



Innovations to Advance Health Equity

Creating Your Hospital's Health Equity Playbook

INTRODUCING THE INCLUSION SCORECARD FOR POPULATION HEALTH™

A Subsidiary of

InclusionINC®
Inclusion Is A Business Strategy ●●●

Founded in 2001 as a Woman-Owned Business



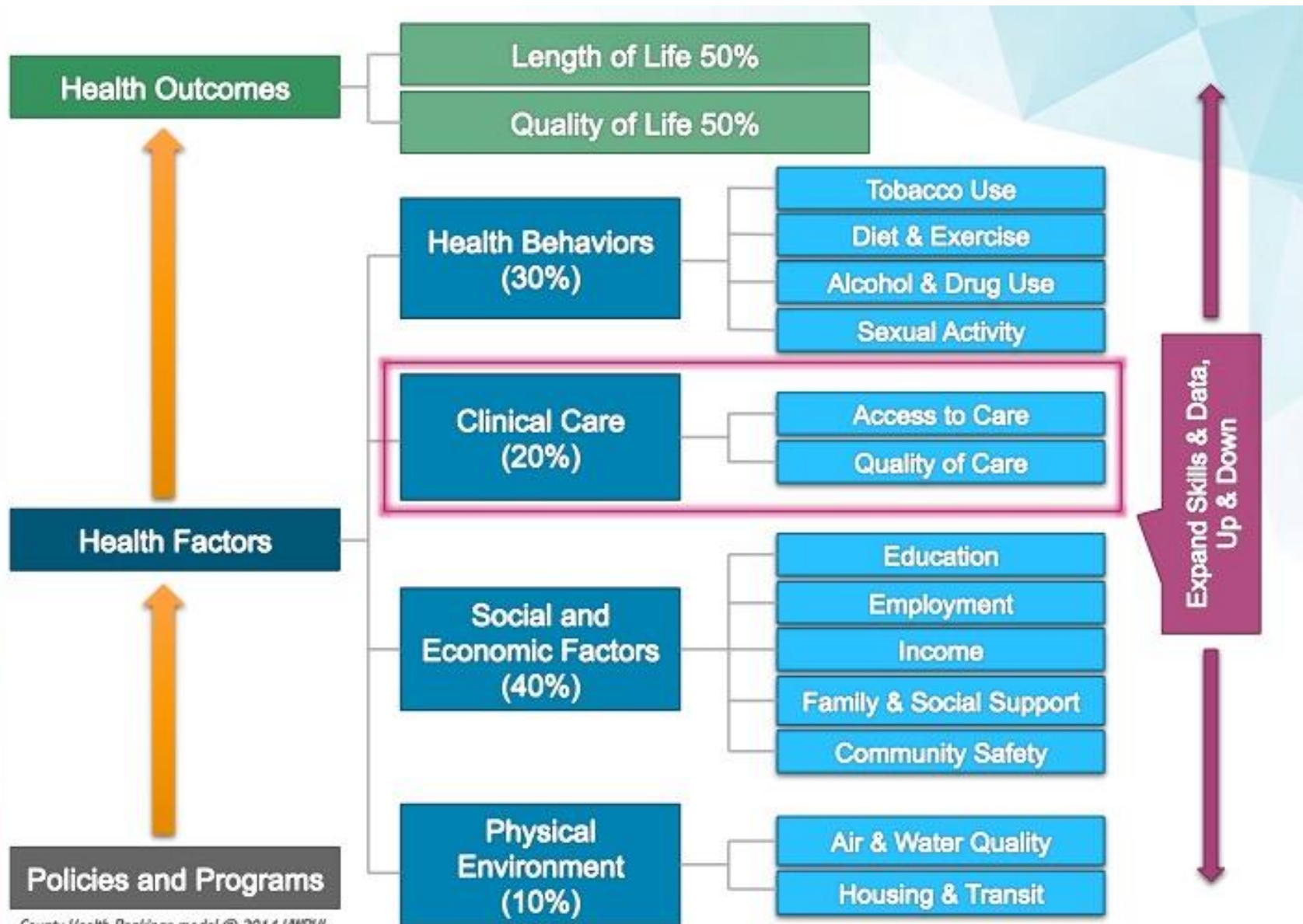
Speaker Bio

Maria Hernandez, PhD
COO Impact4Health



- Principal researcher on the Inclusive Leader 360™, Inclusion Scorecard for Population Health™
- Leading Alameda County's first Pay for Success Asthma Initiative to reduce pediatric asthma emergencies
- Board of Trustee, Alameda Health System

True Population Health Management



County Health Rankings model © 2014 UWPHI

Robert Wood Johnson & University of Wisconsin Public Health Institute

Population Health Initiatives Remain Focused on Identifying and Managing Risk Pools And Cost of Care

In Development

- Deployable
- Under development
- On Road Map
- Client, Third-party Payer

Third-party Payers	
Government	Commercial
Healthcare Exchanges	
Government	Commercial

- At-Risk Contracting and Monitoring
- Accountable Care Readiness Assessment

- Population Risk Evaluation
- Patient Engagement/Communications
- Population Management Content
- Patient Injury Prevention Content



- Network Coverage Optimization
- Member/Patient Satisfaction
- Ordering waste reduction
- Workflow waste reduction
- Defect waste reduction

- Key Process Analyses

- Financial Management
- Activity-Based Costing

● Registries	● Info Distribution	● Knowledge Infrastructure
● Data Acquisition	● Data Integration	● Data Governance

***Population Health strategies
cannot succeed without
understanding the diverse
needs of the populations
being served
or the unique conditions
in which they live and work.***



The Inclusion Scorecard for Population Health Addresses Two Needs:

To review and identify the existing Diversity, Inclusion and Equity best practices regarding staff, patients, and community that support a hospital's response to health disparities.

To create new strategies to advance health equity that need to be more consistently used across your health system or extended to the community organizations that work with you.



The InclusionSCORECARD for Population Health™

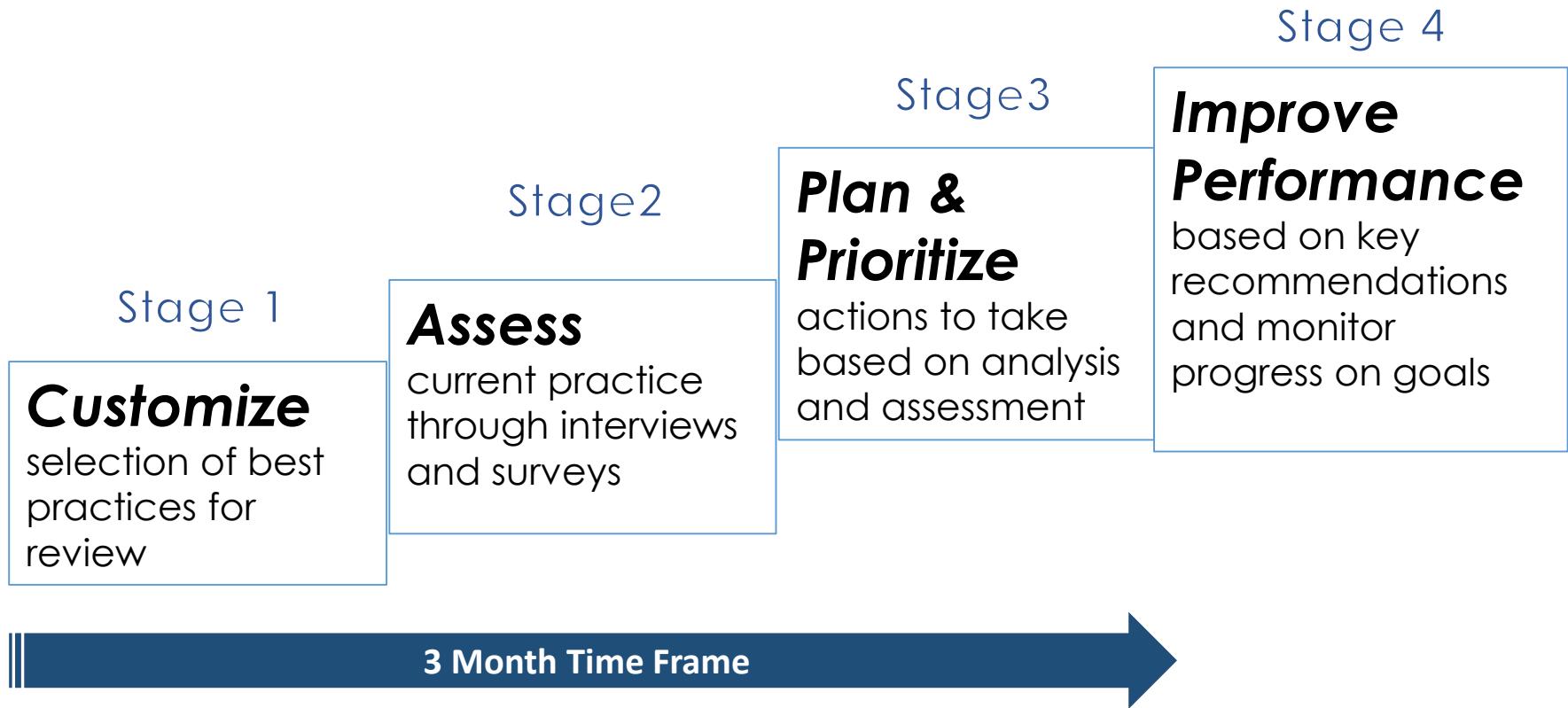


Provides a **comprehensive and systematic approach** to inform and influence health care providers and public health department initiatives aimed at improving care, reducing health disparities, and lowering healthcare costs.

Innovations to Advance Health Equity



Technical Assistance for Building Your Inclusion SCORECARD™ for Population Health





Assessing Best Practice Adoption

	1	2	3	4
Stated Goals and Objectives in Place	Not Evident	In Development	Partially Developed	Finalized
Resources Aligned with Goals	Not Evident	In Development	Partial Alignment	Full Alignment
Procedure, Best Practices Integrated with Strategy	Not Evident	In Development	Partial Integration	Full Integration

Tracking the Metrics of Inclusion for Healthcare



What data are you collecting to see where disparities exist?

How are you tracking your response to those disparities?

- Measuring diverse patient experiences and outcomes inside your system
- Tracking the social determinants of health in key patient communities
- Tracking service utilization patterns by zip codes
- Measuring diverse employee engagement, retention and advancement at all levels
- Tracking participation in training for cross cultural competency, inclusive leadership, unconscious bias and privilege among all employees

How do you demonstrate a value for diversity, cultural effectiveness and cultural humility?

Are diverse patients and staff feeling welcomed?

- Creating site specific patient navigation systems for non-English speakers or other vulnerable populations
- Developing patient services tailored to unique cultural expectations on disease management
- Using Employee or Business Resource Groups to engage and retain diverse staff
- Training for inclusive leadership, cultural competency and health equity
- Use of an ombudsman to address patient grievances



Creating the Culture
of Inclusion for
Health Equity

- Using 360 Performance Evaluations to measure inclusive leadership and management practices
- Linking executive bonuses to diverse employee engagement
- Acknowledging and rewarding inclusive leaders
- Holding executives accountable for community engagement, participation in community nonprofits

Managing the Link Between Inclusion and Quality Outcomes



**How are you
rewarding and
recognizing inclusive
leaders?**

**How are leaders
actively engaged in
addressing health
equity?**

- Publishing the CHNA and health plan to address needs
- Using a community advisory council on health equity
- Advocating health access and equity in local and regional policies
- Working with community organizations to address social determinants of health
- Targeting outreach and health education to community groups serving key populations

How is your hospital partnering with community stakeholders to serve the needs of your patients where they live and work?

How are you addressing the social determinants of health in partnership with community groups?



**Inclusive Community
Engagement in
Prevention and
Health Education**



Inclusion Scorecard for Population Health Maturity Index



Innovations to Advance Health Equity

Why Create Your Scorecard?

1

To Assess & Build Strategy

- Assess your sites existing D/I initiatives to identify gaps and opportunities for new or improved efforts.
- Build your customized strategy to reduce health disparities.

2

To Create Consistency

- Identify existing D/I initiatives that align with known best practices.
- Track the use of those across your system to insure consistency and greater accountability.

3

To Extend Best Practices

- Take your existing equity playbook on population health and build capacity to engage community organizations that can work with your site to address SoDH or create better coordinated care.



Leverage the InsightVision Platform

INSIGHTFORMATION INC.

Build Your Inclusion Scorecard for Population Health™ On-Line

1. Cloud based platform accessible anywhere.
2. Organize, track and monitor activity throughout the healthcare system.
3. Develop “strategy maps” to address specific disparities.
4. Share elements of the Scorecard with community partners to coordinate and collaborate on work.

Inclusion Scorecard for Population Health

powered by: InsightVision

Tracking the Metrics of Inclusion for Healthcare

Managing the Link Between Inclusion and Quality Outcomes



Creating the Culture of Inclusion for Health Equity

Inclusive Community Engagement in Prevention and Health Education

Inclusion Scorecard for Population Health ASSESSMENT

Create Data Import CSV Edit Mode Print

Expand All | Collapse All

Scorecards: Inclusion Scorecard for Population Health ASSESSMENT

QUADRANT ONE: Tracking Metrics of Inclusion

Name	Current Value	Owner	Notes / Actions
PATIENT METRICS			
1.1.1: Define Patient Demographic Profile - Overall Rating	0.00		
1.1.2: Track Patient Utilization by Demographics - Overall Rating	2.00	Russ Archer, CMO	
1.1.3: Patient Health Outcomes by Demographics - Overall Rating	1.33	Russ Archer, CMO	
1.1.4: Conduct HCAHPS "Hospital Survey" Annually - Overall Rating	0.00		
1.1.5: High Risk, Rising Risk and At Risk Populations are Identified by Demographic Groups and by Zipcodes to Inform Care Coordination - Overall Rating	0.00		

COMMUNITY METRICS

EMPLOYEE DEMOGRAPHICS

EMPLOYEE RECRUITMENT, DEVELOPMENT & ENGAGEMENT

Inclusion Scorecard for Population Health ASSESSMENT

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COMMUNITY METRICS			
EMPLOYEE DEMOGRAPHICS			
EMPLOYEE RECRUITMENT, DEVELOPMENT & ENGAGEMENT			

QUADRANT TWO: Creating the Culture of Inclusion for Health Equity

Name	Current Value	Owner	Notes / Actions
INSTITUTIONAL MISSION/VALUES			
PATIENT EXPERIENCE- SERVICE DELIVERY			
PATIENT EXPERIENCE - NAVIGATING FACILITIES			
PATIENT EXPERIENCE - QUALITY OF CARE			
EMPLOYEE EXPERIENCE: Learning and Development			
EMPLOYEE EXPERIENCE: Recruitment, Retention, Engagement			
INCLUSION & DIVERSITY INFRASTRUCTURE			

Inclusion Scorecard

Expand All | Collapse All

QUADRANT ONE:

PATIENT METRIC

1.1.1: Define

1.1.2: Track

1.1.3: Patient

1.1.4: Cond

1.1.5: High

Overall Ratio

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QUADRANT TWO:

INSTITUTIONAL M

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PATIENT EXPERI

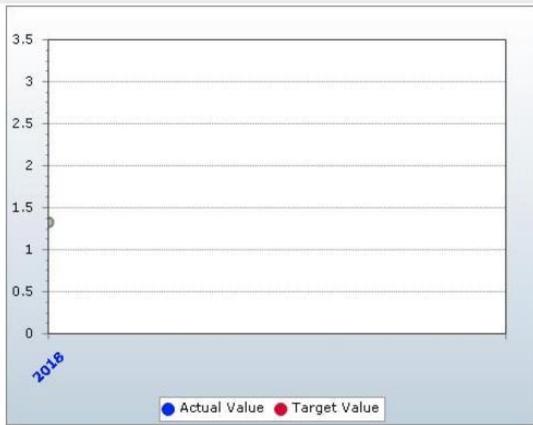
PATIENT EXPERI

EMPLOYEE EXPE

EMPLOYEE EXPE

INCLUSION & DIVERSITY INFRASTRUCTURE

Measure at a Glance



Time Period	Target Value	Actual Value
2018	3.00	1.33

Description

Population Health Metrics Reviewed Across Chronic Conditions

Comments

From Current State

To Desired State

Health outcomes for chronic conditions are not being tracked by ethnic groups.

Health outcomes for chronic conditions are tracked by ethnic groups, and reports on disparities are regularly reviewed to determine action plans.

Owner Notes / Actions

Russ Archer, CMO

Russ Archer, CMO

Owner Notes / Actions

Inclusion Scorecard for Population Health ASSESSMENT

Create Data Import CSV Edit Mode Print

Expand All | Collapse All

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EMPLOYEE EXPERIENCE: Learning and Development			
EMPLOYEE EXPERIENCE: Recruitment, Retention, Engagement			
INCLUSION & DIVERSITY INFRASTRUCTURE			

Each of the best practices is linked to the resource data base.

Last updated: Jul 8, 2017

1.1.3 Patient Health Outcomes by Demographic Group

What's the Core Issue?

Your facility is required by federal and state agencies to measure patient outcomes broadly. The World Health Organization defines an outcome measure as a "change in the health of an individual, group of people, or population that is attributable to an intervention or series of interventions." However, there is no one set of health outcomes consistently used throughout the US. The most common health outcome measures used by the Centers for Medicare and Medicaid Services to measure a hospital's quality of care are:

- Mortality
- Safety of care
- Readmissions
- Patient experience
- Effectiveness of care
- Timeliness of care
- Efficient use of medical imaging

Another common set of health outcomes include the following:

- Longevity, mortality
- Chronic disease and morbidity
- Complications (of disease or of medical care)
- Physical functional status
- Psychosocial functioning
- Quality of life
- Costs of care
- Use of specified services
- Satisfaction with care, experiences with care

Why is this Important?

In order to address health inequities, facilities must also compare health outcomes among key populations--gender, generation, ethnicity and LGBTQ status--in order to be able to detect whether health inequities are taking place.

Resources:

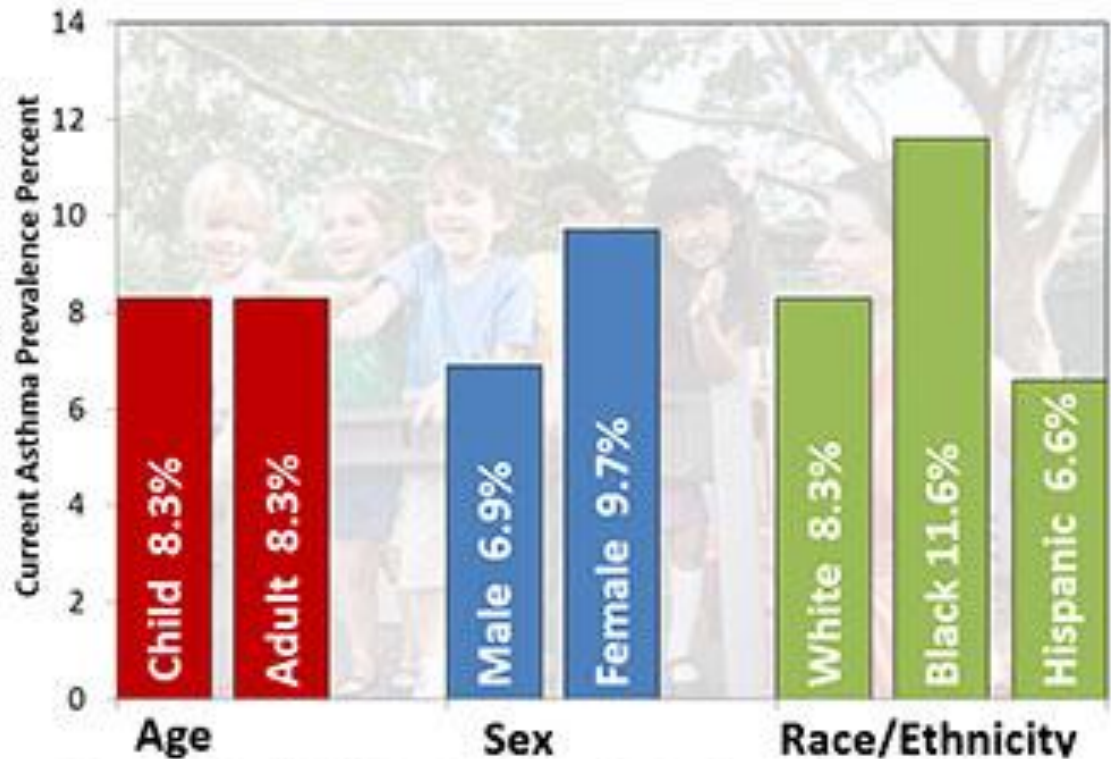
1. The Centers for Disease Control and Prevention has published a guide on common health outcomes and social determinants of health that can be used for health needs assessments. The document is embedded here below or



An Example: Asthma Disparity

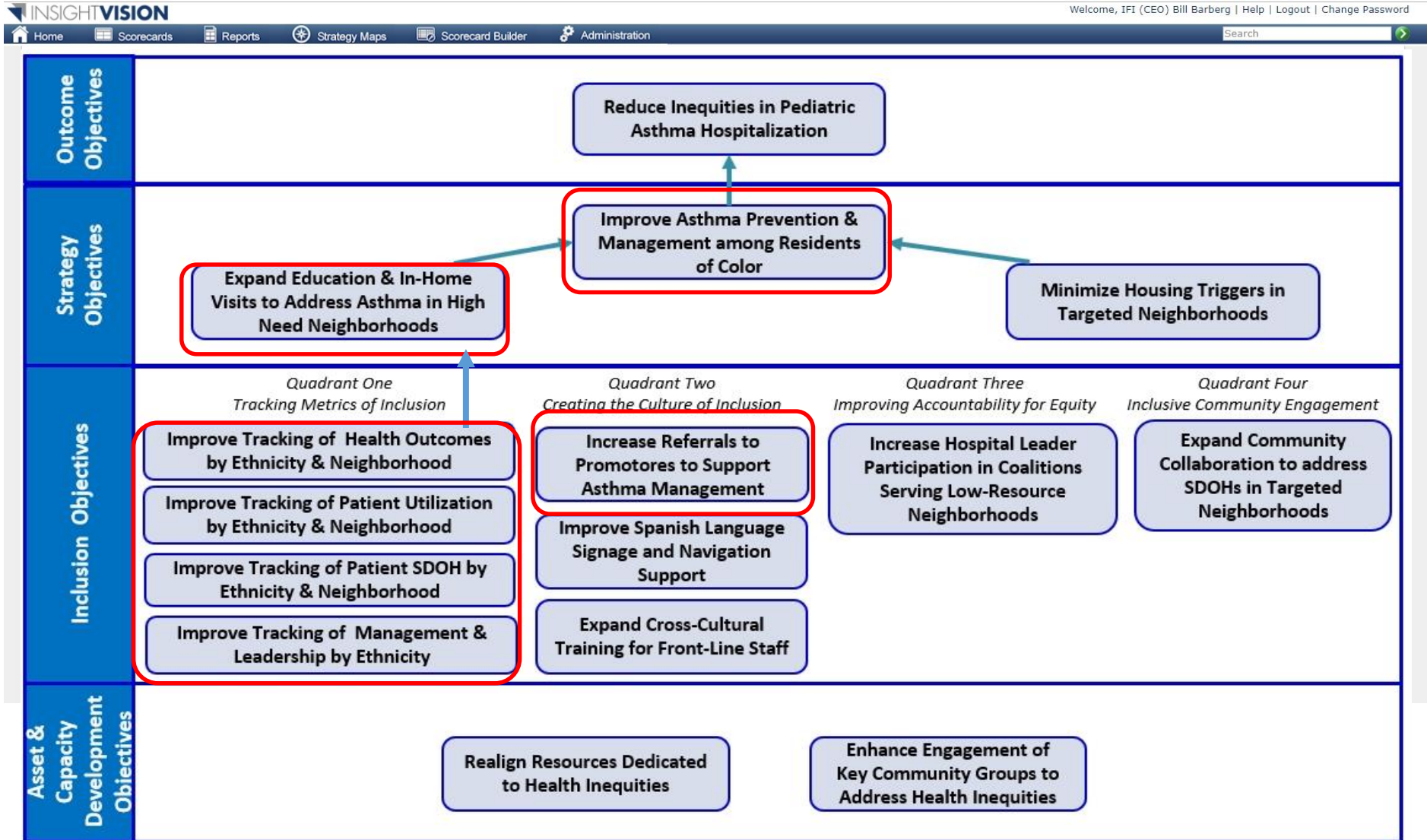
The socioeconomic burden of Asthma has direct and indirect costs with impacts on quality of life, school persistence, psychosocial development.

Current Asthma Prevalence Percent by Age, Sex, and Race/Ethnicity, United States, 2016



Source: National Health Interview Survey, National Center for Health Statistics, Centers for Disease Control and Prevention

Central Hospital's Strategy Map on Reducing Inequities in Pediatric Asthma Hospitalizations





We Look Forward to Partnering with Your Leaders to Advance Health Equity

**Population Health
Patient Services
Human Resources
Diversity, Inclusion & Belonging
AND
Community Organizations**



Thank You!

For more information, please contact

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