Acute Care

Health Equity Annual Report

April 2024

Riverside Health System

Acute Care Work Plan to Advance Health Equity
Annual Report
April 1, 2025

Riverside Health System

This annual report of the acute care work plan to advance health equity is structured to assess each acute care hospital's commitment to health equity using organizational competencies aimed at achieving health equity as defined by the Centers for Medicare and Medicaid Services (CMS). The health equity competencies were designed to meet the Hospital Inpatient Quality Reporting Program (IQR) and recently added Outpatient Quality Reporting (OQR) requirements.

Acute care hospitals attest to five domains and specific elements within each of the domains that are represented in the denominator as a point, for a total of five points, one point per domain. The numerator captures the total number of domain attestations that the hospital can affirm. Hospitals submit attestation responses once a year via the web-based tool that is located within the Hospital Quality Reporting Secure Portal. The reporting period for attestation of the five-health equity structural measures is January 1, 2024, through December 31, 2024. The submission period is from April 1, 2025, through May 15, 2025, and affects the payment determination for Federal Fiscal Year 2026.

In addition to the attestation for the five-health equity structural measures, CMS finalized requirements for reporting on five core health-related social needs domains. The social drivers of health measures SDOH-1 and SDOH-2, assess whether a hospital implements screening of all patients that are 18 years or older at the time of admission, for health-related social needs (HRSNs) including food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

The SDOH-1 measure requires data submission of the numerator and denominator for the screening rate of patients over 18 years at the time of admission. The SDOH-2 measure requires data submission of the numerator and denominator for the percent of patients screened for an HRSN, who screen positive for one or more of the five HRSNs. Hospitals submit data annually via the web-based portal previously described. Mandatory on an annual basis, with CY 2025 data affecting the payment determination for Federal Fiscal Year 2027 and subsequent years.

The new Outpatient Quality Reporting (OQR) program requirements, effective under the FY 2025 final rule, aim to address health equity by incorporating specific measures to assess and improve healthcare access and outcomes for underserved populations. Starting in CY 2025, Hospital Outpatient Departments (HOPDs) will be required to attest on five key health equity domains, which will help identify and address disparities in care. Mandatory reporting in 2025 will impact CY 2027 payment determination. Additionally, HOPDs will report on two measures related to the social determinants of health (SDOH), SDOH-1 and SDOH-2, which focus on

factors such as economic stability, education, and social conditions that impact health outcomes. Voluntary reporting will begin in CY 2025 with mandatory reporting starting CY 2026 that will impact the CY 2028 payment determination.

Definition of Health Equity
The 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 identify, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

DOMAIN 1 Equity is a strategic priority.

Hospital commitment to reducing healthcare disparities is strengthened when equity is a key organizational priority. Attest that the hospital has a strategic plan for advancing healthcare equity and that it includes all the following elements.

A) **The hospital strategic plan (work plan) identifies priority populations who currently experience health disparities.**
B) **The hospital strategic plan (work plan) identifies healthcare equity goals and discrete action steps to achieve these goals.**
C) **The hospital strategic plan (work plan) outlines specific resources which have been dedicated to achieving equity goals.**
D) **The hospital strategic plan (work plan) describes the approach for engaging key stakeholders, such as community-based organizations.**

Riverside developed a workplan to comply with the CMS requirement for a hospital strategic plan. The workplan for the acute care hospitals is considered a part of the Riverside Health System's strategic plan for Diversity, Equity, and Inclusion (DEI). The Riverside workplan identified acute care key performance indicators (KPIs) to initiate identification and analysis of data to inform hospital leaders about populations who experience health disparities.

Milestones were identified for the steps needed to obtain the data to further identify priority populations who currently experience health disparities evidenced in the acute care key performance indicators. Reports go through a methodical development and validation process to ensure it is accurate and complete with respect to race, ethnicity, and SDOH. Once the data validation process is completed, then the steps can be taken to analyze and gain insight from the data. *See Attachment A Milestones for Data Development, Validation, Analysis and Care Improvement.*

Starting in CY 2023 and forward, the acute care key performance indicators (KPIs) for mortality and readmission measures were stratified by race and ethnicity using Premier Quality Advisor and patient experience survey measures were stratified by race and ethnicity, using the Pres Ganey patient experience surveys.

In CY 2024 Riverside has validated and analyzed the data to identify disparities and gain insight. This process involved examining various aspects of the data, such as trends, patterns, outliers, correlations, and relationships with other variables, such as the social drivers of health: food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

Each facility has formed discrete action steps in identified focus areas using performance improvement tools adopted by Riverside to drive improvement. Performance improvement tools include setting smart goals, using driver diagrams to identify key drivers of change ideas, and conducting rapid cycle tests of change. Successful tests of change are then scaled up across the hospital and health system. Performance improvement efforts are anticipated to close gaps in care quality, achieve goals, and sustain the desired outcomes. The acute care hospital leadership and quality team are dedicated to achieving health equity goals. *See Attachment B: Acute Care Key Performance Indicators.*

Riverside Health System engages with many community partners in all markets where the acute care hospitals are located. A variety of strategies are used to engage with the local communities and community partners. A detailed summary report titled the Riverside Health System Community Benefits Tracker was developed to compile detailed information about the community engagement events along with the date, location, community partner, and event type. *See Attachment G: RHS Community Benefits Tracker.*

Riverside Health System engaged with Unite Us, a coordinated care network consisting of healthcare, government, nonprofit, and other organizations. The network partners use Unite Us' software to securely identify, deliver, and pay for services that address the needs of individuals within their communities. The network is supported by Unite Us team members focused on customer and community engagement, network health and optimization, and user support. Riverside launched the platform used by Unite Us on December 5, 2023, to connect patients to services in their local communities that can assist with identified health related social needs such as food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. *See Attachment E: Unite Us Implementation*.

DOMAIN 2 Data Collection

Collecting valid and reliable demographic and social determinant of health data on patients served in a hospital is an important step in identifying and eliminating health disparities. Attest that the hospital engages in the following activities.

- **A) The hospital collects demographic information, including self-reported race and ethnicity including and/or social determinant of health information on the majority of patients.**
- **B) The hospital has training for staff in culturally sensitive collection of demographics and/or social determinants of health information.**
- **C) The hospital inputs demographic and/or social determinants of health information collected from patients into structured, interoperable data elements using a certified EHR (electronic health record) technology.**

Riverside acute care hospitals collect valid and reliable demographic and social determinants of health data. Patient self-reported race and ethnicity information is captured at the time of registration or check in. The self-reported information is then cross walked or mapped to the race and ethnicity fields recognized by the United States Department of the Interior in their published document titled “Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity,” excerpted from the Federal Register, October 30, 1997. As noted, the categories in the recognized classification are social-political constructs and should not be interpreted as being scientific or anthropological in nature.

The standards have been developed to provide a common language for uniformity and comparability in the collection and use of data on race and ethnicity by Federal agencies, including CMS. The standards have five categories for data on race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White. There are two categories for data on ethnicity: "Hispanic or Latino," and "Not Hispanic or Latino." The information is collected from patients into structured, interoperable data elements using a certified EHR technology (Epic) in the Epic demographics section of the Registration (electronic) page. *See Attachment H: iCare Tip Sheet Race and Ethnicity Guidelines v. 3 dated August 28, 2023.*

Riverside provides training for team members who discuss race and ethnicity information with patients. The training addresses use of culturally sensitive and inclusive terminology, and how to respond to patient questions related to why Riverside asks about race and ethnicity information. *See Attachment F: (noted above) and Attachment F: RHS Diversity, Equity, and Inclusion Commitment HealthStream Module.*

Riverside acute care hospitals collect patient self-reported health-related social needs information at the time of admission for patients who are 18 years or older. Social needs information includes food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. The information is collected from patients into structured, interoperable data elements using a certified EHR technology (Epic) in the Epic admission navigator. *See Attachment D: iCare Update Newsletter page 7, dated November 28, 2023.*

DOMAIN 3 Data Analysis

Effective data analysis can provide insights into which factors contribute to health disparities and how to respond. Attest that the hospital engages in the following activities.

A) Hospital stratifies key performance indicators by demographic and/or social determinant of health variables to identify equity gaps and includes this information on hospital performance dashboards.

Riverside acute care hospitals developed a comprehensive data analysis strategy to identify health disparities and provide insight into which factors are linked to, and correlate with specific health disparities or outcomes. As described previously in Domain 1, key performance

indicators for mortality and readmission measures were stratified by race and ethnicity using Premier Quality Advisor. Patient experience survey measures were stratified by race and ethnicity, using NRC, the vendor for patient experience surveys. The next step is to validate and analyze the data to identify disparities and gain insight. This process involves examining various aspects of the data, such as trends, patterns, outliers, correlations, and relationships with other variables, such as the social drivers of health: food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

Once the KPI data has been validated and analyzed, and disparities identified, measurable health equity goals will be developed, and discrete action steps developed using performance improvement tools adopted by Riverside to drive improvement. Performance improvement tools include setting smart goals, using driver diagrams to identify key drivers of change ideas, and conducting rapid cycle tests of change. Successful tests of change are then scaled up across the hospital and health system. Performance improvement efforts are anticipated to close gaps in care quality, achieve goals, and sustain the desired outcomes.

DOMAIN 4 Quality Improvement

Health disparities are evidence that high-quality care has not been delivered equally to all patients. Engagement in quality improvement activities can improve quality of care for all patients.

A) The hospital participates in local, regional, or national quality improvement activities focused on reducing health disparities.

Riverside acute care hospitals endeavor to provide care, treatment, and services that reflect the six dimensions of quality as defined by the Institute of Medicine's 2001 Report "Crossing the Quality Chasm". Care that is safe, timely, effective, efficient, equitable, and patient centered. As such, representatives from the acute care hospitals participate in local, regional, and national quality improvement activities focused on reducing health disparities.

Riverside acute care hospital representatives participate in:

1) The Health Equity Learning Collaborative, launched by the Virginia Hospital and Healthcare Association Foundation and Center for Healthcare Excellence to support health equity initiatives. The program is intentionally structured to help meet regulatory and accreditation requirements for health equity programs, which include screening for race, ethnicity, social drivers of health, and analyzing data.
2) Riverside participates in the Regional Cancer Disparities Collaborative, a group formed through a partnership with the Eastern Virginia Medical School, in collaboration with other health systems and the American Cancer Society. Health disparities are addressed, with a major focus over the past year on colon cancer awareness, prevention, and screening, because colorectal cancer represents the third most commonly diagnosed cancer in men and women combined in the United States and that colon cancer death rates are 40% higher for African Americans.

3) Riverside was a founding member of the Hampton Roads Health Equity Collaborative and the Virginia Organization for Inclusive Concepts and Equitable Solutions (VOICES). *See Attachment C: RHS DEI Strategic Plan*

DOMAIN 5 Leadership Engagement

Leaders and staff can improve their capacity to address disparities by demonstrating routine and thorough attention to equity and setting an organizational culture of equity. Attest that the hospital engages in the following activities.

A) The hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews the strategic plan (work plan) for achieving health equity.
B) The hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews key performance indicators stratified by demographic and/or social factors.

Riverside endeavors to improve the capacity of leaders and team members to identify and address disparities by demonstrating a consistent heightened awareness to equity and by prioritizing and intentionally establishing an organizational culture of equity, as described in *Attachment C: RHS DEI Strategic Plan*

Hospital senior leadership, including the chief executive, and the hospital board of trustees, approved the Acute Care Health Equity Work Plan 2023. As discussed in Domain 1, the workplan for the acute care hospitals is considered a part of the Riverside Health System's strategic plan for Diversity, Equity, and Inclusion (DEI). The workplan identified acute care key performance indicators to initiate identification and analysis of data to inform hospital leaders about populations who experience health disparities. Hospital senior leadership, including the chief executives and the entire hospital board of trustees will receive an annual Acute Care Health Equity Report, each spring, to document progress toward achieving health equity. The annual report includes progress made on the key performance indicators stratified by demographic and social factors.

Attachments

Attachment A: Workplan Milestones for Data Development, Validation, Analysis and Care Improvement.
Attachment B: Acute Care Key Performance Indicators.
Attachment C: 2024 DEI Annual Report
Attachment D: iCare Update Newsletter page 7, dated November 28, 2023
Attachment E: Unite Us Implementation.
Attachment F: RHS Diversity, Equity and Inclusion Commitment HealthStream Module.
Attachment G: 2024 Community Benefits Tracker
Attachment H: iCare Update Newsletter page 7, dated November 28, 2023

Acute Care Work Plan to Advance Health Equity

Milestones for Data Development, Validation, Analysis and Care Improvement

Milestone 1 Demographics and SDOH Screening

- Patient self-reported race and ethnicity information is captured at the time of registration or check in.
- The information is collected from patients into structured, interoperable data elements using a certified EHR technology (Epic) in the Epic demographics section of the Registration (electronic) page.
- SDOH-1 Screening for patients aged 18 years and older at the time of admission to the hospital.
- SDOH-2 Screening of SDOH: health-related social needs (HRSNs) including food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.
- The information is collected from patients into structured, interoperable data elements using a certified EHR technology (Epic) in the Epic admission navigator.

Milestone 2 Train Team Members

- Riverside provided training for team members who discuss race and ethnicity information with patients. The training addresses use of culturally sensitive and inclusive terminology, and how to respond to patient questions related to why Riverside asks about race and ethnicity information.
- Riverside provided training for team members who screen for health-related social needs (HRSNs): food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. The training addresses use of culturally sensitive and inclusive terminology, and how to respond to patient questions related to why Riverside asks about HRSNs.

Milestone 3 Data Mapping for Demographic Data and Collection of HRSN for SDOH Screening

- Self-reported information is cross walked or mapped to the race and ethnicity fields recognized by the United States Department of the Interior in their published document titled “Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity,” excerpted from the Federal Register, October 30, 1997.
- Epic foundation upgrade included a Radar pre-built report on the CMS required data elements SDOH-1 and SDOH-2. The reports were added to the Epic dashboards.

Milestone 4 Build Reports and Dashboards-Demographic Data

Build reports and display data in dashboards and other visualization tools for CY 2023 and forward.

Phase 1 Reports and Dashboards-Demographic Data

- RHS inpatient population stratified by race and ethnicity.
- Hospital specific inpatient population stratified by race and ethnicity.
- RHS inpatient mortality population O/E stratified by race and ethnicity.

- Hospital specific mortality population O/E stratified by race and ethnicity.
- RHS inpatient readmission population O/E stratified by race and ethnicity.
- Hospital specific readmission population O/E stratified by race and ethnicity.
- Hospital specific patient experience (HCAHPS) survey response data stratified by race and ethnicity.

Phase 2 Reports and Dashboards-Demographic Data

- RHS Inpatient mortality population O/E stratified by condition, procedure, race, and ethnicity.
- Hospital specific mortality population O/E stratified by condition, procedure, race, and ethnicity.
- RHS Inpatient readmission population O/E stratified by condition, procedure, race, and ethnicity.
- Hospital specific readmission population O/E stratified by condition, procedure, race, and ethnicity.
- Hospital specific patient experience (HCAHPS) survey response data stratified by survey section, survey question, race, and ethnicity.

Milestone 5 Build Reports and Dashboards- SDOH-1 and SDOH-2 Data

Built reports to display data in dashboards starting CY 2024.

Phase 1 Reports and Dashboards- SDOH-1 and SDOH-2 Data

- Validated Epic dashboard display of SDOH-1 screening rate of inpatients over age 18 years for HRSNs, and SDOH-2 screen positive rate of health-related social needs (HRSNs) including food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

Phase 2 Reports and Dashboards- SDOH-1 and SDOH-2 Data

- Analysis to gain insight of key performance indicators (KPIs) for mortality, readmission and patient experience measures stratified by demographics that include race, ethnicity, age, gender and SDOH.
- Examine various aspects of the data, identifying trends, patterns, outliers, correlations, and relationships with other variables, such as the social drivers of health: food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

Milestone 6 Validate Report and Dashboard-Demographic and KPI Data

- The report and data validation process examines and verifies data to ensure it meets the specific criteria, such as data type, range, format other predefined rules. There is a code check to ensure that a field selected from the list of values available in a report is selected from values that follow standard formatting rules, then the data range, format and consistency check is applied. Sampling of the data is conducted for a final verification step.

Milestone 7 Analyze data- Demographic and KPI Data

- Identify disparities and gain insight through focused case reviews and identification of trends, patterns, correlations, and relationships with other variables.

Milestone 8 Develop Smart Goals

- Develop improvement goals for outcomes measures and/or process measures to close care gaps identified. Smart goals are specific, measurable, achievable, relevant and time bound.

Milestone 9 Develop Driver Diagram and Conduct PDSA Tests of Change

- Develop a key driver diagram that includes overall aim statement, specific measurable goals, key drivers-factors most important and impactful to improvement, secondary drivers-specific steps to take to evaluate changes expected to impact the key drivers.
- Conduct tests of change using the plan-do-study-act model, typically conducted on a segment of a population and in rapid cycles.

Milestone 10 Scale Up

- Successful tests of change can be considered for scaling up.
- Develop a playbook of the successful changes and determine the pace, location, and specific population for scaling up.

Milestone 11 Sustainment

- Develop and implement a plan for ongoing monitoring.