

Hospital Equity Report User Input Template

This template lists the 10 fields from the HCAI Hospital Equity Report that require user input from hospitals using HQI's equity report solution. Use this template to write your responses to these report elements so they can be copied and pasted into the HQIP User Interface and integrated into the downloadable csv report. Also included are optional fields for hospitals to report their CMS HCHE and SDOH Measures, *if available*.

1. Web address for the Hospital Equity Report on the hospital's website (60 characters max)

<https://www.arrowheadregional.org/>

2. Do you have a designated individual who leads hospital health equity activities? ☒ Yes ☐ No

3. Do you provide documentation of policy prohibiting discrimination? ☒ Yes ☐ No

4. Equity Plan: What actions are planned to address the Top 10 Disparities identified in the data, including population impact, measurable objectives, and specific timeframe. (5000 characters max)

Based on our risk stratification data, Arrowhead Regional Medical Center had the following ten key disparities.

Disparity 1: AHRQ Patient Safety Indicator Death Rate among Surgical Inpatients with Serious Treatable Complications expected payor. **Goal:** Enhance equity of care by decreasing the number of treatable complications in patients. Strategies: Risk stratification for all Medicare patients. **Dedicated Transitional Care Team:** Admission representatives, case management team. Concurrent review of serious treatable complications ensure clear, effective communication is occurring. **Population Impact:** Improves patient safety, reduces payor disparities by ensuring safety amongst all patients regardless of payor.

Disparities 2;3;7: Hospital Readmission Race and/or Ethnicity- **Goal:** Decrease disparity amongst race and or Ethnicity by 5%. **Dedicated Transitional Care Team:** Social Determinants of Health (SDOH) support. Access to outpatient services within 7 days for high-risk patients. Review daily readmission episodes to identify trends analyzing data focusing on equity interventions. Placement of post discharge phone calls to connect with patients and identify needs, build on continuity of care, reduce disparities, strengthen community partnership to lower the preventable readmissions. **Population Impact:** Reduces disparities ensuring quality safety care amongst all patients regardless of ethnicity.

Disparities 4;5;8: Hospital Readmission-Age **Goal:** Reduce 30-day all cause readmissions for patient's age. **Transitional Care Team Support:** Social Determinants of Health (SDOH) support. Provide patient education amongst the community regarding preventive care. **Population Impact:** Reduces disparities ensuring quality safety care amongst all patients regardless of age.

Disparity 6: AHRQ Patient Safety Indicator Death Rate among Surgical Inpatients with Serious Treatable Complications Race and/or Ethnicity: **Goal:** Focus on equitable access treatment. **Transitional Care Team Support:** Social Determinants of Health (SDOH) support. Provide patient

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education amongst the community regarding preventive care. **Population Impact:** Reduces disparities ensuring quality safety care amongst all patients regardless of ethnicity.

Disparity 9: Hospital Readmission-Medicare, **Goal:** Reduce 30day all cause readmissions for Medicare patients by 5%. **Transitional Care Team Support:** Increase Patient education on preventive measures, provide medication reconciliation. Increase community outreach programs encouraging patient wellbeing, ensure patients have follow up visit scheduled prior to discharge; providing discharge follow up phone calls. Involvement of interdisciplinary team prior to discharge to identify any needs of patient prior to discharge. **Population Impact:** Reduces disparities ensuring quality safety care amongst all patients regardless of payor source.

Disparity 10: Hospital Readmissions-Male Patients, **Goal:** Reduction of 30-day-all-cause readmissions for male patients by 5% in the first year. **Strategies:** Gender specific discharge plans addressing substance use needs, mental health and cardiovascular. Ensuring chronic management for diabetes, hypertension, and heart diseases. Ensure patients have post-discharge referrals prior to discharge. **Population Impact:** Reduces disparities ensuring quality safety care amongst all patients regardless of sex assigned at birth.

Summary: Arrowhead Regional Medical Center equity plan focuses on interventions to reduce all cause readmissions by utilizing evidence-based strategies. Interventions include interdisciplinary discharge rounding, transitional care, chronic disease management, post discharge calls, and SDOH support. This plan aims to improve patient safety and decrease disparities by including the patient/or designated health designee from admission to discharge regarding their hospital treatment plan. Our hospital recognizes that many of the disparities reflected on our data are related to the demographics of our service area, including race, ethnicity, age, sex assigned at birth, and payor type. While we cannot change the underlying demographics of our service area, ARMC is committed to implementing focused strategies that lessen their impact and advance equity in care delivery.

5. Describe your performance in the priority area of *Person-Centered Care*. (5000 characters max)

Arrowhead Regional Medical Center respects and values the perspectives of the patients and families we serve. We review data from our patient experience scores on HCAHPS, administered by Professional Research Consultant, focusing on effective communication being provided. To ensure that patient needs are addressed. We participate in BETA Heart, a nationally recognized patient safety and culture of safety program that emphasizes empathy and transparency.

6. Describe your performance in the priority area of *Patient Safety*. (5000 characters max)

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At Arrowhead Regional Medical Center, we understand that patient safety is key to quality and trust. Arrowhead Regional Medical Center 2024-2027 Strategic Plan focuses on “Aligning Key Initiatives” to achieve no preventable deaths, no preventable harm, no preventable readmissions, top decile and patient experience scores, top decile in clinical outcomes, with a framework of shared accountability, we will instill standardization, transparency, teamwork, and communication. As a result, excellence, innovation, and learning will be attained on an organization wide level. The approach to improving patient safety and quality delineation in the plan requires a coordinated and collaborative effort. Multiple departments and disciplines are involved in establishing the plans and mechanisms that compromise healthcare safety and quality activities at ARMC. The Organizational Performance Improvement Plan has been developed with broad interdisciplinary input from the Patient Safety Committee and approved by the Joint Conference Committee, Medical Staff Executive Committee (MEC), and the Quality Management Committee (QMC). One of ARMC priority focus is to create a Culture of Patient Safety, Healing Environment, enhancing the environment of care to promote optimal patient safety and healing by ensuring a non-punitive reporting of patient safety events, focusing on process breakdowns not individual behaviors, reporting disruptive behavior, implementing and utilizing processes to report inappropriate conduct by healthcare providers. ARMC is committed to providing practical and evidence-based guidance for communication of adverse events. Set expectations and provide guidance to practitioners of the patient/family that experienced an adverse event to restore trust in a responsible, empathetic and supportive manner. Improve patient safety by learning from errors and adverse events while changing systems to minimize the likelihood of recurrence. Promote transparency around adverse events, emphasizing timely and direct communication with patients/families and seeking resolution(s) when patients experience an adverse event.

7. Describe your performance in the priority area of *Addressing Patient Social Determinants of Health*. (5000 characters max)

ARMC has integrated comprehensive Social Determinants of Health (SDOH) screenings into routine patient care to proactively identify challenges such as food insecurity, housing instability, transportation barriers, behavioral health needs, social isolation, and gaps in preventive care. Through strategic collaboration with community-based organizations and local partners, we effectively connect patients with essential resources, including food banks, housing assistance and navigation services, transportation support, and various social service agencies. Additionally, by fostering strong partnerships with insurance providers, ARMC enhances care coordination efforts, ensuring that patients receive seamless support for both medical and non-medical barriers impacting their health outcomes.

8. Describe your performance in the priority area of *Effective Treatment*. (5000 characters max)

Arrowhead Regional Medical Center is committed to providing high quality compassionate care by ensuring patient safety is priority and timely effective care is provided. Below are a few examples of how ARMC demonstrates their commitment to Effective Treatment:

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Arrowhead Regional Medical Center has received the American Heart Association's Get With The Guidelines® - Stroke: Gold Plus quality achievement award for its commitment to ensuring stroke patients receive the most appropriate treatment according to nationally recognized, research-based guidelines, ultimately leading to more lives saved and reduced disability.

Stroke is the No. 5 cause of death and a leading cause of disability in the U.S. A stroke occurs when a blood vessel that carries oxygen and nutrients to the brain is either blocked by a clot or bursts. When that happens, part of the brain cannot get the blood and oxygen it needs, so brain cells die. Early stroke detection and treatment are key to improving survival, minimizing disability and accelerating recovery times.

Get With The Guidelines puts the expertise of the American Heart Association and American Stroke Association to work for hospitals nationwide, helping ensure patient care is aligned with the latest research- and evidence-based guidelines. Get With The Guidelines - Stroke is an in-hospital program for improving stroke care by promoting consistent adherence to these guidelines, which can minimize the long-term effects of a stroke and even prevent death.

"Arrowhead Regional Medical Center is committed to improving patient care by adhering to the latest treatment guidelines." Get With The Guidelines makes it easier for our teams to put proven knowledge and guidelines to work on a daily basis, which studies show can help patients recover better. The end goal is to ensure more people in San Bernardino County can experience longer, healthier lives.

9. Describe your performance in the priority area of **Care Coordination**. (5000 characters max)

Arrowhead Regional Medical Center case management and social work teams are committed to care coordination ensuring patient needs are met through patient-centered care plans, effective communication, patient engagement, addressing social determinants of health, and interdisciplinary collaboration. Care coordination begins at time of admission through discharge. Multidisciplinary discharge huddles are completed daily to address throughput and patients' aftercare coordination.

10. Describe your performance in the priority area of **Access to Care**. (5000 characters max)

Arrowhead Regional Medical Center case management and social work teams are committed to care coordination ensuring patient needs are met through patient-centered care plans, effective communication, patient engagement, addressing social determinants of health, and interdisciplinary collaboration. Care coordination begins at time of admission through discharge. Multidisciplinary discharge huddles are completed daily to address throughput and patients' aftercare coordination. ARMC is committed to serving our community regardless of insurance or financial status. ARMC offers charity programs to assist our vulnerable population. ARMC is a safety-net provider for our community and is dedicated to outreach programs. One of many resources is our Mobile Clinics, determined to help care for patients with limited resources. These practices align with our mission to ensure equitable access and to remain a trusted safety-net provider for our local community.

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Optional Structural Measures: Hospital Commitment to Health Equity (HCHE) and Social Drivers of Health (SDOH)

1. CMS Hospital Commitment to Health Equity Structural (HCHE) Measure. (If Available)

- a. CMS HCHE Domain 1: Strategic Planning ☒ Yes ☐ No
- b. CMS HCHE Domain 2: Data Collection ☒ Yes ☐ No
- c. CMS HCHE Domain 3: Data Analysis ☒ Yes ☐ No
- d. CMS HCHE Domain 4: Quality Improvement ☒ Yes ☐ No
- e. CMS HCHE Domain 5: Leadership Engagement ☒ Yes ☐ No

2. CMS Screening for Social Drivers of Health (SDOH) and CMS Screen Positive Rate for SDOH and Intervention (If Available) Note: Most hospitals will not be able to provide the values in red, as they were never required to be collected or reports for a CMS SDOH Measure.

SDOH Measure Component/Rate	Value
a. CMS SDOH Overall Screened Numerator: Number of patients admitted to an inpatient hospital stay who are 18 years or older on the date of admission and are <u>screened for all five HRSNs</u> . (9 digits max)	2752
b. CMS SDOH Overall Screened Denominator: Number of patients who are admitted to a hospital inpatient stay and who are 18 years or older on the date of admission. (9 digits max)	16157
c. CMS SDOH Overall Screened Rate: The percent of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, were screened for an HRSN, and who <u>screen positive for one or more of the following five HRSNs</u> : Food insecurity, housing instability, transportation problems, utility difficulties, or interpersonal safety. (4 digits max, i.e. xx.x)	17%
d. CMS SDOH Food Insecurity Numerator: Number of patients screened positive for food insecurity. (9 digits max)	138

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e. CMS SDOH Food Insecurity <u>Positive Rate</u> : CMS SDOH Food Insecurity Numerator divided by CMS SDOH Overall Screened Numerator, multiplied by 100. (4 digits max, i.e. xx.x)	5%
f. CMS SDOH Food Insecurity <u>Intervention</u> : Number of interventions provided for Food Insecurity. (9 digits max)	
g. CMS SDOH Food Insecurity <u>Intervention Rate</u> : CMS SDOH Food Insecurity Intervention divided by CMS SDOH Overall Screened Numerator, multiplied by 100. (4 digits max, i.e. xx.x)	
h. CMS SDOH Housing Instability <u>Numerator</u> : Number of patients screened positive for housing instability. (9 digits max)	126
i. CMS SDOH Housing Instability <u>Positive Rate</u> : CMS SDOH Housing Instability Numerator divided by CMS SDOH Overall Screened Numerator, multiplied by 100. (4 digits max, i.e. xx.x)	5%
j. CMS SDOH Housing Instability <u>Intervention</u> : Number of interventions provided for housing instability. (9 digits max)	
k. CMS SDOH Housing Instability <u>Intervention Rate</u> : CMS SDOH Housing Intervention divided by CMS SDOH Overall Screened Numerator, multiplied by 100. (4 digits max, i.e. xx.x)	
l. CMS SDOH Transportation Problems <u>Numerator</u> : Number of patients screened positive for transportation problems. (9 digits max)	249
m. CMS SDOH Transportation Problems <u>Positive Rate</u> : CMS SDOH Transportation Problems Numerator divided by CMS SDOH Overall Screened Numerator, multiplied by 100. (4 digits max, i.e. xx.x)	9%
n. CMS SDOH Transportation Problems <u>Intervention</u> : Number of interventions provided for transportation problems. (9 digits max)	
o. CMS SDOH Transportation Problems <u>Intervention Rate</u> : CMS SDOH Transportation Problems Intervention divided by CMS SDOH Overall Screened Numerator, multiplied by 100. (4 digits max, i.e. xx.x)	
p. CMS SDOH Utility Difficulties <u>Numerator</u> : Number of patients screened positive for utility difficulties. (9 digits max)	98

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q. CMS SDOH <i>Utility Difficulties</i> <u>Positive Rate</u>: CMS SDOH Utility Difficulties Numerator divided by CMS SDOH Overall Screened Numerator, multiplied by 100. <i>(4 digits max, i.e. xx.x)</i>	4%
r. CMS SDOH <i>Utility Difficulties</i> <u>Intervention</u>: Number of interventions provided for utility difficulties. <i>(9 digits max)</i>	
s. CMS SDOH <i>Utility Difficulties</i> <u>Intervention Rate</u>: CMS SDOH Utility Difficulties Intervention divided by CMS SDOH Overall Screened Numerator, multiplied by 100. <i>(4 digits max, i.e. xx.x)</i>	
t. CMS SDOH <i>Interpersonal Safety</i> <u>Numerator</u>: Number of patients screened positive for interpersonal safety. <i>(9 digits max)</i>	25
u. CMS SDOH <i>Interpersonal Safety</i> <u>Positive Rate</u>: CMS SDOH Interpersonal Safety Numerator divided by CMS SDOH Overall Screened Numerator, multiplied by 100. <i>(4 digits max, i.e. xx.x)</i>	1%
v. CMS SDOH <i>Interpersonal Safety</i> <u>Intervention</u>: Number of interventions provided for interpersonal safety. <i>(9 digits max)</i>	
w. CMS SDOH <i>Interpersonal Safety</i> <u>Intervention Rate</u>: CMS SDOH Interpersonal Safety Intervention divided by CMS Overall SDOH Screened Numerator, multiplied by 100. <i>(4 digits max, i.e. xx.x)</i>	