



2022 Technical Expert Panel Meetings

*Home Health & Hospice Health Equity
Summary Report*



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About This Report

CMS contracted with Abt Associates (Abt) under a Measure & Instrument Development Support (MIDS) Task Order to provide quality measure maintenance and support for its Hospice Quality Reporting Program (HQRP) and Home Health Quality Reporting Program (HH QRP), including the development of a cross-setting home health and hospice health equity structural quality measure. The HQRP and HH QRP Health Equity Structural Composite Measure Development Technical Expert Panel (Home Health & Hospice HE TEP) included health equity experts from hospice and home health settings specializing in quality assurance, patient advocacy, clinical work, and measure development. The TEP convened three times in the fall of 2022. This report provides an overview of the topics discussed over the course of these meetings and a summary of feedback from the TEP members.

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CONTENTS

Glossary of Acronyms	iii
1.0 Background	1
1.1 Introduction.....	1
1.2 TEP Responsibilities.....	2
1.3 TEP Composition.....	2
2.0 Health Equity Structural Measure Concept	5
2.1 Overall Structural Measure Concept: Summary of Feedback.....	5
3.0 Domain 1: Equity as a Key Organizational Priority	8
3.1 Summary of Feedback.....	8
3.2 Revised Domain 1: Equity as a Key Organizational Priority	9
4.0 Proposed Domain 2: Trainings for Health Equity	10
4.1 Summary of Feedback.....	10
4.2 Revised Domain 2: Trainings for Health Equity.....	11
5.0 Proposed Domain 3: Organizational Culture of Equity	12
5.1 Summary of Feedback.....	12
5.2 Revised Domain 3: Organizational Culture of Equity	13
6.0 Confidential Feedback Report: Summary of Feedback	14
6.1 Input on Stratification Variable Options for Health Equity CFRs.....	15
6.2 Input on Quality Measure Options for Health Equity CFRs	15
7.0 Additional Approaches to Measuring Health Equity: Summary of Feedback	17
7.1 Measuring Access to Services.....	17
7.2 Innovative Strategies to Improve Collection and Use of Patient Feedback.....	18
7.3 Other Feedback: Potential Health Equity Frameworks and Public Reporting for Health Equity	18
8.0 Conclusions	20
Appendix A: TEP Member Bios	21
Appendix B: Health Equity Resources Provided by TEP Members	23

Glossary of Acronyms

ADI	Area Deprivation Index
BIPOC	Black, Indigenous, and People of Color
CAHPS®	Hospice Consumer Assessment of Healthcare Providers and Systems
CLAS	Culturally and Linguistically Appropriate Services
CMS	Centers for Medicare and Medicaid Services
CY	Calendar Year
DEI	Diversity, Equity, and Inclusion
DTC	Discharge to Community
FY	Fiscal Year
HCI	Hospice Care Index
HE	Health Equity
HH	Home Health
HH QRP	Home Health Quality Reporting Program
HHVBP	Home Health Value-Based Purchasing
HQRP	Hospice Quality Reporting Program
HVLDL	Hospice Visits in Last Days of Life
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning and other sexual orientations and identities
MedPAC	Medicare Payment Advisory Commission
MIDS	Measure & Instrument Development Support
MIPS	Merit-Based Incentive Payment System
NPRM	Notice of Proposed Rulemaking
OASIS E	Outcome and Assessment Information Set E
QAPI	Quality Assurance and Performance Improvement
SDOH	Social Determinants of Health
SOGI	Sexual Orientation and Gender Identity
TEP	Technical Expert Panel
VBP	Value-Based Payment

1.0 Background

1.1 Introduction

As President Biden’s first action in office, on January 20, 2021, he signed [Executive Order 13985](#) on “Advancing Racial Equity and Support for Underserved Communities Through the Federal Government.” This order called for a comprehensive approach to advancing equity for all by embedding fairness into daily practices by which the Government serves its people. Executive Order 13985 charged the head of each federal agency to identify and address systemic barriers to accessing benefits and opportunities pursuant to agency programs and policies.

The Centers for Medicare & Medicaid Services (CMS) defines health equity (HE) 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.”¹ CMS is working to advance health equity in three critical ways:

1. Designing, implementing, and operationalizing policies and programs that support the health of all the people CMS serves.
2. Eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved.
3. Providing the care and support that enrollees need to thrive.

In 2022, CMS further asserted its commitment to addressing healthcare inequities. First, Administrator Chiquita Brooks-LaSure identified “Advancing Equity” as the first pillar of the 2022 CMS Strategic Plan—highlighting the agency-wide charge to incorporate HE into its core work. Second, CMS released the [CMS Framework for Health Equity, 2022-2023](#), which outlines five priority areas to inform CMS’ efforts to advance equity over the next decade.²

CMS contracted with Abt Associates (Abt) under a Measure & Instrument Development Support (MIDS) Task Order to provide quality measure maintenance and support for its Hospice Quality Reporting Program (HQRP) and Home Health Quality Reporting Program (HH QRP), including the development of a home health and hospice health equity quality measure. As part of its measure development process, Abt recruited and convened a group of stakeholders in November and December 2022, who provided input on the health equity measure development process. The HQRP and HH QRP Health Equity Structural Composite Measure Development Technical Expert Panel (Home Health & Hospice HE TEP) included health equity experts from hospice and home health settings specializing in quality assurance, patient advocacy, clinical work, and measure development.

¹ <https://www.cms.gov/pillar/health-equity>

² **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

1.2 TEP Responsibilities

CMS convened the Home Health & Hospice HE TEP to provide thoughtful input on options for health equity measurement in the home health and hospice care settings. Specifically, the Home Health & Hospice HE TEP was charged with the following:

1. Review a summary of findings from information gathering activities related to health equity in hospice and home health settings.
2. Review a proposed health equity structural composite measure concept as set forth in the Fiscal Year (FY) 2023 Hospice Notice of Proposed Rulemaking (NPRM), Calendar Year (CY) 2023 Home Health NPRM, and a summary of public comments received on health equity and the measure concept.
3. Assess face validity and feasibility of the proposed health equity measure concept.
4. Provide input on potential health equity confidential feedback report options.
5. Generate additional health equity measure concept(s) that may be feasible in hospice and home health settings.

1.3 TEP Composition

Consistent with the [Measures Management System Blueprint](#), Abt solicited nominations for and subsequently formed a TEP to provide input on the development of a home health and hospice health equity structural measure and other health equity measurement approaches. TEP recruitment began in 2022 with a 4-week call for potential members to submit the accompanying nomination form. To solicit nominations from a diverse group of experts comprised of home health and hospice clinicians and staff, measurement developers, researchers, methodologists, and health equity experts, CMS disseminated the call for TEP members through their webpage and various stakeholder listservs. After the nomination period, Abt selected 15 nominees with diverse backgrounds and a range of perspectives and expertise. All selected nominees agreed to serve on the TEP. The final TEP included members from 12 states representing all US regions, with three members representing rural areas. Members bring experience in clinical work, patient advocacy, quality improvement, and research. Table 1 presents the name and a brief profile of each TEP member. For a detailed background of each TEP member, please see Appendix A.

Table 1: List of Home Health and Hospice Health Equity TEP Members

Name	State	Setting	Relevant Experience and Areas of Expertise
Kimberly Acquaviva, PhD, MSW, CSE, FNAP	Virginia	Hospice	Professor; hospice social work, LGBTQ+ inclusive hospice work
Lonnette Campbell	Minnesota	Hospice	Practical nurse; cross-cultural aspects of health care, hospice compliance, CLAS, SDOH, healthcare in Native American communities
Nicole DePace, MS, ARPN, GNP-BC	Massachusetts	Home Health and Hospice	Dual Certification Nurse Practitioner in Gerontology and Palliative Care; home health and hospice in community-based settings, healthcare in low-income and underserved neighborhoods
Shekinah Fashaw-Walters, PhD, MSN	Minnesota	Home Health	Health services researcher, professor, and consultant; health equity and structural racism in home health, post-acute, and long-term care

Name	State	Setting	Relevant Experience and Areas of Expertise
Jenni Gudapati, MBA, RN	Idaho	Home Health and Hospice	Value-Based Healthcare Program Director; rural healthcare and value-based healthcare
Marisette Hasan, BSN, RN	South Carolina	Hospice	President and CEO of the Carolinas Center for Hospice and End of Life Care; racial equity for Black and Brown communities in hospice and home health
Kathleen Holt, MBA, JD	Connecticut	Home Health and Hospice	Associate Director, Center for Medicare Advocacy; Medicare patient advocate, legal expertise in Medicare coverage
Kentrell Liddell, MD, MBA	Mississippi	Home Health and Hospice	Family Medicine Physician and QM consultant; clinical quality management, federally qualified health centers
Jaqueline Lopez-Devine, MSN, RN	Florida	Hospice	Chief Clinical Officer; Administration and Clinical Informatics, emergency management
Suzanne Marmo, PhD, LCSW, APHSW-C	Connecticut	Hospice	Professor; Hospice Social Work, SDOH, Hospice Medicare
Robert Parker, DNP, RN, CENP, CHPN, CHP	Texas	Hospice	Chief Compliance Officer, Intrepid USA; hospice/palliative program development, quality measurement and outcome reports, clinical measurement and outcome reports
Robert Rosati, PhD	New Jersey, Ohio, and Florida	Home Health and Hospice	Senior Research and Quality Executive, VNA Healthcare; quality measures, psychometrics, health equity in post-acute settings
Ernest Roy, PT, DPT, COS-C	New Hampshire	Home Health and Hospice	Quality Director and Compliance Officer, Pemi-Baker Hospice and Home Health; quality assessment and improvement, health equity across socioeconomic status
Cardinale Smith, MD, PhD	New York	Hospice	Professor, health services researcher, and clinician; thoracic oncology, palliative medicine, evaluating treatment disparities in cancer and palliative care, health equity
Toby Weiss, MS	New York	Hospice	Assistant Vice President of Cultural Diversity, MJHS Hospice and Palliative Care; end-of-life care for diverse faith communities, LGBTQ+ patients, and veterans

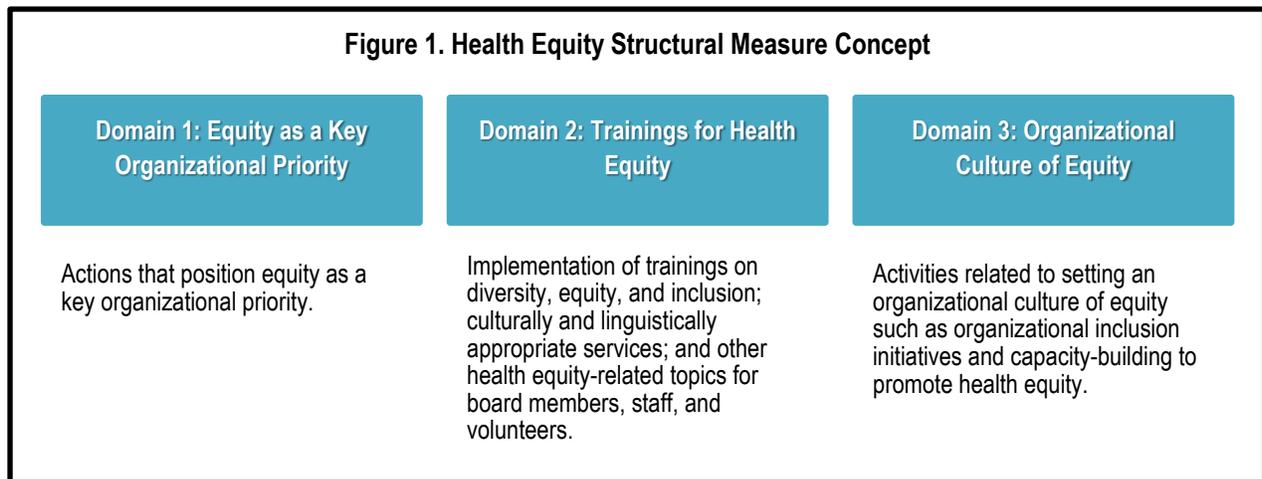
The TEP convened three times in the fall of 2022. Table 2 contains descriptions of each meeting’s content. The subsequent sections of this report provide an overview of the topics discussed over the course of these meetings and a summary of feedback from the TEP members.

Table 2: TEP Meetings and Related Discussions

Date	Meeting Title and Content
November, 2022	TEP Orientation: Defining and measuring health equity in hospice and home health <ul style="list-style-type: none"> • Project objectives, TEP meetings and goals, review and ratification of TEP charter • CMS health equity context, Quality Measure 101, current HH QRP and HQRP measures, background on health equity in home health and hospice, potential health equity structural measure
November, 2022	TEP Discussion 1: Validity and feasibility of proposed structural measure concept; confidential feedback report as a tool for monitoring health equity <ul style="list-style-type: none"> • Input on the proposed health equity structural composite measure concept • Input on potential confidential feedback report for monitoring health equity
December, 2022	TEP Discussion 2: Additional approaches to measuring health equity; final recommendations <ul style="list-style-type: none"> • Brainstorm additional measure concepts for health equity in home health and hospice • Final recommendations for measuring health equity in hospice and home health, including actionable next steps

2.0 Health Equity Structural Measure Concept

An important strategy to advancing equity across health care settings is to pursue novel health equity measurement strategies that can help to hold practitioners accountable, inform policymakers, and empower consumer decision-making. As a part of this work, CMS is considering adopting a structural measure to address health equity in the hospice and home health care settings. A potential cross-setting health equity structural measure concept was set forth in both the FY 2023 HQR and CY 2023 HH QRP rules (see Figure 1).³⁴ The structural measure concept was designed to assess organizational activities to address access to and quality of hospice and home health care for underserved populations. The Home Health & Hospice HE TEP members reviewed and discussed the domains and elements, both as a collective group and in breakout groups by care setting (i.e., hospice, home health). This section summarizes the TEP feedback, including breakout group comments, on the overall structural measure concept and each of the specific domains.



2.1 Overall Structural Measure Concept: Summary of Feedback

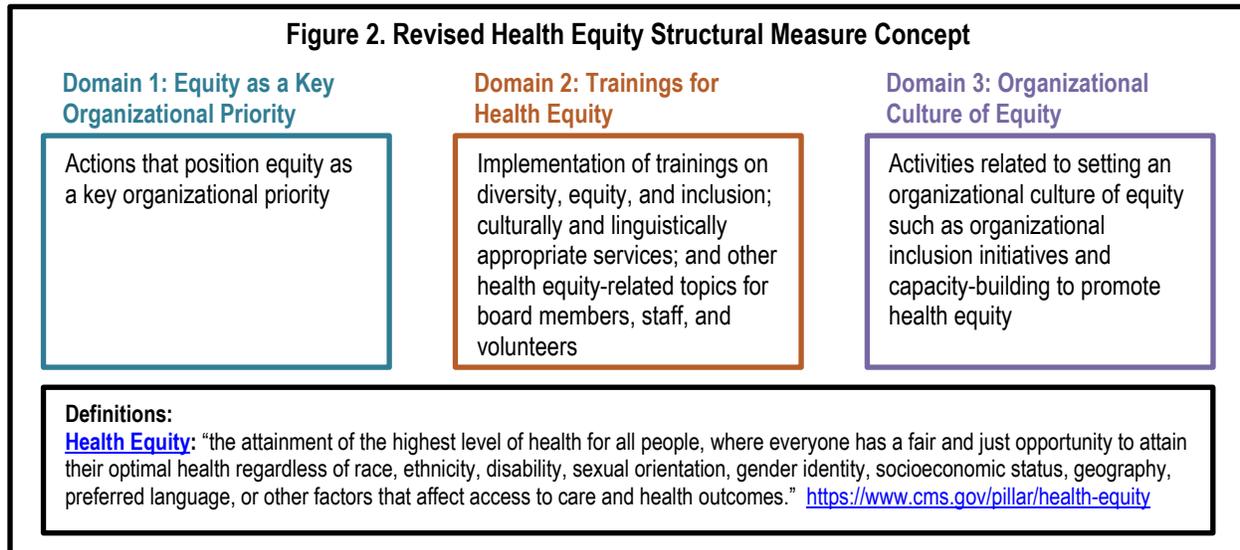
Generally, the TEP supported the structural measure construct as a first step to assessing HE in hospice and home health care settings. The TEP further acknowledged that the next steps should include measuring healthcare delivery through process and outcome measures.

Improving definitions for greater provider accountability. Overall feedback on the HE structural measure concept focused on providing definitions and increasing operationalization of key terms. TEP members suggested that the measure should explicitly integrate a shared definition of equity. Although TEP members had several suggestions for how the CMS definition of HE could be improved, they generally agreed it would be a good option for a shared definition in the structural measure. As seen in Figure 2, Abt Associates added the CMS definition of health equity in response to these suggestions. Additionally, TEP members suggested that each domain should include clearly operationalized definitions of key activities, like strategic planning or community engagement, for provider organizations to report on, as well as standards for those activities, and examples as needed. TEP members noted that improving

³ <https://www.federalregister.gov/d/2022-16214/p-229>

⁴ <https://www.federalregister.gov/d/2022-23722/p-506>

definitions and clarifying key requirements would be critical to ensuring that the structural measure promote greater accountability for providers and organizations.



TEP members expressed concern that without such accountability, providers would simply attest to activities, resulting in unreliable data and a measure that does not deliver sufficient variation in performance across providers. Suggestions included adding a requirement for providers and organizations to submit evidence regarding the reported activities, such as supporting documentation, rather than self-reported attestation—or “checkboxes”—alone. Furthermore, some TEP members noted that without such clarifications to definitions and reporting requirements, organizations that were created specifically to serve marginalized communities and have an unwritten commitment to equity may not perform as well on the HE measure – even though they may be providing high-quality equitable care.

Access is critical to equity. TEP members also pointed out that access is a critical concept missing from the structural measure. They specified that either the structural, or an additional supplemental measure should be used to explicitly address equity in access to services. For example, assessing whether the provider’s patient population is representative of the service area population at large would be one way to measure equitable accessibility. TEP members further discussed options for measuring access to services in a separate session on alternative approaches to monitoring health equity, which is summarized in Section 7.1 - Measuring Access to Services.

Structural measure both as a composite score and individual element scores. Of note, the TEP members expressed interest in developing the HE structural measure both as a composite measure with an overall score and with scores for each individual element in isolation. They noted that each would be useful for different purposes. For providers it would be most useful to view individual element scores so that they would have more specific information on areas for improvement. In contrast, on the consumer side a single overall composite measure would be easier to digest. However, any publicly shared composite score for health equity would need to include an explanation of how the score was computed. Additionally, some TEP members conveyed wanting to know more about how each of the domains and elements would be weighted in a composite measure.

Considerations to limit provider burden. When considering data collection for a structural measure, TEP members voiced concerns about the burden it would create for providers. While TEP members agreed that more specific documentation requirements would be necessary to increase provider accountability, this

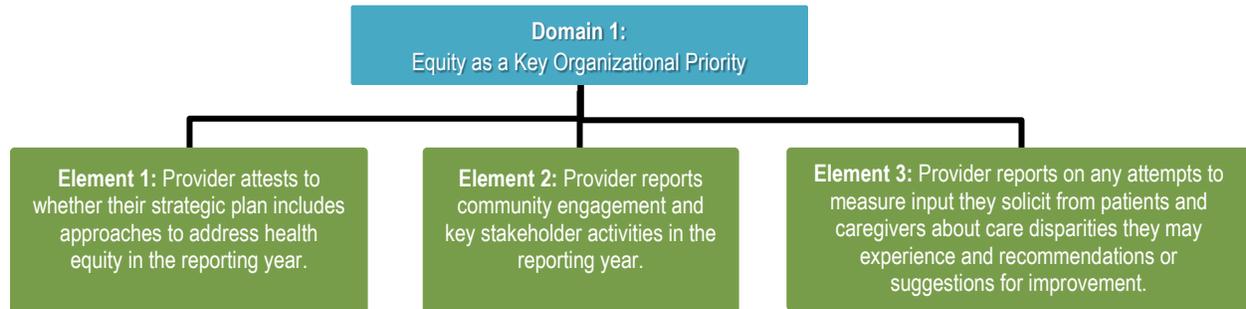
would necessitate additional data collection. Due to on-going workforce shortages, documentation burden is already a major challenge for many providers and organizations. To build capacity for data collection and foundational HE measurement work, TEP members suggested that this measure be implemented using a phased approach over time, such as designation of a pre-implementation year, a performance year, and a payment year.

The following sections provide a summary of TEP feedback for each of the three proposed HE structural measure domains and their respective data elements.

3.0 Domain 1: Equity as a Key Organizational Priority

This section summarizes the feedback provided by the Home Health & Hospice HE TEP on Domain 1, defined as “actions that position equity as a key organizational priority.” The originally proposed Domain 1 Elements can be seen below in Figure 3.

Figure 3. Domain 1: Equity as a Key Organizational Priority



3.1 Summary of Feedback

The TEP largely supported Domain 1, emphasizing that setting expectations at an organizational level would require providers to reflect on their efforts towards operationalizing HE throughout their entire organization. For providers to accomplish this, members suggested that CMS reorganize the elements and include a community needs assessment and organizational assessment of HE as preliminary activities. These assessments should evaluate the community and organization’s unique needs and challenges, including (but not limited to) health literacy levels.

“Community engagement must be more than attending a health fair. It must be meaningful. Community engagement and stakeholder activities should be deep listening sessions and creating partnerships in communities that have not been served by hospice.”
 –TEP Member Quote

Multiple TEP members suggested that CMS provide a Quality Assurance and Performance Improvement (QAPI) framework to organizations that delineates the required HE elements that their strategic plan should include and sets standards for reported activities. Members noted that this framework must allow for the provider to adapt HE plans based on their community needs assessment findings. TEP members also suggested revising Domain 1 elements to list activities that organizations might include in their strategic plans, to define community engagement, and to specify the types of evidence or supporting documentation required for attestation. For example, one TEP member proposed that a key deliverable from providers and organizations could be a list of identified community stakeholders for the provider to develop relationships with over time.

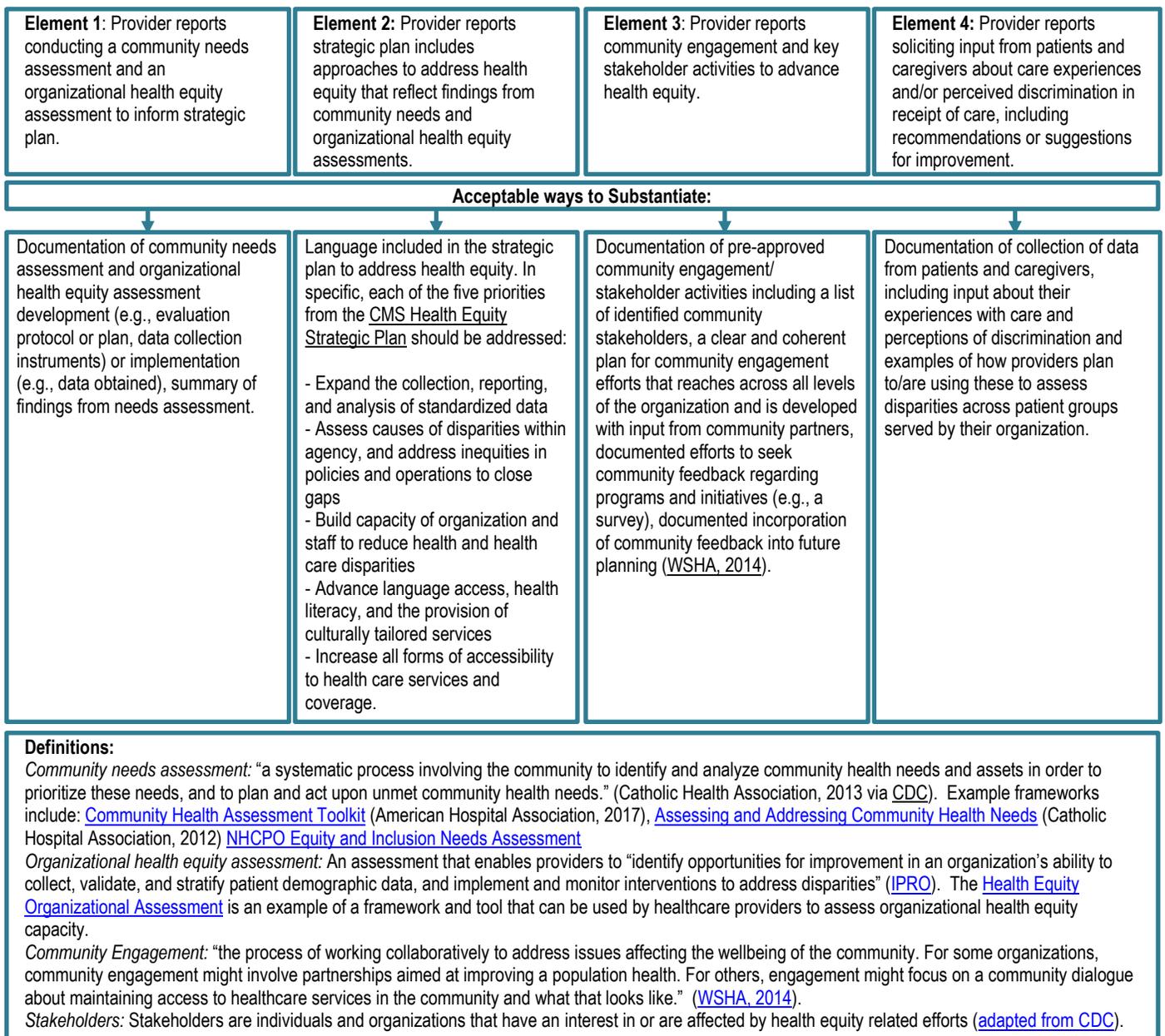
Some TEP members raised concerns that the proposed Element 3, which solicits information from patients and caregivers, puts the onus for measuring care disparities or inequities on the patients or caregivers rather than the provider. Members also raised concerns about Element 3’s language, advising removing the word “attempts” from the element and focus instead on successful efforts to collect such information. One member voiced that “attempts” could remain as there is still value in lessons learned from failed attempts. Due to these challenges, some of the TEP members suggested removing Element 3 from Domain 1 altogether. Ultimately, however, the TEP agreed that the patients and caregivers’ voices should be deliberately included in Domain 1. Instead of asking patients and caregivers about “care disparities they may experience,” TEP members suggested for providers to report on collected input about

overall care experience and perceptions of discrimination, which could then be examined for differences across patient groups.

3.2 Revised Domain 1: Equity as a Key Organizational Priority

Based on the feedback received during TEP meetings, Abt has revised Domain 1 and its corresponding elements for CMS consideration. Abt added a new Element 1 to reflect the TEP suggestions to add a community needs assessment and organizational health equity assessment. Abt revised the subsequent elements in this domain to emphasize that findings from these initial assessments should inform other efforts to center equity as a key priority. Abt also revised the originally proposed Element 3 per TEP suggestion, which is now displayed as Element 4. Additionally, definitions of key words were given with examples of how organizations may substantiate meeting the requirement of each element. Figure 4 below provides a visual representation of the revised Domain 1.

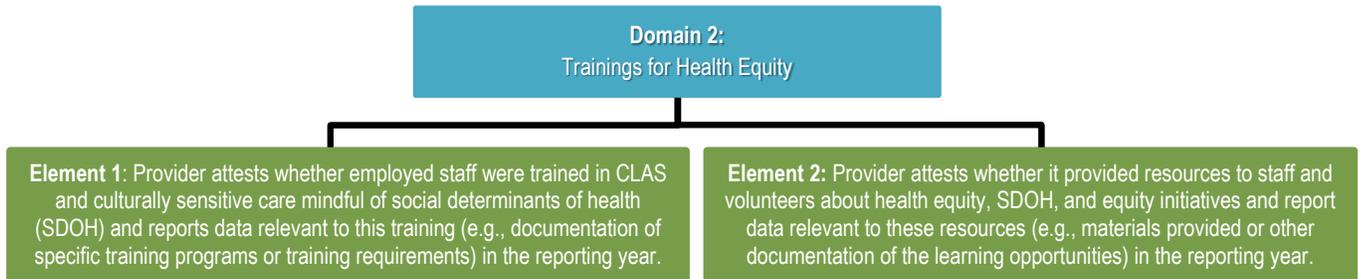
Figure 4. Revised Domain 1: Equity as a Key Organizational Priority



4.0 Proposed Domain 2: Trainings for Health Equity

This section summarizes the feedback provided by the TEP on Domain 2, defined as “implementation of trainings on diversity, equity, and inclusion; culturally and linguistically appropriate services; and other health equity-related topics for board members, staff, and volunteers.” The originally proposed Domain 2 Elements can be seen below in Figure 5.

Figure 5. Domain 2: Trainings for Health Equity



4.1 Summary of Feedback

The TEP largely supported Domain 2, however, members suggested revisions to the language in both of Domain 2 elements. For example, the TEP suggested that in Element 1 “employed staff” should be more specific and include the specific types of employed staff found in the domain definition (e.g., board members, leaders, staff, and volunteers). TEP members also stated that CMS should explicitly specify that leadership, administration, board members, and volunteers be required to participate in at least one equity-focused training annually.

The TEP further raised concerns about the types of training considered under Domain 2. TEP members suggested that the measure call for on-going learning opportunities beyond trainings (e.g., book clubs, work groups), potentially framing these trainings as continuous professional development rather than one annual training. The TEP emphasized that organizations will not be able to do “everything all at once” and advocated for incremental training implementation and for training standards to evolve over time. While considering this suggested incremental change, TEP members also underscored the need for accountability along the way. Additional concerns were raised about organizations using web-based training only for Domain 2. One TEP member expressed that most staff “need space to unpack past experiences, current experiences, and reflect on how to move forward” and that this is typically facilitated by in-person engagement, rather than online trainings. This TEP member further noted that partnerships with community stakeholders could play a key role in training, education, and cultural shifts within organizations.

“Online class[es] gives people a baseline knowledge and terminology, but that’s not how you learn, change, or drive a cultural shift in an organization. Each organization will have a different baseline understanding of this. There should be a minimum baseline that’s done annually online, but somehow this should tie into Domain 1 and the organization’s strategic plan. It should not be static. Just because they are focusing on one issue or population now, does not mean they should not expand their health equity work in the future. There should be incremental training that feels manageable but that providers are held accountable for.”

–TEP Member Quote

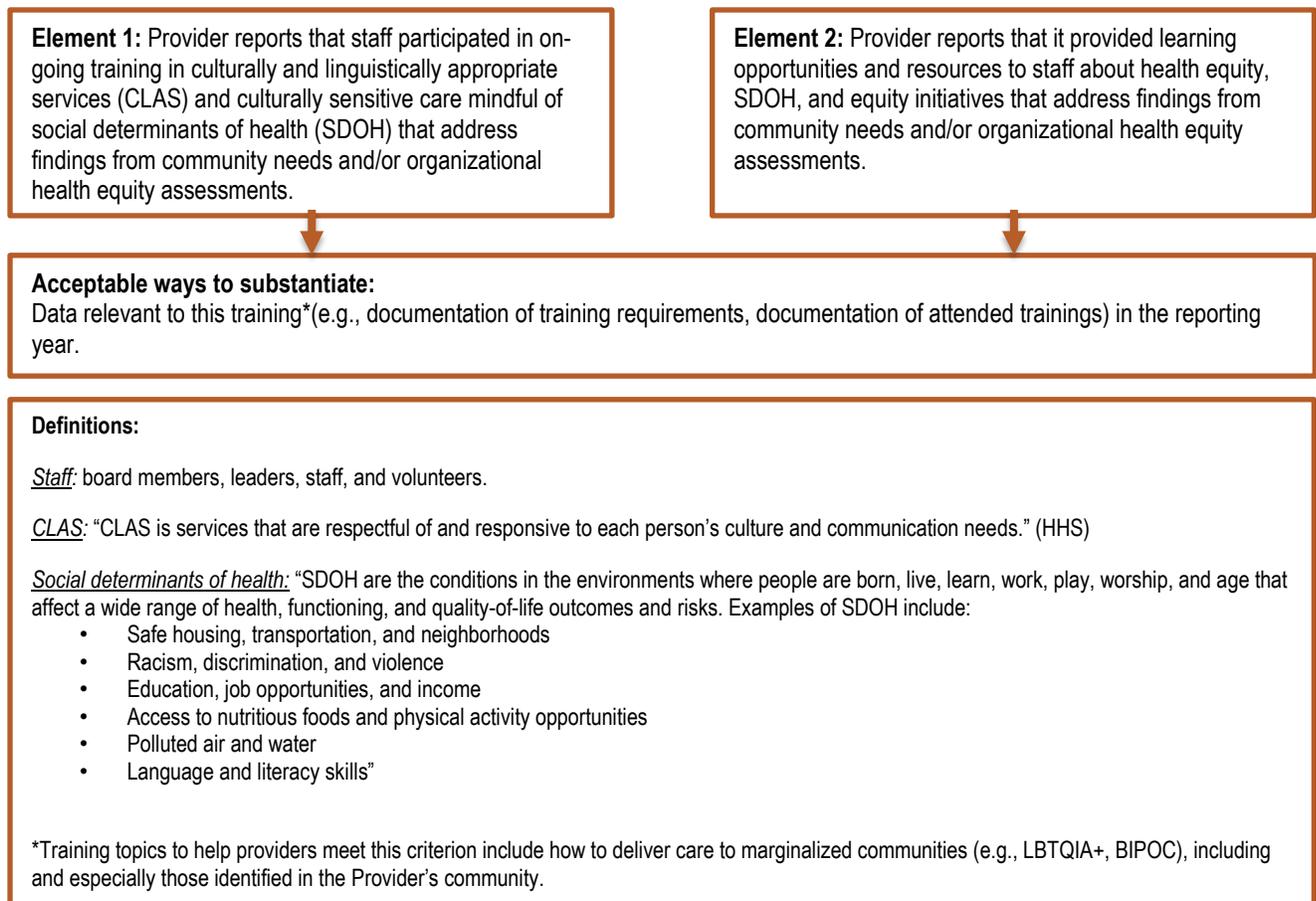
Finally, regarding the training content for Domain 2, the TEP advised that the training and learning requirements should define social determinants of health (SDOH) and standards for culturally and linguistically appropriate services (CLAS) in the measure. The requirements should be explicit about covering trainings on serving specific populations, such as Black, Indigenous, and People of Color (BIPOC) and Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and other sexual orientations and

identities (LGBTQ+). The TEP further suggested that training and learning requirements relate clearly to the strategic plan and the unique needs of marginalized patient groups, as identified through the community needs assessment defined in Domain 1, Element 1. One TEP member also suggested training for these topics could be integrated into curricula for already existing key discipline trainings, instead of organizations creating all new training content.

4.2 Revised Domain 2: Trainings for Health Equity

Based on feedback and suggestions given from the TEP, Abt revised Domain 2 found in Figure 6 below. “Staff” is now defined to encompass all paid and unpaid positions in organizations (e.g., board members, leaders, staff, and volunteers). Additionally, Abt added acceptable ways to substantiate that providers and organizations have been providing and requiring HE trainings (e.g., materials provided or other documentation of the learning opportunities).

Figure 6. Revised Domain 2: Trainings for Health Equity



Element 1: Provider reports that staff participated in on-going training in culturally and linguistically appropriate services (CLAS) and culturally sensitive care mindful of social determinants of health (SDOH) that address findings from community needs and/or organizational health equity assessments.

Element 2: Provider reports that it provided learning opportunities and resources to staff about health equity, SDOH, and equity initiatives that address findings from community needs and/or organizational health equity assessments.

Acceptable ways to substantiate:
Data relevant to this training*(e.g., documentation of training requirements, documentation of attended trainings) in the reporting year.

Definitions:

Staff: board members, leaders, staff, and volunteers.

CLAS: “CLAS is services that are respectful of and responsive to each person’s culture and communication needs.” (HHS)

Social determinants of health: “SDOH are the conditions in the environments 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. Examples of SDOH include:

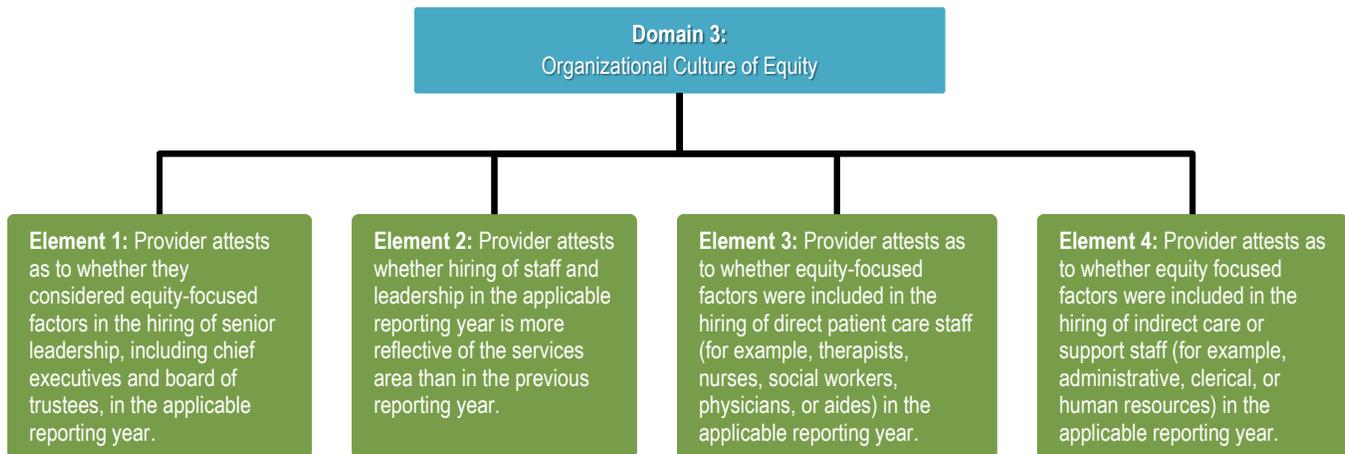
- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills”

*Training topics to help providers meet this criterion include how to deliver care to marginalized communities (e.g., LBTQIA+, BIPOC), including and especially those identified in the Provider’s community.

5.0 Proposed Domain 3: Organizational Culture of Equity

This section summarizes the feedback provided by the TEP on Domain 3, defined as “activities related to setting an organizational culture of equity such as organizational inclusion initiatives and capacity-building to promote health equity.” The originally proposed Domain 3 Elements can be seen below in Figure 7.

Figure 7. Domain 3: Organizational Culture of Equity



5.1 Summary of Feedback

For Domain 3, TEP members suggested the elements reflect a more concrete way to measure how an organization is shifting their culture to advance equity. Specifically, members noted that the word “considered” as well as “attests” would give providers and organizations flexibility to say they considered equity, while not having changed any of their hiring patterns. The TEP agreed that there should be clearer directives and definitions to increase the accountability built into Domain 3.

“Accountability is what moves the needle from thought to action.”
—TEP Member Quote

Some TEP members suggested that this domain define “equity-focused factors” and expand the elements beyond hiring for diversity. The TEP offered, for example, to consider including recruitment, career development, and upward mobility in addition to hiring efforts. Some TEP members also suggested having organizations describe how they are incorporating health equity and addressing biases within the organization, including community engagement activities. For example, one TEP member posed this potential question for organizations to answer:

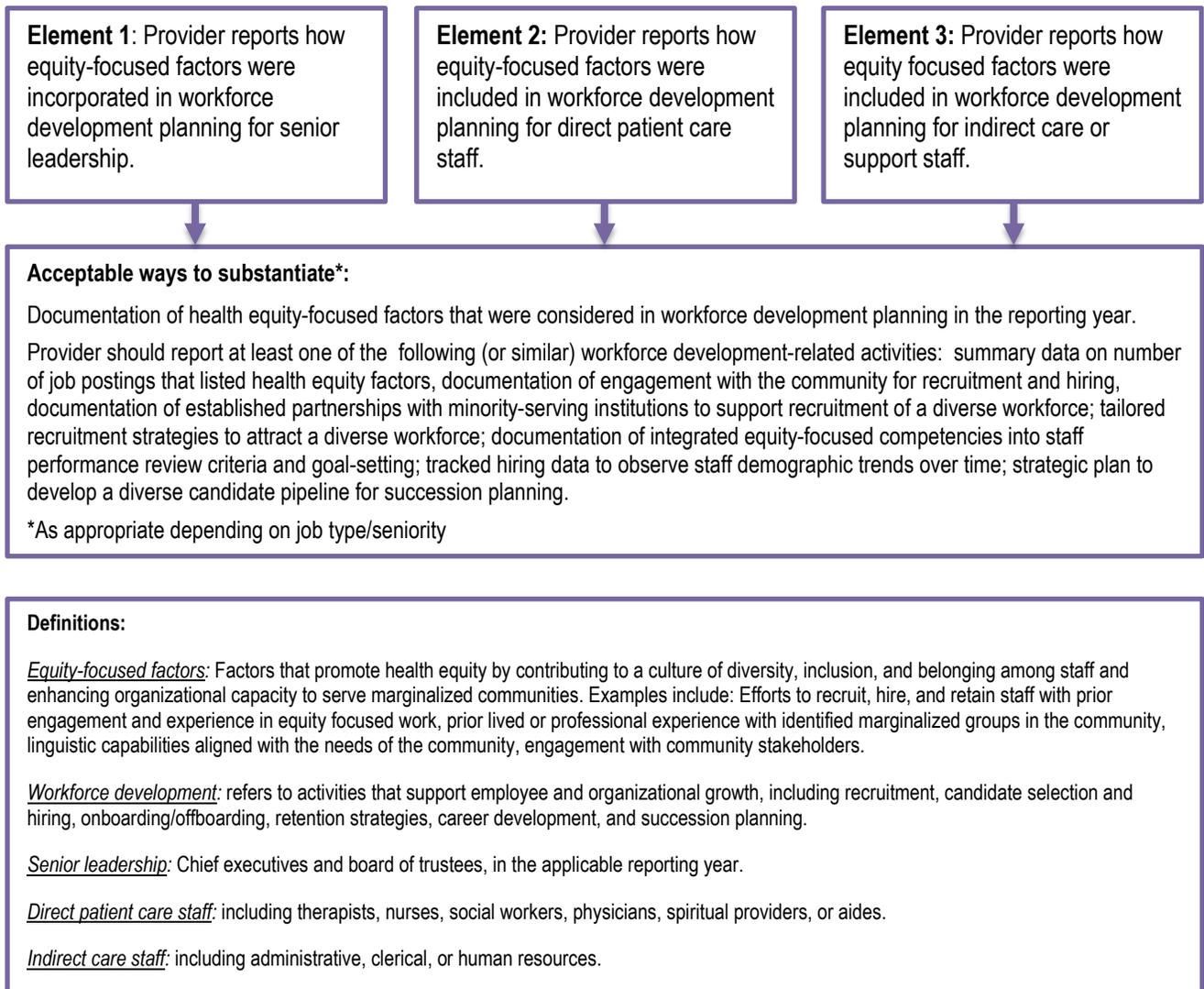
“What action steps did you take to check your own biases and address structural/systemic racism, sexism, etc. in hiring senior leadership?”

TEP members were concerned that due to the workforce shortage prevalent across healthcare sectors, providers will not have the ability to ensure their staffing demographics reflect the communities they serve, particularly for rural and remote organizations. Additionally, some members expressed that Element 2 may have potential to promote tokenization and overemphasize leadership hiring quotas. While some members suggested collection of hiring data, other TEP members noted this might not be relevant for organizations that already have a diverse or representative workforce. The TEP discussed CMS considering at what point does it no longer make sense for an organization to stop focusing on or prioritizing hiring if they have a diverse and representative workforce. Overall members suggested removing Element 2.

5.2 Revised Domain 3: Organizational Culture of Equity

Abt made significant revisions to the Elements in Domain 3 based on TEP feedback, as seen in Figure 8 below. First, Abt removed the originally proposed Element 2. Further, Domain 3 now has three elements that focus on how a provider or organization included equity-focused factors in their workforce development efforts, instead of attesting that they considered it. Moreover, Abt added detailed definitions of key terms to specifically identify what qualifies as “workforce development” and “equity-focused factors.”

Figure 8. Revised Domain 3: Organizational Culture of Equity



6.0 Confidential Feedback Report: Summary of Feedback

The Home Health and Hospice HE TEP also reviewed and provided input on a potential Confidential Feedback Report (CFR) for Health Equity. A CFR displays quality measure data for a specific provider at the patient or agency level and is available for viewing only by the provider agency for the purpose of improving their quality of care. In some cases, CFRs are used as an initial step for providers to preview quality measure information that subsequently moves forward for public reporting.

The goal of the example CFRs for health equity was to allow providers to identify any differences in quality measure (QM) outcomes between beneficiaries enrolled in both Medicare and Medicaid (i.e., dually eligible) as compared to Medicare-only beneficiaries. Therefore, the mock-up CFRs were provider-level reports demonstrating the provider's performance on a specified QRP QM, stratified by beneficiaries' dual eligibility status. Measure stratification helps identify disparities by calculating quality measure outcomes separately for different beneficiary populations. Dual eligibility status was selected as the stratifying variable in this example CFR because it has been recognized as a proxy for low socioeconomic status⁵ and is readily available in Medicare administrative data.

The CFR mock-ups used Discharge to Community (DTC) and Hospice Visits in Last Days of Life (HVLDDL) as the example QM for HH QRP and HQRP, respectively. The DTC measure for HH and HVLDDL measure for Hospice were selected for inclusion in the example CFRs because each has been endorsed by the CMS consensus-based entity as valid and reliable measures for which relevant stratifiers under consideration by CMS would be available. Additional rows in the tables listed the dual eligibility stratified performance of other similar provider groups (e.g., providers in the same state, nationally, or same kind of location, such as urban or rural) as comparison points.

TEP members were hesitant to either fully support or vote against some of the confidential feedback report elements and expressed a need to better understand how the reports are intended to be used, which would have important implications for what the TEP would support. TEP members noted that with a better understanding of the goals and use of the CFRs, certain statistical comparisons may be more useful, such as comparisons between similar provider groups such as those within the same state or geographic region. TEP members emphasized that the reports would need to clearly state how its numbers are calculated, including how quality measures are risk-adjusted. They also discussed the need for better provider access to and education about the report and its contents.

Overall, the TEP agreed this type of data reporting should remain confidential, at least upon initial release, to prevent unintended consequences of public reporting such as deterring patients from seeking services altogether. One TEP member also suggested that it would be useful to conduct a pilot program with a Confidential Feedback Report for Health Equity to assess and maximize its utility prior to implementing it across all providers.

Most members expressed the need to select more meaningful data into the reports prior to implementation. More specifically, they asserted that more deliberate selection of both the quality measures (i.e., DTC and HVLDDL) and stratification variable (i.e., dual-eligibility

“Socioeconomic status also includes education and other measures. Medicare/Medicaid status also might indicate long-term care. Dual eligibility often can mean they have an income (e.g., SSI/SSDI). Because of this, dual eligibility is a poor measure for socioeconomic status and people without incomes are unaccounted for.”

–TEP Member Quote

⁵ Roberts, E. T., Mellor, J. M., McInerney, M., & Sabik, L. M. (2019). State variation in the characteristics of Medicare-Medicaid dual enrollees: Implications for risk adjustment. *Health Services Research, 54*(6), 1233-1245.

status) is necessary to effectively monitor health equity. TEP feedback on the selection of stratification variables and quality measures is summarized in the following sections.

6.1 Input on Stratification Variable Options for Health Equity CFRs

The TEP strongly opposed the use of dual eligibility as a stratifying variable to assess health equity. In particular, members pointed out that Medicaid eligibility has been suggested to be a poor measure of low socioeconomic status, as it is often reflective of chronic disability and therefore receiving some kind of income (e.g., Social Security Disability Insurance, Supplemental Security Income) and greater access to long-term services (e.g., personal care assistants). One TEP member noted that dual eligibility status can also systematically exclude individuals with certain diagnoses (e.g., cancer), because it can require establishment of disability status over an extended period, which some patients do not have, unfortunately. Furthermore, the TEP member noted that some individuals who are Medicaid eligible based on their income status may not apply for Medicaid benefits due to the societal stigma associated with poverty. Another TEP member also pointed out that Medicaid eligibility varies by state, which means there are state-based differences in socioeconomic characteristics of Medicaid beneficiaries. TEP members asserted that dual-eligibility status would not be the most accurate indicator of SES and that other stratification variables would more reliably assess such disparities.

Members suggested use of SDOH indicators as stratifying variables for health equity. Suggested SDOH stratification variables included food insecurity, housing instability, need for language interpreter services, and other measures of socioeconomic status. Some TEP members noted that some of these are already available through QRP assessment data, such as OASIS; others noted that additional SDOH items could be obtained by incentivizing or requiring use of Z codes.⁶ Other TEP members suggested integrating Area Deprivation Index scores⁷ to use for stratification purposes. Additionally, TEP members suggested considering comparing outcomes across types of geographical location (e.g., rural vs. urban). Lastly, most TEP members raised race/ethnicity as an important stratification variable to assess equity in quality of care across racial and ethnic groups. For example, one alternative idea suggested for the Hospice CFR was to stratify Hospice Care Index (HCI) by race/ethnicity. Furthermore, one TEP member noted that it would be useful to consider the intersectionality of race/ethnicity and marginalized groups (e.g., BIPOC & LGBTQIA, BIPOC & Female).

6.2 Input on Quality Measure Options for Health Equity CFRs

Generally, TEP members also opposed the use of DTC and HVLDL as the selected quality measures for which to assess HE. This was due to the perception that these measures have limitations that may make it challenging to accurately assess equity issues. With regards to the DTC, TEP Members noted that discharging a patient to the community is not appropriate for all patients and there are cases in which it is appropriate to transfer to a hospital. This often applies to individuals with long-term chronic conditions, some of which are more likely to affect already underserved populations. TEP Members noted that this

⁶ Z codes are a tool for identifying a range of issues related – but not limited – to education and literacy, employment, housing, ability to obtain adequate amounts of food or safe drinking water, and occupational exposure to toxic agents, dust, or radiation. Z codes can be used in any health setting (e.g., doctor’s office, hospital, skilled nursing facility and by any provider (e.g., physician, nurse practitioner). <https://www.cms.gov/files/document/z-codes-data-highlight.pdf>

⁷ The Area Deprivation Index is based on a measure created by the Health Resources & Services Administration (HRSA) over three decades ago. It allows for rankings of neighborhoods by socioeconomic disadvantage in a region of interest (e.g., at the state or national level). It includes factors for the theoretical domains of income, education, employment, and housing quality. It can be used to inform health delivery and policy, especially for the most disadvantaged neighborhood groups. <https://www.neighborhoodatlas.medicine.wisc.edu/>

measure may penalize providers who are providing quality care, or worse, incentivize providers to systematically avoid patients who are less likely to be discharged to the community. Stratifying the DTC measure may therefore yield biased results that do not account for differential rates of appropriate hospital transfer across communities nor the potential provider selection consequences of the measure. Similarly, there was discussion around use of the HVLDDL as a QM for which to assess HE, given that patient and caretaker preferences can vary at end of life, including a preference to decline visits from providers or to have visits from other types of providers (e.g., chaplain) who are not considered in this measure. Because such preferences may be more common among certain communities, TEP members noted that this may introduce bias in stratified results.

One Home Health TEP member suggested that a potential quality measure to include is number of nursing minutes, for example by race/ethnicity or geographical area, to assess whether patients are receiving the same level of care across groups. Other alternative quality measures suggested by the TEP for home health providers were hospitalization rates and functional outcome measures. For hospice settings, TEP members recommended early live discharge and HCI as alternative QMs to include in a health equity CFR. Lastly, members highlighted that (regardless of the quality measure utilized) stratified reporting QM outcomes alone would not allow providers to evaluate inequities in access to services, since QM data are collected only on patients who receive care and not those who do not access services. The following section includes a summary of additional TEP member discussion regarding options for measuring access to services.

7.0 Additional Approaches to Measuring Health Equity: Summary of Feedback

In the second TEP discussion, members were asked to discuss potential novel approaches to measuring health equity in hospice and home health and actionable next steps. The TEP met collectively as well as in hospice and home health breakout groups, this section presents a summary of overall TEP suggestions as well as themes found in hospice and home health breakout groups respectively.

7.1 Measuring Access to Services

Throughout the three TEP meetings, a main concern among the TEP members was ensuring that CMS not only measures equity in service provision, but also equity in access to services.

In the home health breakout group, members discussed that an important determinant of equitable access is insurance coverage. Members emphasized that often there are stark differences in coverage by insurance providers which can result in inequities in access. Therefore, TEP members agreed that to evaluate equity in access, CMS should examine how insurance coverage and restrictions may vary across individuals and populations.

HH-based TEP members also emphasized that another critical driver of inequities in HH access is “cherry-picking.” This refers to the practice of HH providers to intentionally select lower-risk or less medically complex patients to perform better on a quality measure. This translates into limited access to care among patients with chronic, long-term, and/or degenerative conditions, who are more likely to be members of underserved and marginalized groups - ultimately exacerbating inequities. One TEP member noted that the Medicare Payment Advisory Commission (MedPAC) definition of access, i.e., the number of agencies in a ZIP code area, is flawed because it does not assess whether the agencies are serving all people in their ZIP code area equitably. TEP members proposed that one approach to measuring cherry-picking would be to track who in the underlying patient population HHAs are not serving, though the group acknowledged it is not clear how this could be operationalized at this time.

“I am really concerned that although we see this overall increase in quality and maybe access overall, that’s experienced differently by different groups. Finding a way to track who a [home health agency] is accepting or where they are serving is really important.”

–TEP Member Quote

One TEP member in the HH breakout group discussed the potential opportunity to align HE measures with QMs used in value-based payment (VBP) models.⁸ However, the majority of TEP members did not agree with this approach because they believe the measures used in the expanded Home Health Value-Based Purchasing (HHVBP) Model may intensify patient selection issues already seen in the HH QRP. TEP members noted that in the expanded HHVBP Model there is still power in the referral system for providers to select patients and that QMs included in the program mostly focus on improvement of condition. Therefore, agencies may be more likely to serve patients who are expected to improve rather than remain stable or decline, as described in the previous paragraph. Most TEP members expressed concerns about aligning with the quality measures used in the expanded HHVBP Model for this reason.

In the Hospice breakout group, members similarly discussed the importance of finding ways to capture information about patients who were not served, and why they were not served. Additionally, the hospice

⁸ “Value-based programs reward health care providers with incentive payments for the quality of care they give to people with Medicare... Value-based programs are important because they’re helping us move toward paying providers based on the quality, rather than the quantity of care they give patients.” – [CMS.gov](https://www.cms.gov)

group raised concerns about collecting data from family or caregivers of hospice decedents rather than collecting data directly from patients while they are receiving care. Vulnerable populations, such as hospice patients who do not have family members to help with their care or unhoused people, often do not have a contact post-mortem, and thus would be left out of data collection.

The TEP members across both HH and hospice generally agreed that evaluating whether the patient population, rather than the staff population, reflects the community it serves (i.e., designated service area) would give a better perspective on equity in access and utilization.

7.2 Innovative Strategies to Improve Collection and Use of Patient Feedback

Overall, the TEP indicated that strategies to improve measurement of patient feedback should include collecting confidential patient experience data while ensuring that patients are comfortable sharing, and that their care will not be negatively impacted by providing feedback. The TEP suggested that this type of feedback be collected through a phone survey administered by neutral third parties and emphasized that information should be collected from the patient themselves rather than a caregiver whenever possible. The TEP also noted that many of the surveys patients and caregivers are asked to complete are lengthy. While some TEP members suggested adding specific questions, multiple TEP members emphasized the need to “keep it simple.”

TEP members noted there should be a continuous feedback loop to inform agency staff how to improve the provision of care, through more frequent patient feedback. While some TEP members described challenges with low response rates in their patient populations, one member gave an example from their own experience of texting patients in the week after care was received and asking a simple 5-question survey.

In breakout groups, Hospice TEP members discussed adding specific questions to the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)⁹ about cultural sensitivity. They suggested following up with all survivors and asking specifically if they felt treated with dignity and respect with regard to 1) their race and/or ethnicity and 2) their sexual orientation and gender identity (SOGI). Alternatively, one TEP member suggested that a more generic approach to soliciting this information would be to ask survivors if they felt treated with dignity and respect regarding “diversity and difference.” The Home Health breakout group suggested adding items to CAHPS to include the new Outcome and Assessment Information Set E (OASIS E) items.

7.3 Other Feedback: Potential Health Equity Frameworks and Public Reporting for Health Equity

“With respect to access to care, CMS could look at if providers are serving the communities that they’re in in an equitable way. For example, if you looked at the demographics of the agency service area (e.g., county), does the patient population match those demographics?”

–TEP Member Quote

Throughout the TEP meeting discussions, two additional topics were identified: 1) including options for frameworks that CMS may use to implement health equity initiatives, and 2) how to publicly report the demographics of patients that are being served.

One TEP member suggested [Merit-Based Incentive Payment System](#) (MIPS) as a pre-established framework for reporting process measures among physicians. The MIPS process outlines four core areas of quality from which the provider can select a set number of measures to report on and that contribute to the overall quality score. This member noted this framework would be familiar to providers and could be

⁹ For more information on the Home Health Care CAHPS Survey: <https://homehealthcahps.org/>
For more information on the Hospice care CAHPS Survey: <https://hospicecahpsurvey.org/>

used as a structured approach to implementing HE measures that would still allow for flexibility – acknowledging that providers are starting from different places with regards to equity work. With regards to implementing initiatives to promote health equity, such as DEI programs, this member suggested that the use of a process improvement model (e.g., Lean Six Sigma) may be a useful vehicle.

Multiple TEP members brought up transparency and suggested reporting demographic data of the patient population that providers and organizations serve. While some concerns about personal health information and possible unintended consequences were raised, members emphasized that data should be reported at a community level. This demographic data should report on who the hospice and home health agencies serve, including aggregate data on patients served by socioeconomic status and race/ethnicity. Overall, the TEP noted the importance of patients having the provider-level information they need to make a more informed decision regarding their care.

8.0 Conclusions

Overall, the three domains in the structural measure concept were well received by the TEP even though they offered a considerable amount of constructive feedback for each domain's elements. The TEP raised concerns about implementation of the measure and proposed using a phased approach. Broad themes that recurred throughout discussions were community access and alignment between the community population and the organization's patient population. A key suggestion regarding additional HE measurement was ensuring a framework is in place for providers and organizations to use as a guide when implementing a new organizational culture of equity.

For Domain 1, element revisions reflect suggestions to ensure that the equity-focused priorities of organizations reflect the needs of the communities they serve. In Domain 2, revisions included providing examples to organizations on appropriate ways to substantiate that they provided training and learning opportunities. In Domain 3, major element revisions reflect expansion to include all workforce development efforts (as opposed to just hiring) and to consider a broader range of "equity-focused factors" in such efforts, beyond solely hiring for diversity.

As for Confidential Feedback Reports, members proposed that such reports for HE should include the purposeful selection of data to effectively monitor and assess health equity. The TEP generally agreed that such a report would need to include a more clearly defined purpose and that providers would need to be educated on how to access and utilize the information in the report. Further, TEP members overall agreed that the report should remain confidential for the time being. They also offered alternative suggestions for both quality measures (e.g., number of nursing minutes) and stratification variables (e.g., SDOH items, race/ethnicity) that may be more appropriate for monitoring health equity. TEP discussions regarding additional approaches to measure equity in access to services, included the importance of capturing information about patients who were not served and why they were not served. Additionally, TEP members emphasized organizational transparency, advising to collect and report demographic data of the patient population that providers and organizations serve. Lastly, TEP members highlighted the importance of data collection directly from patients rather than caregivers whenever possible.

Throughout the TEP's discussion, they referred to equity-related resources that they use in their practices. These resources may be useful to organizations and providers who are looking to integrate equity into their organizational culture. Appendix B lists each resource along with a brief description and source.

Appendix A: TEP Member Bios

- **Kimberly Acquaviva, PhD, MSW, CSE, FNAP** is a professor at the University of Virginia School of Nursing with a disciplinary background in social work and clinical background in hospice social work. Her research focuses on LGBTQ+ inclusive hospice work. She applied to the TEP due to a long-term interest in improving LGBTQ+ inclusion within the hospice setting, as well as lived experience.
- **Lonnette Campbell** has 38 years of hospice experience with a disciplinary background in cross-cultural aspects of health care. Her clinical background includes work within Native American communities, experience as the director of home health agencies, bedside work in the hospice setting, and hospice compliance experience. She applied to the TEP seeking to create impact in area that has been long overlooked.
- **Nicole DePace, MS, ARPN, GNP-BC** is a nurse practitioner based in Boston, MA. Her clinical background is in community-based palliative care, encompassing direct-patient care and program development. She currently works with a home-health provider overseeing advanced illness and palliative care programs. She is a PhD student at the University of Massachusetts Boston, researching health policy and population health. She applied to the TEP hoping to contribute to meaningful action in addressing the needs of seriously ill patients served by home health and hospice providers, particularly between diverse urban and rural communities being served by smaller local organizations.
- **Shekinah Fashaw-Walters, PhD, MSN**, is an Assistant Professor at the University of Minnesota. She is trained as a health services researcher, with a focus on equity in home health setting. She applied to the TEP because she was interested in the measurement of quality and how those definitions impact equity in terms of access and outcomes.
- **Jenni Gudapati, MBA, RN** is a program director at Boise State University. She is a practical academic bringing real world experience to curriculum development. She served as President of the Idaho Association for Home Care and Hospice for several years before being appointed to a national organization. She is currently a PhD Student in Public Policy development. She applied to the TEP to share her clinical experience in rural areas of Idaho and Oregon, which have demonstrated the disparity between urban and rural healthcare settings.
- **Marisette Hasan, BSN, RN** is the current President and CEO of The Carolinas Center for Hospice and End of Life Care and Chair of the South Carolina Coalition for the Care of the Seriously Ill. She is a National Hospice and Palliative Care Organization (NHPCO) Diversity Advisory Council member, is working with the Center to Advance Palliative Care (CAPC) on race curriculum and is working with Ariadne Labs as an advisory member on a race dialogue tool. She has been a registered nurse for 41 years. She applied to the TEP because to share her experience seeing African-American organized Hospice centers attain demonstrated improvements in African-American enrollments. She hopes to improve access within served communities.
- **Kathleen Holt, MBA, JD** is the Associate Director of the Center for Medicare Advocacy, a nonprofit law firm that works with potential Medicare beneficiaries. She has experience with several TEPs, including panels on the patient driven and unified payment model. She applied to the TEP because she is looking to expand access and identify people not being measured and/or served.
- **Kentrell Liddell, MD, MBA** is a family medicine physician representing home health and hospice. She is an expert in clinical quality management and federally qualified health centers. She has consulted for a home health and hospice center in the Mississippi Delta for 15 years. She serves on National Association for Home Care & Hospice Rural Advisory Committee and is the CEO of Test-

Taking Solution in Jackson, MS. She applied to the TEP because healthcare is becoming increasingly complicated and is leaving historically marginalized people behind.

- **Jacqueline Lopez-Devine, MSN, RN** has 17 years of experience in the hospice setting with a background in nursing. Her expertise is in administration and clinical informatics and emergency management. She applied to the TEP because of her personal connection to hospice through her parents and hopes to demonstrate the benefit of hospice to underserved communities.
- **Suzanne Marmo, PhD, LCSW, APHSW-C** is an Assistant Professor of Social Work with 28 years of experience in hospice social work. She applied to the TEP to impact change in hospice care and expand equitable end of life care through a measurement and solution focused lens.
- **Robert Parker, DNP, RN, CENP, CHPN, CHP** is the Chief Compliance Officer for a freestanding hospice and palliative care organization. His focus is on programmatically organizing palliative care for improved continuity of care, mostly in underserved communities. He is a current PhD student with research focusing on exclusionary language found in hospice policy. He is excited by the opportunity to collaborate and learn with other experts around the country toward goal of promoting equitable hospice care.
- **Robert Rosati, PhD** has a background in psychology and applied research. Most of his career has been in healthcare and for over 20 years focused in improving the quality of home health care and hospice. He is the Vice President of Research and Quality at VNA Healthcare, a home health and hospice provider in New Jersey, Ohio, and Florida. He is excited by the direction of CMS and eager to integrate discussion from TEP in VNA's equity programs.
- **Ernest Roy, PT, DPT, COS-C** is the Quality Director and Compliance Officer for home health and hospice center in Plymouth, NH, and physical therapist by trade. He brings 12 years of experience in home health and hospice. He facilitates interest groups including quality directors and rehabilitation centers. He was motivated to join the TEP by research and exposure to disparities in outcomes among different socio-economic groups and is eager to promote equity-based solutions.
- **Cardinale Smith, MD, PhD** is a health services researchers specializing in thoracic oncology, palliative medicine, health equity, cancer quality, and cancer care delivery. She believes this new proposed HE TEP presents a critical opportunity to provide input on development of a home health and hospice health equity structural quality measure to address access to and quality of hospice and home health care for underserved populations.
- **Toby Weiss, MS** is the Assistant VP of Cultural Diversity for MGHS Hospice and Palliative Care in New York City. She leads a team of cultural sensitivity liaisons and outreach coordinators serving diverse patient populations. She has experience in community outreach and cultural humility trainings as well as cultural assessments. She values discussion around SDOH, specifically clarifying how EMRs incorporate SDOH and other quality measures.

Appendix B: Health Equity Resources Provided by TEP Members

Resource	Description
<p><i>National Hospice and Palliative Care Organization Diversity (NHPCO) Toolkit:</i></p>	<p>“The Inclusion and Access Toolkit was created by the NHPCO Diversity Advisory Council to give you tools and resources to create an inclusive organization. Some foundations of inclusive care are described in each section to help you better understand the needs of your unique communities. This toolkit includes suggestions based on the experiences of hospice providers in many settings throughout the United States.” More info can be found here: https://www.nhpc.org/education/tools-and-resources/diversity/</p>
<p><i>Center to Advance Palliative Care (CAPC) Project Equity:</i></p>	<p>“Major structural change is required to achieve a U.S. health system that provides high-quality, person-centered, equitable care for all patients with serious illness. The goal of CAPC’s Project Equity initiative is to create paths and tools the palliative care field can use to effectuate meaningful change that will reduce the inequities experienced by traditionally marginalized communities.” More information can be found here: https://www.capc.org/project-equity-improving-health-equity-for-people-with-serious-illness/</p> <p>“Health professionals have a unique opportunity to lead in achieving health equity by establishing trust and alleviating suffering for traditionally oppressed or excluded patients. This toolkit provides curated tools and resources to improve the quality of care provided to these patient groups and move the needle on equity for all people living with serious illness.” CAPC’s Health Equity Toolkit can be found here: https://www.capc.org/toolkits/achieving-health-equity/</p>
<p><i>American Academy of Hospice and Palliative Medicine (AAHPM):</i></p>	<p>“Diversity, Equity, and Inclusion Resources - AAHPM is committed to educating and building a community that embraces diversity, equity, and inclusion. The following resources are intended to provide education and learning opportunities and are not officially endorsed by AAHPM.” More tools and resources can be found here: http://aahpm.org/membership/dei-resources</p>
<p><i>National Coalition for Hospice and Palliative Care:</i></p>	<p>“Below is a list of resources created by Coalition Members to help us and those in our field learn and self-reflect on issues surrounding health and racial equity. This list is an ongoing effort by the Coalition to provide a hub for tools and resources to help our field learn, challenge ourselves, and have the hard conversations with our peer groups, our colleagues and within our institutions.” More information can be found here: https://www.nationalcoalitionhpc.org/dei/</p>

<p><i>National Association for Home Care & Hospice:</i></p>	<p>“While organizations commit to correcting imbalances in the workplace, they’re often met with significant challenges. What’s missing is the critical connection point between monitoring DEI metrics and using that data to improve the effectiveness of DEI programs to create lasting, meaningful change.” NAHC’s video on how to execute DEI initiatives that net meaningful change can be found here: https://www.nahc.org/video-on-demand-how-to-execute-dei-initiatives-that-net-%20meaningful-change/</p>
<p><i>National Rural Health Resource Center</i></p>	<p>Rural Health Equity and Quality Summit (Sept 2022):</p> <p>“The goal of this report is to help rural hospitals, clinics, and network leaders move forward on their path to value-based care (VBC) and alternative payment models (APMs) by focusing on the objectives and outcomes of the summit, including solutions for achieving rural health equity offered by panelists.”</p> <p>https://www.ruralcenter.org/sites/default/files/Rural%20Health%20Equity%20and%20Quality%20Summit%20Report%20FINAL_0.pdf</p>
<p><i>The National Institute on Minority Health and Health Disparities (NIMHD)</i></p>	<p>The <u>National Institute on Minority Health and Health Disparities</u> (NIMHD) is the lead institute on research to improve minority health and reduce health disparities.</p> <p>“The NIMHD Minority Health and Health Disparities Research Framework is a multi-dimensional model that depicts a wide array of health determinants relevant to understanding and addressing minority health and health disparities. The framework facilitates assessment of progress, gaps, and opportunities in the NIMHD and NIH minority health and health disparities research portfolios.”</p> <p>https://www.nimhd.nih.gov/about/overview/research-framework/</p>
<p><i>American Public Health Association (APHA)</i></p>	<p>American Public Health Association. Equity, Diversity, Inclusion: Action Toolkit for Organizations.</p> <p>“This toolkit serves as an encouraging first step for any organization ready to implement E-D-I practices. Using this toolkit, board and staff members can assess their current practices and find resources to ensure continued growth in diversity and equity. Lastly, E-D-I work is an ongoing journey, which a committed organization must regularly and frequently revisit.”</p> <p>https://www.apha.org/-/media/files/pdf/affiliates/equity_toolkit.ashx</p>
<p><i>Books and Articles about Equity:</i></p>	<p>Evans, M. K. (2020). Health equity—are we finally on the edge of a new frontier? <i>New England Journal of Medicine</i>, 383(11), 997-999. Article can be found here: https://www.nejm.org/doi/full/10.1056/NEJMp2005944</p> <p>Acquaviva, K.D. (2017) <i>LGBTQIA-Inclusive Hospice and Palliative Care: A Practical Guide to Transforming Professional</i></p>

	<p><i>Practice</i>. Columbia University Press. More information about the book can be found here: https://www.lgbtq-inclusive.com/</p> <p>Jones, CP. (2000). Levels of Racism: A Theoretic Framework and a Gardener's Tale. <i>Am J Public Health</i> 90, 1212-1215. (PDF).</p> <p>Dahlin, Constance MSN, ANP-BC, ACHPN, FPCN, FAAN; DePace, Nicole MS, GNP-BC, APRN, ACHPN; Ford, Jeanna DNP, ACNS-BC, APRN, ACHPN, FPCN; Maani-Fogelman, Patricia DNP, FNP-BC, CRNP, ACHPN; Chow, Kimberly DNP, MBA, ANP-BC, ACHPN. Promoting Health Equity: Palliative Nurses on the Frontlines. <i>Journal of Hospice & Palliative Nursing</i> 24(4): 218-224, August 2022. DOI: 10.1097/NJH.0000000000000864</p>
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