# Health Equity Action Plan

Health Quality Innovation Network

Utilize this action plan to design and implement a population health quality improvement project that focuses on understanding and addressing key social drivers of health. This will help hospitals meet the CMS Hospital Commitment on Health Equity (HCHE) and Joint Commission health equity standards, as well as improve health equity outcomes.

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|---|---|
| Health System: | |
| Facilities involved (if applicable): | |

**Core Team Members**

| Team Member Title | Team Member Name | Responsibilities |
|---|---|---|
| Health Equity Leadership Champion | | |
| Team Lead | | |
| Other Members | | |
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**PROBLEM STATEMENT:** Thinking about the health disparities identified in your health system/ hospital, pinpoint the disparity you want to address and the priority population impacted by the identified disparity.

You can use this format to develop your problem statement:
Current situation is _____ , leading to _____ (undesirable event).

**INTERNAL PARTNERSHIPS:** Identify which staff roles and/or departments within your organization will be involved in creating and implementing this program (This could include those who may approve screening tools used, interview patients, collect and analyze data, document patient information, provide community resources, and/or lead the effort):

**EXTERNAL PARTNERSHIPS:** Identify entities within the community you want to engage about plans to implement this program (This could include community based organizations, payers, academic institutions, faith based organizations, EHR vendors, etc.):

**ACTION PLAN:** Using this chart, outline 1 to 3 goals to address your problem statement. For each goal, describe the actions you will take to achieve your goals, the resources required, how you will measure your success and how you will monitor your impact.

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|---|---|---|
| **GOALS** | List out your **SMART** goal(s). (**S**pecific, **M**easurable, **A**chievable, **R**elevant, **T**ime Bound) | |
| **ACTION STEPS** | List the action steps needed to achieve your goal(s) and include estimated completion dates for each step. | |
| **RESOURCES AND KEY STAKEHOLDERS** | List the resources needed to accomplish action steps, including key staff or stakeholders. | |
| **METRICS** | What will you monitor?<br><br>What data will you use to track progress and how often? | |
| **MEASUREABLE OUTCOMES/IMPACT** | Consider long term outcomes: How will you evaluate the impact and sustainability of your actions? | |

**Resource:** CMS Disparity Impact Statement

Complete the following if your action plan relates to implementing social drivers screening:

**SCREENING WORKFLOW:** Screening for social drivers requires deciding when and how you should screen patients, what to screen for, and how to provide resources to those in need. Answer the following questions by selecting the options you plan to utilize in your screening process.

| When will the screening be initiated? | Who will conduct the screening? | How will resources be provided to patients who screen positive and accept resources? |
|---|---|---|
| Select all that apply:<br>☐ Registration<br>☐ Bedside anytime during stay<br>☐ Bedside at a designated time<br>☐ After discharge is scheduled<br>☐ Pre-registration (i.e., via patient portal for scheduled or anticipated inpatient stays, e.g., labor and delivery, elective procedures)<br>☐ Post-discharge<br>☐ Other _____<br>☐ Other _____ | Select all that apply:<br>☐ Registration Staff<br>☐ Medical Assistants<br>☐ Nurses<br>☐ Providers<br>☐ Social Workers<br>☐ Case Managers<br>☐ Community Health Workers<br>☐ Patient self-administered (via paper or electronically)<br>☐ Other _____<br>☐ Other _____ | Select all that apply:<br>☐ Printed list of resources generally provided in discharge summary<br>☐ Printed list of tailored resources based on patient needs provided in discharge summary<br>☐ Resources mailed to address on file after hospital stay<br>☐ Handoff to hospital staff equipped to provide resource navigation and follow-up (CHWs, Case Management, etc.)<br>☐ Electronic referrals made via a closed-loop referral system<br>☐ Inpatient visits from local resource representatives to provide information<br>☐ Other _____<br>☐ Other _____ |

| Who will provide information about/ connection to community resources? | Which social drivers will patients be screened for? | Where in your facility will you screen? |
|---|---|---|
| Select all that apply:<br>☐ Registration Staff<br>☐ Medical Assistants<br>☐ Nurses<br>☐ Providers<br>☐ Social Workers<br>☐ Case Managers<br>☐ Community Health Workers<br>☐ Other _____<br>☐ Other _____ | Select all that apply:<br>☐ Food Insecurity*<br>☐ Housing Instability*<br>☐ Utility Difficulties*<br>☐ Transportation Needs*<br>☐ Interpersonal Safety*<br>☐ Financial Strain<br>☐ Employment<br>☐ Loneliness/Social Isolation<br>☐ Education<br>☐ Physical Activity<br>☐ Substance Use<br>☐ Mental Health<br>☐ Disabilities<br>☐ Child Care<br>☐ Other _____<br>☐ Other _____<br><br>Which screening tool(s) will you use?<br><br>*Required by CMS in 2024 | Select all that apply:<br>☐ All units, all inpatients 18+<br>☐ All units, all inpatients 0+<br>☐ Pediatric units, all patients<br>☐ Specific units, all patients 18+ (list units)<br>☐ Specific units, all patients 0+ (list units)<br>☐ Specific pediatric units, all patients (list units)<br>☐ All units, representative sample of inpatients 18+<br>☐ All units, representative sample of inpatients 0+<br>☐ All pediatric units, representative sample of inpatients<br>☐ Specific units, representative sample of inpatients 18+ (list units)<br>☐ Specific units, representative sample of inpatients 0+ (list units)<br>☐ Specific pediatric units, representative sample of inpatients (list units)<br>☐ Other _____ |

**PROCESS MAP:** Using the information provided above, sketch out your screening workflow using a process map. It can serve as an overview to help you visualize where social driver screening is initiated, what happens when a patient screens positive for social drivers as well as when they do not. Be sure to include steps from the point in which a patient is offered a screening to when a patient receives resources. If your health system is going beyond the requirements of the Joint Commission and CMS by providing closed loop referrals, case management post discharge or other wrap around services, please include that process as well. You are welcome to produce your process map in whichever format works best for you

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