Racial Equity in Healthcare Progress Report Crosswalk
2023 National Hospital Equity Measures (CMS) and Standards (TJC) for Hospitals and Health Systems

Background

In the face of racial and ethnic health disparities arising from social and economic inequalities, the Illinois Health and Hospital Association (IHA) has committed to supporting Illinois hospitals and community health centers in their equity journey to address racial health disparities.

The Racial Equity in Healthcare Progress Report (Progress Report) was developed with the Civic Consulting Alliance of Chicago and a small working group of healthcare professionals. It serves as a long-term accountability tool that Illinois hospitals and health systems can utilize to assess their performance in achieving health equity. In 2021, Rush University Medical Center in partnership with University of Chicago Medicine secured a grant from The Commonwealth Fund to test and validate the Progress Report on a national scale.

The Racial Equity in Healthcare Progress Report

The Progress Report embeds the ideas that advancing health equity requires measurement and accountability. It is designed to assess how hospitals and health systems are addressing racial disparities through the care they provide in an effort to drive collective improvement. Through its baseline self-assessment, hospital and health system leaders have the opportunity to measure progress, assess their implementation of key strategies, understand provider and community assets in racial equity work, and identify areas of improvement.

National Health Equity Landscape

Since the launch of the Progress Report, national policymakers have shown growing interest in hospitals' health equity work. As a result, new mandatory regulations and accreditation requirements have been developed. Most significantly, the Centers for Medicare & Medicaid Services (CMS) and The Joint Commission (TJC) have adopted new measures and standards around health equity that require hospitals to adopt new practices or collect and report health equity-related data.

In partnership with The Commonwealth Fund grantees, IHA conducted a review of available assessment tools and found strong alignment between the Progress Report, three new CMS Inpatient Quality Reporting (IQR) program measures and TJC's Health Care Equity Standards. This led to the development of a crosswalk to identify how the Progress Report aligns with health equity-related CMS measures and TJC standards. This crosswalk is intended to support healthcare facilities in updating policies and practices, documenting progress, and planning improvement initiatives to advance health equity in the most efficient way.

Note: This crosswalk is not a substitute for a compliance evaluation of policies and practices for meeting regulatory and accreditation standards.

Resources:

- **CMS IQR Health Equity Measures:**
  - **Hospital Commitment to Health Equity Measure (HCE)** – *Mandatory Calendar Year (CY) 2023*
  - **Hospital Screening for Social Drivers of Health and Screening Positive Measures (SDOH-1 & 2)** *-Voluntary CY 2023, Mandatory CY 2024*
- **Joint Commission R3 Report on New Health Equity Standards**

Crosswalk Terms Glossary:

- CMS = Centers for Medicare & Medicaid Services
- IQR = CMS Inpatient Quality Reporting Program
- HCHE = Hospital Commitment to Health Equity (CMS IQR Measure)
- HRSN = Health Related Social Need (CMS)
- SDOH-1 = Hospital Screening for Social Drivers of Health (CMS IQR Measure)
- SDOH-2 = Screen Positive Rate for Social Drivers of Health (CMS IQR Measure)
- LD = Leadership (a chapter of The Joint Commission's standards for accreditation)
- EP = Element of Performance (the specific ways hospitals must demonstrate compliance with a Joint Commission standard that forms the basis of hospital surveys)
- RC = Record of Care, Treatment and Services

Centers for Medicare & Medicaid Service (CMS) Health Equity Measures: CMS IQR Hospital Commitment to Health Equity Measure (CMS HCHE) Mandatory CY 2023	Progress Report Pillar	Progress Report Composite Metric
Domain 1: Equity is a Strategic Priority Hospital commitment to reducing healthcare disparities is strengthened when equity is a key organizational priority. Please attest that your hospital has a strategic plan for advancing healthcare equity and that it includes all of the following elements. Select all that apply (note: attestation of all elements is required in order to qualify for the measure numerator):		
A: Our hospital strategic plan identifies priority populations who currently experience health disparities.	**Our Organization**	**Composite Metric 4:** Leadership Practices to Advance Racial Equity
B: Our hospital strategic plan identifies healthcare equity goals and discrete action steps to achieving these goals.	**Our Organization**	**Composite Metric 4:** Leadership Practices to Advance Racial Equity
C: Our hospital strategic plan outlines specific resources which have been dedicated to achieving our equity goals.	**Our Community**	**Composite Metric 10:** Partnerships with Patients and Community
D: Our hospital strategic plan describes our approach for engaging key stakeholders, such as community-based organizations.	**Our Community**	**Composite Metric 10:** Partnerships with Patients and Community
Domain 2: Data Collection Collecting valid and reliable demographic and social determinant of health data on patients served in a hospital is an important step in identifying and eliminating health disparities. Please attest that your hospital engages in the following activities.		
A: Our hospital collects demographic information, including self-reported race and ethnicity, and/or social determinant of health information on the majority of our patients.	**Our Patients**	**Composite Metrics 5 & 6:** Patient Assessment Questions & Patient Support for SDoH
B: Our hospital has training for staff in culturally sensitive collection of demographic and/or social determinant of health information.	**Our People**	**Composite Metric 3:** Diversity and Inclusion in Our Workforce
C: Our hospital inputs demographic and/or social determinant of health information collected from patients into structured, interoperable data elements using a certified 2 EHR technology.	**N/A**	**N/A:** EHR Technology not addressed by Progress Report
Domain 3: Data Analysis Effective data analysis can provide insights into which factors contribute to health disparities and how to respond. Please attest that your hospital engages in the following activities.		
A: Our hospital stratifies key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and includes this information on hospital performance dashboards.	**Our Organization**	**Composite Metric 4:** Leadership Practices to Advance Racial Equity
Domain 4: Quality Improvement Health disparities are evidence that high quality care has not been delivered equally to all patients. Engagement in quality improvement activities can improve quality of care for all patients.		
A: Our hospital participates in local, regional, or national quality improvement activities focused on reducing health disparities	**All Domains Apply**	**Entire Assessment Applies**
Domain 5: Leadership Engagement Leaders and staff can improve their capacity to address disparities by demonstrating routine and thorough attention to equity and setting an organizational culture of equity. Please attest that your hospital engages in the following activities. Select all that apply		
A: Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews our strategic plan for achieving health equity.	**Our Organization**	**Composite Metric 4:** Leadership Practices to Advance Racial Equity
B: Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews key performance indicators stratified by demographic and/or social factors.	**Our Organization**	**Composite Metric 4:** Leadership Practices to Advance Racial Equity

Centers for Medicare & Medicaid Service (CMS) Health Equity Measures: CMS IQR Hospital Screening for Social Drivers of Health and Screening Positive Measures (CMS SDH) *Voluntary CY 2023, Mandatory CY 2024*	Progress Report Pillar	Progress Report Composite Metric
Hospital Screening for Social Drivers of Health (SDOH-1) The Screening for Social Drivers of Health Measure assesses whether a hospital implements screening for all patients that are 18 years or older at time of admission for food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety. To report on this measure, hospitals will provide: (1) The number of patients admitted to the hospital who are 18 years or older at time of admission and who are screened for each of the five HRSNs: Food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety; and (2) the total number of patients who are admitted to the hospital who are 18 years or older on the date they are admitted.	**Our Patients**	**Composite Metric 5:** Patient Assessment Questions
Screen Positive Rate for Social Drivers of Health (SDOH-2) The Screen Positive Rate for Social Drivers of Health Measure provides information on the percent of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, were screened for an HSRN, and who screen positive for one or more of the following five HRSNs: Food insecurity, housing instability, transportation problems, utility difficulties, or interpersonal safety	**Our Patients**	**Composite Metric 5:** Patient Assessment Questions

Joint Commission Health Care Disparities Reduction and Patient-Centered Communication Accreditation Standards Standard LD.04.03.08: Leadership (LD) Chapter Standard RC.02.01.01: The Record of Care, Treatment, and Services (RC) requirement to collect patient race and ethnicity	Progress Report Pillar	Progress Report Composite Metric
Standard LD.04.03.08 EP 1: The [organization] designates an individual(s) to lead activities to reduce health care disparities for the [organization's] [patients].	**Our Organization**	**Composite Metric 4:** Leadership Practices to Advance Racial Equity
Standard LD.04.03.08 EP 2: The [organization] assesses the [patient's] health-related social needs and provides information about community resources and support services.	**Our Patients**	**Composite Metric 5:** Patient Assessment Questions **Composite Metric 6:** Patient Support for SDoH
Standard LD.04.03.08 EP 3: The [organization] identifies health care disparities in its [patient] population by stratifying quality and safety data using the sociodemographic characteristics of the [organization's] [patients].	**Our Patients**	**Composite Metric 7:** Quality Improvement Practices
Standard LD.04.03.08 EP 4: The [organization] develops a written action plan that describes how it will address at least one of the health care disparities identified in its [patient] population.	**Our Organization**	**Composite Metric 4:** Leadership Practices to Advance Racial Equity
Standard LD.04.03.08 EP 5: The [organization] acts when it does not achieve or sustain the goal(s) in its action plan to reduce health care disparities.	**Our Patients**	**Composite Metric 4:** Leadership Practices to Advance Racial Equity
Standard LD.04.03.08 EP 6: At least annually, the [organization] informs key stakeholders, including leaders, licensed practitioners, and staff, about its progress to reduce identified health care disparities.	**Our Patients**	**Composite Metric 7:** Quality Improvement Practices
Standard RC.02.01.01: The [medical] record contains information that reflects the [patient's] care, treatment, and services.	**Our Patients**	**Composite Metric 5:** Patient Assessment Questions **Composite Metric 6:** Patient Support for SDoH