospital meets the above basic/ fundamental and mid/intermediate levels of implementation plus: • Hospital stratifies more than one (or many) patient safety, quality and/or outcome measure by REAL and other demographic data (beyond REAL) such as disability status, sexual orientation/gender identity (SOGI), veteran status, geography and/or other social determinants of health (SDOH) or social risk factors.
Communicate Findings Description: Hospital uses a reporting mechanism (e.g., equity dashboard) to routinely communicate outcomes for various patient populations.	Hospital uses a reporting mechanism (e.g., equity dashboard) to routinely communicate patient population outcomes to hospital senior executive leadership (including medical staff leadership) and the Board	Hospital meets the above basic/ fundamental level of implementation plus: • Hospital uses a reporting mechanism (e.g., equity dashboard) to routinely communicate patient population outcomes widely within the organization (e.g., quality staff, front line staff, managers, directors, providers, committees and departments or service lines).	Hospital meets the above basic/ fundamental and mid/ intermediate levels of implementation plus: • Hospital uses a reporting mechanism (e.g., equity dashboard) to share/communicate patient population outcomes with patients and families (e.g., PFAC members) and/or other community partners or stakeholders.

Address and Resolve Care Gaps Description: Hospital implements interventions to resolve differences in patient outcomes.	Hospital engages multidisciplinary team(s) to develop and test pilot interventions to address identified disparities in patient outcomes. Multidisciplinary teams can include diversity & inclusion committee, data/analytics, Patient and Family Advisory Councils (PFACs), patient safety committee, information technology, quality/ performance improvement, patient experience, corporate auditing and finance, etc.	Hospital meets the above basic/ fundamental level of implementation plus: • Hospital implements interventions (e.g., redesign processes, conducts system improvement projects and/or develops new services) to resolve identified disparities and educates staff/workforce regarding findings.	Hospital meets the above basic/ fundamental and mid/intermediate levels of implementation plus: • Hospital has a process in place for ongoing review, monitoring, and recalibrating interventions (as needed) to ensure changes are sustainable.
Infrastructure and Leadership Description: Hospital has organizational culture and infrastructure to support the delivery of care that is equitable for all patient populations.	Hospital has a standardized process to train its workforce to deliver culturally competent care and linguistically appropriate services (according to the CLAS standards).	Hospital meets the above basic/ fundamental level of implementation plus: • Hospital has named an individual (or individuals) who has leadership responsibility and accountability for health equity efforts (e.g., manager, director or chief equity, inclusion, and diversity officer/council/ committee) who engages with clinical champions, patients, and families (e.g., Patient and Family Advisory Councils (PFACs)) and/or community partners in strategic and action planning activities to reduce disparities in health outcomes for all patient populations. Note: This doesn't have to be a member of the c-suite.	Hospital meets the above basic/fundamental and mid/intermediate levels of implementation plus: • Hospital has made a commitment to ensure equitable health care is prioritized and delivered to all persons through written policies, protocols, pledges or strategic planning documents by organizational leadership and board of directors (e.g., mission/vision/ values reflect commitment to equity and is demonstrated in organizational goals and objectives).
SDOH Z Code Collection Description: Hospital includes ICD-10-CM codes, categories Z55-Z65 and Z75 ("Z codes") to identify and address non-medical factors that may influence a patient's health status.	Hospital collects SDOH data at intake through health risk assessments, screening tools, person-provider interaction, and individual self-reporting.	Hospital document SDOH data in a patients EHR in the problem or diagnosis list, patient or client history, or provider notes. Hospital assigns Z-codes SDOH-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.) to SDOH data.	Hospital authorizes Coders to assign SDOH Z codes based on self-reported data and/or information documented in an individual's health care record by any member of the care team. Hospital uses SDOH Z Code Data to identify individuals' social risk factors and unmet needs, inform health care team on needed services and follow-up, trigger referrals to social services, track referrals between providers and community based social service organization.

Table 2: HEOA Category Resource Guide

Resources	Data Collection	Data Collection Training	Data Validation	Data Stratification	Communicate Findings	Address & Resolve Care Gaps	Infrastructure & Leadership	SDOH Z Code Collection
Improving Quality and Achieving Equity: A Guide for Hospital Leaders								
Building an Organizational Response to Health Disparities								
Disparities Action Plan-Revised March 2021								
Eliminating Health Care Disparities: Implementing the National Call to Action Using Lessons Learned								
Healthcare Equality Index LGBTQ 2018								
Health equity and race and ethnicity data								
Inventory of resources for Standardized demographic And language data collection								
Inventory Of Resources For Standardized Demographic And Language Data Collection								
Race, Ethnicity, Language Data Collection Best Practices								
Improving Health Equity Through Data Collection AND Use: A Guide for Hospital Leaders								
Do Ask, Do Tell – A Toolkit for Collecting Data on Sexual Orientation and Gender Identity in Clinical Settings								
HHS Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status								
New York State Toolkit to Reduce Health Care Disparities: Improving Race and Ethnicity Data								

PRAPARE Assessment Tool_Eng.								
Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE) Overview								
Sexual and Gender Minority Clearinghouse CMS								
The Accountable Health Communities								
A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool: Promising Practices and Key Insights (PDF)								
Clinical Conversations Training Program Evaluation Tool_1								
Clinical Conversations Training Program Evaluation Tool_2								
Clinical Conversations Training Program NIH								
Collection of Data on Race, Ethnicity, Language, and Nativity by US Public Health Surveillance and Monitoring Systems: Gaps and Opportunities Public Health Reports 2018, Vol. 133(1) 45-54								
Health-Related Social Needs Screening Tool								
Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement_NIH_2009								
American Society of Healthcare Risk Management Equity of Care Assessment Tool								
Reducing Health Care Disparities: Collection and Use of Race, Ethnicity and Language Data								
Advancing Effective Communication, Cultural Competence and Patient and Family Centered Care for the Lesbian, Gay, Bisexual and Transgender (LGBT) Community								

Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care_TJC Roadmap								
AHA Disparities Toolkit								
Healthy People 2020 Social Determinants of Health								
HHS Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status								
Ready, Set, Go! Guidelines and Tips For Collecting Patient Data on Sexual Orientation and Gender Identity (SOGI) – 2020 Update								
The Feasibility of Screening for Social Determinants of Health: Seven Lessons Learned September/October 2019								
A Framework for Stratifying Race, Ethnicity and Language Data								
AHRQ National Healthcare Quality and Disparities reports								
Improving Patient Safety Systems for Patients With Limited English Proficiency								
CMS Office of Minority Health Mapping Medicare Disparities Tool								
Do Ask, Do Tell: How to Use SO/GI Data								
Equity of Care: A Toolkit for Eliminating Health Care Disparities								
Essential Health Equity, Diversity & Inclusion Resources								
Health Equity in Healthy People 2030								
A Guide to Presenting Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries								

Building an Organizational Response to Health Disparities: Five Pioneers from the Field Executive Summary								
Health Equity Organizational Road Map-Minnesota Hospital Association_2021								
A Practical Guide to Implementing the National CLAS Standards								
Becoming a Culturally Competent Health Care Organization								
Guide To Developing A Language Access Plan								
Making CLAS Happen: Six Areas for Action								
National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care								
Providing Language Services To Diverse Populations: Lessons From The Field								
A Playbook for Fostering Hospital-Community Partnerships to Build a Culture of Health								
AHA Social Determinants Of Health Series: Food, Housing, Transportation, Health Behaviors, & Violence								
Emerging Strategies to Ensure Access to Health Care Services 2017								
Fee-for-Service (FFS) Beneficiaries CMS_ DATA HIGHLIGHT | JANUARY 2020								
ICD-10 Code Lookup (free)								
ICD-10-CM Coding for Social Determinants of Health_ American Hospital Association | January 2022								
Johns Hopkins Healthcare Provider Update_ ICD-10 Codes to Identify Social Determinants of Health February 2020								
Social and Physical Environments that Promote Health (Social Determinants of Health) WI DHS								

Social Determinants of Health (SDOH) and PLACES Data CDC								
The Health Equity Roadmap								
USING Z CODES: The Social Determinants of Health (SDOH) Data Journey to Better Outcomes CMS 2021								
Utilization of Z Codes for Social Determinants of Health among Medicare Fee-for-Service Beneficiaries CMS DATA HIGHLIGHT | SEPTEMBER 2021								
Z Codes Utilization among Medicare								

This guide was adapted in part from 2021 Minnesota Hospital Association Health Equity Organizational Road Map, Michigan Hospital Association Eliminating Disparities to Advance Health Equity and Improve Quality Guide, and Washington State Hospital Association Health Research & Educational Trust (HRET) HIIN Health Equity Organizational Assessment Guide 2018.