

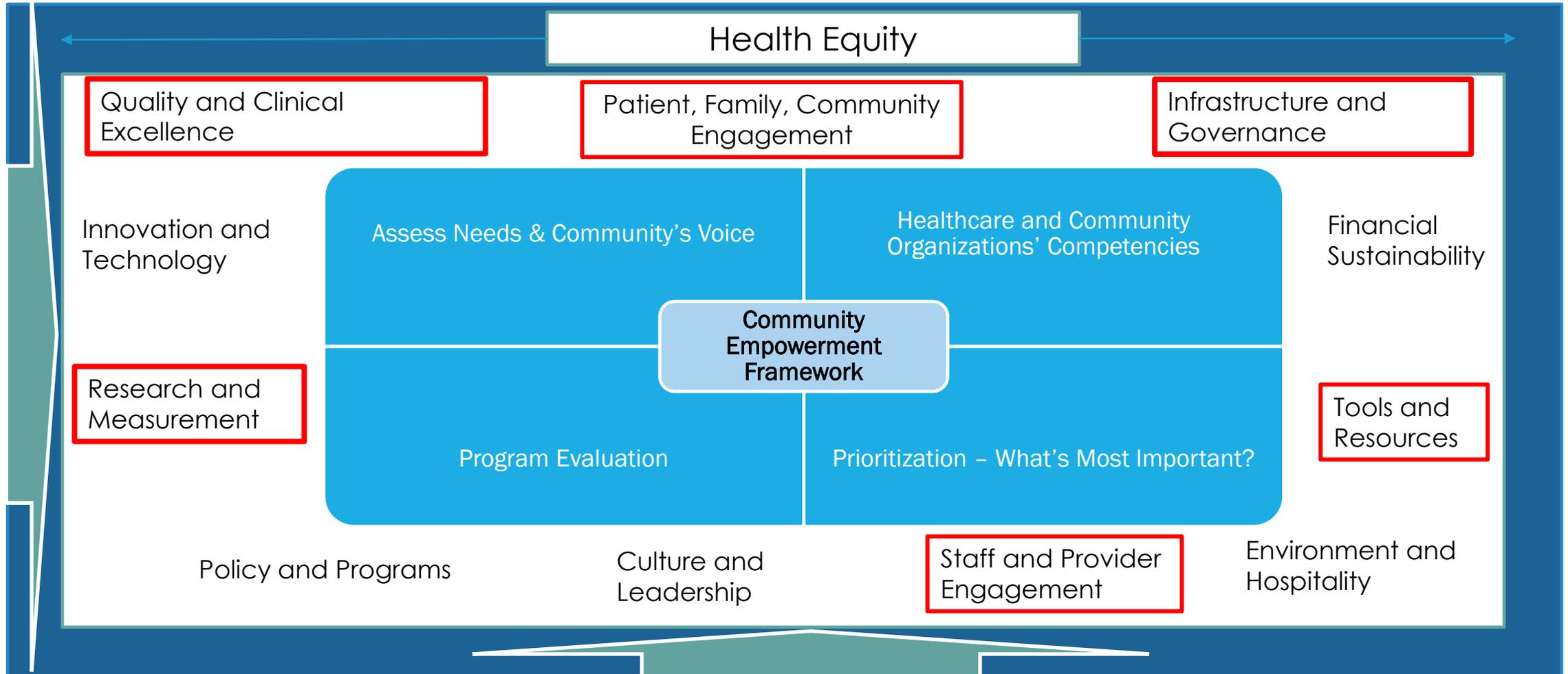


# **APPLYING A HEALTH EQUITY LENS TO CLINICAL QUALITY PROGRAMS**

A NCQA Digital Quality Measure Community v-log  
Contributed by Vanessa Guzman, SmartRise Health

# BUILDING HEALTH EQUITY AMONG HEALTHCARE AND COMMUNITY STAKEHOLDERS

Value-Based Care & Healthcare Reforms



Change Management

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# HEALTH EQUITY PROBLEMS

Lack of actionable data or data use to act upon identified disparities and reduce inequities

Provider or system care delivery complexities with poor process adoption to support patients within specific ethnic groups or those with limited English proficiency, and how it has been disproportionately challenging to navigate.

Care process issues related to care providers, including stereotyping, the impact of race and ethnicity on decision making, and clinical uncertainty due to poor communication.

Patient-related issues including patient's mistrust, poor adherence to treatment, and delays in seeking care

# UNDERSTANDING CAUSES OF INEQUITY ENABLED CUSTOMIZED INTERVENTIONS

Capture important data regarding other factors that influence health, such as patient values and beliefs about healthcare and specific healthcare interventions, housing stability, financial resource strain, culture, gender identity, food insecurity, social connectedness, and other social determinants of health.

- Standard SDOH screening
- Z-codes to standardize responses
- Race, ethnicity, language (among other demographics)
- EHR and claims data

To develop a complete picture and understand root causes contributing to lower adherence or gaps closure rates

Using literature and engagement to understand disparities and available evidence about how to increase screening rates in vulnerable populations, which increased its understanding of barriers, and activities to remedy those barriers.

# CLINICAL SEGMENTS AND INTERVENTIONS

## Opportunity to Integrate Health Equity in Measurement Activities



### Opportunity

#### IDENTIFICATION AND REPORTING

**Primary care**—diabetes, hypertension, asthma, pediatric immunizations, cancer screening, no show-rates, primary care provider assignment.

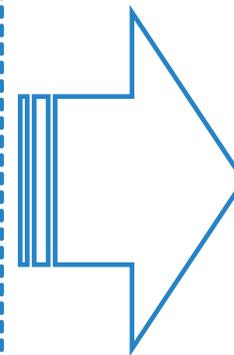
**Obstetric care**—breastfeeding, transfusion, post-partum hemorrhage, pre-term delivery, fetal loss.

**Mental health**—depression screening, depression claims, outpatient follow-up.

**Emergency care**—ED utilization, wait times, use of restraints/seclusions.

**Hospital care**—potentially avoidable hospitalizations for diabetes, HF, asthma, COPD, pneumonia and depression, readmissions, high-tech imaging claims.

**Pharmacy utilization**



### Impact

- Identification of disparities in their communities, target resources, and interventions that can reduce those disparities
- Targeted social and community services that the organization or provider should prioritize for partnership and collaboration.
- Improved design and implementation of payment reform effort by:
  - Identifying the infrastructure needs of health care organizations and providers
  - Allowing for improved methods of risk adjustment

# POPULATION HEALTH & REPORTING

## Opportunity to Integrate Health Equity in Population Health and Reporting Activities



### Opportunity

#### CHANGE MANAGEMENT

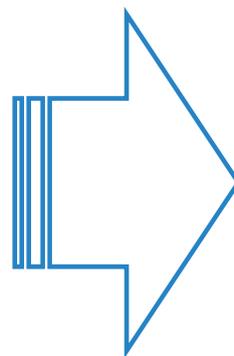
Set accountability and governance by:  
Raising awareness on population-specific performance such as:

- Race/Ethnicity
- Gender
- Poverty level
- Education

#### MOBILIZATION OF RESOURCES

Use information gathered through identification and screening to:

- Risk stratify population to identify opportunities, approach and resources to support population needs
- Determine engagement



### Impact

1. **Personalized or customized care** based on population needs and effective engagement methods

- Preventive Care
- Well-Visits
- Care management programs
- Immunizations
- Patient outreach campaigns
- Automated decision support tools
- Appropriate level of social and clinical support

2. **Demographic and social data embedded in dashboards** and workflow to easily identify and address disparities

3. Monitor the **effectiveness of its interventions on the populations** at highest risk for the poorest screening rates



## KEY TAKEAWAYS

Commit to strengthen your organization's commitment to identify disparities and advance health equity.

- Goals and Objectives
- Organizational competencies
- Program Structure
- Using Data for Segmentation
  - Population Needs
  - Resources
  - Activities
- Delivery system evaluation



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