Hello. Thank you all for joining us today for the CMS OMH Health Equity Symposium. On this slide is today's agenda. We will begin with an overview on the Centers for Medicare and Medicaid Services Office of Minority Health; review the health equity definition; provide insights into CMS's action plan and strategic pillars; and discuss the newly released CMS framework for health equity. Following these items, our guest speaker, Sutter Health, will provide a presentation on culturally and linguistically appropriate services, as well as the importance of data collection and analysis. We will then touch on a few additional items including an overview of our health equity data and stratified report. We will have a brief Q&A session, and we'll conclude with final thoughts from CMS OMH. On this slide, we also have instructions regarding accessibility for today's event. In order to access the live transcript feature, go to the menu bottom -- menu, I'm sorry, at the bottom of your screen and click the live transcript icon. After you click the icon, click on view full transcript, which will allow closed captioning to appear on the bottom of your screen. And the transcript will show on the right-hand side of your screen. We would now like to introduce our first speaker, Pamela Gentry, Senior Advisor of the CMS Office of Minority Health. Pamela, you may begin.

Hello, everyone. It's great to be here with you today. I'd like to thank you all for joining us, and I'm looking forward to a robust conversation that we'll be having on health equity. Before I begin, I'd also like to thank our guest speakers from Sutter Health. We're so pleased to have you join us today, and I'm excited to hear more about your efforts and the ways your organization is working to advance health equity in the communities you serve. Next slide, please.

First, I'd like to provide a brief overview about CMS and our -- and our office specifically. CMS is the largest provider of health insurance in the United States, responsible for ensuring that more than 170 million individuals supported by CMS' programs are able to get the care and the health coverage they need and deserve. Our office, the Office of Minority Health, is one of eight minority health offices within the larger Department of Health and Human Services. We serve as principal advisors to the entire CMS agency on the needs of minority and medically underserved populations, including people of racial and ethnic communities; people with limited English proficiencies; gay, sexual, transgender, and lesbians and the queer person; and persons with disabilities; and persons who live in rural areas; and persons and otherwise adversely affected by persistent poverty or inequities. Next slide, please.

On this slide, we have listed our office's mission and vision statement. Our mission is to lead the advancement and integration of health equity in the development, evaluation, and implementation of CMS policies, programs, and partnerships. Our vision is to see all those served by CMS achieve their highest level of health and well-being and we have eliminated disparities in healthcare, quality, and access. Next slide.

On this slide, we have listed our major initiatives. I won't go into details for every item as we will touch on some of these later in the presentation. But we -- but we have works surrounding data analysis, our grant program, and I like to highlight our rural health work. CMS recognizes the unique challenges of people living in rural, frontier, tribal communities, and the US territories. And we seek to develop programs and policies that ensure that rural Americans have access to high-quality care and offer support for rural providers and not disadvantage them.

In addition, our Coverage to Care initiative helps people to understand their health coverage and connect to primary care and preventive services that are right for them through health literacy, resource -- health literacy resources and information. Next slide, please.

On this slide are some of CMS OMH's resources that we offer, and all of these can be found on our website at go.CMS.gov/OMH. Next slide.

I'd now like to introduce our office Director, Dr. LaShawn McIver. Dr. McIver will now address some of the larger health equity efforts happening across CMS programs. Dr. McIver, you may begin.

Thank you, Pamela. And thank you to everyone joining us today. We are so excited to share these updates in the new CMS Framework for Health Equity. It is an honor to work on health equity and lay out a path for bringing real change across Medicare, Medicaid CHIP in the Marketplace. Next slide, please.

Within CMS, we define 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 identity, socioeconomic status, geography, preferred language, or other circumstances. CMS is working to advance health equity in three ways.

First, we are designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs. Secondly, we are working to eliminate avoidable differences in health outcomes experienced by people who are disadvantaged or historically underserved. And, lastly, we are working to provide the care and support that our enrollees need to thrive. We understand true quality does not exist without equity. Our agency strives to advance progress in creating a care journey that is free from inequity while optimizing opportunities, access, and outcomes for historically underserved and under resourced communities. Next slide, please.

In this section, I will discuss CMS' action plan and Health Equity pillars. Next slide.

The Administrator believes that CMS needs to lead the way. I'm having a little technical -- here we go Excuse me one moment. I had a bit of a technical difficulty on this end. Okay. There we go. The Administrator believes that CMS needs to lead the way for the healthcare system. She has stated that CMS actions on health equity must be concrete. They must be actionable. They must go beyond observations and into direct explicit steps we are taking to achieve health equity and eliminate disparities. She has also noted that we at CMS need to examine our policies, programs, and choices to make sure we understand and are mitigating unintended consequences that impact minority and underserved communities and the safety net providers who serve these communities.

As a reminder, consistent with Executive Order 13985 and other recent executive orders related to health equity, when we refer to minority and underserved communities, we are talking about racial and ethnic minorities; individuals with disabilities; members of the LGBTQ+ community; individuals with limited English proficiency; members of rural populations; and other individuals adversely affected by persistent poverty or inequality. Our Administrator has stated three goals for how we assess our health equity impact, which includes understanding and for us to articulate how we're measuring health equity.
What is our measuring stick for equity when we consider a particular policy decision? Using the information, we have to close gaps to address aspects of our policies and programs where we find inequitable access, policy and outcomes, and to engage our stakeholders who serve these communities. Finally, she wants our assessments to allow us to invest in policies that will address disparities in both health and healthcare. Next slide.

As we think about quality, equity, and our path forward, today we focus on our work together. We are a community of providers, payers, caregivers, healthcare teams, quality improvers, advocates, individuals, and patients; and we are leading the way together toward our healthiest nation. Today, we assert our bold commitment to change our healthcare landscape to move from disparities to equity. Across the government, we are operationalizing Executive Order 13985 and the other executive orders focused on health equity for the populations that we serve. Across all of our work, we're thinking about how to identify, understand, and address structural policy and operational barriers.

To do this, we are driven by input and direction from our communities. In particular, when we think about equity, we are focused on the needs and voices of underserved and under resourced communities as noted previously. We are working together across CMS to improve the ways we communicate and design our policies and programs to be inclusive and reflective of the priorities and preferences of individuals in every walk of life and community we serve with multifaceted identities and needs that change over time. We are also working within CMS and across the government to think about how we can achieve equity in health and healthcare by understanding and addressing people's needs outside of the walls of a healthcare setting. And as we talk about social risk factors and social determinants of health, we do not use these terms lightly.

These are individual factors that shape people's lives and the way they seek and receive care. And we are continuously working across our programs to think about the health of the whole person and how our services, benefits, and coverage can be tailored to meet each individual where they are. We seek to ensure our programs are designed to enable all members of care teams in every community, state territory, tribal nation to treat people how they need to be treated so that they can get the care they need the way that they need it to help each person and family attain their highest level of health. Next slide.

The CMS framework for Health Equity discusses a plan to operationalize health equity at CMS over the next decade. But I also wanted to take the time to show you the connection to the CMS strategic pillars released by our Administrator. Each of these pillars on the screen represents a critical priority of our administrator for CMS.

On the left, the first pillar is to advance health equity by addressing the health disparities that underlie our health system. From this graphic, you can tell that health equity is at the forefront of the CMS strategy. It is a strategic imperative in accomplishing our mission. CMS OMH is leading a data-driven stakeholder-informed approach to identifying structural barriers and uniting the agency to eliminate them. And as we talk more about CMS' framework for health equity, I want to underscore three points.

First, the people we serve will always be central to our work, no matter which end they're in, Medicare, Medicaid, or the Marketplace. We'll build on the Affordable Care Act, expand access to quality affordable health coverage; modernize the Medicare program; and address the high cost of prescription drugs to deliver -- to deliver quality care at a lower cost to patients and families we serve. The people we serve, including providers, plans, individuals, community organizations are what set our priorities; and we remain committed to adapting, adjusting, and course correcting to ensure we are meeting the needs of those we serve, first and foremost.

Second, stakeholders will be engaged throughout the policymaking process. My commitment is to clearly explain the actions we take to our stakeholders and how it will improve health outcomes.

And, third, the centers within CMS will work across HHS to tackle such issues as improving maternal health outcomes, advancing behavioral health, and being better prepared for the next pandemic. CMS will work with states, tribal nations, US territories, health plans, and community providers to be a driver of more integrated care that will ultimately better serve those who rely on our programs. Next slide.

And now I want to talk a bit about how we will work together to operationalize health equity this year and for the next ten years and how every one of you listening and watching can work with us towards this same shared goal. This slide speaks to our anchor and our true north as we carve a path to equity across the healthcare system. Guiding the way are the communities we represent, the voices and perspectives of those we serve. We have decades of research to draw upon to learn about the needs, barriers, and opportunities among members of our communities. But we also want to understand firsthand what the most critical needs are and what our partners who serve our communities feel CMS could do to have the most impact on health equity and eliminating disparities locally.

For these focus listening sessions that we've conducted over the last year, we mapped out CMS' approach to operationalizing the first pillar from the slide we just saw to chart a path for advancing equity in partnership with all of our communities, individuals, and stakeholders. Next slide.

This means we have taken time and energy to deepen our engagement with stakeholders across programs, identify areas of focus that are important to our communities, and align existing CMS and HHS initiatives and work to build on success and fill gaps. Next slide.

Building on the Biden Harris's -- the Biden Harris administration's ongoing efforts to provide high-quality affordable healthcare for all people and drive health equity across HHS, CMS outlined an action plan that includes the following steps: Expand and standardize the collection and use of data, including race, ethnicity, preferred language, sexual orientation, gender identity, disability, income, geography, and other factors across CMS programs; close gaps in healthcare access, quality, and outcomes for underserved populations; promote culturally and linguistically appropriate services to ensure understandable and respectful care and services that are responsive to preferred languages, health literacy and other diverse communication needs; Build on outreach efforts to enroll eligible people across all of our programs so Medicare, Medicaid, CHIP, and the Marketplace; evaluate policies to determine how CMS can support safety net providers caring for underserved communities and ensure care is accessible to those who need it; ensure engagement with and accountability to communities served by CMS and policy development and implementation of CMS programs, incorporate screening for and promote broader access to health-related social needs, including greater adoption of related quality measures, coordination with community based organizations, and collection of social needs data to standardize formats across CMS programs and activities; ensure CMS programs serve as a model and catalyst to advance health equity through our nation's healthcare system, including with states, providers, plans, and other stakeholders.

And, finally, promote the highest quality outcomes and safest care for all people through the use of the framework under the CMS National Quality Strategy. Next slide.

Across the agency, there are various health equity initiatives underway, one of which is being spearheaded by the CMS Innovation Center or CMMI. CMMI is working to advance health equity by developing new models and modifying existing models to address social determinants of health, increase the number of people who receive care from underserved communities, evaluate models specifically for impact on health equity, and strengthen data collection. CMS is also committed to taking care of the whole person, which includes behavioral health and oral health.

So, for example, we know oral health is an integral part of physical, emotional, mental, and socioeconomic well-being and that poor oral health is an indicator of social inequality. We are working to address these and many other important issues as part of our health equity initiatives across our health programs. These are just two examples, but I encourage you to visit cms.gov to learn more about all the great health equity initiatives underway across the agency. Next slide.

A lot of health equity announcements have come from CMS in the last couple of weeks, so we want to summarize here for you some of the current and open ways you can get involved and have your voice heard. We would like to highlight a series of listening sessions that the CMS Rural Health Council will be hosting in May.

During these sessions, CMS will be seeking feedback on our current rural health strategy and will be looking for ways to improve this approach to advancing rural health. To register for a session, visit the Rural Health page on the CMS -- on the CMS OMH website.

Additionally, the fiscal year 2023 Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System proposed rule was recently released. Listed here on the slide are a few of the areas in which CMS is seeking public comment. We've provided links to help you find out more, and included is the link to the Federal Register to view the proposed rule. The public will be able to submit comments on the proposed rule in the coming days. And once the comment period has opened, the public will have 60 days to submit their comments. Next slide.

So we are ready to dive into the CMS Health Equity Framework. Our office is proud of the work that happened to create this framework and excited to continue operationalizing health equity in the next decade across CMS programs.

At this time, it is my absolute pleasure to introduce to you Alexandra Bryden, Acting Group Director of our Program Alignment and Partner Engagement Group within the Office of Minority Health, to begin discussing the framework. Alex.

Thank you, Dr. McIver. And thank you all for joining us today. As we said, in this section, we're going to start discussing the newly released CMS Framework for Health Equity. Next slide, please.

On April 22, CMS released the CMS Framework for Health Equity. The CMS Framework for Health Equity updates the previous Medicare focused CMS equity plan for improving quality and Medicare with an enhanced and more comprehensive ten-year approach to further embed health equity across all CMS programs, including Medicare, Medicaid, CHIPs, and the health insurance marketplaces.

While the initial equity plan identified high-impact priorities based on stakeholder engagement, a review of the evidence base and discussions around HHS, CMS, and among our federal partners, their framework refined CMS's health equity priorities and broadened the agency's focus beyond Medicare. The CMS Framework for Health Equity is informed by stakeholder input, evidence review, and knowledge and understanding gained through the agency's work.

The five priorities included in the framework encompass both systems and community level approaches to achieve equity across CMS programs. Each of the priorities are complementary, and their integrated adoption and implementation is central to the elimination of barriers to health equity for all Americans. Next slide, please.

On this slide, we list the five priority areas included in the CMS Framework for Health Equity. The first priority area is expanding the collection, reporting, and analysis of standardized data. The second priority area is assessing causes of disparities within CMS programs and addressing inequities in policies and operations to close gaps. The third priority area is building capacity of healthcare organizations and the workforce to reduce health and healthcare disparities. The fourth priority area is advancing language access, health literacy, and the provision of culturally tailored services. And the fifth priority area is increasing all forms of accessibility to healthcare services and coverage. In the following slides, we're going to explore a little more each of the priority areas listed. Next slide, please.

We often say that data -- we must start with data. So you'll see that this first area that we're focusing on today and in the Framework for Health Equity is data. It's essential, and it includes data regarding social risk factors or social drivers of health; experience of care; and comprehensive patient demographic data. All of this is valuable for quality improvement.

Increasing access to standardized data helps CMS and our stakeholders address changes in populations over time and connect individuals to appropriate and needed services and support. We are committed to improving data collection and reporting. And we'll continue to collaborate with federal and external partners to support health equity and reduce disparities. Next slide, please.

To achieve health equity CMS must continue to understand where disparities in coverage and access exist and adjust our policies to optimize health equity. To do this, we will work to evaluate CMS program, policies, and operations for impact on health equity and help advance health equity among those we serve. We will also monitor responsibilities related to conditions of participation and conditions or coverage that healthcare organizations must meet in order to participate in our programs. CMS is responsible for adapting policies to make coverage across all programs more affordable and available. We will continue to increase our work and partnership with agency experts and external stakeholders to understand the impact of existing and new programs and policies on underserved communities.

I'd like to now introduce my colleague in CMS OMH Darci Graves, who is serving in our office as a Technical Adviser and can talk through the remaining priority areas. Darci.

Thank you so much, Alex. Appreciate that welcome. Next slide, please.

Priority 3 focuses on building our collective capacity to meet the needs of those we serve by amplifying best and promising practices, research and health equity tools and resources. For example, to improve healthcare professionals' capacity to improve behavioral healthcare through Medicaid and CHIP, CMS is committed to partnering with states to bring behavioral health services, both mental health and addiction treatment, up to parity with physical health services.

CMS' leading role in quality improvement and focus on health equity can help healthcare organizations bring their goals into focus. The unique partnership between CMS and federal, state, territorial, tribal, and local governments; quality improvement networks; health plans; health systems; providers; and community partners allows the agency to bring validated approaches to reducing disparities.

We will continue to identify approaches that reduce disparities. This includes approaches to healthcare delivery that address barriers to access and healthcare services, such as workforce shortages and network coverage. These can heavily impact underserved communities, including rural areas, tribal communities, and other communities who have experienced structural and historical inequities. Next slide, please.

As many of us are aware, language, health, and health insurance literacy and culture can either promote or inhibit effective communication. Approximately 9% of the US population are persons with limited English proficiency, and 36% of individuals have a low health literacy. People with limited English proficiency and low health literacy report poor health status nearly twice as much as those without these barriers.

CMS has a powerful role in strengthening efforts across the healthcare system to improve access to culturally and linguistically tailored health literate care and services for our increasingly diverse population. The agency and our partners can improve information available to individuals about their providers' language, skills, helping to ensure a person can find a healthcare professional who can communicate with them in a way they understand.

CMS works with underserved communities to identify challenges in accessing care and coverage. This ensures that information is delivered in ways individuals, families, and caregivers can understand and that resources are widely available for use by providers, other stakeholders, and local trusted partners. Next slide, please.

Our final priority area focuses on accessibility. Accessibility is essential to obtaining necessary and appropriate care and services, particularly for people with disabilities. One in four American adults has some form of disability, including those related to mobility, cognition, independent living, hearing, vision, and self-care. Rates of disability increase with age with two in five adults over the age of 65 reporting a disability. These rates are higher among racial and ethnic minorities.

CMS helps reduce barriers to accessible healthcare and services by working with healthcare professionals and individuals with disabilities. We have a responsibility to ensure that individuals and families are able to access healthcare services when and where they need them in a way that is comfortable and respectful by making sure that there are infrastructure improvements; strengthening training for providers and staff; and ensuring services are designed to meet the needs of people with disabilities.

CMS will continue to engage with stakeholders to understand persistent and emergency -- emerging accessibility barriers to the provision of healthcare services and coverage and strengthen opportunities for people with disabilities to receive safe, accessible care. Next slide, please.

We'd now like to take a moment to highlight CMS OMH's Health Equity Technical Assistance Program. The program offers personalized coaching and resources, guidance on data collection and analysis, assistance in developing a language access plan or Disparities Impact Statement, and resources on culturally and linguistically tailored care and communication. The program offers customized responses and coaching on health equity and how partners whether in CMS or externally, can implement equity in their work.

It may be -- it may be in writing a Disparity Impact Statement; understanding how to use tools, find data, or develop a language access plan. The requests vary greatly, but it's an important part of hands-on individual work. Anyone can contact our Technical Assistance team for assistance. All you have to do is email the team at healthequityta@cms.hhs.gov to get started. Next slide, please.

Speaking about the Technical Assistance Program is actually the perfect way to introduce our guest speakers. We are joined today by Sutter Health, who first became known to our office through a technical assistance request some time ago. They have been doing wonderful work that shows how someone outside of CMS can draw from these same priority areas and make advances in health equity.
Today we are joined by Kristen Azar and Maria Moreno. Kristen serves as the Scientific Medical Director for the Center Health Institute for Advancing Health Equity. And her colleague Maria -- Maria is a Health Equity Program Manager as part of the Clinical Leadership team at Sutter Health. I will now turn it over to Kristen and Maria.

Hello, and thank you so much for having us here today. We are so excited to share some insights that we have gained into the importance of data and analytics in advancing health equity within our large integrated healthcare system. Next slide, please.

Here's an overview of what we hope to cover today. We will give you some background regarding our health system and the Institute and then share four examples that demonstrate the importance of data and analytics in this work. And, finally, we will share some remaining challenges and lessons learned along the way. I'd like to turn it over now to my colleague, Maria, to walk us through an overview of our health system to give you a context for what we will discuss later.

Thank you, Kristen. Next slide, please.

So it's an honor and pleasure to be here today and share with you some of the great work that we've been doing, et cetera. And I want to start by giving you just a little bit of background of who we are. Next slide.

So Sutter Health is a large not-for-profit healthcare network in Northern California. We pride ourselves in serving some of the most diverse populations in Northern California. In fact, we provide care to over 3 million patients every year across 23 counties.

As you can see here on the visual on the left, we provide care from the Oregon border down to the Central Valley with website down in San Diego County. And, again, we provide care to such diverse populations. As you could see on the visual on the right, the majority of our patients self-report as racial ethnic minority with a great representation in terms of language services as well. Next slide. Next slide, please.

So here in this -- one more back. Sorry. Thank you. Here you can see our affiliates. So we have 24 affiliates, again, across northern California and San Diego and Hawaii. We could see the racial ethnic minority dominant group within each of the affiliates, and you could see again great representation in terms of our racial ethnic diversity. But we also have diversity in terms of geography. As I said, we go from the Oregon border to Central Valley. We have rural, urban Sacramento, Oakland, San Francisco, Lakeside, Modesto, and so forth. But we also -- so -- which is really an asset for us to represent a national -- we're almost a representative national scope of the United States but as well as economic diversity across our vast network. So next slide.

With that, I will turn it over to Kristen, who's going to share about our Institute.

Thank you, Maria. Next slide, please.

So, as you see, we serve an extremely diverse patient population; and the need to advance health equity is very much ingrained in our mission to enhance the well-being of people in the communities we serve. Oftentimes, achieving equity for our patients may require the disproportionate allocation of resources, as we see in this well-known Robert Wood Johnson figure.

While equal treatment would mean providing the same bicycle to all regardless of need or ability, equity focuses on getting the right treatment to the right individuals in order to achieve equal outcomes. In this case, everyone is able to ride away on a bicycle that is suited to them.

Next slide, please.

Given these principles, we conceptualize our work in three main domains of expertise: metrics and insights, where we examine our data to identify equity gaps but also develop novel methods of quantifying those gaps, and we then use that information to inform our solutions development and advocacy work where we shift the focus to actually closing those equity gaps once they are identified. And, finally, we focus on education and training to provide opportunities for equity minded trainees, clinicians, and scientists to do this work, as well as to ensure that our workforce is well-equipped to care for our diverse patient population. We lead initiatives such as unconscious or implicit bias training mitigation strategies and other types of training to ensure that our workforce can provide the highest quality care to our diverse patients. Next slide, please.

We have five key focus areas shown here with examples of how impact may be measured. This is not an exhaustive list, and I won't go into detail here. But just to give you an idea of the focus areas that we arrived at, based on extensive strategic planning within our system but also in the external landscape of disparities that have been known to exist throughout the nation. Next slide, please.

Our ultimate goal is to advance the science of health equity and close gaps by incubating, implementing, evaluating, and disseminating data-driven, effective solutions that can improve clinical and quality outcomes for our Sutter patients but also people living in the communities that we serve and, when possible, making national impact as well. We try to find a balance where rapid improvement and rapid research meets rigor, accelerating the cycle of innovation without sacrificing scientific methods. Next slide, please.

And that's a great segue into thinking about the importance of data and analytics in doing this work in advancing health equity. As we consider the importance of data analytics, at the heart of the issue is that you can't manage what you don't measure. And, with that, I'd like to hand it over to Maria to share more about our work around race, ethnicity, ancestry, language data collection and use and also our social determinants of health data collection efforts within our system.

Thank you, Kristen. Next slide.

As Kristen said, again, I want to share with you today just two examples, beginning with the importance of data collection response, specifically around race, ethnicity, ancestry and language or, as I'll call it, REAL. Next slide.

So back in the early 2000s, we were reflecting on, again, what is happening across our organization with respect to the cultural diversity, the language needs of our patients. And, honestly, we said -- there was a small group who said, where do we start here? And we said, let's start with the class standards. What do the standards specify?

So we begin with the principal standard, which states, To provide effective, equitable, understandable, and respectful quality care and services that are responsive to the diverse cultural health beliefs and practices, preferred languages, health literacy, and other communications needs. So we said, Yes. That makes sense. Let's go there. Next slide.

So we said, Great. How do we start again? So, again, there wasn't a process. There wasn't anything designed for us. But, again, we went back to the federal standards for collecting race and ethnicity from the federal registry to see is there a model that we could follow? And, in fact, there was. So that's exactly what we did. We looked at the way that the Federal Registry was collecting race ethnicity, and we modeled it.

So to the right here you can see a visual of our actual survey in which we collected race with some granularity, as you can see; ethnicity, which is reference to Hispanic; third is ancestry; fourth was what's the preferred spoken language; and then fifth is interpreter service need in a clinical setting. And so all of this data were very important to us. And so what we decided to do is roll out a pilot in one of our ambulatory sites back in 2007. It took about 16 months. But during that process of asking every single patient that came to our site these questions, we collected over 400,000 patient surveys, which allowed us to then build a business case to then present to our system leadership.

As I said, we're a vast network. And so we put together the business case, and it was perfect timing. I believe it was around 2009, that we were presenting this to our system leadership because it was around that time that Sutter was contracting with our future Electronic Health Record system Epic. And so it took about a year to present this and get the support and buy-in from our leadership. But, lo and behold, it was received, well-received and accepted. nd so, when Epic started to roll out in our very first hospital down at Mills Peninsula in Burlingame in 2010, this was part of the Epic package. And it took five years for all 24 of our sites to roll out Epic. But all five -- all of our hospitals rolled out Epic with this package. And, to date, we collect these data of all of our patients. Next slide.

So what did we do with it? Again, going back to the class standards and being responsive to our patients needs, beginning with language services, communication services.

So back in the early 2000s, we were aware that a lot of our bilingual employees were serving in a dual role as bilingual interpreters. And so we decided to set up an internal process to work with a vendor who was going to do a language competency test of both spoken and written second language of our employees to be able to confidently use these employees as dual role interpreters.

So, again, to date, we've tested over 3000 bilingual employees who serve in this role when asked or when needed. Then we did something similar with phone interpretation and in-person interpretation. Where we assessed what is current practice across our system, and we realized there wasn't a standard practice. So, after some time, the small team, we gathered information, and we put out a competitive bid process to then select a system vendor for both phone and in-person interpretation.

And then, lastly, in the late teens, what we decided to do is take a look at video interpretation, which was not common back then. And so we got a -- we got a Robert Wood Johnson grant to fund us to do a three-year pilot to basically test out video interpretation at one of our large hospitals in San Francisco, which then resulted in us realizing this really was a useful tool in addition to what we already had. And so we did the same thing. We put out a competitive bid process to then select a system vendor. Next slide.

So I just want to show you the utilization of these language service vendors over the last five years. As you could see, over-the-phone interpretation has slowly declined. But at the same time, video remote interpretation has increased.

In fact, it's increased dramatically beginning in 2021, which, if we reflect back what's happened in the last two years with, you know, people being more isolated, working remotely, most of us are common in using FaceTime and Zoom. But I think that having the connection with the individual with video is really important, and that's something that we've learned with clinical experience as well. So that's -- I think that is how video interpretation has become very common, more used. In-person interpretation has decreased, and then in-person American Sign Language has stayed constant over the last five years. Next slide.

I'm going to switch gears here and move over to social determinants of health and give you just an overview of what we've done over the last three years and how we're responding to these data collection. Next slide.

I'm going to begin with a definition because it's important. I'm not going to, you know, spell it out for you and read it. But I just want you to be aware this is really critical and important to us. And the importance of social determinants of health is that the patient's health and well-being is central. And, as was said earlier, whole person care is critical.

So all of these factors are very important in the care of the whole person. So that is why it is important for us to collect these data to be able to fully respond to the patient's needs and ultimately address their health and well-being. Next slide.

So, in 2018, when Sutter Health received its annual Epic upgrade, with the Epic upgrade, we received this social determinants of health package, which included 24 questions covering these ten domains. And so, once we got that in 2018, our Health Equity team said, this is outstanding. Now, what do we do with it? Next slide.

So what did we do? In 2019, the Health Equity team then began to roll out three consecutive pilots of collecting these data. And so we realized we need to understand what is efficient? How do we collect these data in an efficient and effective way to be able to then respond to our patients? So, in 2019, the Health Equity Institute team rolled out three consecutive pilots. And, at the same time, two other large teams across Sutter also began rolling out their own respective pilots with their teams across their patients. And so, over the last three years, we've really learned a lot from these pilots.
And that's basically where we are at, at this point is, we are in the process of learning from the pilots on what is a system standard and recommended methods of collecting these data in an efficient and effective way so that we can learn the needs of our patients and better respond to those needs.

So that's kind of where you see the second component is the data collection standardized work piece of it, which then would lead us to the dashboard and populating the dashboard.

Our system is in the process of creating a dashboard, which will be populated by these data across the entire system for all of our patients, which will ultimately allow us to understand our operation service needs. Do we have all the case managers, social workers, everything that we need to be able to respond to the needs of our patients? And then, secondly, are we connecting them to the services and agencies that these patients need across our communities? Next slide.

So, again, it is really important to do this, and it's critical to our patients' health and well-being. But we also know that accountability is coming. And so what we are wanting to do is be proactive in this space. We understand that there are organizations like CMS, which will be recommending that these data would, will be or should be collected for some of their patients. And so, instead of waiting for a mandate, we, again, understand this is really critical and important for all of our patients. And we're doing it for the health and well-being of our patients. But, at the same time, we want to be responsible and be proactive in this space. Next slide.

So, with that, I will turn it over to my colleague who will talk to you about vaccine equity metrics. Thank you.

Thank you, Maria. Next slide, please.

So we're shifting gears a bit. So we've been really active in our response to the COVID-19 pandemic. Early on our study was among the first to use electronic health record data from my health system to quantify and confirm that there were, indeed, emerging disparities and outcomes among COVID-19 patients. And in publishing these results in Health Affairs, Sutter Health became a voice in the national conversation that followed. Having identified race, ethnic, and age related disparities in COVID-19 infections and hospitalizations, we anticipated a need to not only work with community based partners to increase access to testing but also to put in place a framework to ensure equitable vaccine distribution. Next slide, please.

In setting our targets for action, we employed an equity framework from the start. We published this work recently for those interested in more details as the development of our COVID-19 vaccine equity -- excuse me -- as to the development of our index. But, briefly, at the time of the alpha, the alpha and delta variants, it was considered that 70% uptake was crucial to achieving herd immunity at the population level. Given this equality approach would have meant that our target uptake would be 70% across all patient subgroups, regardless of race, ethnicity, or other factors. This is a focus on equal treatment.

We instead chose to incorporate equity, adjusting the herd immunity target to reflect the differential risk for bad outcomes among some patients subgroups. So this would be infections or hospitalizations. Our targets will be quite different if we take this into account, where we would aim to vaccinate 81% of our African-American Black individual -- individuals, in our patient population in order to achieve the same outcomes as we would observe if we were to vaccinate 57% of our non-Hispanic White patients. This is a focus on equal outcomes, so it's an equity focus.

What we ended up doing was establishing a hybrid approach where the minimum target was 70% uptake for every patient subgroup. And once this was achieved by a given subgroup, resources were diverted to help other groups achieve their equity goal, which was higher. It is important to note that we did not deny vaccine to anyone but, instead, focused on distributing limited resources to achieving equitable outcomes using these tools. It's also important to note that, in addition to race ethnicity, we also stratified by age and used geospatial tools with our pop health teams and our quality teams to aid in this work. Next slide, please.

And speaking of those teams, this work really was made possible by deliberate collaboration with leaders across our system from all key stakeholder groups. And that's represented in this wheel here. And so we brought together these leaders in a workgroup and set about the task of first working on our data and analytics to set our targets and track our progress, as I just described. And then once we had that in place, we could shift the focus to deployment and testing of interventions in order to close those gaps. Next slide, please.

So once opportunities were identified, we partnered with community based organizations and others to enhance our targeted outreach efforts, rapidly but rigorously testing innovative solutions to increase access, increase awareness, and overcome misinformation. Next slide, please.

Our final example is the work that we've been engaged in around adding health equity metrics to our executive level dashboard for our health system. Next slide.

And shifting our focus to this work to track health equity metrics on our executive dashboards, there has been a growing recognition that finding ways to identify and respond health equity gaps has become an essential aspect of the provision of the highest quality care. And our work has been evolving in this space for some time. Next slide.

We again convened a group of system stakeholders and collaborators to aid in our efforts, and you can see all the groups that were engaged here. In addition to this, we looked at other health systems and sought their perspectives and processes to inform our work. We do extensive review of peer reviewed literature, white papers, reports to understand what was done in this area to date and also looked at trends and recommendations among external regulating bodies to begin to think about how we might implement and operationalize a framework within our system. Next slide, please.

And so, as we went about this work, we had these guiding principles that emerged as we selected our metrics. We wanted to leverage existing dashboard measures because we felt that those would be socialized pretty easily; and all represented very important indicators in terms of quality. So we wanted to add an equity lens to those indicators. We focused on a set of objective measures.

We wanted the metrics to be actionable so that we could see gaps close as we started to implement interventions. And we wanted to include at least one patient experience metric and are still working on this in the next iteration in the months to follow. But we landed on four ambulatory metrics and three acute care metrics which are shown here to be included. Next slide, please.

This is a screenshot of the high-level view of our executive dashboard. A drill-down with more details is available but not shown here. And it's important to note as I explain this that we're still in the process of really optimizing the visuals and the thresholds of how we define an inequity and how we prioritize action. But, for now, you can see here that we track four ambulatory and three acute care metrics, assigning a healthcare equity index score, based on the ratio of a suboptimal outcome of a given patient subgroup compared to the overall eligible population for that metric.

The patient subgroups consists of the intersection of three social demographic domains that have been linked to well-known health disparities. These include race, ethnicity, sex, and socioeconomic status, which is defined as less than two times the federal poverty level for median household income of a family of four and which was derived from geocoded census tract level data. The overall metric is a weighted average of the suboptimal outcome ratios. And the color coding helps us to prioritize the need based on the extent of the gap and disparity. So SDOH data, we can then develop targeted, highly effective interventions to close gaps and track progress as we go, really honing in on the groups based on these three domains as opposed to focusing on just one domain of equity, such as race, ethnicity, or socioeconomic status. Next slide, please.

So I realize that was brief. We're happy to answer questions. And we're in the process of publishing that methodology, as well, for those who may be interested in details. But wanted to just give a quick note to the lessons that we learned along the way. I'm not going to go into each one. I think the greatest one is that this is a journey, a process, a constant evolution that we are committed to and are really looking forward to finding partners along the way who are also committed to this work. But, on the next slide, there are some major challenges that we and I'm sure others have encountered or are encountering as we speak. And I think some of the biggest challenges we face in terms of data and analytics is the need for standardization, interoperability, and harmonization of metrics across institutions, regulatory agencies and platforms. It's a monumental effort to introduce and capture new metrics system-wide into health system operations. So having the right metrics and agreement for those metrics is crucial.

For example, integration with electronic health records is a key aspect of this work. And projects like the United States Court Data For Interoperability and the Gravity Project are promising initiatives to address some of these barriers and help introduce a common language that we can all use. Also, we need clear governance and a mechanism for continual review and refinement of these metrics. And a way to break down the silos that we -- and between different institutions that we experience today. So, with that, I'll end on the last slide. We really do appreciate this opportunity to be here with you all and hope to be in contact with anybody interested in finding out more in the future. Thank you so much.

Great. Thank you both for that wonderful presentation. We always love hearing from people outside of CMS who are working on the ground with health equity. Our next speaker is Meagan Khau of the CMS OMH Data and Policy Analytics Group. Meagan, you may begin.

Sorry. Thank you, Haley, for that introduction. Sutter spoke of the importance and actualization of data collection and how it can be used to advance health equity. Data collection is our first priority in the CMS Framework for Health Equity and a priority for the agency. Today I'll be highlighting some of the work that is coming out of our office Data and Policy Analytics Group or DPAG.

This group, which is within CMS OMH, conduct special study for CMS and HHS programs and policies that impact minority populations. The findings from these studies help inform CMS policy and decisions. In addition to conducting these studies, this group is responsible for planning for new initiatives in data analysis to monitor and improve aspects of healthcare across the agency. We also work collectively with agency partners to improve data collection, analysis, and reporting of health equity and social determinants of health data.

Listed here are some of the few DPAG's activity that we maintain, including the Mapping Medicare Disparities tool, which we'll go into more detail about on the next slide; stratified reports; data highlights; and data snapshots, which all provide overviews of key data and policy reviews on health services and outcome for minorities. Next, please.

This slide here shows a bit more detail on our Mapping Medicare Disparities tool, which we developed to address chronic conditions with an equity lens. We wanted to be sure to point this out to you all in case it might be useful for your work. The tool provides a granular lens into chronic conditions by identifying areas of disparities between subgroups of Medicare or people with Medicare fee for service, such as racial and ethnic groups, age, or sex, including for health outcomes, utilization, and spending. It is an excellent starting point to understand and investigate geographic and racial and ethnic differences in health outcomes. This information may be used to inform policy decisions and to target populations and geographies for potential interventions. Next, please.

And I'm happy to say that yesterday CMS OMH released the 2022 report on racial, ethnic, and gender disparities in healthcare in Medicare Advantage to further understand health disparities. This report details the racial, ethnic, and sex differences in healthcare experiences in clinical care received by Medicare Advantage enrollees in 2021. It is based on an analysis of two sources of information.

The first is HEDIS, the Healthcare Effective Data Information Set, which collects information from medical records and administrative data on the quality of care that people enrolled in Medicare received. The second is the CAHPS survey, the Medicare Consumer Assessment of Healthcare Providers and Systems survey, which is conducted annually by CMS and focuses on the healthcare experiences of people with Medicare across the nation. Healthcare professionals, organizations, researchers, and hospital leaders can utilize this report, along with other CMS tools and resources, to help raise awareness of health disparities, develop healthcare interventions for racially and ethnically diverse populations, and implement quality improvement efforts that improve health equity. Next, please.

To comprehensively address and eliminate health disparities, it is necessary to measure and publicly report the nature and extent of healthcare disparities in a standardized and systematic way. Stratified reporting provides useful information for targeting quality improvement activities, monitoring health and drug plan performance, and advancing the development of culturally and linguistically appropriate quality improvement interventions and strategy. Next, please.

Listed here on this slide are some of our more recent stratified reports, which can be found on the CMS OMH website; and I hope everyone will take a moment to peruse them. Next, please.

And, lastly, we also wanted to make note of our data highlights which presents national and regional data on healthcare service utilization, spending, and quality indicators for the Medicare, Medicaid, and marketplace populations. These data highlights include overviews of specific public health issues, provide brief qualitative and/or quantitative analysis of data, and explain how the findings support or related to CMS or HHS Policy and Initiatives. These data products are valuable to the work of researchers, policymakers, and healthcare professionals; and we hope to produce more in the near future. This concludes my portion of the presentation, and I will now turn it over to my colleague Pamela Gentry, who will facilitate the Q&A session.

Pamela. Thank you, Meagan. We'll now have questions and answer session. And for the question and answer session, we ask that you submit your questions through the question chat box. We'll address as many questions as time allows. So let's get started here. Okay. All right.

The first one is for Dr. McIver.

Thank you, Dr. McIver, for all that you've done with your OMH team. Question is how does OMH and CMS plan to support primary care practices in achieving data collection and social risk screening goals, giving the pressing resources constraints and the growing administrative burdens?

Thank you so much for that question. Well, one of the resources that our office can make available to those who are exploring how to do this with their resources is our health equity teaching program that we mentioned. We provide individualized coaching and support for those who are working on health equity -- health equity initiatives within their respective areas. And so I would encourage -- I would encourage those who are on the webinar today to help us spread the news about our external health equity TA program because we have worked with many incredible partners and, you know, across the healthcare system; and that is definitely a resource.

I will say this is something we're thinking about across CMS about those who serve our populations.

We know many, many of our populations are served in the primary care setting. And so it's a part of other -- there may be other efforts underway across the agency. But for our office in particular, I would point them to our health equity TA program that was discussed earlier. Thank you.

Thank you, Dr. McIver. The next question for Meagan. It looks like, Will the race of providers be collected so that analysis of the impact that race match between provider and patients has on quality of care be possible? And since we know ZIP codes is the biggest determinant of one's health and mature -- and morality, which CMS -- what's CMS's s role to address housing discrimination in pockets of poverty that maintain health disparities?

That seems to be a lot of question into one big question.

It is, it is. Do you want to start with the first one.

Yes.

Okay. Let's start with the race of the provider.

Yes. We totally understand that, you know, for us to be able to collect providers' race in any additional demographic data is important. And as outlined in our first priority in the framework, data collection is something that we're currently strategizing in terms of when, you know, how we should approach and what data we can collect and take into consideration our authority, the use of data, and what kind of stratification we can do. So I can't directly say yes or no, but I can say that is definitely as part of our strategy to figure out how to improve our data collection effort.

And the second part, if I remember correctly, Pamela, is talking about is it -- -The ZIP codes and where people live and, you know, how much that will impact? Do we get enough data on that to determine the needs of those communities?

-Yes.

So, as an example, the Mapping Medicare Disparities tool, where we have the data at the national, state, and county level, which, of course, is slightly different from the ZIP code. But to the extent that we're -- we have the data available and we're able to look at across geography, we will try to do that. And if you have a chance, take a look at the Mapping Medicare Disparities tool. And you can see how we identify prevalence across certain chronic conditions, for example, for the county or looking at other costs, there's type of utilization. So, to the extent that we're able to do that, we would definitely try to do that. I think the ZIP code is not the problem. It's a matter of getting the data that falls within the ZIP code. So, again, it goes back to our data strategy and how we can better improve our data collection.

Thank you. The next question I have is for Sutter Health. Who performs the SDOH screening questions you reference? Is that -- is that worked into your roaming -- your roaming process, or is it done through My Chart questionnaire? I think that's roaming process, or is it done through your My Chart questionnaire?

Yeah. Thank you for that question. That's an excellent question. That's part of the pilot and what we're learning. So, as I stated, we have done five consecutive pilots. Some of them are inpatient; some of them are outpatient. And that is part of what we're learning. So we did put the 24-question questionnaire into what we call My Health Online, which is similar to My Chart where the questions get sent out prior to a scheduled ambulatory appointment for the patient. They get sent out to their My Health Online account. And we, you know, if the patient can complete it in their own time at home or whenever, great. If not, we ask them again to complete it on site at the clinic or hospital. And that is part of the pilot and part of the learning process is what makes sense? Is it to send it to them prior? Is it to do it over the phone.

So one of the pilots, we do have nurse navigators that do it over the phone with our patients. One of the other pilots, we had a paper survey where we handed the patient the survey when they waited at clinic prior to being roomed into the patient room. So, again, five different pilots, about three different ways of doing this. And that's part of the learning process for us that then recommend a system standard for the organization. Kris, did I leave anything out you wanted to add?

Yeah. And our system standard, actually, as we make our -- we're going to create a toolkit and an implementation strategy for the system to give a menu. So the idea would be in your setting in the system, here are the different options that you can use to collect the data, and use the one that works for your setting because we learned from different settings, different opportunities and requirements were needed.

-Thank you. Dr. McIver, the next question is for you. How does CMS OMH intend to measure success for each of the five priority areas as it's defined? And there's a second part to the question and that is, what's the number one question about health equity that CMS and OMH needs to answer to make meaningful progress on these important goals?

Thank you, Pamela. And I see that Alex has come on camera as well. So I'll start relating to how will we track our progress. We intend to continue to report out the progress of the plan as we have in the past. What's really unique about this time right now is the entire agency, each of our programs have released their respective health equity priorities and ways that they'll be measuring their progress and their success. And so, as we are operationalizing the framework, which really serves as a lens for how we're thinking about our policies and programs and priority areas, the framework plays an important role to help shape the pathway for the agency. In the past, we have done progress reports on how we are achieving the different priority areas. I'll pause there to see if Alex has anything to add. But, also, if you'd like to speak to the number one question we get around health equity. Thank you.

Thank you, Dr. McIver. I'll just add, you know, the -- as Dr. McIver mentioned, you know, the framework really is a set of guideposts, sort of, for all of us to think through. And every program will operationalize health equity a little bit differently. So you'll see things come out, I think, across the agency, across different programs. There are reports that come out for different programs that will show measurement in different areas. I think that dovetails to sort of the number one question that we seek to answer but really also that we would look for our communities to help us answer is how are our communities measuring progress? What are the different measuring sticks that are showing promise? What's working to move the needle? I think we all seek to answer that question together. But, really, it means different things in different settings and for different programs.

And so I think, as much as we can learn about where -- what interventions are working to move the needle and what's working for different communities, for different populations in different geographic areas would be, I think, so informative to all of us. And we seek to answer that question as well. Dr. McIver, back to you in case there's something to add, as well, that you'd like to say about the number one question.

I would just add, I think what I hear the most, you know, I've had the pleasure of interacting with many of you across the country over the last year. And the number one question we get often in that setting is related to data collection, and what is CMS doing to improve our data collection activities. And I'm excited to share that we are working intensively on addressing that across our programs to ensure we are able to collect the best possible data to help us make the best decisions for the policy efforts for our program. So that's the number one question that I get. So thank you. Pamela.

Thank you. Let me see. I have so many questions here. I'm just trying to scroll down. Let's see what's the next one coming up here. Here's one.

I would love to understand more -- more how CMS OMH plan to assist state agencies, payers, and providers in a cohesive standardized health equity data, including but not limited to race, ethnicity, language, gender identity, and sexual orientation. Not sure who would like to take that. But I'll start with Meagan.

Can you repeat the first part of the question, Pamela?

I would love to understand more about how we plan to assist state agencies, payers. And providers in cohesive standardization of health equity data.

Yeah. So we do work closely with our Medicaid and CHIP team as we strategize how to improve our data collection. It is not just for the Medicare side, but we're looking across the three M's, Medicare, Medicaid and the Marketplace. And we are fully aware that, you know, under the Medicaid program is a federal and state programs. So we have, you know, all 50 states, the DC and then the territories, so it's important that we take into consideration what each of the states is currently doing, the limitation and all that. So it is part of that -- our strategy to determine how we can provide better assistance to the states in the near future. And so we're really looking forward to having more conversation with states about that.

The data questions keep coming. Meagan, I've got one more for you real quick. Thanks for your presentation. I noticed recently you released the OMH report on Disparities in Healthcare in MA by Race Ethnicity. Going to the question, being to the could you comment on the reason for this -- oh, okay. It has been changed from White MA beneficiaries to national average. Could you comment on the reason for that change? Thank you.

Yes. I was typing my response to Doug. Doug was it? The reason we make that change, as you can see, we've now had years of that report coming out. And we want to be cautious, you know, of the populations that we're advising. So we're looking at maybe that is better that we look at the overall Medicare population, instead of the national average instead of specifically White as a reference. So simply because White population may fare well, it doesn't necessarily mean that they are not having any impact from a health equity perspective. So we're trying to determine to the extent where the data are available and what kind of analysis we're looking in, that we want to make sure that we take that into consideration and be cognizant of all our populations, not specifically pointing out one or the other. And that's why we took a turn with this latest report and see what that outcome may look like if we were to use the national average as a reference instead of specifically the White MA beneficiary.

Thank you very much.

Pamela.

Yeah.

I'm sorry. One moment.

If we can, maximize the screen so that the interpreter can be seen more clearly, please. And then also, I see we have several questions in the chat for Sutter Health. I want to make sure we get to some of those, too. Thank you.

Yes. I was trying to get down to them there next. And I think they've answered two of the ones. I don't see another. I think I've gotten two of them. Let me see if there's -- we have so many coming in. Don't have that one.

And, Pamela, we also included our contact information. So I saw, I saw a handful of questions around describing our team and so forth. We'd be more than happy to follow up if individuals want to send us emails. We'd be more than happy to address their questions, as well.

I think I found another one for you here. It says, I found that there's a delicate balance between our health systems between the concept of population health regardless of where patients we see their health services and patients who are directly served by our health system. And a combination with that is that, for Sutter Health, can you describe the team leading the efforts over the last three years? There it is.

I can take that, Maria, and you can feel free to add. But, yes. So we have a really robust Community Benefit, Community Health team that does a lot of work with our broader communities. And we do hope to engage and collaborate with them in the future as the Institute in its current state was stood up in

December 2020. So we are fairly new in our work. And we are structured in a way where we really do engage leadership throughout our system.

We have an internal advisory board for -- internal advisory committee, for example, that includes VP level leadership from our functions of population health, quality, research, operations, kind of that whole spectrum in the circle I showed you that come together on a quarterly basis to advise us. We are connected with our physician leadership within our physician groups that are health equity leaders. They come together on a physician advisory board -- or, sorry, counsel that informs our work. And we have -- so a lot of people, to answer the question about the team make up kind of the work in addition to kind of the core group that is kind of the nervous system that brings it together. And that -- it was an evolution of four or five years worth of work to take all the really amazing work that was being done at our affiliates in silos and bring it to the system level to really create a system level strategy.

But, in terms of the definition of their populations and our patients, there -- that's definitely something that we navigate closely with our population health teams and do feel it is important to provide the best care to anybody who comes through our doors. Do you want to add, Maria?

I was just going to say, again, our institute was launched about a year and a half ago. But as Kristen referenced, a lot of this work, I mean, I've been at Sutter almost two decades. Kris has been at Sutter 13 years. So we've been doing this work for, you know, since day one, as well as other colleagues across our organization at the system level and at affiliates. Again, we have 24 hospitals. So, really, this institute allows us to pull everybody together and, as Kristen said, have this central nervous system so that we can collectively move this work forward as a system.

Well, thank you both very much. And thank all of our speakers today. That's all the time we have for questions, but we will internally review the unanswered questions that have been submitted. Can I get the next slide.

Before concluding today's symposium, we'd like to share these concluding thoughts. This slide lists some of the health equity successes the agency has experienced. These are all public, but we wanted to highlight them for you in one place to add to the information earlier in this presentation about the most recent payment rules that Dr. McIver -- McIver reviewed. Among the wins listed in the CMS approving -- was the approving of Utah's primary care network, Section 1115 demonstration amendment. It was approved on March 4 of 2022.

And this amendment allows Utah to provide housing related services and support including tenancy support, community transition and support -- and supportive living services to adults ages 19 through 64 with income at 0% of the federal poverty level and with no dependent children who are enrolled in targeted adult -- and who are enrolled in targeted populations under the demonstration and who meet other need-based criteria and risk factors.

Another win for CMS is the proposed policies to advance maternal health. On April 19 of 2022, the agency published the FY 2023 Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System rule, which proposes a birthing friendly hospital designation and additionally qualified -- an additional quality measure reporting to drive importance -- to drive the improvement in maternal health outcomes and maternal health equity. Next slide, please.

And one of the greatest programs our office has been able to sustain is the Minority Research Grant Program. This program supports researchers at minority serving institutions that are exploring how CMS can better meet the healthcare needs of racial and ethnic minorities, people with disabilities, sexual and gender minorities, and rural populations. The grant program gives the opportunity for our communities to benefit from the research, but they are also fantastic opportunities to help minority serving institutions and help equity researchers grow their -- grow in their work and their portfolios.

We'd like to play a short video to hear directly from one of our current grantees doing health equity research at Meharry College. Meharry College is an HBCU that was one of our awardees last year and our most recent funding opportunity.

One of the things we're seeing in the research base is sort of the issue with big data and the use of new technologies and analytics from artificial intelligence and machine learning. And we want to be able to introduce some of the early stage investigators, particularly our minority serving institutions, and hop in to help them become familiar with these techniques and with the SIMS Medicare Medicaid data. The Medicare and Medicaid data is probably the largest dataset that's out there, again, for conducting health services research. And we hope to be able to train young investigators to use this to conduct health disparities research and to be able to look at differences across racial ethnic groups by using the claims data and the pharmacy data and for prescription drug data, those sorts of things. And researchers in general in terms of biomedical sciences are underrepresented, in terms of minorities are underrepresented. And I think this is important because it provides a different perspective and interpretation of data and that bring a different perspective to that. So, you know, in terms of training, minority investigators in the area of health disparities, you know, we're hoping to be able to shed some new light on issues that have been looked at previously but from different perspectives.

Next slide, please.

Listed on this slide is our contact information. We have several mailboxes listed here with the main one being omh@cms.hhs.gov. We encourage you to visit our website at go.cms.gov/OMH, and sign up for our listserv so that you can stay up to date on all of our health equity related initiatives. We want to thank you all again for joining us today and hope you have a great rest of your day.