TAHOE FOREST HOSPITAL DISTRICT

2025-05-07 Board Quality Committee Meeting

Donner Conference Room - Tahoe Forest Hosptial

Wednesday, May 07, 2025 at 10:30 a.m.

10978 Donner Pass Rd, Suite 3, Truckee CA 96161

Meeting Book - 2025-05-07 Board Quality Committee Meeting

TAHOE FOREST
HOSPITAL DISTRICT

QUALITY COMMITTEE
AGENDA

Wednesday, May 07, 2025, at 10:30 a.m.
Donner Conference Room – Tahoe Forest Hospital
10978 Donner Pass Rd, Suite 3, Truckee, CA 96161

1. CALL TO ORDER

2. ROLL CALL

Alyce Wong, Chair; Rob Darzynkiewicz, MD, Board Member

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA

4. INPUT – AUDIENCE

This is an opportunity for members of the public to address the Committee on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Board Clerk 24 hours prior to the meeting to allow for distribution. Under Government Code Section 54954.2 – Brown Act, the Committee cannot take action on any item not on the agenda. The Committee may choose to acknowledge the comment or, where appropriate, briefly answer a question, refer the matter to staff, or set the item for discussion at a future meeting.

5. APPROVAL OF MINUTES OF: 02/10/2025 .... ATTACHMENT

6. CLOSED SESSION

6.1. Hearing (Health & Safety Code § 32155)

Subject Matter: Case Review
Number of items: One (1)

6.2. Hearing (Health & Safety Code § 32155)

Subject Matter: Board Quality Dashboard Review

6.3. Hearing (Health & Safety Code § 32155)

Subject Matter: Standard Work Bundle Review

6.4. Approval of Closed Session Minutes

6.4.1. 02/10/2025 Closed Session Board Quality Committee

7. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

7.1. Informational Reports

7.1.1. Patient & Family Centered Care

7.1.1.1. Patient & Family Advisory Council (PFAC) Update............................... ATTACHMENT

Quality Committee will receive an update related to the activities of the Patient and Family Advisory Council (PFAC).

7.1.2. Patient Safety

7.1.2.1. BETA HEART Program Progress Report .... ATTACHMENT

Quality Committee will receive a progress report regarding the BETA Healthcare Group Culture of Safety program.

7.2. Safety First

7.3. Board Quality Committee Charter & Goals .... ATTACHMENT
Review the Board of Directors Quality Committee Charter and goals and provide input on the 2025 priorities.

7.4. Quality Criteria for President and CEO Incentive Compensation FY 2026
Discuss and recommend quality metrics for the President and CEO Incentive Compensation FY 2026.

7.5. Annual Quality Assessment Performance Improvement (QA PI) Report to the Board of Directors
Discuss the regulatory required annual Quality Assessment Performance Improvement (QA PI) report to the Board of Directors and provide input on what should be reviewed during the presentation

7.6. Quality Star Rating Overview ....ATTACHMENT
Provide an overview of the CMS Care Compare metrics and measurement process.

7.7. Process Improvement Projects
An update will be provided regarding Management Systems, and future process improvement activities.

7.8. Health Equity Regulations .... ATTACHMENT
A review of the federal and state regulations and how we plan to obtain the data from our patients.

7.9. Board Quality Education .... ATTACHMENT
The Committee will review the educational article listed below and discuss topics for future board quality education.
Centers for Medicare & Medicaid Services, *The CMS Framework for Health Equity (2022-2032)* (2022).

8. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

9. NEXT MEETING DATE

The next committee date and time will be confirmed for August 2025.

10. ADJOURN

*Denotes material (or a portion thereof) <u>may</u> be distributed later.

Note: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of services, hiring, training and employment practices on the basis of color, national origin, sex, religion, age or disability including AIDS and related conditions. Equal Opportunity Employer. The telephonic meeting location is accessible to people with disabilities. Every reasonable effort will be made to accommodate participation of the disabled in all of the District's public meetings. If particular accommodations for the disabled are needed or a reasonable modification of the teleconference procedures are necessary (i.e., disability-related aids or other services), please contact the Executive Assistant at 582-3583 at least 24 hours in advance of the meeting.

TAHOE
FOREST
HOSPITAL
DISTRICT

QUALITY COMMITTEE
DRAFT MINUTES

Monday, February 10, 2025 at 12:00 p.m.
Eskridge Conference Room – Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA 96161

DRAFT

1. CALL TO ORDER

Meeting was called to order at 12:01 p.m.

2. ROLL CALL

Board Alyce Wong, Chair; Robert Darzynkiewicz, Board Member
Staff in attendance: Louis Ward, Interim Chief Executive Officer ; Dr. Brian Evans, Chief Medical Officer; Janet Van Gelder, Director of Quality & Regulations; Christine O'Farrell, Risk Manager; Sarah Jackson, Executive Assistant / Clerk of the Board

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA

No changes were made to the agenda.

4. INPUT – AUDIENCE

None

5. APPROVAL OF MINUTES OF: 11/22/2024

Director Darzynkiewicz moved to approve the Board Quality Committee Minutes of November 22, 2024, seconded by Director Wong.

Open Session recessed at 12:05 p.m.

6. CLOSED SESSION

6.1. Hearing (Health & Safety Code § 32155)

Subject Matter: Case Review

Number of items: One (1)

Discussion was held on a privileged item.

6.2. Hearing (Health & Safety Code § 32155)

Subject Matter: Board Quality Dashboard Review

Discussion was held on a privileged item

6.3. Approval of Closed Session Minutes

6.3.1. 11/22/2024 Closed Session Board Quality Committee

Recommended for approval

Open Session reconvened at 12:38 p.m.

7. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

7.1. Informational Reports

7.1.1. Patient & Family Centered Care

7.1.1.1. Patient & Family Advisory Council (PFAC) Update

Mr. Kevin Ward, PFAC representative joined the meeting at 12:40 pm

Quality Committee received an update related to the activities of the Patient and Family Advisory Council (PFAC).

Director Darzynkiewicz asked Mr. Ward what he thought was going well with the PFAC. He advised that increased communication with administration has been going well. It increases patient satisfaction when patients know that the leadership is listening.

Director Darzynkiewicz also asked if there was anything that could be provided for more support. Mr. Ward advised that not all departments know what the PFAC is, so increased knowledge would be good.

Director of Quality advised that the Interim CEO and CMO frequently attend the PFAC meetings; the Medical Director of Quality, Dr Conway attends. The incoming CEO Anna Roth has expressed an interest in attending.

The Interim CEO advised that the Board Community Engagement Community Meeting may be an opportunity for the PFAC to attend and engage with that community and their mission in another way.

CMO advised that having Maria Martin, Lizzy Hennessey, and Megan Shirley, PA-C attend the PFAC may also be an advantageous way to interact between Community Health and PFAC.

7.1.2. Patient Safety

7.1.2.1. BETA HEART Program Progress Report

Dr. Streit, Dr. Fletcher, Dr. Allison Semrad are attending the BETA HEART training program this year at the end of February.

The SCOR Culture of Patient Safety survey will be occurring in February.

The Beta HEART Progress Report for 2025 was reviewed.

7.2. Safety First

CMO reviewed the purpose of the Safety First agenda item at the Board Quality Committee Meeting.

Interim CEO reviewed the Thrift Store pipes freezing. This issue creates concern due to no running water, no restrooms, and store closures. Concerns brought up by an employee. We are working with the owner of the building to rectify the situation.

7.3. Quality Assessment Performance Improvement (AQPI-05)

Quality Committee reviewed the draft AQPI-05 plan presented by Director of Quality. There were no recommended changes to the revised plan for 2025.

7.4. CAH National Patient Safety Goals

Quality Committee reviewed the National Patient Safety goals.

DRAFT

Director Darzynkiewicz questioned how success is measured against these goals? Director of Quality advised that everything is tracked through both the safety huddles and the event reporting system.

CMO advised that this is indicative of the shift of our organization of measuring our standards of work and setting processes.

7.5. Process Improvement Projects

CMO provided an update on our process improvement journey and Management Systems. We started with an Access to Care project which we are mostly complete with. We are mostly complete with the Behavioral Health projects, the Coding project, and the Orthopedics project. At this point in time we haven't distributed the training to a system wide group of individuals, but have trained the smaller cohorts of individuals in each project.

Interim CEO added that during this journey we learned early on we should have a Director of Process Improvement and that person, Jeff Cisneros, started today. It is highly likely that there will be overlap with Vizient and Jeff Cisneros while the Director of PI comes up to speed on all projects.

Further discussion was held on projects.

7.6. Board Quality Education

The Committee will review the educational article listed below and discuss topics for future board quality education.

Centers for Medicare & Medicaid Services, *The CMS Framework for Health Equity (2022-2032)* (2022).

No discussion was held. Deferred to the next meeting.

8. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

Director Wong would like Committee Charter, Board Quality Education, Goals added to the next committee agenda.

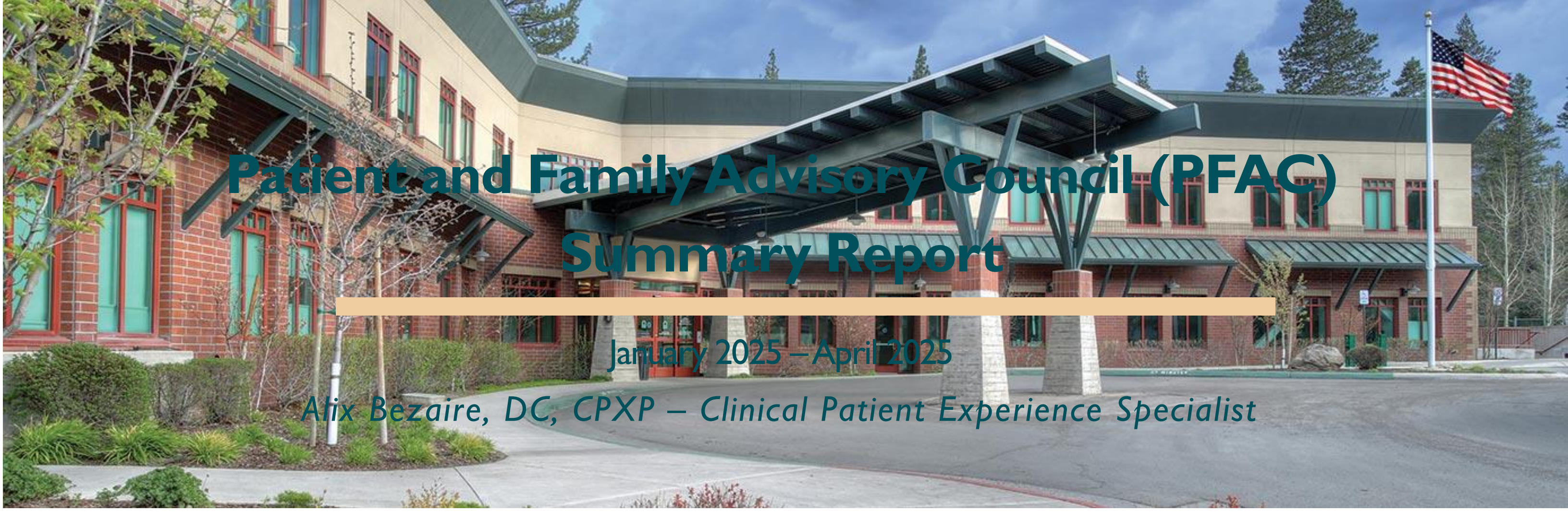
9. NEXT MEETING DATE

The next committee date and time will be confirmed for May 2025.

10. ADJOURN

Meeting adjourned at 1:29 p.m.

DRAFT



Patient and Family Advisory Council (PFAC) Summary Report

January 2025 – April 2025

Alix Bezaire, DC, CPXP – Clinical Patient Experience Specialist

Summary of Monthly Topics

January – Christine O'Farrell, Risk Manager/Patient Safety Associate, presented a case review/analysis in which a medical error occurred. The case involved an ICU nurse who inadvertently administered IV insulin to a patient instead of a different medication. The error was immediately identified and intervention began promptly, resulting in no harm or symptoms to the patient. There was discussion about the event analysis process, including the disclosure to patient and family members, identifying contributing factors, and the action plan to prevent similar situations from happening again.

February – Chris Malone, Director of Urgent Care, and Dr. David Lemak, Urgent Care Medical Director, presented on the Urgent Care Clinics and goal to improve efficiency and care. Overall, total visit time has been decreased from 138+ minutes (December 2022) to 67 minutes (September 2024). RN triage system allows independent evaluation/order testing prior to patient being seen by provider to streamline visit. UC has also implemented "On My Way" feature to help spread patients out throughout the day versus loaded mornings. Ryan Solberg, Director of Therapy Services, also came to request feedback/input on consistently high cancellation/no-show rates. PFAC input was that appointment reminder system ineffective for preventing no-shows, and suggested new system requiring patient "confirmation" of appointment, or risk losing appointment. Also suggested a "cancellation/no-show" fee, as other outside services generally utilize.

March – Alan Kern was named as PFAC Co-Chair and we held workshop to improve meeting structure, focus and council utilization. Generated a presentation template for all presenters to utilize that explicitly identifies their top challenges within their service line/department, and prompts pointed questions from the PFAC for input. Received input on proposed meeting format and template from the group, and asked for specific topics/areas of interest for future meetings from the group. Due to Med Staff meetings conflicting with PFAC meetings, it was agreed to move meetings to the 4th Tuesday of the month, effective in May.

April – Dr. Brian Evans, Chief Medical Officer, provided update on previous Access to Care project that has been ongoing for the past year. Overall goal has been to improve quality of care through improved efficiency and consistency (i.e., 'standard work'). Patient access to timely appointments remains priority, and tracking "3rd Next Available" appointment is the industry standard for measuring. We have attained goal for some clinics, but are not yet there for others. Dr. Evans and CEO Anna Roth expressed an interest in better leveraging the PFAC for future improvement initiatives, and providing more opportunities for the PFAC to be utilized.

PATIENT AND FAMILY ADVISORY COUNCIL (PFAC) SUMMARY REPORT

January 2025 – April 2025

Current Overview

- Ongoing goal is to have PFAC more actively involved and leveraged in hospital-wide process improvement initiatives.
- Topics of interest for future meetings include Scheduling/Authorizations/Referrals, patient advocacy/support groups for oncology patients, primary care medical director and operational director, retail pharmacy and impact of closed local pharmacies, addressing complaints trends, affordable care, etc.
- PFAC meets every month, 9 months in the year, on the 4th Tuesday of the month. We do not meet during the months of July, August, or December.
- Next PFAC meeting is May 27, 2025.

Current Members and Start Date

Kevin Ward	9/20/2018	Cris Valerio	12/1/2022
Sandy Horn	9/5/2019	Jane Rudolph-Bloom	1/1/2024
Violet Nakayama	10/31/2019	Amber Mello	5/1/2024
Alan Kern	2/20/2020	Sharon Strojny	6/1/2024
Kathee Hansen	4/1/2021	Bob Barnett	2/1/2024
Carina Toledo	11/17/2022		

Support Staff: Alix Bezaire, Janet Van Gelder, Anna Roth, Jim Sturtevant

Beta HEART Progress Report for Year 2025

(April 2025)

- Beta HEART Validation Survey completed May 22, 2024: validated in all 5 domains, cost savings of $159,866.
- Annual domain validation scheduled on April 29, 2025

Domain	History of Incentive Credits (2% annually)	Readiness for next Validation	Goal	Comments
Culture of Safety: A process for measuring safety culture and staff engagement (Lead: Tena Mather, Clinical Quality Analyst)	Validated 2024: $31,973.20	100%	Greater than 75% completion rate for SCOR Culture of Safety Survey Achieve Tier 2 in Zero Harm (OB & ED)	• SCOR culture of safety survey was administered February-March 2025 with a 74% response rate. Director/Managers will debrief with their staff and develop an action plan of the top 2 areas for improvement. • TFHD Women & Family Center and TFH/IVCH Emergency Departments will be participating in Zero Harm programs again in 2025. • 3 physicians & 5 leaders attended February workshop
Rapid Event Response and Analysis: A formalized process for early identification and rapid response to adverse events that includes an investigatory process that integrates human factors and systems analysis while applying Just Culture principles (Lead: Christine O'Farrell, Risk Manager)	Validated 2024: $31,973.20	100%	75% or greater response time for event analyses within 45 days of event reported 75% or greater response time for closure of action items within 90 days of event reported	• TFHD incorporates the transparent and timely reporting of safety events to ensure rapid change in providing safer patient care. All investigations utilize collaborative just culture and high reliability principles and encourage accountability. A member of the Reliability Management Team reviews all action plans to address strength of action items. • Tahoe Forest Hospital District Serious Safety Event Checklist was developed to guide the response after a serious safety event. • 3 physicians & 5 leaders attended February workshop
Communication and transparency: A commitment to honest and transparent communication with patients and family members after an adverse event (Lead: Christine O'Farrell, Risk Manager)	Validated 2024: $31,973.20	100%	75% or greater response time for closure of event within 60 days	• Disclosure checklist updated and refined as we update process and leaders trained to respond to events. • Risk Management provided a case presentation to PFAC in January 2025 to promote transparency and request feedback on action items. • 3 physicians & 4 leaders attended April workshop
Care for the Caregiver: An organizational program that ensures support for caregivers involved in an adverse event (Lead: Lauren Caprio, Peer Support Lead)	Validated 2024: $31,973.20	100%	75% or greater response time for peer supporter deployment made in 0-12 hours	• Ongoing training and quarterly peer support and steering committee meetings. Currently have 40 peer supporters available to all staff. • 2024 average time from peer support request to deployment was 45 minutes. • Peer Support team member trained as a Mental Health First Aid trainer and will provide in-house training to staff and Medical Staff in 2025. • Interested Medical Staff have been asked to complete an application and participate in formal training • 3 physicians & 4 leaders attended April workshop
Early Resolution: A process for early resolution when harm is deemed the result of inappropriate care or medical error (Lead: Christine O'Farrell, Risk Manager)	Validated 2024: $31,973.20	100%	75% or greater response time for closure of event within 60 days	• QAPI polices reviewed and updated as needed to reflect process improvement • 3 physicians & 9 leaders plan to attend the September workshop

Charter

Quality Committee
Tahoe Forest Hospital District
Board of Directors

PURPOSE:

The purpose of the charter is to delineate the Committee’s duties and responsibilities.

RESPONSIBILITIES:

The Quality Committee shall function as the standing committee of the Board responsible for providing oversight for Quality Assessment and Performance Improvement, assuring the Health System’s quality of care, patient safety, and patient experience.

DUTIES:

1. Recommend to the Board, as necessary, policies and procedures governing quality care, patient safety, environmental safety, and performance improvement throughout the organization.
2. Assure the provision of organization-wide quality of care, treatment, and service provided and prioritization of performance improvement throughout the organization.
3. Monitor the improvement of care, treatment, and services to ensure that it is safe, beneficial, patient-centered, customer-focused, timely, efficient, and equitable.
4. Monitor the organization’s performance in national quality measurement efforts, accreditation programs, and subsequent quality improvement activities.
5. Monitor the development and implementation of ongoing board education focusing on service excellence, performance improvement, risk reduction/safety enhancement, and healthcare outcomes.

COMPOSITION:

The Committee is comprised of at least two (2) board members as appointed by the Board Chair, the Medical Director of Quality and Chief Medical Officer.

MEETING FREQUENCY:

The Committee shall meet quarterly.

Tahoe Forest Hospital Star Rating Overview

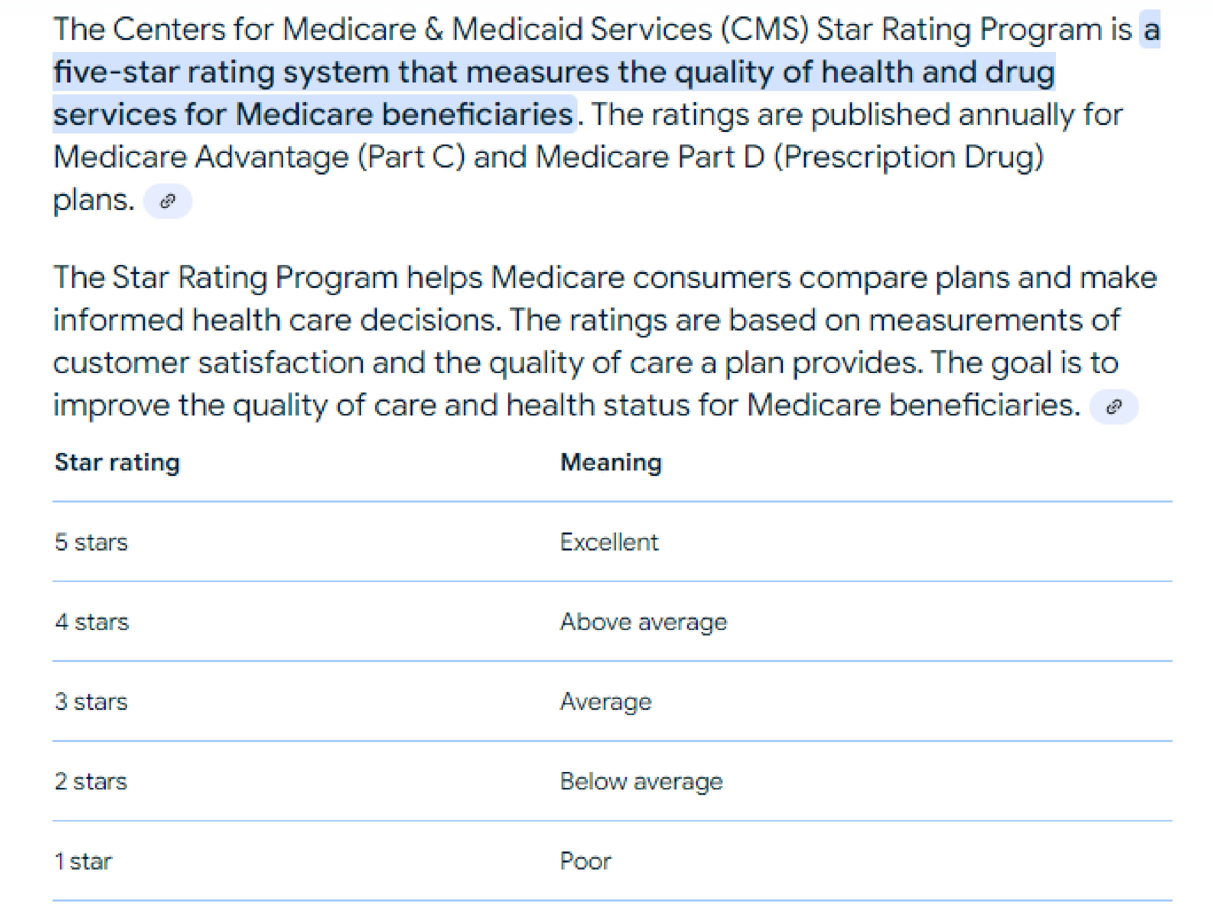
2025

Janet Van Gelder, RN, DNP, CPHQ
Director of Quality & Regulations

Confidential

What is a Star Rating?

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
5-Star Quality Rating System
★★★★★

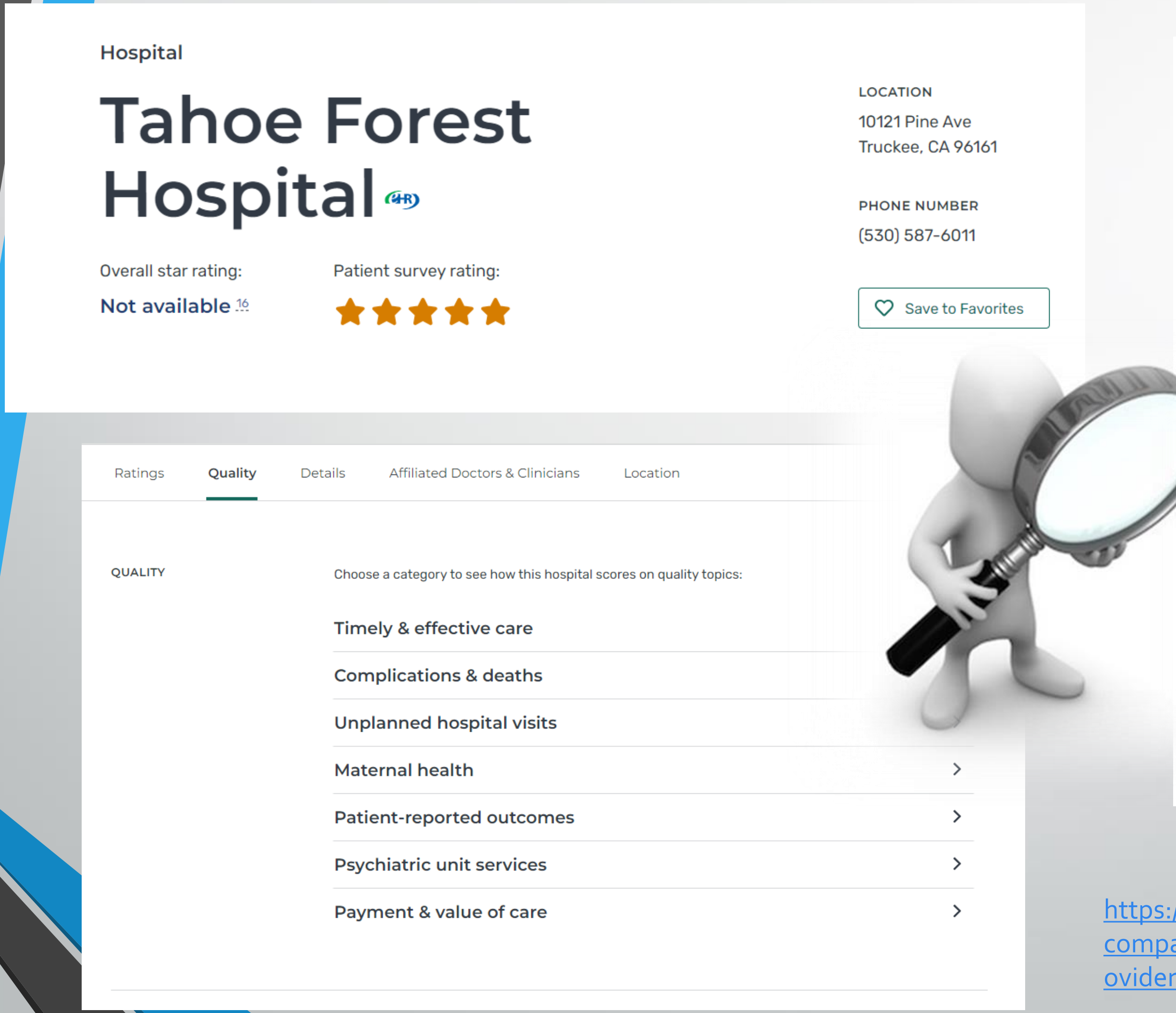


The Centers for Medicare & Medicaid Services (CMS) Star Rating Program is a five-star rating system that measures the quality of health and drug services for Medicare beneficiaries. The ratings are published annually for Medicare Advantage (Part C) and Medicare Part D (Prescription Drug) plans.

The Star Rating Program helps Medicare consumers compare plans and make informed health care decisions. The ratings are based on measurements of customer satisfaction and the quality of care a plan provides. The goal is to improve the quality of care and health status for Medicare beneficiaries.

Star rating	Meaning
5 stars	Excellent
4 stars	Above average
3 stars	Average
2 stars	Below average
1 star	Poor

Care Compare website



Hospital

Tahoe Forest Hospital

Overall star rating:
Not available 16

Patient survey rating:
★★★★★

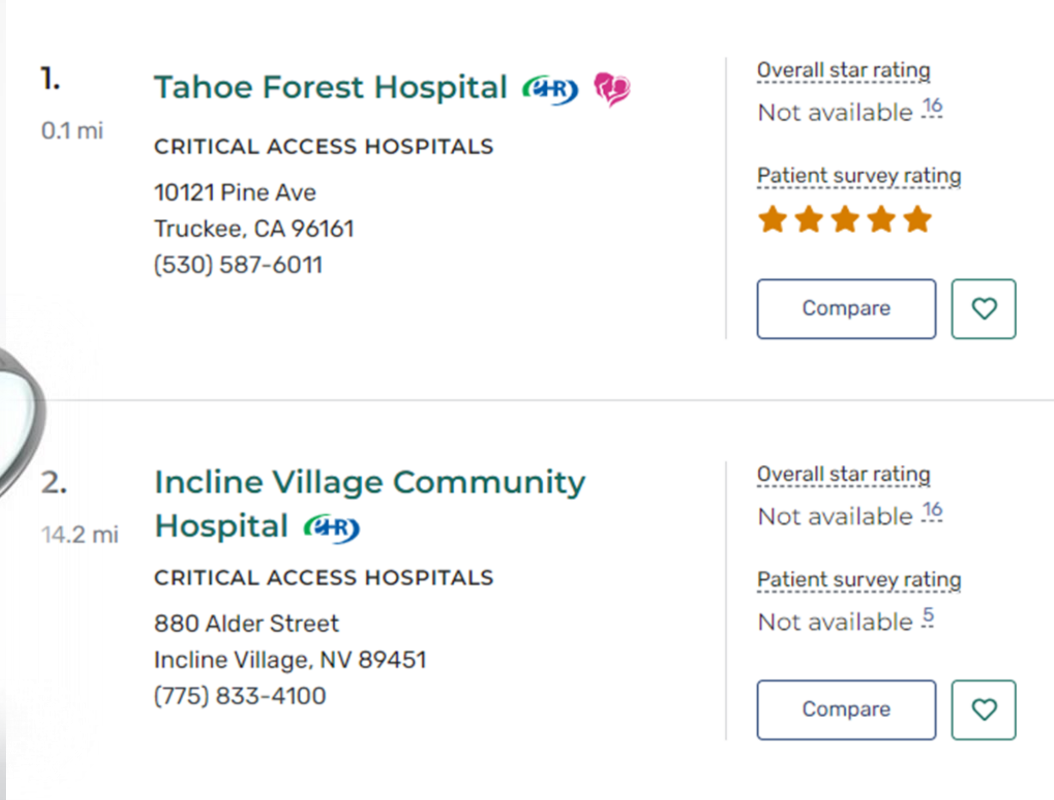
LOCATION
10121 Pine Ave
Truckee, CA 96161

PHONE NUMBER
(530) 587-6011

QUALITY

Choose a category to see how this hospital scores on quality topics:

- Timely & effective care
- Complications & deaths
- Unplanned hospital visits
- Maternal health ›
- Patient-reported outcomes ›
- Psychiatric unit services ›
- Payment & value of care ›



1\. **Tahoe Forest Hospital**
0.1 mi
CRITICAL ACCESS HOSPITALS
10121 Pine Ave
Truckee, CA 96161
(530) 587-6011

Overall star rating
Not available 16

Patient survey rating
★★★★★

2\. **Incline Village Community Hospital**
14.2 mi
CRITICAL ACCESS HOSPITALS
880 Alder Street
Incline Village, NV 89451
(775) 833-4100

Overall star rating
Not available 16

Patient survey rating
Not available 5

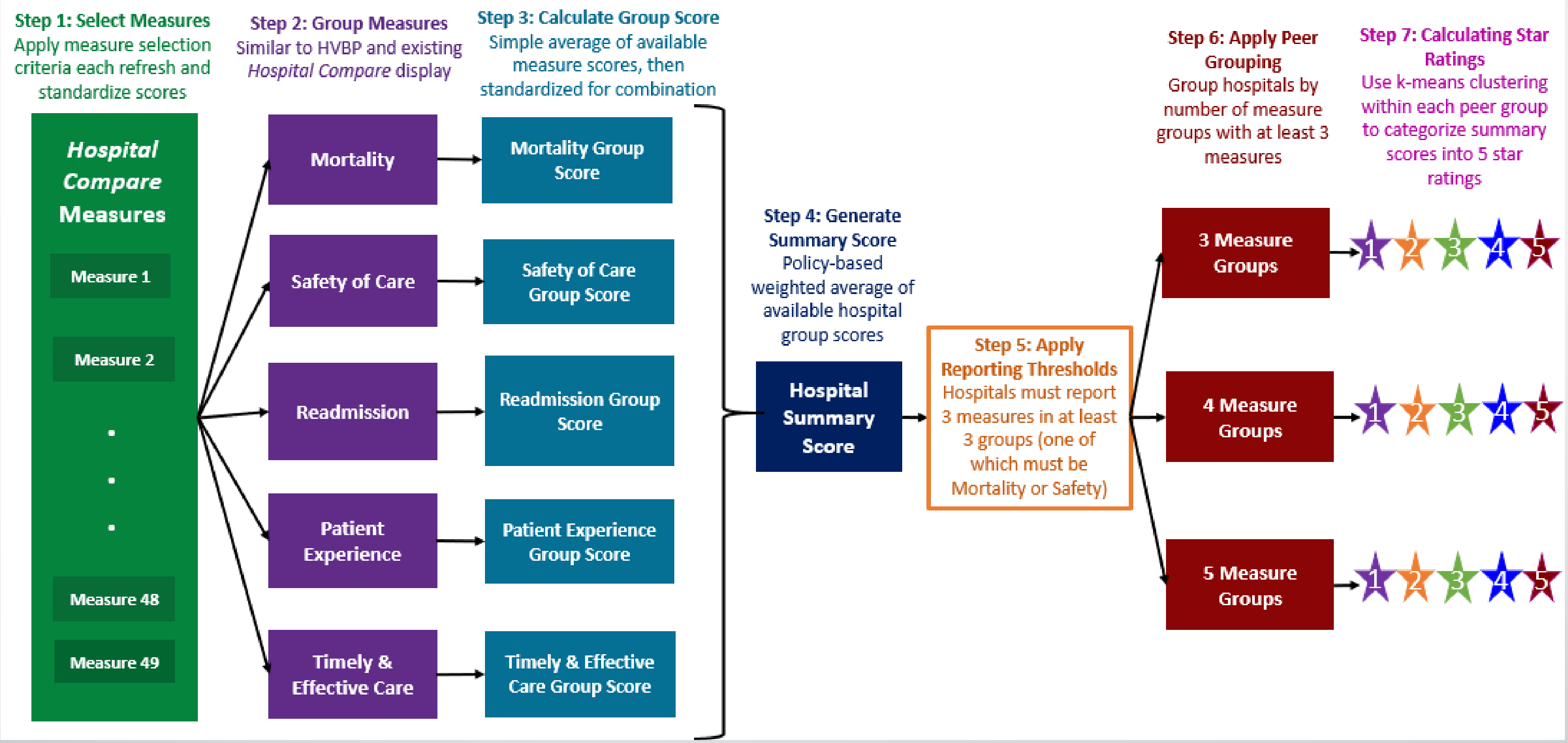
https://www.medicare.gov/care-compare/details/hospital/051328?city=Truckee&state=CA&zipcode=96161#ProviderDetailsQualityIndicatorsContainer

What is needed to receive a Quality Star Rating?

- Only hospitals that met the minimum reporting requirement (***3 measure groups with 3 measures per group, 1 of which must specifically be Mortality or Safety of Care***) will receive the summary score and a Quality Star Rating.
- Our hospital's measure group score is calculated from the individual measure scores and the individual measure weights for measures that are reported.
- Hospitals that do not meet the minimum measure reporting threshold will not receive a summary score or Overall Star Rating.
- Our last quality rating reported July 2023 was 3 stars

TAHOE FOREST HEALTH SYSTEM

Overview of the **NEW** Algorithm



Step 1: Select Measures
Apply measure selection criteria each refresh and standardize scores

***Hospital Compare* Measures**
- Measure 1
- Measure 2
- .
- .
- .
- Measure 48
- Measure 49

Step 2: Group Measures
Similar to HVBP and existing *Hospital Compare* display

- Mortality
- Safety of Care
- Readmission
- Patient Experience
- Timely & Effective Care

Step 3: Calculate Group Score
Simple average of available measure scores, then standardized for combination

- Mortality Group Score
- Safety of Care Group Score
- Readmission Group Score
- Patient Experience Group Score
- Timely & Effective Care Group Score

Step 4: Generate Summary Score
Policy-based weighted average of available hospital group scores

Hospital Summary Score

Step 5: Apply Reporting Thresholds
Hospitals must report 3 measures in at least 3 groups (one of which must be Mortality or Safety)

Step 6: Apply Peer Grouping
Group hospitals by number of measure groups with at least 3 measures

- 3 Measure Groups
- 4 Measure Groups
- 5 Measure Groups

Step 7: Calculating Star Ratings
Use k-means clustering within each peer group to categorize summary scores into 5 star ratings

Clear as mud right?!!!!

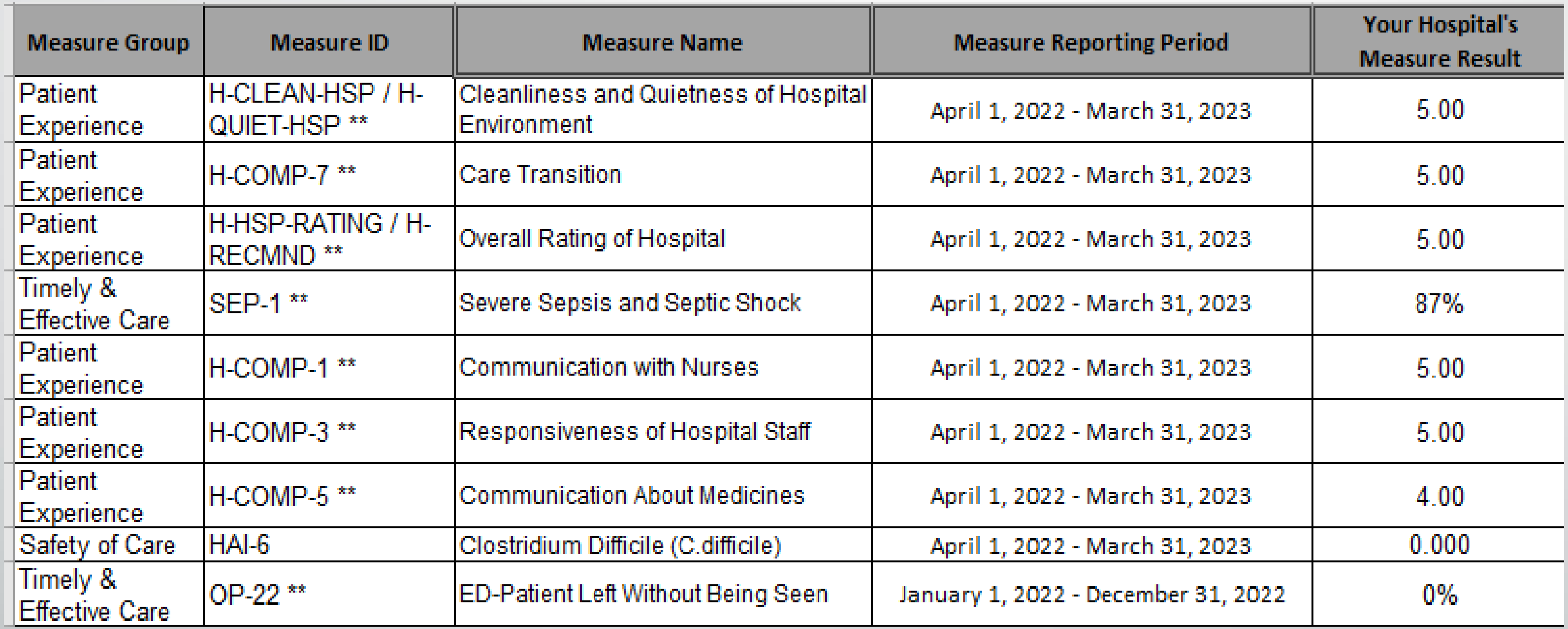
Tahoe Forest Health System

Measures for Tahoe Forest

Timely & Effective Care 12%	Readmission 22%	Patient Experience 22%	Mortality 22%	Safety of Care 22%	Details
Sep-1: Severe Sepsis and Septic Shock	EDAC-30-PN: Excess Days in Acute Care after Hospitalization for Pneumonia (PN) (Claims)	Cleanliness and Quietness of Hospital Environment	MORT-30-PN: Pneumonia (PN) 30-Day Mortality Rate (Claims)	HAI-6: Clostridium Difficile (C.difficile)	**HIGHEST PERFORMING MEASURES LIST FIRST IN ORDER (28 total measures)**
OP-22: ED Left Without Being Seen	OP-36: Hospital Visits after Hospital Outpatient Surgery (Claims)	Care Transition	MORT-30-HF: Heart Failure (HF) 30-Day Mortality Rate (Claims)	COMP-HIP-KNEE: Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA) (Claims)	*****Out of a possible 47 measures, TFH only has enough data for 28-30 scored measures**
IMM-3: Healthcare Personnel Influenza Vaccination	OP-35: Admissions for Patients Receiving Outpatient Chemotherapy (Claims)	Overall Rating of Hospital	MORT-30-COPD: Chronic Obstructive Pulmonary Disease (COPD) 30-Day Mortality Rate (Claims)	**To get a Star Rating we must have at least 3 measures in one of these- Mortality or Safety of Care**	*****if the measure is not from Claims or Press Ganey, it is manually submitted to CMS-HQR portal**
OP-18b: Median Time from ED Arrival to ED Departure for Discharged ED Patients	EDAC-30-HF: Excess Days in Acute Care after Hospitalization for Heart Failure (Claims)	Communication with Nurses			
PC-01: Elective Delivery Prior to 39 Completed Weeks Gestation (retiring)	READM-30-HOSP-WIDE: HWR Hospital-Wide All-Cause Unplanned Readmission (Claims)	Responsiveness of Hospital Staff			**Yellow= we did not get a score for this measure last release**
OP-29: Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients	READM-30-HIP-KNEE: Hospital-Level 30-Day All-Cause Risk- Standardized Readmission Rate (RSRR) Following Elective Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA) (Claims)	Communication About Medicines			
HCP COVID-19:COVID-19 Vaccination Coverage Among HCP	OP-35: Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy (Claims)	Communication with Doctors			
OP-10: Abdomen CT Use of Contrast Material (Claims)		Discharge Information			
Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery (Claims)		****These all come from Press Ganey***			
OP-8: MRI Lumbar Spine for Low Back Pain (Claims)					

Measures come from a variety of sources: claims data, patient satisfaction survey data, & manual submissions
***eCQMs are not included**

Top Measures



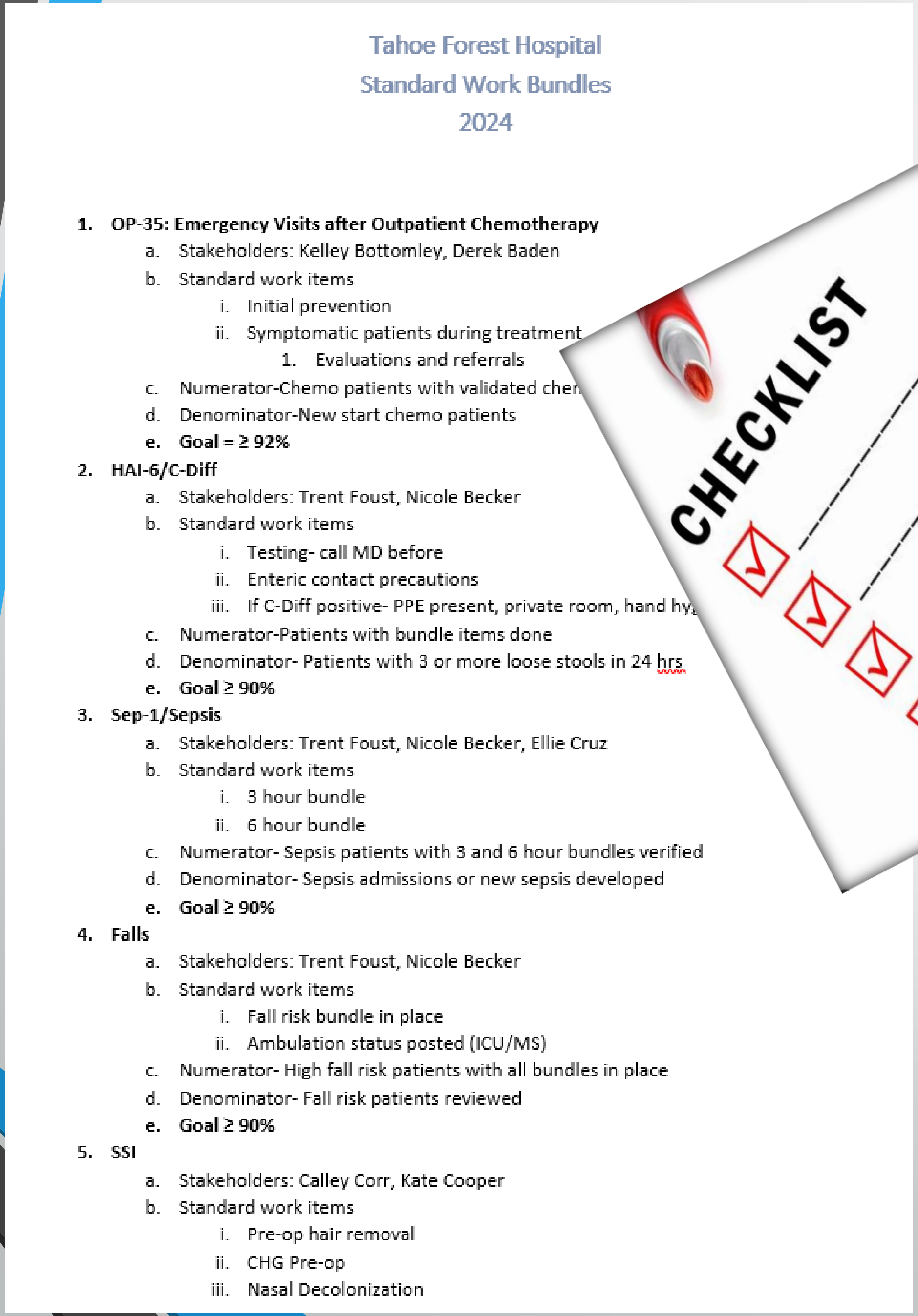
Measure Group	Measure ID	Measure Name	Measure Reporting Period	Your Hospital's Measure Result
Patient Experience	H-CLEAN-HSP / H-QUIET-HSP **	Cleanliness and Quietness of Hospital Environment	April 1, 2022 - March 31, 2023	5.00
Patient Experience	H-COMP-7 **	Care Transition	April 1, 2022 - March 31, 2023	5.00
Patient Experience	H-HSP-RATING / H-RECMND **	Overall Rating of Hospital	April 1, 2022 - March 31, 2023	5.00
Timely & Effective Care	SEP-1 **	Severe Sepsis and Septic Shock	April 1, 2022 - March 31, 2023	87%
Patient Experience	H-COMP-1 **	Communication with Nurses	April 1, 2022 - March 31, 2023	5.00
Patient Experience	H-COMP-3 **	Responsiveness of Hospital Staff	April 1, 2022 - March 31, 2023	5.00
Patient Experience	H-COMP-5 **	Communication About Medicines	April 1, 2022 - March 31, 2023	4.00
Safety of Care	HAI-6	Clostridium Difficile (C.difficile)	April 1, 2022 - March 31, 2023	0.000
Timely & Effective Care	OP-22 **	ED-Patient Left Without Being Seen	January 1, 2022 - December 31, 2022	0%

TAHOE FOREST HEALTH SYSTEM

Summary

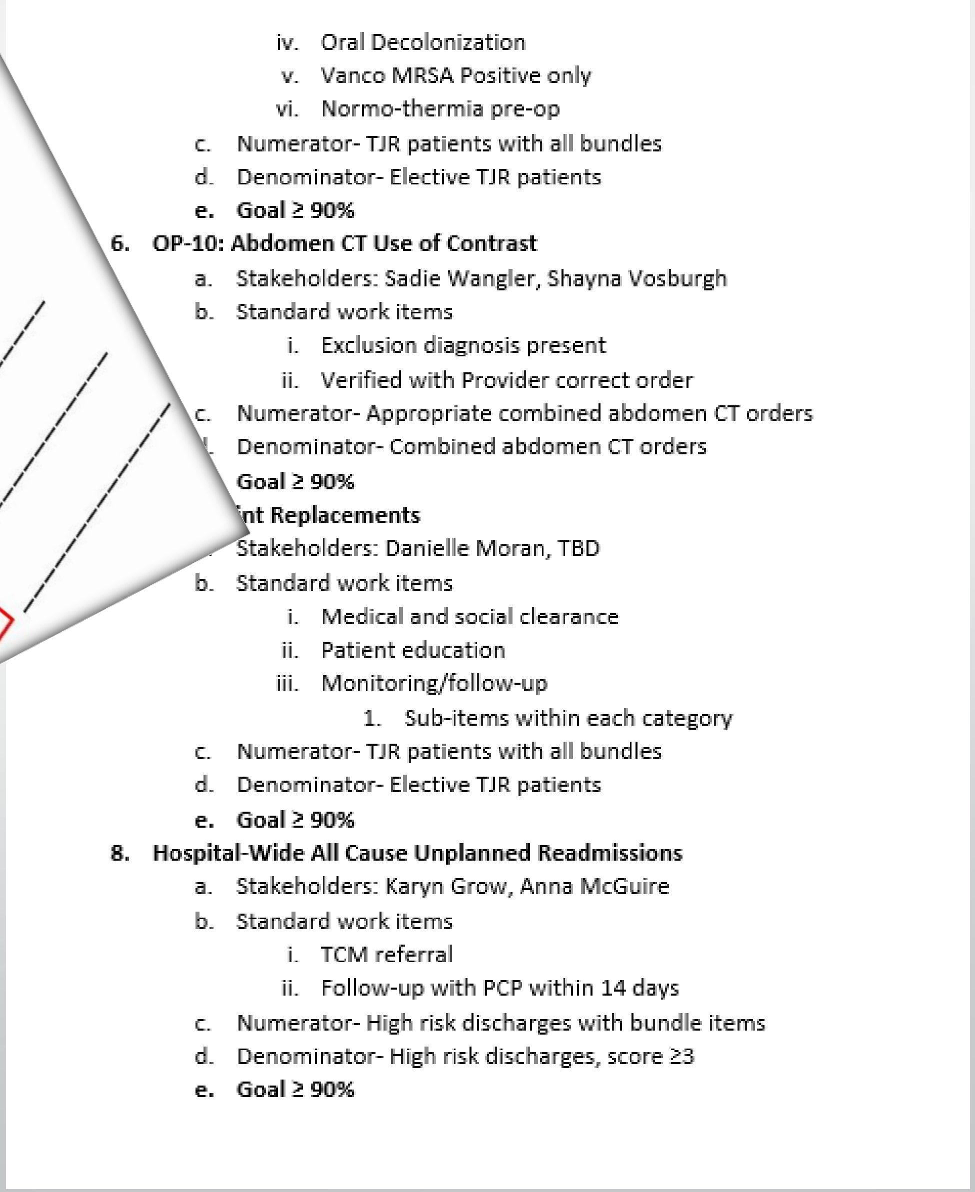
- Perform well on all patient experience measures, sepsis, ED measures, and C-difficile (to name a few)
- Focused improvement efforts include:
  - Documentation and accurate coding that impact all quality measures
  - Readmissions, total joint complications, ED visits after chemotherapy, inappropriate use of contrast and imaging, pneumonia and heart failure mortality
    - Many of the measures we have little control over, i.e., heart failure mortality, and exploring earlier hospice referrals with the Cardiologist, which is an exclusion criteria
    - Discovered Mercy Epic issues and coding are impacting our imaging measures
    - Significant strides in readmissions and complications with our Transitional Care Management (TCM) program and the pre-operative clinic, which optimizes patients before surgery
      - These improvements will be reflected once the reported data is current

Standard Work Bundles



Tahoe Forest Hospital
Standard Work Bundles
2024

1. **OP-35: Emergency Visits after Outpatient Chemotherapy**
   a. Stakeholders: Kelley Bottomley, Derek Baden
   b. Standard work items
      i. Initial prevention
      ii. Symptomatic patients during treatment
         1. Evaluations and referrals
   c. Numerator-Chemo patients with validated che
   d. Denominator-New start chemo patients
   e. Goal = ≥ 92%
2. **HAI-6/C-Diff**
   a. Stakeholders: Trent Foust, Nicole Becker
   b. Standard work items
      i. Testing- call MD before
      ii. Enteric contact precautions
      iii. If C-Diff positive- PPE present, private room, hand hy
   c. Numerator-Patients with bundle items done
   d. Denominator- Patients with 3 or more loose stools in 24 hrs
   e. Goal ≥ 90%
3. **Sep-1/Sepsis**
   a. Stakeholders: Trent Foust, Nicole Becker, Ellie Cruz
   b. Standard work items
      i. 3 hour bundle
      ii. 6 hour bundle
   c. Numerator- Sepsis patients with 3 and 6 hour bundles verified
   d. Denominator- Sepsis admissions or new sepsis developed
   e. Goal ≥ 90%
4. **Falls**
   a. Stakeholders: Trent Foust, Nicole Becker
   b. Standard work items
      i. Fall risk bundle in place
      ii. Ambulation status posted (ICU/MS)
   c. Numerator- High fall risk patients with all bundles in place
   d. Denominator- Fall risk patients reviewed
   e. Goal ≥ 90%
5. **SSI**
   a. Stakeholders: Calley Corr, Kate Cooper
   b. Standard work items
      i. Pre-op hair removal
      ii. CHG Pre-op
      iii. Nasal Decolonization



      iv. Oral Decolonization
      v. Vanco MRSA Positive only
      vi. Normo-thermia pre-op
   c. Numerator- TJR patients with all bundles
   d. Denominator- Elective TJR patients
   e. Goal ≥ 90%
6. **OP-10: Abdomen CT Use of Contrast**
   a. Stakeholders: Sadie Wangler, Shayna Vosburgh
   b. Standard work items
      i. Exclusion diagnosis present
      ii. Verified with Provider correct order
   c. Numerator- Appropriate combined abdomen CT orders
   . Denominator- Combined abdomen CT orders
   Goal ≥ 90%
int Replacements
   Stakeholders: Danielle Moran, TBD
   b. Standard work items
      i. Medical and social clearance
      ii. Patient education
      iii. Monitoring/follow-up
         1. Sub-items within each category
   c. Numerator- TJR patients with all bundles
   d. Denominator- Elective TJR patients
   e. Goal ≥ 90%
8. **Hospital-Wide All Cause Unplanned Readmissions**
   a. Stakeholders: Karyn Grow, Anna McGuire
   b. Standard work items
      i. TCM referral
      ii. Follow-up with PCP within 14 days
   c. Numerator- High risk discharges with bundle items
   d. Denominator- High risk discharges, score ≥3
   e. Goal ≥ 90%

What is our GOAL?

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
Five-Star Quality Rated

CMS
5-Star
RATED
QUALITY CARE
2022

Goal update discussion

- Due to our inability to meet ***3 measure groups with 3 measures per group, 1 of which must specifically be Mortality or Safety of Care*** we will not have a Quality Star rating
- CMS Care Compare data is old (2020-2023 timeframe)
- TFHD goal is to improve 3 out of 8 below benchmark quality metrics
- Should we add compliance with the standard work bundles or improved quality metrics as noted on the BOD Quality dashboard?


ANY
QUESTIONS?

Health Equity Regulations

Janet Van Gelder, RN, DNP, CPHQ

Director of Quality & Regulations

CMS hospital commitment to health equity

- Expand and standardize the collection and analysis of data, including data on race, ethnicity, preferred language, sexual orientation, gender identity, disability, income, geography, health-related social needs, and other factors.
- Annual attestation of the following 5 areas is posted on CMS Compare as of 2024
  - Equity is a strategic priority
  - Data collection and analysis
  - Quality improvement
  - Leadership engagement
- score can be a total of 0 to 5 points (one per area). The measure score is based on the total number of areas the hospital has successfully fulfilled.
- shows a hospital's commitment to health equity for racial and ethnic minority groups, people with disabilities, members of the LGBTQ+ communities, people with limited English proficiency, rural populations, religious minorities, and people facing socioeconomic challenges (social determinants of health).

CMS Health Equity fact sheet

Find Healthcare Providers: Compare Care Near You | Medicare

Nevada Revised Statutes 239B.026

- requires the collection of sexual orientation and gender identity (SOGI) or expression data on forms that also request race/ethnicity data
- annual confidential data report to the Director of the Legislative Counsel Bureau on December 31st of each year
- includes a summary of the information received related to SOGI, including the number of people who identify as lesbian, gay, bisexual or transgender according to race and gender

NRS: CHAPTER 239B - DISCLOSURE OF PERSONAL INFORMATION TO GOVERNMENTAL AGENCIES

California Assembly Bill 1204

- requires California-licensed hospitals to submit an annual hospital equity report to the California Department of Health Care Access and Information (HCAI)
- requires the Department of Health Care Access and Information (HCAI) to develop and administer a hospital equity report program to collect and post hospital equity reports
- required to include measures on patient access, quality, and outcomes by race, ethnicity, language, disability status, sex assigned at birth, sexual orientation, gender identity, and payor
- required to include a plan to prioritize and address disparities for vulnerable populations identified in the data and as specified by the Advisory Committee
- reporting period is January 1 to December 31 of the year prior to the year that a report is due with the first report due by September 30, 2025
- $500 per day fine for not reporting up to $5000 total

Hospital Equity Measures Reporting Program – HCAI

Bill Text - AB-1204 Hospital equity reporting.

California Assembly Bill 3161

- A process for a team of facility staff to conduct analyses, including, but not limited to, root cause analyses of patient safety events. The process shall also include analyses of patient safety events, including the following sociodemographic factors, to identify disparities in these events:
  - (A) Age
  - (B) Race
  - (C) Ethnicity
  - (D) Gender identity
  - (E) Sexual orientation
  - (F) Preferred language spoken
  - (G) Disability status
  - (H) Payor
  - (I) Sex
- Commencing January 1, 2026, and biannually thereafter, health facilities shall submit patient safety plans to CDPH.
- CDPH may impose a fine not to exceed five thousand dollars ($5,000) on health facilities for failure to adopt, update, or submit patient safety plans.

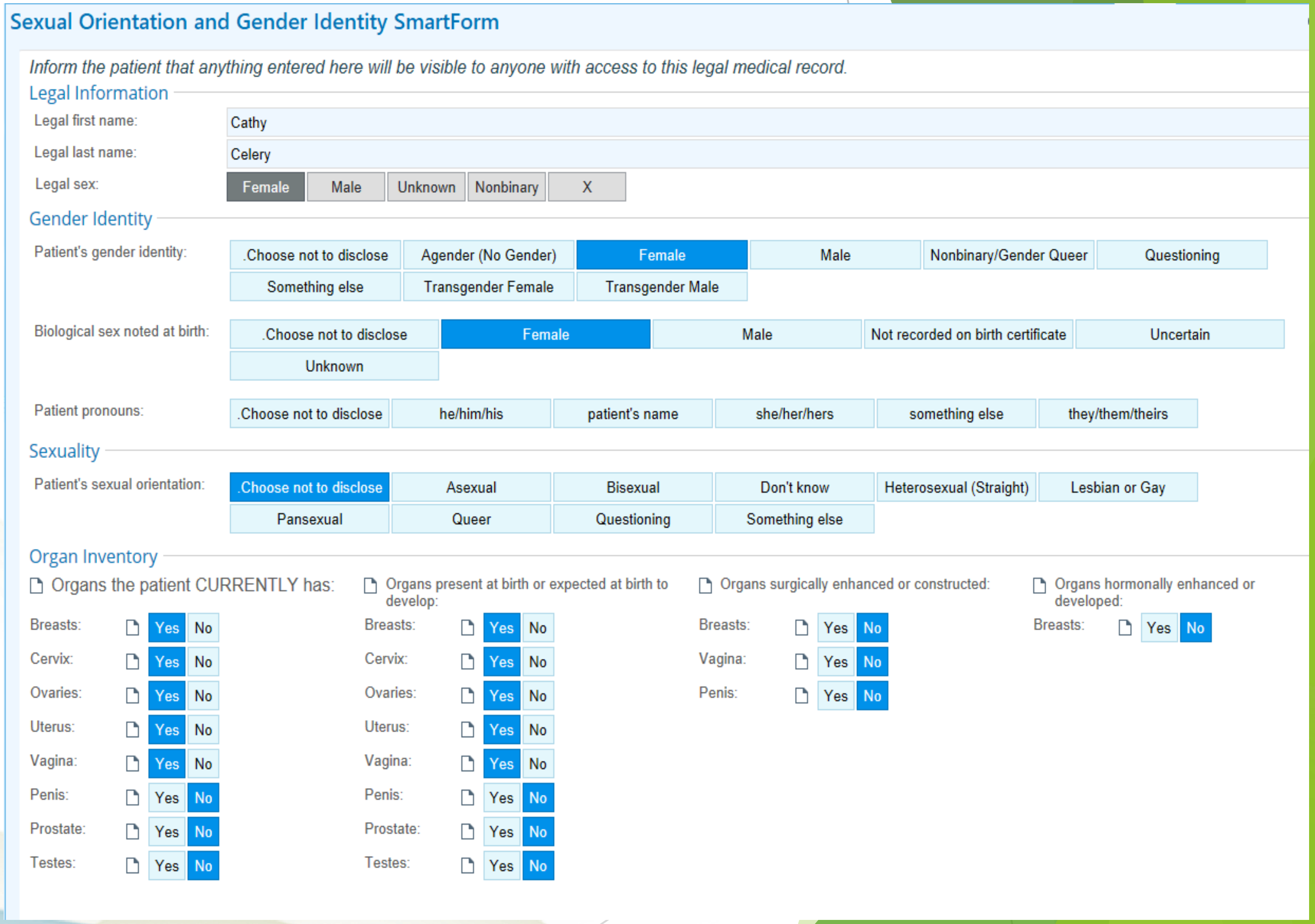
Bill Text - AB-3161 Health facilities: patient safety and antidiscrimination.

Mercy Epic

Smartform Details

Includes information on:

- Legal sex:
- Gender identity
- Patient pronouns
- Sexual orientation
- Organ Inventory



Sexual Orientation and Gender Identity SmartForm

Inform the patient that anything entered here will be visible to anyone with access to this legal medical record.

Legal Information

Legal first name: Cathy

Legal last name: Celery

Legal sex: [✓ Female] Male Unknown Nonbinary X

Gender Identity

Patient's gender identity: Choose not to disclose Agender (No Gender) [✓ Female] Male Nonbinary/Gender Queer Questioning Something else Transgender Female Transgender Male

Biological sex noted at birth: Choose not to disclose [✓ Female] Male Not recorded on birth certificate Uncertain Unknown

Patient pronouns: Choose not to disclose he/him/his patient's name she/her/hers something else they/them/theirs

Sexuality

Patient's sexual orientation: [✓ Choose not to disclose] Asexual Bisexual Don't know Heterosexual (Straight) Lesbian or Gay Pansexual Queer Questioning Something else

Organ Inventory

Organs the patient CURRENTLY has:

Breasts: [✓ Yes] No
Cervix: [✓ Yes] No
Ovaries: [✓ Yes] No
Uterus: [✓ Yes] No
Vagina: [✓ Yes] No
Penis: Yes [✓ No]
Prostate: Yes [✓ No]
Testes: Yes [✓ No]

Organs present at birth or expected at birth to develop:

Breasts: [✓ Yes] No
Cervix: [✓ Yes] No
Ovaries: [✓ Yes] No
Uterus: [✓ Yes] No
Vagina: [✓ Yes] No
Penis: Yes [✓ No]
Prostate: Yes [✓ No]
Testes: Yes [✓ No]

Organs surgically enhanced or constructed:

Breasts: Yes [✓ No]
Vagina: Yes [✓ No]
Penis: Yes [✓ No]

Organs hormonally enhanced or developed:

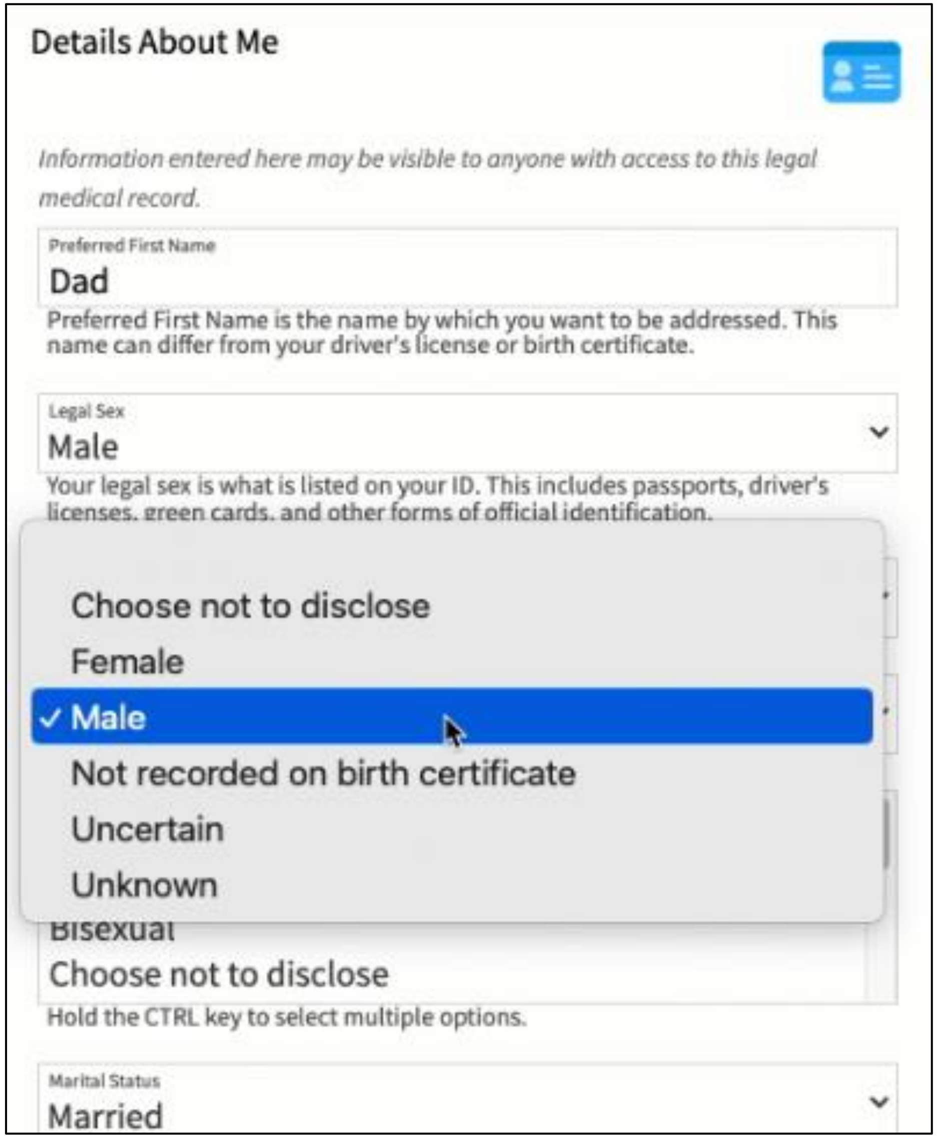
Breasts: Yes [✓ No]

Implementation Plan

- Utilize MyChart to obtain the SOGI information
- MyChart educational note sent out on 4/14/25 & 5/12/25 regarding the regulatory requirement and how to complete in MyChart
- Patient Registration staff will continue to obtain the legal sex information
- RN will complete the SOGI in the IP or OB Nurse Admission Navigator
- Education Department will assign *Communicating About Sensitive Information With Patients With Expansive Gender* training module for patient registration & hospital based clinical staff
- IT developed TFHD specific tip sheets that have been distributed by Education
- IT initiated the MyChart functionality and SOGI module April 14, 2025
- Marketing posted an overview of the SOGI regulations on tfhd.com website

https://www.dynahealth.com/nursing-skills/communicating-about-sensitive-information-with-patients-with-expansive-gender

MyChart



Details About Me

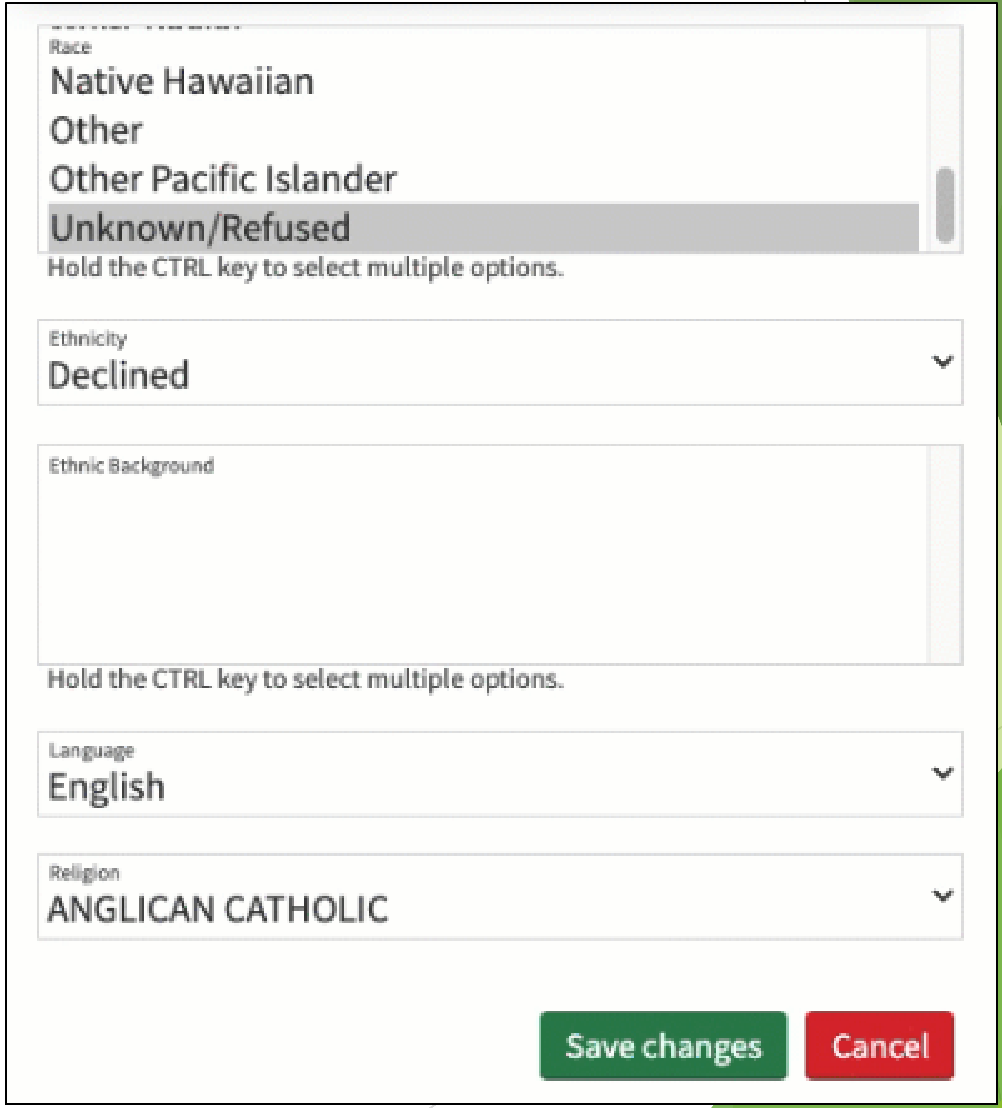
Information entered here may be visible to anyone with access to this legal medical record.

Preferred First Name
Dad
Preferred First Name is the name by which you want to be addressed. This name can differ from your driver's license or birth certificate.

Legal Sex
Male
Your legal sex is what is listed on your ID. This includes passports, driver's licenses, green cards, and other forms of official identification.

Bisexual
Choose not to disclose
Hold the CTRL key to select multiple options.

Marital Status
Married



Race
Native Hawaiian
Other
Other Pacific Islander
Unknown/Refused
Hold the CTRL key to select multiple options.

Ethnicity
Declined

Ethnic Background

Hold the CTRL key to select multiple options.

Language
English

Religion
ANGLICAN CATHOLIC

Questions


HEALTH EQUITY
race
gender
quality
difference
care
age
equity
health
healthcare
education
age
injury
society
discrimination
ethnicity
society
disease
opportunities
mental
health
equity
treatment
insurance
location
opportunities
policy
care
practice
disparity
mortality
practice
policy
disease
injury
disability
location
race
difference
insurance
system
testing
health

CMS Framework for Health Equity 2022–2032

GO.CMS.GOV/OMH

Contents

CMS Office of Minority Health Director's Foreword

> "As the nation's largest health insurer, the Centers for Medicare & Medicaid Services has a critical role to play in driving the next decade of health equity for people who are underserved. Our unwavering commitment to advancing health equity will help foster a health care system that benefits all for generations to come."

Dr. Martin Mendoza, Director, CMS Office of Minority Health,
Chief Health Equity Officer, CMS

The *CMS Framework for Health Equity* provides a strong foundation for our work as a leader and trusted partner dedicated to advancing health equity, expanding coverage, and improving health outcomes. This includes strengthening our infrastructure for assessment, creating synergies across the health care system to drive structural change, and identifying and working together to eliminate barriers to CMS-supported benefits, services, and coverage for individuals and communities who are underserved or disadvantaged and those who support them.

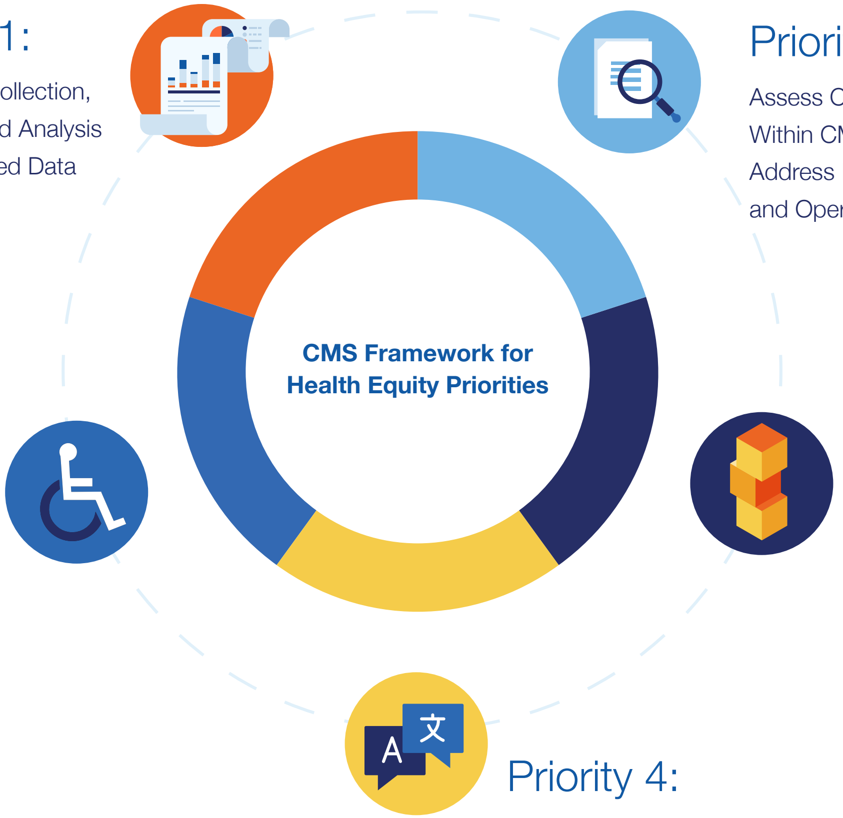
Across our Centers and Offices, we are committing to taking an integrated, action-oriented approach to advance health equity among members of communities, providers, plans, and other organizations serving such communities, who are underserved or disadvantaged.

We strive to identify and remedy systemic barriers to equity so that every one of the people we serve has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

This Framework challenges us to incorporate health equity and efforts to address health disparities as a foundational element across all our work, in every program, across every community. We are designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our enrollees need to thrive.

Executive Summary

CMS is the largest provider of health insurance in the United States, responsible for ensuring that more than 170 million individuals supported by CMS programs (i.e., Medicare, Medicaid, Children's Health Insurance Program (CHIP), and the Health Insurance Marketplaces) are able to get the care and health coverage they need and deserve.[1] Consistent with the Department of Health and Human Services' Healthy People 2030 Framework,[2] CMS recognizes that addressing health and health care disparities and achieving health equity should underpin efforts to focus attention and drive action on our nation's top health priorities. CMS defines health equity as the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.[3]



Priority 1:

Expand the Collection, Reporting, and Analysis of Standardized Data

Priority 2:

Assess Causes of Disparities Within CMS Programs, and Address Inequities in Policies and Operations to Close Gaps

Priority 3:

Build Capacity of Health Care Organizations and the Workforce to Reduce Health and Health Care Disparities

Priority 4:

Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services

Priority 5:

Increase All Forms of Accessibility to Health Care Services and Coverage

The *CMS Framework for Health Equity* is consistent with the Healthy People 2000 Framework which first incorporated health equity as a guiding objective as well as other efforts undertaken across HHS to address health equity and disparities reduction as a critical aspect of health and health care. The Framework is also consistent with the bold goals CMS Centers and Offices have articulated in our program areas, including Medicaid and CHIP and the CMS Innovation Center.[4, 5] This Framework reinforces the concept that in order to attain the highest level of health for all people, we must give our focused and ongoing attention to address avoidable inequalities and eliminate health and health care disparities.[6]

Consistent with Executive Order 13985 on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government, the term "underserved communities" refers to populations sharing a particular characteristic, including geographic communities that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life, as exemplified in the definition of "equity."[7] This includes members of racial and ethnic communities, people with disabilities, members of the lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community, individuals with limited English proficiency, members of rural communities*, and persons otherwise adversely affected by persistent poverty or inequality.[8, 9]

This plan focuses on people who experience, or serve those who experience, disproportionately high burdens of disease, worse quality of care and outcomes, and barriers to accessing care. The *CMS Framework for Health Equity* was developed with particular attention to disparities in chronic and infectious diseases such as diabetes, chronic kidney disease, cancer, dementia, cardiovascular disease, maternal and infant health, behavioral health, as well as HIV/AIDS, and COVID-19, which disproportionately impact members of underserved communities due to prevalence, complexity, and social risk factors.[10, 11, 12, 13, 14, 15, 16] This plan also considers the impacts natural disasters (e.g., earthquakes, fires, viral outbreaks) and manmade disasters (e.g., oil spills, lead poisoning, climate change) have on specific communities — both during an event and in response and recovery — as health and social risk factors may work together to cause or worsen existing health and health care disparities.[17, 18, 19, 20, 21]

This *CMS Framework for Health Equity* updates the previous Medicare-focused *CMS Equity Plan for Improving Quality in Medicare* [22] with an enhanced and more comprehensive 10-year approach to further embed health equity across all CMS programs including Medicare, Medicaid, CHIP, and the Health Insurance Marketplaces.

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* In referencing members of rural communities, we are inclusive of individuals in frontier areas, tribal lands, and those residing in the U.S. territories.

The updated *CMS Framework for Health Equity* also brings focus to CMS's work supporting health care organizations, health care professionals and partners — providers, health plans, federal, state, and local partners, tribal nations, individuals and families, quality improvement partners, researchers, policymakers, and other stakeholders — in activities to achieve health equity. The initial *CMS Equity Plan for Improving Quality in Medicare* identified high-impact priorities based on stakeholder engagement, a review of the evidence base, and discussions across HHS, CMS, and among federal partners. This enhanced and expanded *CMS Framework for Health Equity* refines CMS's health equity priorities and broadens our focus beyond Medicare. It is informed by the seven interim years of stakeholder input, evidence review, and knowledge and understanding gained through the Agency's work. The five priorities of this new, enhanced, and comprehensive *CMS Framework for Health Equity* are described in detail throughout this plan. These priorities encompass both system and community-level approaches to achieve equity across CMS programs. Each of the priorities are complementary, and their integrated adoption and implementation is central to the elimination of barriers to health equity for all Americans.

This plan aligns with the federal government's goal in advancing equity, which is to provide everyone with the opportunity to reach their full potential.[23] Consistent with this aim, the *CMS Framework for Health Equity* supports CMS's ability to assess whether, and to what extent, its programs and policies perpetuate or exacerbate systemic barriers to opportunities and benefits for the communities referenced above. This includes understanding and addressing the ways in which Medicare, Medicaid, CHIP, and the Health Insurance Marketplaces (Marketplaces) meet the needs of those we serve, particularly underserved communities and individuals.

CMS will identify, establish, and monitor progress of our efforts across the Agency. We will draw on CMS data and other available sources to monitor and assess whether disparities in health and health care quality, access, and outcomes are improving across CMS programs and among the individuals we serve. Our progress in advancing health equity will reflect our commitment to continuous quality improvement for all individuals, and we will incorporate ongoing input from those that participate in CMS programs — our communities, providers, plans, and other partners — to help us innovate and improve over time. True success will be realized only when all those served by CMS have achieved their highest level of health and well-being, and that we have eliminated disparities in health care quality and access. While this vision may not be fully attainable in the ten-year horizon of this plan, we will report on our progress and continuously identify opportunities to improve.

Aligning with CMS and HHS

The United States has made progress towards improving health care quality, but well-documented disparities persist for members of racial and ethnic communities, people with disabilities, members of the LGBTQ+ community, individuals with limited English proficiency, members of rural communities, and persons otherwise adversely affected by persistent poverty or inequality.[24, 25, 26, 27] CMS promotes health equity by using policy levers and program authorities and engaging health care stakeholders across settings and communities. We consistently identify and disseminate new and promising practices and embed health equity into CMS programs to better meet the needs of all communities — particularly underserved communities. In addition, we facilitate knowledge sharing and collaboration among stakeholders and engage with new audiences to expand and extend efforts to achieve equity. In particular, CMS leverages existing and new quality improvement initiatives to support and amplify best practices that are proven to address social risk factors and unmet social needs and reduce disparities.

The *CMS Framework for Health Equity* is structured to align with HHS initiatives that seek to achieve health equity and reduce disparities among minority and underserved populations. This includes the Healthy People 2030 Framework,[28] which establishes the foundational principle that "achieving health and well-being requires eliminating health disparities, achieving health equity, and attaining health literacy."[29] This also includes but is not limited to Department-wide strategies and approaches to embedding health equity across our program — for example, the HHS Rural Action Plan,[30] the HHS Maternal Health Action Plan,[31] the HHS National Standards for Culturally and Linguistically Appropriate Standards (CLAS) in Health and Health Care,[32] the HHS National Quality Strategy,[33] and the IHS Strategic Plan which ensures that across HHS we are providing federal health services to American Indian and Alaska Native people.[34] Healthy People 2030 also outlines a Social Determinants of Health (SDOH) Framework[35] with five domains including economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. Healthy People 2030 and related work across HHS underscores that social risk factors and unmet social needs contribute to wide health and health care disparities and inequities. Stakeholders across the health care spectrum have a role to play in addressing social determinants of health.[36]

Of primary and critical importance, the *CMS Framework for Health Equity* aligns across CMS initiatives and other existing strategy documents such as the Administrator's Strategic Vision for CMS,[37] the CMS Rural Health Strategy,[38] the CMS Quality Strategy,[39] the CMS Innovation Center's Strategy Refresh,[40] and CMS's Strategic Vision for Medicare and CHIP.[41] These strategies focus on eliminating disparities as a cross-cutting criteria to be applied throughout the Agency's work. The *CMS Framework for Health Equity* also aligns with other Agency-wide efforts, particularly strengthening infrastructure and data systems, empowering individuals, families, and caregivers as partners in their health care, and addressing the need for measures for population-based payment through alternative payment models. Work across these areas supports the Agency in monitoring trends in quality of care and health outcomes, learning directly from the communities and families CMS serves, and incorporating population health improvement activities into measurement and payment. All of these activities are essential to achieving health equity across care settings and health conditions.

Priorities for the 2022–2032 *CMS Framework for Health Equity*

The next section of the *CMS Framework for Health Equity* outlines five priorities that inform CMS's efforts for the next ten years and how the Agency may operationalize each priority to achieve health equity and eliminate disparities. Each priority area reflects a key area in which CMS stakeholders from communities that are underserved and disadvantaged express that CMS action is needed and critical to advancing health equity. Together, the five priorities provide an integrated approach to build health equity into existing and new efforts by CMS and our stakeholders.

Priority 1: Expand the Collection, Reporting, and Analysis of Standardized Data

CMS strives to improve our collection and use of comprehensive, interoperable, standardized individual-level demographic and SDOH data, including race, ethnicity, language, gender identity, sex, sexual orientation, disability status, and SDOH. By increasing our understanding of the needs of those we serve, including social risk factors and changes in communities' needs over time, CMS can leverage quality improvement and other tools to ensure all individuals have access to equitable care and coverage.

Priority 2: Assess Causes of Disparities Within CMS Programs, and Address Inequities in Policies and Operations to Close Gaps

CMS is committed to move beyond observation and into action, assessing our programs and policies for unintended consequences and making concrete, actionable decisions about our policies, investments, and resource allocations. Our goals are to explicitly measure the impact of our policies on health equity, to develop sustainable solutions that close gaps in health and health care access, quality, and outcomes, and to invest in solutions that address health disparities.

Priority 3: Build Capacity of Health Care Organizations and the Workforce to Reduce Health and Health Care Disparities

CMS has a commitment to support health care providers, plans, and other organizations who ensure individuals and families receive the highest quality care and services. Health care professionals, particularly those serving minority and underserved communities, have a direct link to individuals and families and can address disparities at the point of care. CMS policy, program, and resource allocation decisions must build capacity among providers, plans, and other organizations to enable stakeholders to meet the needs of the communities they serve.

Priority 4: Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services

CMS must ensure that all individuals we serve, including members of communities that are underserved, can equitably access all CMS benefits, services and other supports, and coverage. Language access, health literacy, and the provision of culturally tailored services play a critical role in health care quality, patient safety and experience, and can impact health outcomes. CMS has opportunities across our operations, direct communication and outreach to enrollees and consumers, and guidance to plans, providers, and other partners to improve health care quality, patient safety, and the experience individuals have within the health care system.

Priority 5: Increase All Forms of Accessibility to Health Care Services and Coverage

CMS has a responsibility to ensure that individuals and families can access health care services when and where they need them, in a way that is responsive to their needs and preferences. CMS must seek direct feedback from individuals with disabilities, including physical, sensory and communication, intellectual disabilities, and other forms of disability, to understand their experiences navigating CMS-supported benefits, services, and coverage and tailor our programs and policies to ensure equitable access and quality.

Priority 1: Expand the Collection, Reporting, and Analysis of Standardized Data

A growing body of literature suggests that increasing the collection of standardized demographic and language data across health care systems is an important first step towards improving population health.[42, 43, 44, 45] In addition, certain settings — including Post-Acute Care and Home and Community Based Services — offer unique opportunities to connect individuals with social services while receiving health care services and as they transition across care settings. Data on social risk factors, experience of care, and comprehensive patient demographic data, including race, ethnicity, language, gender identity, sex, sexual orientation, and disability status is a valuable tool for quality improvement. This data collection should be voluntary for individuals to ensure individuals are protected, and existing data should be leveraged to ensure alignment across HHS and other federal agencies. Increasing available standardized data across settings and programs enables CMS and our stakeholders to address changes in populations over time and leverage information to connect individuals to appropriate and needed social services and supports. This also includes understanding and standardizing data collection across other federal agencies serving underserved communities, including tribal communities, rural communities, and programs with benefits that address individuals' social risk factors and unmet social needs.

Health outcomes and experience of care are driven by the conditions in the environment, or SDOH, where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[46] For example, individuals with unmet social needs including inadequate access to food or stable housing are at greater risk of developing chronic conditions and experience more difficulty managing those conditions.[47] Communities experiencing persistent poverty or inequality tend to disproportionately experience unmet social needs. Communities may experience structural barriers which can create disparities including exposure to toxins and environmental hazards, limited choice and access to health care services, and can lead to widespread viral transmission across communities — creating sickness and diminishing opportunities to seek appropriate care.[48, 49] Further, because of social risk factors or underlying health risks, some communities may also experience disproportionate impacts of natural and manmade disasters and require unique or tailored emergency response services or treatment.[50, 51] Healthy People 2030 groups SDOH into five domains, including economic stability, educational access and quality, health care access and quality, neighborhood and built environment, and social and community context. SDOH data can include information on health literacy, transportation, social isolation, housing insecurity, food insecurity, geography, and more.[52]

For Example: In the FY2020 Prospective Payment System Rules for Post-Acute Care Settings Including Skilled Nursing Facilities,[53] Inpatient Rehabilitation Facilities,[54] Home Health Agencies,[55] and Long-Term Care Hospitals,[56] CMS added seven Standardized Patient Assessment Data Elements (SPADEs) to the patient assessment tools related to demographic and SDOH data. Patient assessments now collect race, ethnicity, preferred language, need for interpreter, health literacy, transportation and social isolation for the first time, giving CMS and our stakeholders the ability to tailor programs and policies in post-acute care settings based on needs and disparities.

Developments in health information technology have significantly improved the ability to measure disparities at the provider level.[57] The need for complete and accurate demographic and SDOH data is promoted widely within the provider community and encouraged by federal programs and policies. In addition, individuals' use of technology can help CMS leverage patient self-reported data obtained through technology among certain underserved communities. For example, about 8 in 10 White, Black, and Hispanic adults own a smartphone; about a quarter of Black and Hispanic adults primarily access the internet using mobile devices, meaning they may lack traditional broadband internet and use smartphones to access information online.[58] However, underserved communities have higher rates of cut off or suspended smartphone service.[59] If individuals have a smartphone and are able to reliably use the device to access the internet, this technology can help CMS harness data directly from individuals we serve to augment provider data collection. However, CMS must be mindful of the disparities in access to technology among underserved or disadvantaged communities, including rural areas and Indian reservations lacking broadband access, and ensure that provider and patient self-reported data collection is standardized and accessible across settings, regions, and communities such that no individual the Agency serves is excluded.

Demographic, SDOH, and social risk factor information can help drive quality improvement and dramatically improve CMS's ability to evaluate changes in the prevalence of SDOH and social risk factors, and their influence on health outcomes. To ensure individual choice and privacy, this data collection should be voluntary. However, CMS may use information it is able to collect and leverage from other sources to support health care organizations in building strategic relationships with other local community partners to better understand and meet patients' unmet social needs. Better quality, linked data can also enhance emergency and disaster readiness, response, and recovery as federal agencies seek to target resources and tailor policies. For these reasons, data standardization, interoperability, and accessibility of one's own clinical information are critical to improving health outcomes.

CMS's collaboration with the HHS Office of the National Coordinator for Health Information Technology (ONC) and others to advance interoperability and bring administrative and clinical data together is important not just to identify patients with social risk factors, but also to make sure individuals in underserved communities and their providers have access, as appropriate, to the information they need for decision-making. Examples of initiatives under which HHS and CMS are working in partnership include, but are not limited to: the 2011 HHS Data Standards,[60] United States Core Data for Interoperability (USCDI) standards,[61] HHS Disparities Action Plan,[62] HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) Social Risk and Medicare's Value Based Purchasing Programs Report to Congress,[63] CMS Accountable Health Communities Model,[64] data elements in CMS surveys and assessments including the SPADEs[65] collected across Post-Acute Care settings and Consumer Assessment of Healthcare Providers & Systems (CAHPS)[66] surveys collected across all health care settings, meaningful use incentives, and the ONC's interoperability initiatives addressing social determinants of health data elements.[67, 68, 69, 70]

CMS will continue to work within our Agency's statutory authorities to strengthen our collection of accurate and reliable data on social risk factors and SDOH across health care settings and systems and in doing so, will also seek to better understand and address the barriers to collecting and using this data. Across our Centers and Offices, CMS is committed to improving data collection and reporting. For example, the CMS Innovation Center will require all new model participants to collect and report demographic data of their enrollees and, as appropriate, data on social needs and SDOH. We are also mindful of the need to ensure privacy and safety of individuals' personal health information and protection from data breaches and discrimination, and data would be collected in a manner that complies with HIPAA and all other applicable laws.[71] In addition, Medicaid and CHIP are centrally focused on ensuring our data is accurate and that we can measure progress against a baseline with clear, consistent, and comparable stratification of critical quality and outcome metrics across the program. To advance these aims, CMS will work with states to improve measurement of health disparities across a core set of stratified metrics.[72]

Through collaboration with federal and external partners, we will work to advance our shared goal of standardized collection of these data elements. This collaborative effort supports the health care system in driving improvements where they can have the greatest impact on health equity and reducing disparities. Further, it underpins CMS's — and the federal government's — ability to have data-driven responses to public health emergencies, disasters, and public health threats, and ensure we are responsive and appropriate in meeting the needs of underserved communities in times of crisis.

Priority 2: Assess Causes of Disparities Within CMS Programs, and Address Inequities in Policies and Operations to Close Gaps

CMS programs support the health of millions of individuals. This makes the Agency a critical engine for opportunities to center health equity in the delivery of health care, rulemaking, and policy development, related to benefit and payment design, data collection, quality improvement, and research. Several CMS programs and initiatives, such as the Network of Quality Improvement and Innovation Contractors,[73] the Center for Medicaid & CHIP Services Quality Improvement Program,[74] the Quality Payment Program,[75] Health Insurance Marketplace Quality Initiatives,[76] and Center for Medicare & Medicaid Innovation[77] models and demonstrations, have stated that health equity and disparity reduction are a focus area or guiding principle.[78, 79, 80, 81, 82] CMS is developing consistent ways to assess each program's impact on health equity and engineering tailored solutions across communities and settings of care. Many opportunities exist across Medicare, Medicaid, CHIP, and the Health Insurance Marketplaces to enhance our understanding of how these programs impact unique communities and to design and test solutions. CMS continues to seek ways to systematically evaluate and assess our programs, policies, and operations for health equity impacts and drivers of disparities and strengthen our approach to care delivery, measurement, and payment to advance health equity among those we serve.

For example, HHS ASPE's Reports to Congress as mandated by the IMPACT Act[83] assessed the extent to which Medicare's value-based purchasing programs can and should account for individuals' social risk factors. Informed by HHS ASPE's Report to Congress, CMS has several options to further evaluate the impact that social risk factors have on payment and value-based purchasing programs. Deepening our understanding of the relationship between social risk factors and payment can help us identify drivers of disparities across programs and policies, and facilitate CMS-driven equity solutions related to unmet social needs that directly impact populations to reduce these disparities. In addition, as CMS centers health equity in health and health care, we may consider exploring opportunities to collaborate with our network of partners to engineer or test more proactive approaches to reducing disparities.

For Example: The CMS Innovation Center is focused on understanding the current impacts of its models across all patients and identifying areas for reducing inequities at the population level. One such example is the Medicare Advantage Value Based Insurance Design (VBID)[84] Model's Health Equity Incubation Program.[85] This Incubation Program is geared to help Medicare Advantage plans identify disparities among their enrollees and utilize flexibilities available through the VBID Models to close gaps and advance health equity by targeting enrollees who are eligible for a certain low-income subsidy or have chronic conditions.

This could include leveraging demographic and SDOH data and parts of the health care delivery system to enhance the way services are delivered. For example, identifying individuals who could benefit from social supports or home and community-based services and bringing needed services to individuals could improve quality and access in underserved communities.

In addition to addressing aspects of payment and service delivery, CMS has monitoring and oversight responsibilities related to Conditions of Participation (CoPs) and Conditions for Coverage (CfCs)[86] that health care organizations must meet in order to participate in our programs. These standards are the foundation for improving quality and protecting the health and safety of individuals receiving services from a health care organization. Reviewing these standards and considering ways to strengthen health care organizations to advance equity as they provide care is a critical policy lever. This helps CMS identify and eliminate potential barriers that underserved communities and individuals may face to enrollment in, and access to, CMS benefits and services. Further, CMS plays a pivotal role in ensuring health care professionals and health insurance issuers who receive funding through any CMS programs uphold civil rights laws and protections which prohibit discrimination based on race, color, national origin, sex, age, or disability. CMS has a responsibility to monitor and oversee health care organizations' adherence to these laws. CMS also has a responsibility to embed equity solutions and policies that safeguard these rights for all those we serve, particularly members of underserved or disadvantaged communities.

Finally, and of critical importance, CMS has a responsibility to increase access to health care coverage for underserved populations. Expanding and strengthening health care coverage, through Medicaid, CHIP, Medicare, and Health Insurance Marketplaces, have been some of CMS's most significant actions to improve health equity over the past decade. Within Medicaid and the Health Insurance Marketplaces in particular, coverage expansions and premium assistance have helped millions of individuals in underserved areas access covered health care services, many for the first time.[87, 88] However, disparities in coverage persist among members of racial and ethnic communities and others affected by systemic inequalities.[89, 90] Individuals, families, and caregivers in communities that are underserved or disadvantaged are more likely to experience gaps in coverage and underinsurance,[91] which can lead to cost-related missed treatments, skipped medications, foregone preventive services, and ultimately missed or delayed diagnoses and adverse outcomes.[92, 93] CMS has the opportunity and responsibility to adapt policies to continue to make coverage across all programs more affordable and available. CMS also has a responsibility to ensure that every individual served by the Agency can get the care they need at a provider to whom they can travel, who will serve them, and who they are comfortable with.

This means understanding what may be causing disparities in coverage and then addressing gaps related to health insurance network adequacy, opportunities to enroll in coverage, affordable, comprehensive coverage options, and provider availability and shortages. These barriers are acutely felt in rural, tribal and other communities that are underserved where there are existing provider shortages and limited coverage options. To achieve health equity, CMS must continue to understand where disparities in coverage and access exist and adjust our policies to optimize health equity.

CMS will continue and deepen our work with Agency experts and external stakeholders to understand the impact of existing and new programs and policies on communities that are underserved. We recognize that the best ideas and approaches for how to tackle health disparities will come from voices and stakeholders, not from CMS. We are committed to partnering with all CMS stakeholders so that health equity — and accountability for closing identified disparities in access, quality and outcomes — is at the forefront of our policy decisions, and at the top of the priority list for every health care provider and health plan. That means working with our partners on evidenced-based interventions targeted at reducing health disparities that hold all partners in the health care system accountable to ensure continued progress on reducing gaps in health equity.

Some examples of this work that are already underway include Medicaid and CHIP encouraging all states to implement the 12-month postpartum coverage option now available and broadly applying a health equity lens to many of the innovative discussions underway with states, including section 1115 demonstrations and other Medicaid funding approaches. In addition, new CMS Innovation Center models will include individuals from populations who are underserved and safety net providers, such as community health centers and disproportionate share hospitals. Across CMS we are taking a whole-person view when investing in appropriate, targeted health equity interventions: identifying areas for reducing inequities at the population level, such as avoidable admissions, and setting targets for reducing those inequities, and considering how to make investments in key populations with especially large disparities in health outcomes including maternal/post-partum health, individuals involved in the justice system, and individuals with housing instability.[94, 95]

Priority 3: Build Capacity of Health Care Organizations and the Workforce to Reduce Health and Health Care Disparities

Health care organizations, including CMS's network of quality improvement contractors, and health care professionals have a direct link to individuals, families, and caregivers. They are able to address disparities in the moment health care services are delivered or supports are extended to a community or individual. They are able to structure care teams and extend health services and supports in ways that can address access barriers and ensure every individual gets care that is right for them, when and where they seek it, including home and community based services. Members of the health care team have a unique role in understanding and addressing many of the social risk factors and unmet social needs that can lead to health and health care disparities. CMS's partnership with health care organizations and the workforce is critical, and together we can drive system-wide change. CMS can help build our collective capacity to meet the needs of those we serve by amplifying best and promising practices, research, and health equity tools and resources. CMS utilizes its broad reach to identify, gather, and disseminate information that can assist organizations, providers, and others in ensuring individuals, families, and caregivers receive the highest quality care and services.

For example, CMS Innovation Center models and demonstrations including the Accountable Health Communities model,[96] Community Health Access and Rural Transformation model,[97] and the CMS OMH Minority Research Grant Program[98] support CMS's efforts to explore and test ways health care can be transformed and delivered in communities that are underserved to reduce disparities. Going forward, the CMS Innovation Center aims to engage providers who have not previously participated in value-based care and ensure that eligibility criteria and application processes do not inadvertently exclude or disincentivize care for specific populations, including patients in communities that are rural and underserved.[99] To improve health care professionals' capacity to provide behavioral health care, through Medicaid and CHIP CMS is committed to partnering with states to bring behavioral health services (both mental health and addiction treatment) up to parity with physical health services. This is an ongoing effort. For example, Medicaid funding was recently awarded to states for community-based mobile crisis intervention services, and we are working towards guidance to all states on how to implement mobile crisis services.[100]

CMS diffuses innovation and learnings from these models and grants across our programs. CMS also shares tools and resources proven to reduce disparities with health care organizations and individual providers. CMS works in collaboration with stakeholders to ensure that health equity is a shared goal and that providers and health care organizations have tools they can use to reduce disparities. Some examples of CMS's communities of learning and outreach tools include: collaboratives with State Medicaid Agencies and health plans, technical advisory groups with communities that are underserved such as the Tribal Technical Advisory Group,[101] affinity groups with quality improvement stakeholders, learning and action networks with individual providers and organizations, State Medicaid Director Letters,[102] Health Plan Management System[103] memos, and Medicare Learning Network® educational resources,[104] Annual Letters to Issuers in the Federally-facilitated Exchanges,[105] Disability Competent Care Training Resources,[106] and Technical Assistance Resources for Marketplace stakeholders including the CMS Opportunity to Network & Engage website (CMSzONE) and the Registration for Technical Assistance Portal (RegTAP) Community.[107] Each interaction with a member of a health care team, whether clinical, behavioral, social, or administrative, is another opportunity to make someone's health care, and health status, better. However, health care professionals across settings must be equipped with resources and knowledge of what works to reduce disparities. Each organization and team must establish their shared vision of health equity in order to shift from addressing health issues in silos to an embedded approach that drives improvements and closes gaps in access, quality, and outcomes among specific populations.[108]

For Example: The CMS Health Equity Technical Assistance Program helps health care organizations ready themselves to systematically take action to address health and health care disparities. Health Equity Technical Assistance includes: personalized coaching and resources to help embed health equity into a strategic plan; help with data collection and analysis; and help developing a language access plan and ensuring effective communication with individuals, families and caregivers.

CMS's leading role in quality improvement and focus on health equity can help health care organizations bring their goals into focus. CMS can also help organizations embed health equity in their programs to reduce disparities. CMS's unique partnership and ongoing communication with federal, state, territorial, tribal, local governments, quality improvement networks, health plans, health systems, providers, and community partners allows the Agency to promote validated approaches to reducing disparities. This includes bridging federal resources from across HHS and to the health care settings and communities where they can be most useful. The CMS Health Equity Technical Assistance Program[109] is a cornerstone of our work in this area. This program provides a pathway for CMS stakeholders to receive individually tailored coaching and curated resources from CMS experts. One element of this technical assistance is the CMS Disparities Impact Statement.[110] This tool helps organizations embed equity into their policies, programs, and quality improvement initiatives.

CMS will continue to focus on identifying and promoting promising approaches to reduce disparities. This includes approaches to health care delivery that address barriers to access and health care services such as workforce shortages and network coverage, which can heavily impact communities that are underserved, including rural areas, tribal communities and other communities who have experienced structural and historical inequities. This also includes quality improvement tools to identify and reduce disparities and resources tailored to communities, which can be applied across CMS programs to build the capacity of health care organizations and the workforce.

Priority 4: Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services

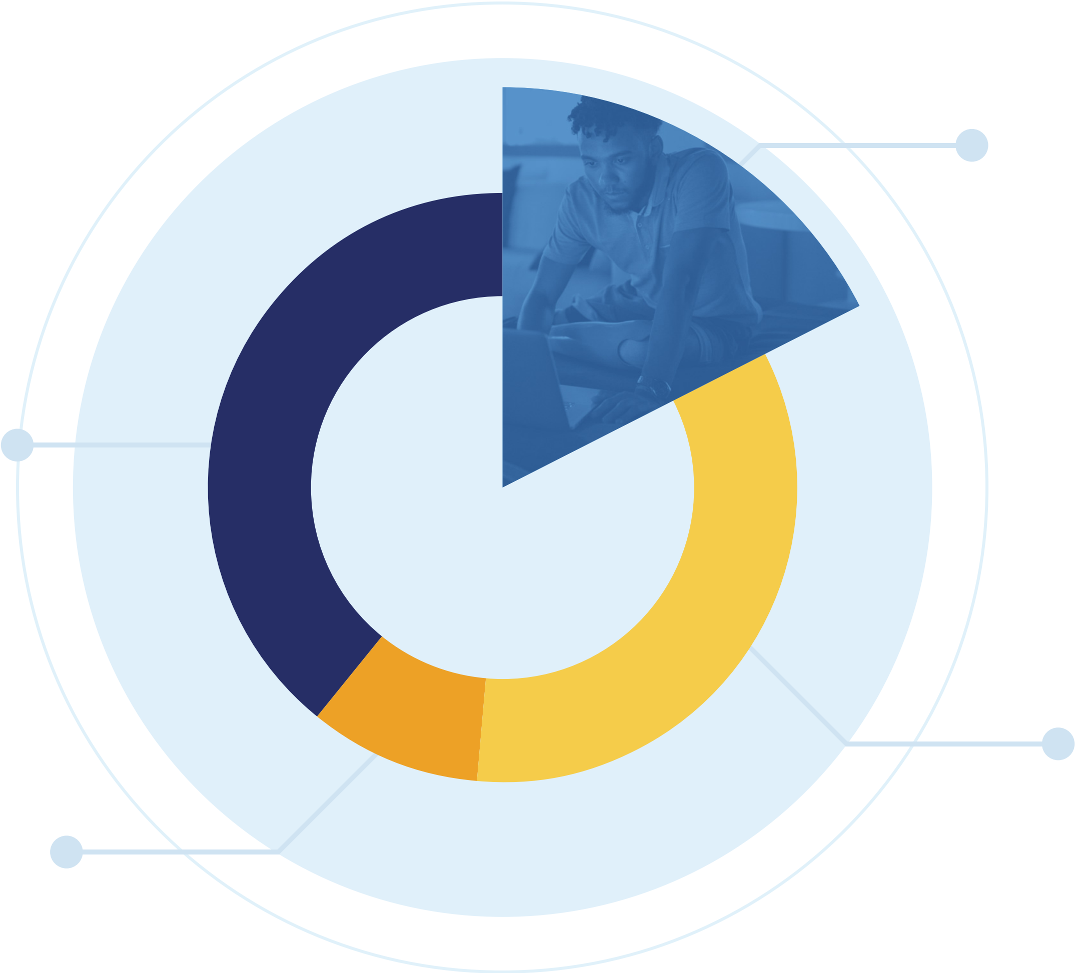
Language access, health literacy, health insurance literacy, and the provision of culturally tailored services play a critical role in health care quality, patient/consumer safety, and experience, and can impact health outcomes and enrollment in coverage.[111, 112, 113, 114, 115] Research indicates that people with limited English proficiency and low health literacy report poor health status nearly twice as much as those without these barriers.[116] Nearly nine percent of the U.S. population are persons with limited English proficiency[117] and nearly 36 percent have low health literacy.[118] Language, health and health insurance literacy, and culture can either promote or inhibit effective communication.

This can have an impact on quality of care, clinical outcomes, diagnosis and management of health conditions, hospital stays, and rates of readmission. Failure to address language, health literacy, and culture can result in patient safety and adverse events including diagnostic errors, missed screenings, and inappropriate care transitions.[119, 120, 121, 122, 123] For example, effectively addressing mental health disparities among American Indians and Alaska Natives requires understanding healing, locally relevant coping strategies, and treatment that is consistent with cultural beliefs and practices within this community.[124] Further, insurance status seems to correlate with health literacy status as well. Individuals with Medicaid are at increased risk of low health literacy.[125] Medicare-enrolled individuals with low health literacy experience increased hospital admissions and visits to emergency departments,[126] as well as higher medical costs[127] and lower access to care.[128] CMS stakeholders continue to emphasize that CMS should consider language, literacy, and cultural aspects if they wish to improve health outcomes and increase enrollment in health care coverage. Stakeholders consistently request best practices and examples of ways to tailor health care services to meet the needs of their communities. One way CMS addresses this within the Health Insurance Marketplaces is through the Navigator program.[129] Navigators play a vital role in helping consumers understand and enroll in the right health care plan that meets their financial and health care needs. They also provide outreach and education to local communities and can help link people to consumer assistance programs[130] as well as appeals programs[131] and ombudsmen[132] to help resolve complaints.

For Example: CMS works to develop and advance resources and tools tailored to the communities we represent, including having Medicare[133] and Marketplace[134] materials available in multiple languages. This attention to communication and cultural needs and health literacy levels equips consumers with the information they need to make informed health coverage choices. These tailored resources and tools include: quality improvement, frameworks and plans, toolkits, and guides to meet many of the unique needs of specific populations.

Each person CMS serves should receive effective, understandable, and respectful care that is responsive to their preferred languages or dialects, health literacy, cultural health beliefs and practice, traditions, and other communication needs.[135, 136] The ideas people have about health, the languages they use, the health literacy skills they have, and the contexts in which they communicate about health, reflect their cultures. Organizations can increase communication effectiveness when they recognize and bridge cultural differences that may contribute to miscommunication.[137] Further, CMS and our partners can improve information available to individuals about their providers' language skills, helping to ensure a person can find a health care professional who can communicate with them in a way they understand. This results in informed shared decision making among providers, patients, and their families and support networks, higher quality of care, better health outcomes, and reduced disparities.[138, 139, 140]

Across our programs and health care settings, we seek to increase the provision of linguistically and culturally appropriate care. To improve equity in health care quality, CMS will continue to identify language, health literacy, and cultural needs among those we serve across different care settings, and strive to meet those needs. Three such examples of this work are the Coverage to Care initiative,[141] the 2020 CMS #FightFlu campaign,[142] and the Disability-Competent Care Training Resources.[143] Through these efforts and others, CMS works with communities that are underserved to identify the challenges and barriers individuals, families, and caregivers experience in accessing care and coverage. We develop culturally tailored resources to meet the needs of those we serve, translate products into multiple languages, and bring messages into our communities by sharing them with trusted local partners. This ensures that information is delivered in ways individuals, families, and caregivers can understand and that resources are widely available for use by providers, other stakeholders, and local trusted partners. This can be particularly important in communities in which individuals speak languages other than English, have ranges of health literacy, or have cultural traditions or values that influence perspectives on health and health care. It also helps build promising practices within our own programs. With over 170 million individuals served by CMS, we have a powerful role in strengthening and enhancing efforts across the health care system to improve access to culturally and linguistically tailored, health literate care and services for our increasingly diverse population.[144]



Priority 5: Increase All Forms of Accessibility to Health Care Services and Coverage

Accessibility is essential to obtaining necessary and appropriate care and services, particularly for people with disabilities. The CDC estimates that 1 in 4 American adults has some form of disability, including related to mobility, cognition, independent living, hearing, vision, and self-care.[145, 146] Rates of disability increase with age, with 2 in 5 adults over age 65 reporting a disability. These rates are higher among racial and ethnic minorities.[147, 148] Individuals with disabilities are more likely to experience higher rates of chronic conditions, including obesity, heart disease, and diabetes. They may be more susceptible to infectious diseases such as COVID-19, than individuals without disabilities.[149, 150] In addition, emergency and disaster readiness efforts must ensure that plans are disability-inclusive and state health agencies, health care organizations, and communities are collaborating to understand the barriers individuals with disabilities may face during an emergency. This includes preparing for, mitigating, and overcoming challenges together so that disparities are not caused or worsened.[151]

CMS has a responsibility to ensure that individuals and families are able to access health care services when and where they need them in a way that meets individuals' needs and preferences. One prominent challenge for people with disabilities is overcoming barriers to entering and navigating health care information and facilities. People with disabilities may face communication barriers as well as physical barriers, including inaccessible entrances, hallways, signage, information shared during a health care visit, medical equipment, and restrooms.[152, 153] Health care organizations and providers can meet the needs of each person who seeks care by systematically assessing the accessibility of their services for individuals with disabilities. This includes: making infrastructure improvements, strengthening training for providers and staff, and ensuring services are designed to meet the needs of each person they serve, and when appropriate, considering the role of families and caregivers who may be critical to the success of a health care encounter, interaction with a member of the care team, or treatment plan.

CMS has a key role in increasing awareness of the barriers individuals with disabilities face in accessing care. CMS can also help reduce barriers to accessible health care and services by working with health care professionals and individuals with disabilities. Researchers and stakeholders have identified a need to better enforce health care-related accessibility requirements.

They have also noted a need to collect data from health care professionals on accessibility. CMS can address these gaps, including aligning data collection with the 2011 HHS Data Standards[154] which includes physical, communication, cognitive, and functional elements of disability. CMS can also ensure monitoring and oversight of civil rights protections. CMS will continue to provide technical assistance to health care organizations on accessibility requirements. This includes supporting Medicare Advantage plans by providing technical assistance through health plans management system notices, including frequently asked questions with respect to section 504 requirements, ensuring that Medicare Advantage plans attest to accessibility through a checklist each year, and supporting other CMS efforts to advance health equity and eliminate disparities.[155] We will continue to develop training for health care professionals on disability-competent care, and work with health care organizations to increase awareness of programs for people with disabilities. This includes programs such as Medicaid programs for individuals who need help with Activities of Daily Living,[156] Home and Community Based Services (HCBS),[157] and Disability Competent Care Training Resources.[158] For example, CMS is currently supporting state investments to improve local HCBS services and begin investment in needed structural changes. We will continue to work with Congress and other federal partners to advance HCBS improvement and reform and to make continued investments in this area.[159] CMS will continue to engage with stakeholders to understand persistent and emerging accessibility barriers to the provision of health care services and coverage and strengthen opportunities for people with disabilities to receive accessible, equitable care.

For Example: Across CMS, components strive to ensure that all aspects of our programs are accessible to those we serve. CMS convenes federal partners, people with disabilities, and community-serving organizations to understand their perspective on barriers and opportunities for individuals with disabilities. Informed by this input, we develop training curriculum and resources, including the Medicare-Medicaid Coordination Office's Resources for Integrated Care for Health Plans and Providers[160] to help support providers and plans in delivering disability-competent and accessible care.

Conclusion

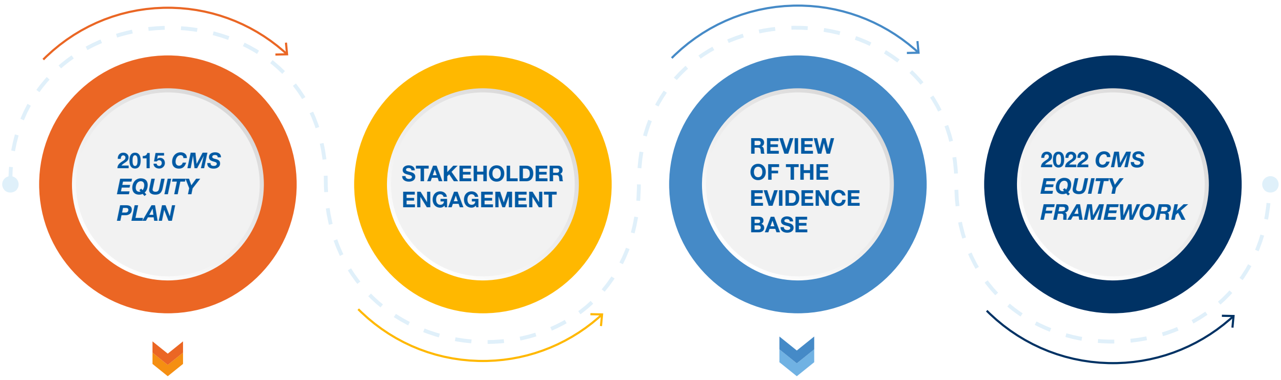
CMS is committed to placing health equity at the center of our work. Through the priority areas described in this Framework, CMS will examine health inequities to identify and address drivers of disparities. CMS must lead by example, working with health care organizations and the individuals we serve to develop and refine our initiatives, including focusing on overcoming health disparities, eliminating structural barriers that underlie our health system, and forward-planning across all CMS programs to advance health equity.

CMS has a pivotal role to play across every health care setting in every community. However, to achieve the greatest impact, we must work together with our partners and stakeholders such as health care and service providers, health systems, health plans, federal, state, territorial, tribal, local partners, quality improvement networks, individuals, family members, caregivers, patient advocates, health professional organizations, and community partners. We will need each of our partners to commit with us to to meet our shared goal: that all individuals we serve, including members of racial and ethnic communities, people with disabilities, members of the LGBTQ+ community, individuals with limited English proficiency, members of rural communities, and persons otherwise adversely affected by persistent poverty or inequality, realize their highest level of health and well-being, and that we have eliminated disparities in health care quality, access, and outcomes.

Appendix: Foundation for Planning

This section describes the development process for the *CMS Framework for Health Equity*.

FIGURE 1: CMS FRAMEWORK FOR HEALTH EQUITY DEVELOPMENT AND EVOLUTION



- Lessons learned
- Continued refinement
- Assess progress

- Feedback from diverse stakeholders
- Listening sessions

- Regulatory and statutory guidelines
- Recommendations from federal commissions and advisory groups
- Consultations with wide range of SMEs
- Literature reviews

- Stakeholder engagement
- Review of the evidence base
- Continued refinement

Figure 1 illustrates our process to establish the *CMS Framework for Health Equity*. It begins with the 2015 *CMS Equity Plan for Improving Quality in Medicare* and carries the plan forward through continuous stakeholder engagement, review of the evidence base, and into the updated *CMS Framework for Health Equity* we are now initiating.

2015 CMS Equity Plan for Improving Quality in Medicare

In 2015, CMS issued its first strategic approach to embedding health equity in programs and policies: The *CMS Equity Plan for Improving Quality in Medicare*.[161] This strategy plan outlined our five-year approach to advance health equity in the Medicare program. Over the past several years, CMS has built on existing work done by the Agency as well as external partners. We added new areas of focus to increase understanding of disparities, developed and shared solutions to reduce disparities, and promoted sustainable actions to achieve health equity across the Agency and among our partners. CMS's progress under the *CMS Equity Plan for Improving Quality in Medicare* is described in *Paving the Way to Equity: A Progress Report (2015-2021)*.[162]

The development of the first *CMS Equity Plan for Improving Quality in Medicare* drew heavily on the evidence base and the perspectives of internal and external experts. These experts included: representatives from health care organizations of all types, providers in diverse settings and communities, quality improvement organizations and networks, health insurance and drug plans, integrated health systems, health equity researchers and policy experts, health educators, and individuals from communities that are underserved (e.g., members of racial and ethnic communities, people with disabilities, members of the LGBTQ+ community, individuals with limited English proficiency, and members of rural and tribal communities). To ensure all of these voices were collected, CMS OMH hosted a series of listening sessions designed to seek insight into:

- Significant disparities in health care quality, and the drivers of those disparities;
- Barriers to implementing successful strategies to reduce disparities;
- Promising practices not yet reflected in the published literature;
- Opportunities for CMS to accelerate equity action; and
- Potential partners for CMS to advance this goal.

Stakeholder Engagement and Review of the Evidence Base

Since the initial release of the *CMS Equity Plan for Improving Quality in Medicare* in 2015, CMS has continued and intensified our stakeholder engagement with our initial partners. We have also expanded to new areas. This includes, but is not limited to, additional teams and workgroups within CMS and external stakeholders such as managed health care organizations, State Medicaid Agencies and state and local health departments, representatives of individuals and organizations representing specific health conditions, provider groups, health care settings, and community partners providing social supports and services. We have continuously reevaluated the evidence base, assessed and incorporated new literature, and updated regulatory and statutory guidelines. We have also identified emerging areas of opportunity to drive progress in health equity and to reduce disparities across CMS programs on an ongoing basis.

In 2019, we sought to broaden the existing plan to all CMS programs. We revisited the evidence base, taking a detailed inventory of recommendations and feedback CMS has received through federal commissions and advisory committees including but not limited to: the Medicare Payment Advisory Commission (MedPAC), the Medicaid and CHIP Payment and Access Commission (MACPAC), the Health Equity Task Force for Delivery & Payment Transformation, the National Council on Disability Report, the National Quality Forum Roadmap for Promoting Health Equity and Eliminating Disparities, and the National Academies of Science, Engineering, and Medicine. We also assessed opportunities and recommendations yielded through stakeholder associations and consumer representatives, including those given at CMS Quality Conferences and other CMS forums and listening sessions, updated published literature, promising practices from the field across diverse settings and communities, and public feedback related to key regulatory and statutory areas of CMS programs including Medicare, Medicaid, CHIP, and the Health Insurance Marketplaces.

From 2020 through 2022, CMS again conducted a series of listening sessions with stakeholders who are driving health equity across all CMS programs. We probed participants for their perspective on current pressing and emerging disparities, and their drivers, across each of CMS's core programs. We also sought insight into the unique barriers, challenges, and opportunities that specific communities that are underserved face related to CMS functions. This included areas for further exploration and opportunities to improve health care access, data and measurement, quality improvement and payment, and health equity-related technical assistance. Stakeholders noted pressing disparities across health conditions. They discussed concerns specific to communities that are underserved including members of racial and ethnic communities, people with disabilities, members of the LGBTQ+ community, individuals with limited English proficiency, members of rural communities, and persons otherwise adversely affected by persistent poverty or inequality. They also highlighted the important link between SDOH, social risk factors and unmet social needs, and health and health care disparities. During these listening sessions, CMS heard detailed feedback related to data collection and stratification for demographic and SDOH data, barriers and opportunities in reimbursement and benefit design, CMS quality improvement initiatives, ideas for training and technical assistance, and considerations for working with trusted partners.

In addition, since the inception of the initial *CMS Equity Plan for Improving Quality in Medicare* and on a continuous basis, we have engaged with federal and CMS experts, teams, and workgroups. We have sought — and continue to seek — ideas around areas of opportunity, improvement, and collaboration. This input and feedback on our activities from the individuals and groups driving progress and improvement in health equity across CMS program areas and core functions brings an Agency-wide perspective to the *CMS Framework for Health Equity* and will continuously inform our work.

Centers for Medicare & Medicaid Services, *The CMS Framework for Health Equity (2022-2032)* (2022).

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Paid for by the U.S. Department of Health and Human Services
July 2024