PUBLIC WEBINAR

From Data to Action:

How CMS and Stakeholders are Addressing Inequities in Healthcare

Sarah DeSilvey, Gravity Project
Steven Martino, RAND
Nancy Chiles Shaffer, CMS Office of Minority Health
Kate Buchanan, Battelle

Welcome and Learning Objectives

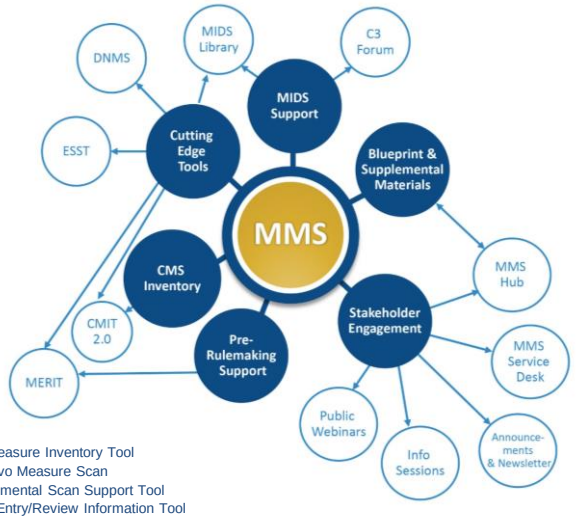
Participants will:

- **Hear about challenges to achieving health equity** and how CMS is working to mitigate them.
- **Learn of current projects** that experts are undertaking to improve the way we measure and address inequities in healthcare.

Later in the slide deck there will be a review of the CMS health equity framework from the Office of Minority Health (OMH). Also, RAND Health will discuss some different approaches to health equity measurement, and the Gravity Project will elaborate on their work on standardized data elements for social drivers and social determinants of health (SDOH).

Overview of the Measures Management System (MMS)

- CMS developed the **MMS** to foster and support standardization, flexibility, and innovation in quality measurement.
- The MMS contract supports stakeholder outreach and education, which **includes annual public webinars**, monthly information sessions, a newsletter, and other ad hoc outreach activities.



CMIT - CMS Measure Inventory Tool
DNMS - De Novo Measure Scan
ESST - Environmental Scan Support Tool
MERIT - MUC Entry/Review Information Tool
MIDS - Measure and Instrument Development and Support

CMS is committed to providing *Education and Outreach* opportunities about the quality measure development process to interested stakeholders to improve understanding of the process. CMS also seeks continual feedback to improve and/or expand its offerings to the healthcare quality measure development community and interested stakeholders.

To date, CMS has implemented an *Education and Outreach* webinar series and has created resource materials that break down and explain various components and challenges in the measure development process. There are dedicated websites, listservs, and roadmap documents that are available to support those that are working in quality measure development, or are just curious and want to learn more about how it is done.

Today's Presenters

- Kate Buchanan, Battelle
- Nancy Chiles Shaffer, CMS Office of Minority Health
- Steven Martino, RAND
- Sarah DeSilvey, Gravity Project

Background

Image by rawpixel.com

Defining Health Equity

"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"

U.S. Department of Health and Human Services. (2022, April). *CMS framework for health equity 2022–2032*. https://www.cms.gov/files/document/cms-framework-health-equity.pdf. Accessed January 2023.

Equity vs. Equality

EQUALITY:
Everyone gets the same–regardless if it's needed or right for them.

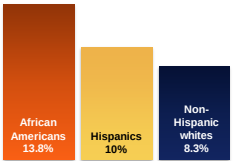
EQUITY:
Everyone gets what they need–understanding the barriers, circumstances, and conditions.

Source: Robert Wood Johnson Foundation. (2017, January). *Visualizing Health Equity: One Size Does Not Fit All Infographics*. https://www.rwjf.org/en/library/infographics/visualizing-health-equity.html. Accessed January 2023.

Health Equity in the US

How do we know healthcare isn't already equitable?

- Compared with whites, non-white Americans experience poorer healthcare coverage and worse healthcare outcomes across most categories
  - Coverage
  - Chronic disease
  - Mental health
  - Disease-specific mortality



50% of premature death could be attributed to **lower socioeconomic status**

- Compared with non-LGBT+ people, LGBT+ Americans report higher rates of ongoing health conditions or disabilities

Table 1: Many LGBT+ people are living with ongoing health conditions or disabilities

Share of people ages 18-64 who report having at least one of the following

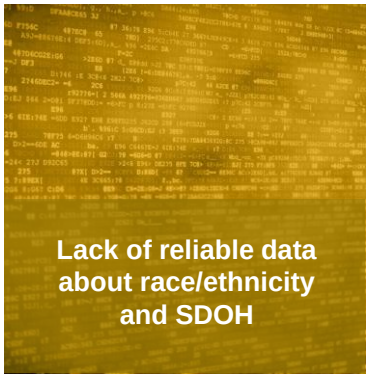
	Ongoing health condition requiring regular monitoring, medical care, or medication	Disability or chronic disease preventing full participation in work, school, housework, or other activities
Sexual Orientation		
LGBT+	47%*	21%*
Non-LGBT+	40%	14%

Sources:
1 Center for American Progress. (2020, May 7). *Fact Sheet: Health Disparities by Race and Ethnicity.* https://www.americanprogress.org/wp-content/uploads/2020/05/HealthRace-factsheet.pdf. Accessed January 2023.
2 Dawson L et al. LGBT+ People's Health and Experiences Accessing Care. Kaiser Family Foundation. Jul 22, 2021. https://www.kff.org/report-section/lgbt-peoples-health-and-experiences-accessing-care-report/#health-status. Accessed January 2023.

It is important to understand the current health landscape in thinking about the achievement of health equity in the US. Depicted on this slide are descriptive statistics which highlight the disparities by race, ethnicity, sexual orientation and socioeconomic status.

Barriers to Achieving Equitable Care

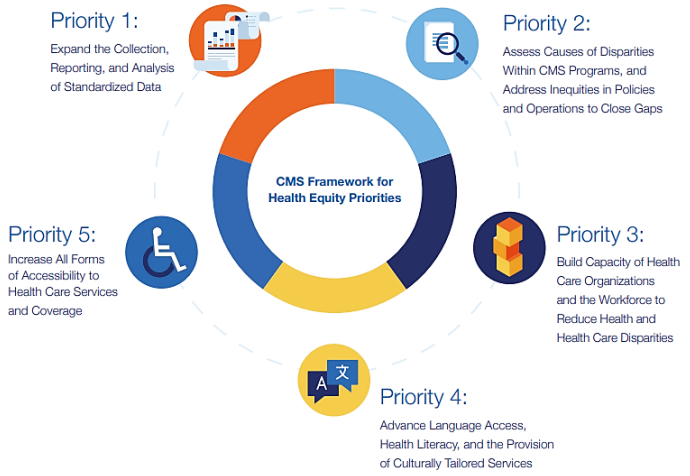
What are the factors impeding our progress?



Sources:
1 Mainous AG 3rd, King DE, Garr DR, Pearson WS. *Race, rural residence, and control of diabetes and hypertension*. Ann Fam Med. 2004 Nov-Dec;2(6):563-8. https://pubmed.ncbi.nlm.nih.gov/15576542/. Accessed January 2023.
2 Cross SH, Califf RM, Warraich HJ. *Rural-Urban Disparity in Mortality in the US From 1999 to 2019*. JAMA. 2021;325(22):2312–2314. https://jamanetwork.com/journals/jama/article-abstract/2780628. Accessed January 2023.

The Path Forward:
CMS Health Equity Framework 2022-2023

CMS Health Equity Priorities



On this slide we introduce the five priorities:

Priority 1—Expanding the collection, reporting and analysis of standardized data.

Priority 2—Assessing causes of disparities within CMS programs and addressing inequities in policies and operations to close gaps.

Priority 3—Building capacity of healthcare organizations and the workforce to reduce health and healthcare disparities.

Priority 4—Advancing language access, health literacy, and the provision of culturally tailored services.

Priority 5—Increasing all forms of accessibility to healthcare services and coverage.

Priority 1: Expand Use of Standardized Data

- **Improve collection, reporting, and analysis of data** related to race, ethnicity, language, gender identity, sex, sexual orientation, disability status, and other social determinants of health (SDOH).
- Better understanding of the needs of those we serve **enables CMS to leverage quality improvement** and other tools to ensure all individuals have access to equitable care and coverage.

The United States Core Data for Interoperability (USCDI) is a standardized set of health data adopted as a standard in the Cures Final Act (2022)

Sources:
1 U.S. Department of Health and Human Services. (2022, April). *CMS framework for health equity 2022–2032*. https://www.cms.gov/files/document/cms-framework-health-equity.pdf. Accessed January 2023.
2 Office of the National Coordinator for Health Information Technology. *Cures Act Final Rule: United States Core Data for Interoperability*. https://www.healthit.gov/sites/default/files/page2/2020-03/USCDI.pdf. Accessed January 2023.

> ***"Accurate and complete data elements support CMS in its efforts to create evidence-based policies and regulations and to assess how well these policies and regulations align with the needs of the communities and individuals that CMS serves."***
>
> From the white paper: *The Path Forward: Improving Data to Advance Health Equity Solutions*

In its role as the largest payer of healthcare in the US, CMS can set the bar for meaningful health equity data collection and use across the healthcare system. Health equity data elements are essential to understanding and addressing health disparities for enrollees across CMS programs.

The lack of consistent data collection at a disaggregated level broken down into detailed subcategories presents barriers to understanding the needs of specific subgroups, as well as to comparing data across programs and populations. CMS has made efforts to address these health equity data-related issues and will continue to prioritize them.

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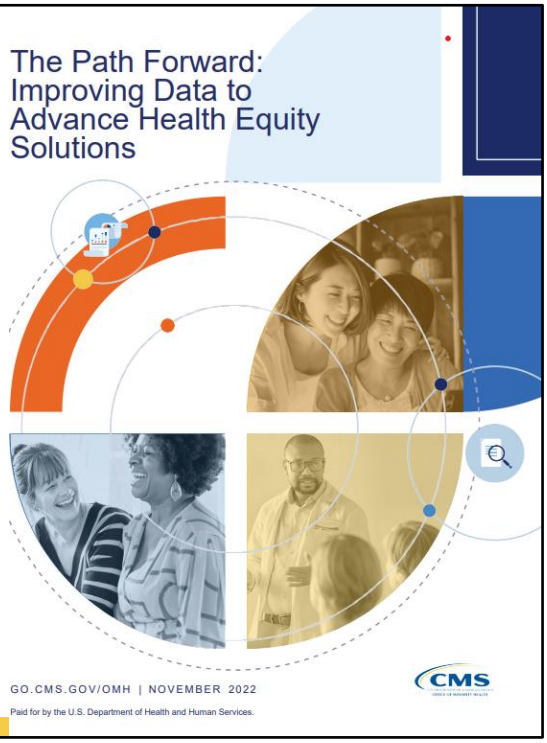
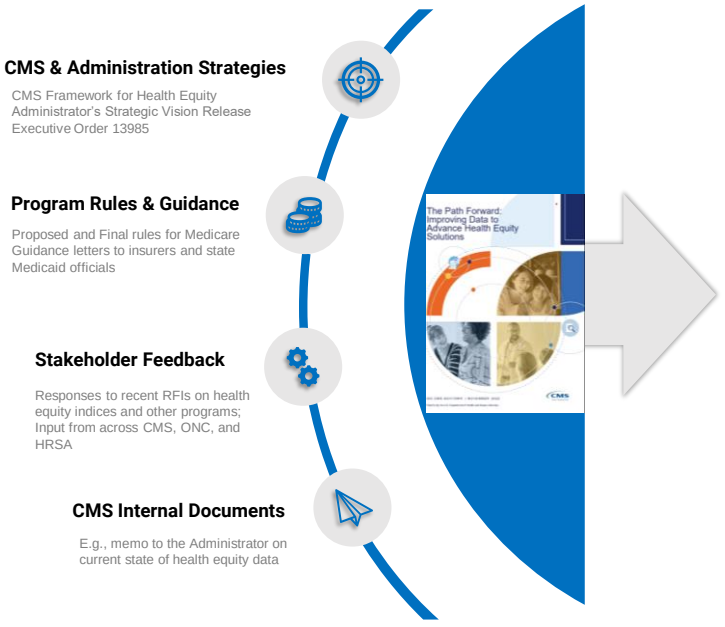
OMH's Data White Paper

- Describes the current state of health equity data collection and consolidation across CMS programs
- Details progress to date
- Defines CMS' future actions to continue the improvement of health equity data and achieve a future vision of health equity data at CMS



The white paper supports the CMS framework for health equities priorities by outlining how CMS intends to expand the collection, reporting and analysis of standardized data and use of health equity data to achieve its equity goals aligned with Priority 1, "expanding the collection, reporting and analysis of standardized data," and Priority 2, "assessing causes of disparities within CMS programs and addressing inequities in policies and operations to close gaps."



The white paper aims to achieve broad awareness of CMS' vision for health equity data, which pulls from a wide range of sources, including CMS and the administration strategies, proposed program rules and guidance, feedback from stakeholders across CMS, ONC and HRSA and internal documents from CMS.

1. Sociodemographic and social determinants/drivers of health (SDOH) health equity data can help drive quality improvement and improve program/policy evaluation
2. Despite progress, there are gaps in the availability, completeness, and quality of health equity data remain across CMS programs
3. CMS is committed to improving the quality, accuracy, and completeness of data that can enable improvements in health equity
4. Efforts to address these health equity-related data issues are already underway and will be prioritized

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Although significant progress has been made to date, gaps still exist in the data across CMS programs, along with challenges to overcome in order to improve the collection of these health equity data.

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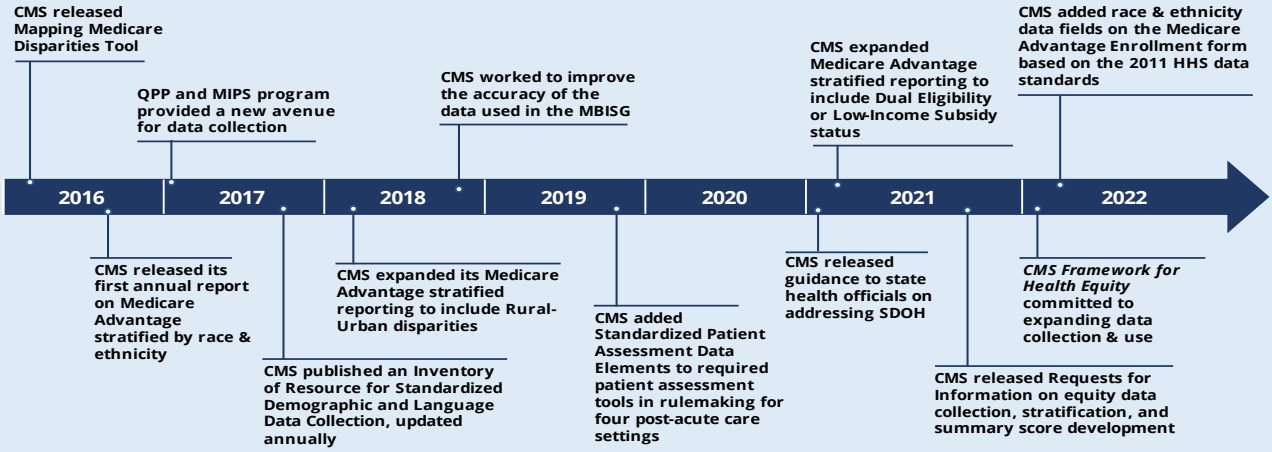
CMS Health Equity Data Initiative Highlights



The timeline on this slide represents actions CMS has taken over the past few years towards improving health equity data. In the interest of progress, continued collaboration with other federal agencies and industry partners is key in order to receive data, establish standards, and approve program changes to support equity data improvement. Feedback from organizations is vitally important as CMS assesses the feasibility of process changes and determines the metrics useful to its programs.

Continuous monitoring of such progress of CMS data collection, standardization and use across CMS programs, will help increase awareness of health disparities and their causes. It will also allow for the creation, testing and implementation of solutions and lead to sustainable actions to advance equity.

Lessons from the Field: Developing Health Equity Measures (RAND)

RAND HEALTH

Developing Health Equity Measures

Steven Martino

Background

Measuring how equitably health care organizations provide care allows us to:

- Identify areas and organizations needing improvement
- Monitor progress toward national health equity goals and attach incentives to performance in this realm

Objectives and Methods

Objectives

- Identify and describe health equity measurement approaches
- Determine which merit consideration for inclusion in Medicare's value-based (VBP) and quality reporting (QR) programs

Methods

- Literature review to identify measurement approaches developed or used for systematic performance assessment
- Technical expert panel (TEP) to evaluate the potential of these approaches

20 Details of this study are available in a report posted here: https://aspe.hhs.gov/pdf-report/developing-health-equity-measures 2/28/2023

The purpose of this study was to assess current health equity measurement approaches. Methods and metrics were published since the time of the study not covered in this presentation, including the work of the Gravity Project. The TEP panel members were nationally recognized experts in health and healthcare equity, quality measurement and CMS' VBPs/QRPs.

Defining a Health Equity Measure

An approach to illustrating or summarizing the extent to which the quality of health care provided by an organization contributes to reducing inequities in health and health care at the population level by improving the care and health of underserved patients

To guide the literature search and our evaluation of the measurement approaches, we developed a definition of a health equity measure. The overarching focus of this definition is on the "extent to which an organization is doing things to elevate the health and healthcare of underserved groups."

Categories of Measurement Approaches

Approaches focused on measure identification—Identifying processes for improving health equity, or contributing to an equity-focused healthcare culture, or determining the existing healthcare quality measures appropriate for comparison across organizations or across groups of patients.

Approaches focused on measure-by-measure comparisons—Category include ones focused on comparisons between healthcare providers, comparisons within healthcare providers or both, such as comparisons focused on point-in-time performance, improvement in performance or both.

Summary indices—These approaches involved developing a system for combining multiple measures of healthcare equity into a summary index.

Principles for Health Equity Measurement (Evaluation Criteria)

A health equity measurement approach should:

- Be based on measures of care for which inequities are known to exist or measures that attempt to remedy inequities
- Guard against unintended consequences of worsening quality or access or disincentivizing resources for any patients
- Establish measurability requirements
- Capture information about small groups where possible

Summary indices should additionally:

- Summarize information in a way that is valid and in line with policy objectives
- Allow for disaggregation of data

A health equity measurement approach should establish measurability requirements, such as minimum sample sizes and target levels of reliability to make reliable distinctions among provider organizations. Summary indices should disaggregate the data to easily identify quality improvement targets. These identified approaches were all evaluated against these criteria by the expert panel.

Main Takeaways

For Approaches Focused on Measure Identification

- The NQF Disparities-Sensitive Measure Assessment was the most favorably viewed approach focused on measure identification
- Used carefully-drawn criteria to identify 76 NQF-endorsed measures as disparities-sensitive
- Potentially applicable to any Medicare VBP or QR program that collects one or more of the 76 disparities-sensitive measures
- Potential to enhance other approaches by incorporating one or more of the 76 disparities-sensitive measures
- Work needed to determine which of these measures is linkable to data on SDOH or group membership

One set of criteria was developed for judging measures of condition prevalence, healthcare access and quality. A second set of criteria was developed for judging measures of processes used to improve health equity, such as measures of cultural competence and care coordination. The authors of this approach developed a scoring system based on these criteria and applied it to over 500 measures.

Main Takeaways

For Approaches Focused on Measure-by-Measure Comparisons

- Of approaches focused on measure-by-measure comparisons, the approach underlying the Minnesota Healthcare Disparities Report was judged most favorably
- Perceived advantages:
  - Carefully chosen set of measures
  - Focus on multiple characteristics: race, ethnicity, preferred language, country of origin
  - Ability to reliably distinguish performance among providers
  - Focus on incentivizing achievement for underserved beneficiaries
  - Anchoring of performance to the overall state average
- Potentially applicable to all Medicare VBP and quality reporting programs

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This report evaluates healthcare performance for Minnesota patients enrolled in state and federally funded programs. Scores on 12 process and outcome measures are reported stratified by race, ethnicity, language and country of origin.

Comparisons are made at the *state* and *medical group* level. At the state level performance for different groups of patients are compared to each other, and to the overall state average on measures. At the medical group level performance by different groups of patients are compared to the overall state average, and to the state average for the specific patient group.

The expert panel recognized that this approach uses a carefully chosen set of measures, believed to be of benefit in that the approach incorporates multiple patient factors associated with risk for receiving poorer care, and further provides a method of gauging performance among providers.

Main Takeaways

For Summary Indices

- Of summary indices, the Health Equity Summary Score (CMS OMH) was judged most favorably
- Perceived advantages:
  - Consideration of cross-sectional performance and improvement
  - Focus on patient experience and clinical quality
  - Inclusion of multiple patient factors: race, ethnicity, dual/LIS eligibility
  - Attention to sample size and reliability
  - Direct applicability to certain VBP and QR programs
- OMH is developing a dashboard to provide MA contracts with confidential Health Equity Summary Score data

The Health Equity Summary Score approach initially applied to Medicare Advantage plans but has been extended to the hospital patient experience of care context. The Score focuses on stratified measurement of each plan's performance for individuals dually eligible for Medicaid, or eligible for a low-income subsidy and those who are Black, Hispanic, Asian or Pacific-Islander to highlight and incentivize performance.

The score summarizes performance across seven CAHPS and HEDIS measures, linkable to patient-level data on race/ethnicity and dual/LIS eligibility status. The Medicare Advantage Health Equity Summary Score incorporates cross-sectional performance to recognize good care to underserved groups in the most recent two years of data on performance measures and accounts for within-plan and overall improvement in performance to incentivize low-performing but improving providers.

Discussion

- Evaluation criteria developed for this project can be used to assess suitability of new measures of health equity emerge
- Attaching incentives to health equity measures requires:
  - Consideration of alignment with policy/program goals
  - Broad stakeholder input
- Success of any scheme requires that organizations are given:
  - Timely, detailed, and reliable data at the finest possible level
  - Specific guidance on how to improve

Lessons from the Field:
Enabling the Collection of Social Determinants of Health Data (The Gravity Project)

Meet Our Speaker

Sarah DeSilvey, DNP, FNP-C

Gravity Project, Director of Terminology

Agenda

- Gravity Project Background
- Gravity Project Scope & Accomplishments: Our WHAT
- Health Equity, Data Justice, and Governance
- How to Engage

Gravity Project Mission

Advance and promote equitable health and social care by leading the development and validation of consensus-driven interoperability standards on social determinants of health.

A Social Determinants of Health Lexicon

Systems Level

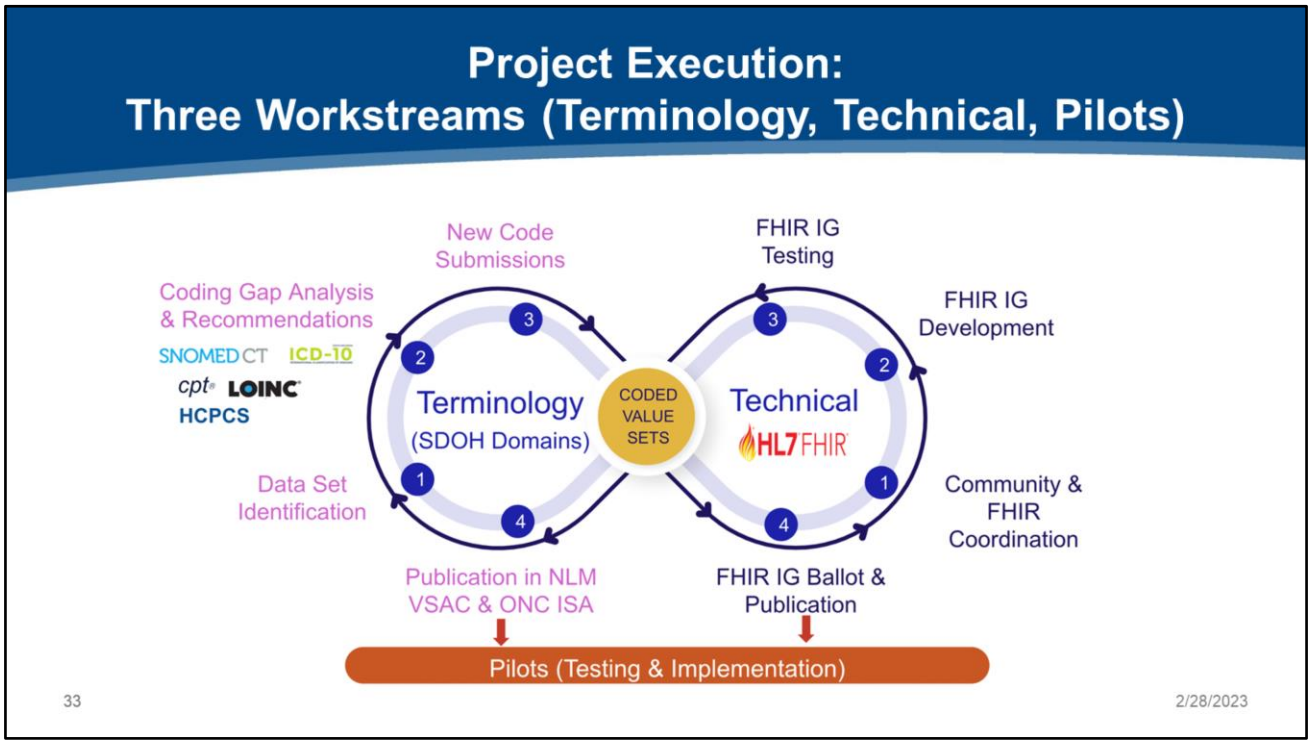
Community Level

- **Health Equity** is "*achieved when every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances*".
  - **Social Determinants of Health**: "*the conditions in which people are born, grow, live, work and age," which are "shaped by the distribution of money, power and resources.*
    - **Protective Factors:** characteristics or strengths of individuals, families, communities or societies that act to mitigate risks and promote positive well-being and healthy development.
    - **Social Risks:** Adverse social conditions associated with poor health.
    - **Social Needs:** Non-medical patient prioritized needs that impact health.

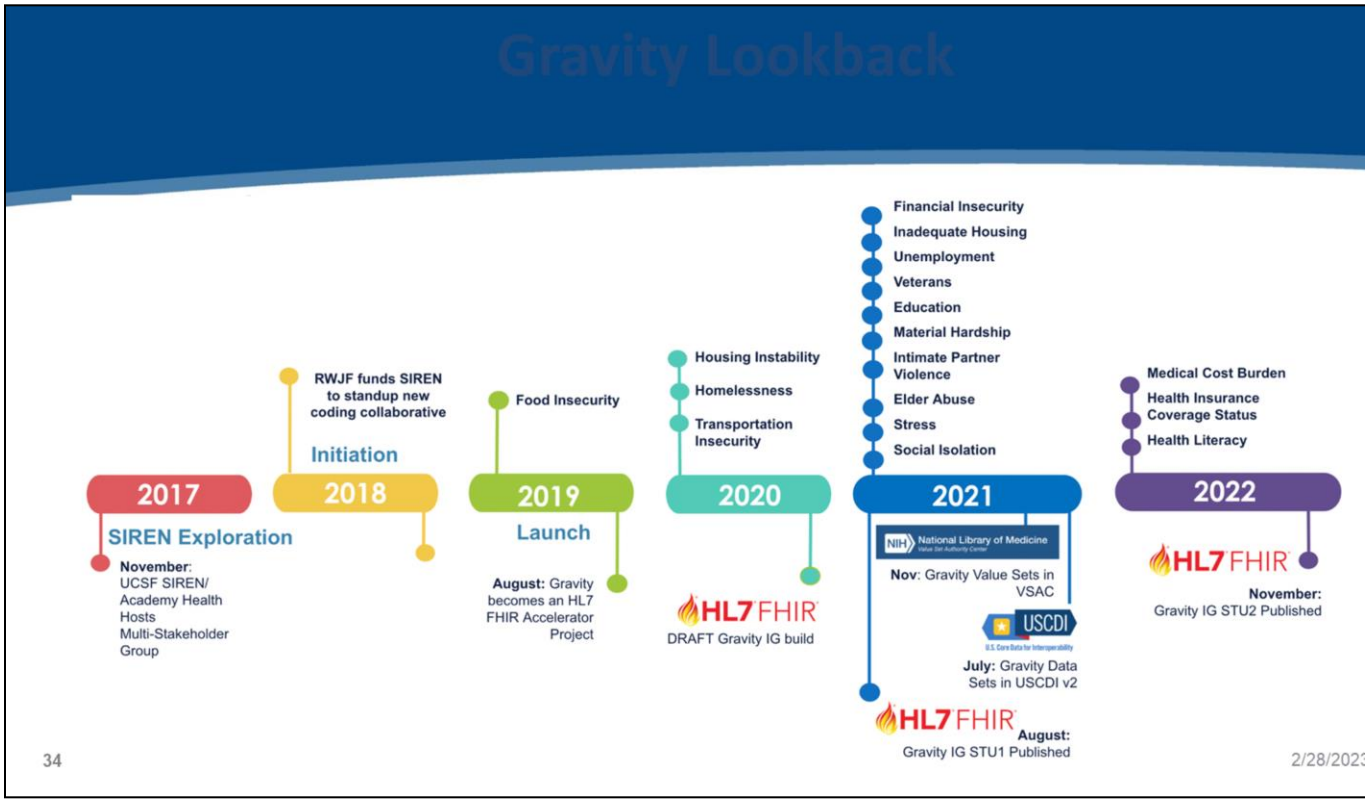
Individual Level

Addressing structural and individual SDOH are critical steps to improve equity and reduce disparities.

Alderwick and Gottlieb (2019) Meanings and Misunderstandings: A Social Determinants of Health Lexicon for Health Care Systems
Center for the Study of Social Policy (2018) About Strengthening Families™ and the Protective Factors Framework
Physician-Focused Payment Model Technical Advisory Committee (2021) SDOH and Equity Report to the Secretary



Depicted on this slide is the Gravity Project model represented by three different work streams. In the terminology division, the primary role is to define critical data elements for different social risks. We define those data elements and further curate them into value sets housed in the NLM VSAC, completed through an open consensus-based project and then placed into the ecosystem of HL7.



Since its inception which kickstarted in 2017 as a national gathering and then launched in 2019 with one domain of food insecurity, which over the course of the last few years further addressed 17 social risks. There were two versions of the IG published. Also published are 159 different value sets in VSAC that align with each of the domains and activities addressed in more detail in the slides ahead.

Project Scope

- **Develop data standards** to represent and exchange patient level SDOH data documented across four clinical activities:
  - Screening,
  - Assessment/diagnosis,
  - Goal setting, and
  - Treatment/interventions.
- **Test and validate** standardized SDOH data for use in patient care, care coordination between health and human services sectors, population health management, public health, value-based payment, and clinical research.

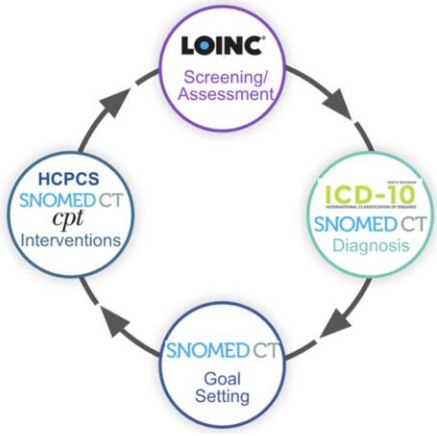
35 Domains grounded by those listed in the NASEM "Capturing Social and Behavioral Domains in Electronic Health Records" 2014

2/28/2023

Depicted on the left side of this slide are the 17 domains addressed to date in Gravity's work.

Terminology Workstream Accomplishments

- **17** SDOH Domains with consensus definitions and code submissions
- **16** domains with **LOINC** encoded screening instruments
- **14** domains with **ICD-10-CM** and/or **SNOMED CT®** codes
- **16** domains with **SNOMED CT®** intervention codes
- **159** value sets in National Library of Medicine (NLM) Value Set Authority Center
  - Including USCDI SDOH activity value sets
- For an up to date list of current terms see VSAC and the Gravity confluence



https://confluence.hl7.org/display/GRAV/SDOH+Data+Elements+And+Status

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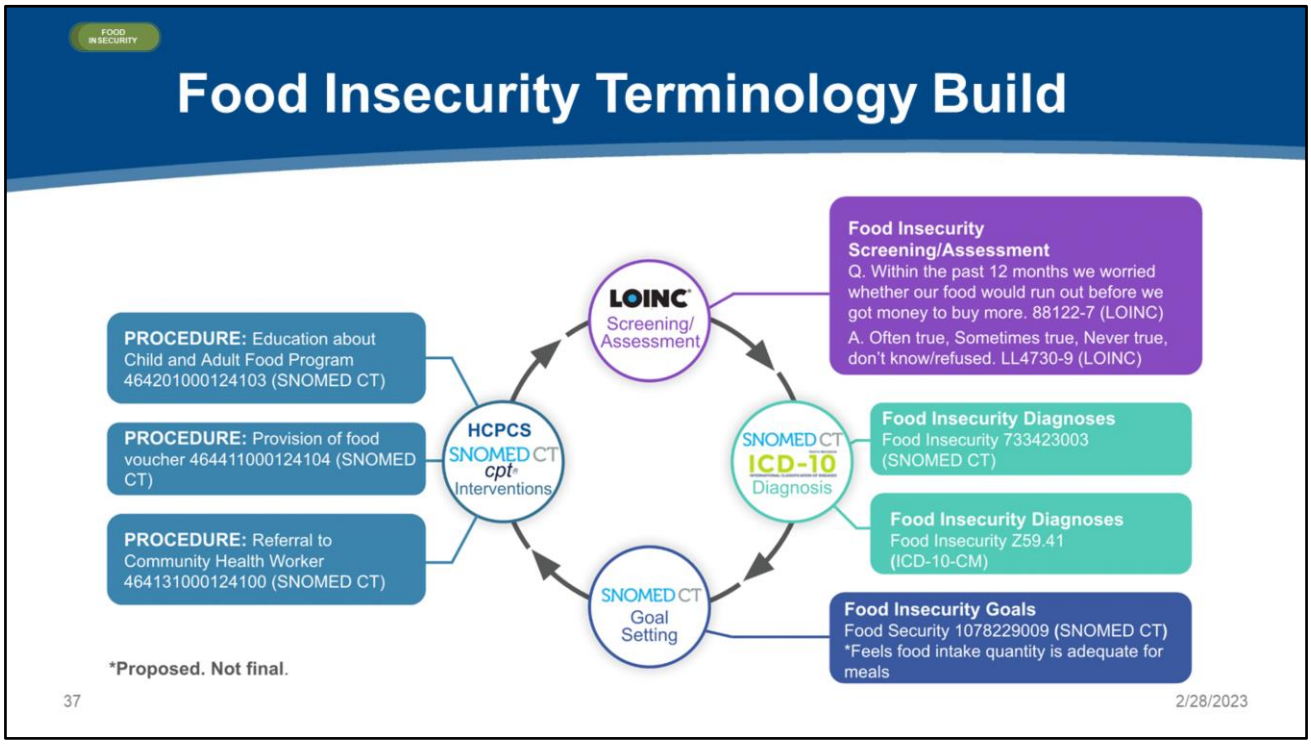
For an up-to-date list of the current terms, please reference the Gravity confluence containing robust information across all of its workstreams. Alternatively, reference VSAC with the Gravity Project as steward.



Illustrated here is an example of food insecurity containing the encoded screening instrument extracted from the hunger vital sign. Also noted are the goal statements in development and related interventions, referral to CHWs, a critical role in health equity addressed in the social care ecosystem that didn't exist prior to Gravity, and then the provision to food vouchers.

Depicted at the top of this slide is the focus on aligning with any federal program of reference. With respect to the USDA, HUD, or an aging services program we ensure that the program is included in an intervention to align with the federal policies and regulations.

Technical Workstream-
HL7 FHIR SDOH Clinical Care Implementation Guide

- A framework Implementation Guide (IG) supporting:
  - multiple SDOH domains; and
  - the following clinical activities
    - Assessments
    - Health Concerns / Problems
    - Goals
    - Interventions including referrals
    - Consent
    - Aggregation for exchange/reporting
    - Exchange with patient/client applications
    - Draft specifications for race/ethnicity exchange
  - **STU2 published November 2022!**

https://confluence.hl7.org/display/GRAV/Technical+Workstream+Dashboard

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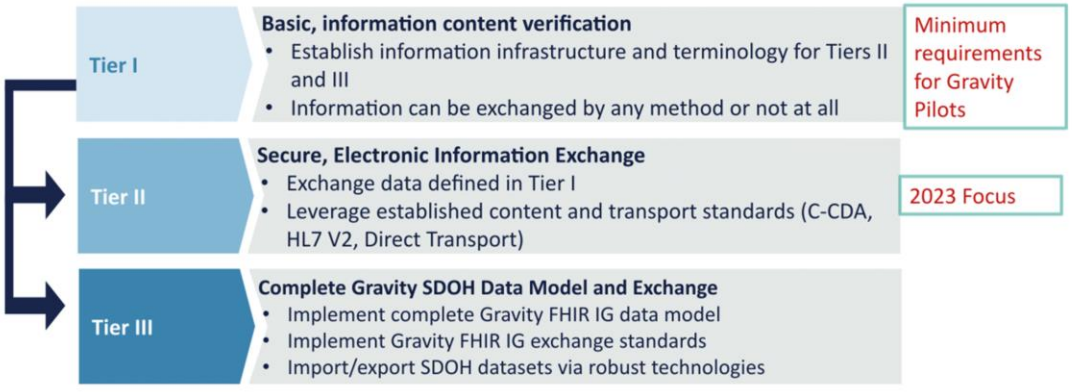
STU2 published in November 2022— Created draft specifications for race/ethnicity exchange aligned with federal guidelines with the OMB, along with the emerging work of critical health equity, such as gender harmony, a sister project within HL7 focusing on gender identity.

Gravity Three-Tiered Piloting Approach

- Defines incremental tiers for testing Gravity standards (terminology and technical).- *Entities may participate at any Tier.*
- Supported through a community of implementers in the Pilot Affinity Group



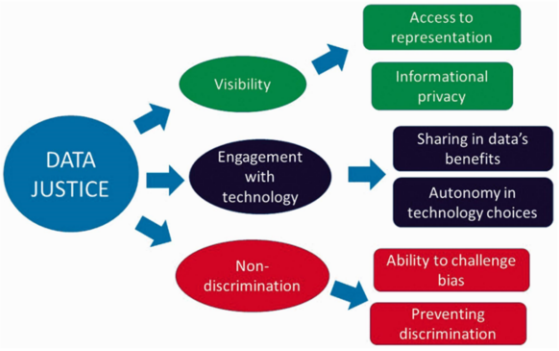
Health Equity, Data Justice, and Governance

2/28/2023

Health Equity and Data Justice- Critical Intersections

Pillars of Data Justice- fairness in the way people are made visible, represented and treated as a result of their production of digital data (Taylor, 2017)

- (in)visibility
- (dis)engagement with technology
- anti-discrimination



Taylor, (2017) What is data justice? The case for connecting digital rights and freedoms globally, Accessed Jan 2023- https://doi.org/10.1177/2053951717736335

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Disengagement—An opportunity for patient applications and engagement with technology, but Gravity recognizes the right to disengage due to elements of risk and bias. Just because data exists, there are no assurances that the applications are fair and equitable.

Antidiscrimination—These pillars of data justice weave through everything Gravity does, since as it builds data standards to address gaps, it acknowledges the risk of being present in the data stream.

Gravity Project Data Use Principles for Equitable Health and Social Care

- Improving Personal Health Outcomes
- Improving Population Health Equity
- Ensuring Personal Control
- Designing Appropriate Solutions
- Ensuring Accountability
- Preventing, Reducing, and Remediating Harm

https://confluence.hl7.org/display/GRAV/Gravity+Data+Principles

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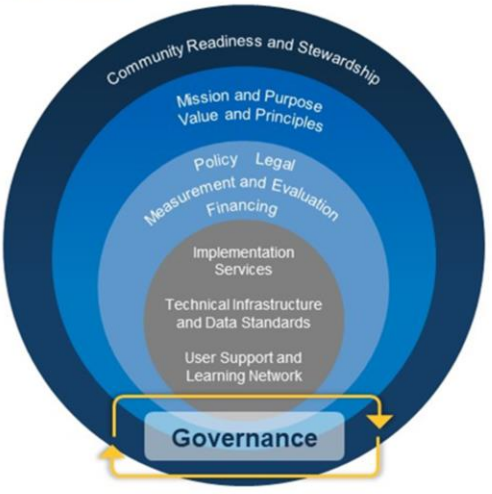
Gravity has *six* core principles in its work defined through a consensus process. For more information, these principles are further addressed on Gravity's confluence.

Establish SDOH Information Exchange Foundational Elements



43 https://www.healthit.gov/news/events/oncs-social-determinants-health-information-exchange-learning-forum 2/28/2023

We encourage anyone to attend the SDOH Learning Forum that ONC just kicked off. Information is readily accessible easily online. Just to note, we can have all the data standards that we want. But if we don't have the appropriate governance to ensure that communities are invested and engaged in this work, it's rather missing the mark.

How to Engage!

Gravity Project Public Health and Health Equity Pilots

- Supported by a grant from Robert Wood Johnson Foundation, in partnership with Gravity Project members, CIVITAS Networks for Health, we are currently seeking pilot sites to leverage Gravity Project data elements toward ***public health and health equity use cases***
  - Support for broad stakeholder exchange and establishing community-led governance.
  - Join the Pilot Affinity Group to learn more- https://confluence.hl7.org/display/GRAV/Sign-Up+for+the+Pilots+Affinity+Group

An opportunity being kicked off in 2023 is an RWJ-focused pilot in partnership with the CIVITAS Networks for Health. There the focus is on applications in Gravity terminology standards in public health and health equity use cases over 2023. Anyone is free to join the Pilot Affinity Group to learn more through the link shown on this slide.

Join the Gravity Project!

Learn More

https://confluence.hl7.org/display/GRAV/Join+the+Gravity+Projec

- **Join the Gravity Project Pilot Affinity Group!** https://confluence.hl7.org/display/GRAV/Sign-Up+for+the+Pilots+Affinity+Group
- **Help sponsor our new domains of Digital Access and Digital Literacy**
  - **Contact-** jillian.annunziata@emiadvisors.net
- **Help us with Gravity Education & Outreach**

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Help us find new sponsors and partners

Partner with us on development of blogs, manuscripts, dissemination materials

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2/28/2023

Gravity is kicking off a new digital access and digital literacy domain. If anyone is interested in assisting with this work, please contact Jillian Annunziata. You may find us on social media and the confluence.

Questions

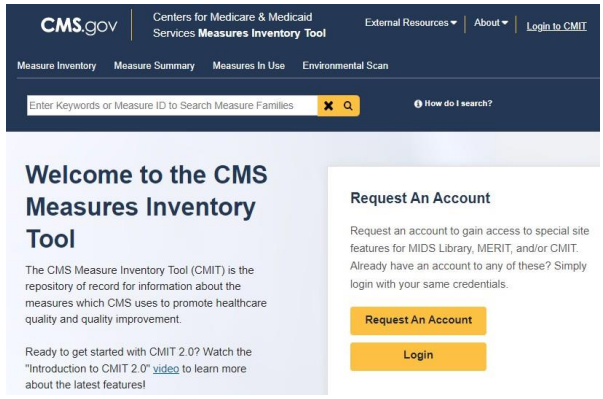
Get Connected

Want to learn more?

Visit: https://mmshub.cms.gov/

CMIT 2.6 - Coming Soon!

- The CMS Measures Inventory Tool (CMIT) is improving to enhance your experience!
  - Updated terminology, IDs, and new features and content
  - Join our webinar on March 29th at 2 PM E.T. to learn more
- CMIT 2.6 will launch in late March
- **Join us for an Info Session 3/29 Register here!**



Battelle
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CMS
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