



ENHANCING ONCOLOGY
MODEL

EOM 2024 HEALTH EQUITY PLAN GUIDE

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Section 1: 2024 EOM HEP Requirements

This section of the guide provides an overview of the importance of health equity in the Enhancing Oncology Model (EOM).

1.1 Focus on Health Equity

EOM aims to drive transformation and improve care coordination in oncology care by preserving and enhancing the quality of care furnished to beneficiaries undergoing treatment for cancer while reducing program spending under Medicare fee-for-service. Under EOM, participating oncology practices will take on financial and performance accountability for episodes of care surrounding systemic chemotherapy administration to patients with seven included common cancer types. EOM seeks to improve the quality of care and ensure equitable health outcomes for all EOM beneficiaries. Research has highlighted differential cancer prevention, screening, diagnosis, treatment, and health outcomes across sociodemographic factors such as race, ethnicity, socioeconomic status (SES), and geography.^{1,2,3,4,5}

The Center for Medicare & Medicaid Innovation (Innovation Center) believes that equitable care is a key component necessary to achieve high-quality care for Medicare beneficiaries and is therefore critical to EOM's success. The Centers for Medicare & Medicaid Services (CMS) defines "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 factors that affect access to care and health outcomes. CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our beneficiaries need to thrive.⁶ The term "underserved communities" refers to populations with shared characteristics and geographic communities that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life, such as Black, Latino and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely

¹ Morris, A.M., Rhoads, K.F., Stain, S.C., Birkmeyer, J.D. (2010). Understanding Racial disparities in cancer treatment and outcomes. *Journal of the American College of Surgeons*. Retrieved from:

<https://www.sciencedirect.com/science/article/pii/S1072751510001857?via%3Dihub>

² Green, A.K., Aviki, E.M., Matsoukas, K., Patil, S., Korenstein, D., & Blinder, V. (2018). Racial Disparities in Chemotherapy Administration for Early-Stage Breast Cancer: A Systematic Review and Meta-Analysis. *Breast Cancer Research and Treatment*. Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6958704/>

³ AACR Cancer Disparities Progress Report. (2020). American Association for Cancer Research. Retrieved from: https://cancerprogressreport.aacr.org/wp-content/uploads/sites/2/2020/09/AACR_CDPR_2020.pdf

⁴ Blake, K.D., Moss, J.L., Gaysynsky, A., Srinivasan, S., & Croyle, R.T. (2017). Making the case for investment in rural cancer control: An analysis of rural cancer incidence, mortality and funding trends. *Cancer Epidemiol Biomarkers Prev*. Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5500425/>

⁵ National Cancer Institute. GIS Portal for Cancer Research. Rural-Urban Disparities in Cancer. Retrieved from: <https://gis.cancer.gov/mapstory/rural-urban/index.html>

⁶ CMS. Health Equity. Retrieved from: <https://www.cms.gov/pillar/health-equity>

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affected by persistent poverty or inequality.⁷ In referencing members of rural communities, we are inclusive of individuals in frontier areas, tribal lands, and those residing in the U.S. territories.^{8,9}

Equitable care is one of the six domains of health care quality developed by the National Academy of Medicine (formerly the Institute of Medicine) and promoted by the Agency for Healthcare Research and Quality (AHRQ). Equitable care does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, or socioeconomic status. As such, EOM is introducing several policies to promote health equity. The requirements are the following:

1.2 Collect Sociodemographic Data

EOM participants are required to collect beneficiary-level sociodemographic data (e.g., race, ethnicity, language preference, disability status, sexual orientation, gender identity) from EOM beneficiaries that have not opted out from sharing this information, and to report the collected data to CMS. The sociodemographic data reported to CMS will be used for CMS's monitoring and evaluation activities. CMS may also use the data to stratify feedback reports and dashboards shared with EOM participants.

1.3 Use Health-Related Social Needs Screening Tools to Address Disparities

EOM participants are also required to use health-related social needs (HRSN) screening tools to collect HRSN data (e.g., food insecurity, housing instability and transportation concerns) from EOM beneficiaries to identify potential health disparities within their beneficiary populations. CMS encourages EOM participants to address the identified HRSNs through a combination of patient navigation and care planning activities—both required Participant Redesign Activities (PRAs) under EOM.¹⁰ While EOM participants are not currently required to report HRSN data to CMS, we may require EOM participants to report HRSN data to CMS in later years of the model.

1.4 Provide Patient Navigation

EOM participants are required to provide patient navigation, as appropriate, to EOM beneficiaries, including but not limited to facilitating linkages to follow-up services and community resources (e.g., make referrals to cancer survivor support groups and community organizations or other third parties that provide child/elder care, transportation, or financial support). Patient navigation bridges gaps in care to reduce health disparities, such as access to clinical trials and connections to other health specialists or community resources.

⁷ Advancing Racial Equity and Support for Underserved Communities Through the Federal Government, E.O. 13985, 86 Fed. Reg. 7009 (Jan. 21, 2021), Retrieved from: <https://www.federalregister.gov/documents/2021/01/25/2021-01753/advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government>

⁸ CMS Framework for Health Equity 2022-2032, Centers for Medicare & Medicaid Services (April 2022), Retrieved from: <https://www.cms.gov/files/document/cms-framework-health-equity.pdf>

⁹ CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities (November 2022), Retrieved from: <https://www.cms.gov/files/document/cms-geographic-framework.pdf>

¹⁰ Freund, K.M., Battaglia, T.A., Calhoun, E., Dudley, D.J., Fiscella, K., Paskett, E., Raich, P., & Roetzheim, R.G. (2008). National Cancer Institute Patient Navigation Research Program: methods, protocols and measures. ACS. Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2698219/>

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We encourage EOM participants to develop relationships with community partners to accomplish this goal. The Centers for Disease Control and Prevention developed the workbook, [Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health](#), to address health care inequities. It provides examples of health disparities and ways to provide equitable care for underserved communities. Community-based case studies are included, as examples for developing community initiatives to provide impactful interventions to underserved communities.

1.5 Establish A Health Equity Plan (HEP)

EOM participants are required to establish a health equity plan (HEP) as part of their use of data for continuous quality improvement (CQI) participant redesign activity (PRA). We believe it is important for EOM participants to identify and monitor where disparities exist in their EOM beneficiary population, and to use the data that they collect to implement evidence-based strategies aimed at addressing the identified health disparities and advancing health equity.

Section 2: EOM HEP Requirement

Consistent with EOM's goal to drive care transformation and reduce Medicare costs, the Innovation Center is requiring all EOM participants to develop and implement a HEP. The purpose of a HEP is to collect and use data for continuous quality improvement, which is a model requirement. As part of the HEP, model participants will:

- Provide a statement of understanding/commitment to health equity;
- Identify existing disparities in their beneficiary population;
- Select disparity(ies) to address;
- Implement evidence-based strategies to reduce the disparities that are identified;
- Track/monitor progress on the strategies that are implemented; and
- Update the HEP throughout the model performance.

Section 3: The Health Equity Plan

EOM participants are required to submit a 2024 HEP to CMS no later than March 29, 2024, for review. The EOM HEP is a tool EOM participants should use to identify health disparities,¹¹ define health equity goals, establish a health equity strategy, and propose a plan for implementing the health equity strategy and monitoring and evaluating progress to achieve health equity for underserved communities.

The HEP consists of fifteen questions across four categories as described in Section 6: Using Data to Identify and Select Health Disparities and Underserved Communities, Set Health Equity Goals for your Disparity and Monitor Progress, Identify and Select Evidence-Based Interventions and Identify Engagement Strategies.

¹¹ For disparities and recommended mitigating actions involving protected classes of beneficiaries, EOM participants will be required to submit data substantiating the disparity and demonstrating that the data supports the need for protected class-conscious interventions, and that there is no protected class-neutral intervention that will address the disparity.

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There are a number of HEP resources available to support development and submission of the HEPs. These resources will be available on EOM Connect. For example, EOM participants may use the HEP example as a reference tool for submission preparation. EOM participants will also have access to an EOM HEP Starter Tips document, that outlines example activities and resources to support HEP development. We also developed a HEP Checklist that EOM participants can reference while completing the HEP online to ensure all questions and activities are completed before submission.

Section 4: 2024 HEP Submission Instructions

1. Log on to the [EOM Participant Portal](#).
2. Logging in will load the EOM POST home page. Navigate to the **Agreements & Attestations** section and then the **Health Equity Plan** tab.
3. On the HEP landing page, in the middle of the page, click on “Submit Health Equity Plan” which will open the introduction to the HEP.
4. Fill-in all required questions in the form. You can save your progress by hitting “save”. You can return to this saved form at anytime. NOTE: After 30 minutes of inactivity, the form will time out and users will lose unsaved responses and data.
5. To submit your 2024 HEP response hit the **Submit** button. CAUTION: Please be sure to review all responses prior to submission. You will not be able to go back and modify your 2024 HEP responses once submitted.
6. A PDF version of your HEP will be available for download at the end of March.

Additional information on portal submission can be found in the [EOM Portal User Manual](#) which is located on the Home Page under Helpful Links. Questions related to the HEP for 2024 should be sent to the EOM Help Desk (EOM@cms.hhs.gov).

Section 5: HEP Review

All HEP submissions will be reviewed by CMS. Because of their importance, CMS conducts thorough reviews of the HEPs and will aim to complete its review of a HEP within 60 business days of submission deadline and will notify the EOM participant of any issues with or questions about the HEP during that time, as well as any revisions that may be requested to conform with the instructions in this guide. CMS may request additional information from individual EOM participants to supplement its review. Should the EOM participant be asked to revise its HEP, a revised HEP should be submitted to CMS within 30 days of receipt of the request for revisions. CMS will aim to complete its review of all revised HEP submissions within 60 business days of receipt of the revised HEP.

Table 1 shows the specific deadlines for the HEP submissions.

If an EOM participant is asked to revise a HEP that was previously submitted to CMS, the EOM participant should re-submit the updated HEP with material changes to CMS for review before implementing such revisions to their HEP. Such revisions to the HEP may include, but are not limited to, changes to the: 1) chosen health disparity(ies) or underserved community(ies); 2) data sources or measures; 3) interventions; 4) marketing materials; and goals. Submitting a revised HEP

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to CMS allows flexibility for EOM participants to reassess the underserved community(ies), health disparity(ies), and proposed intervention(s) described in their HEPs. The first annual HEP is due March 29, 2024.

The EOM participant should not initiate the interventions or other health equity activities identified in the HEP submissions until CMS has completed its review of the submissions and any HEP revisions have been submitted to CMS and reviewed by CMS.

Table 1: HEP Submission and Review Timeline

HEP	Applicable Performance Period(s)	Deadline for Submission
2024 Annual HEP *	2,3	March 29, 2024
2025 Annual HEP	4,5	March 28, 2025
2026 Annual HEP	6,7	March 27, 2026
2027 Annual HEP	8,9	March 26, 2027
Revised HEP		As Needed

* This is the first required HEP.

Section 6: HEP Development

This section provides resources and tools to help model participants as they think through the various steps of developing, implementing, and updating a HEP. When answering each question, try to be as descriptive as possible to ensure each narrative provides critical information on your underserved community(ies) and proposed activities to measure and reduce health disparities. For the 2024 HEP, additional drop-down responses were added to most questions in an effort to reduce participant reporting burden. That being said, if your intended response is not included in the list(s), please choose, “other” and write in your preferred response.

6.1 Using Data to Identity and Select Health Disparities and Underserved Communities

1. Please list the data source(s) you will use to select a health disparity and identify related underserved communities in your beneficiary population.
 - a. List the data sources that your organization will use to identify disparities in access, outcomes, and/or beneficiary experience. Select from the following menu options:
 - Area Deprivation Index
 - Beneficiary feedback
 - Caregiver feedback (e.g. patient/family advisory councils)
 - Claims data



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- Community Health Needs Assessment
 - County Health Ranking
 - EHR/EMR
 - Enrollee advisory committees (or other group forums)
 - Health care utilization data (e.g. HCUP, proprietary database)
 - Health Related Social Needs (HRSN) Screening (from HRSN screening tool)
 - Health Risk Assessment (HRA)
 - Mapping Medicare Disparities Tool
 - NCCN Distress Thermometer
 - Patient/Caregiver Needs Assessment
 - Patient surveys (e.g., internal surveys, CAHPS)
 - Provider feedback
 - Publicly available data (e.g. US Census/state demographic data)
 - Social Determinants of Health (SDOH) Assessment
 - Other
- b. List data year(s)
- c. What did you learn from the data? Select all that apply from the following menu options:
- Conditions impacting the health of our population
 - Data is insufficient
 - Disparities by condition
 - Diversity of the community we serve
 - Health conditions in our population
 - How our costs compare to country, state and/or national averages
 - How to interpret impact of HRSN on our population
 - Impact of poverty on patient outcomes
 - Insurance coverage
 - Medically underserved areas
 - Mortality and morbidity rates by sociodemographics
 - Our HSRN domains
 - Percentage of households receiving government subsidies and benefits
 - Populations most impacted by socioeconomic disparities
 - Practices with highest sociodemographic disparities
 - Service gaps
 - Sociodemographic disparities
 - Top areas of concern
 - We need to learn how to understand the data
 - Other (If you chose “Other”, please specify in the text field)
- d. Provide link to data source (if applicable).
2. Please describe the standardized process that your organization already has or is developing for collecting, analyzing, verifying, and stratifying patient sociodemographic and HRSN data to identify and address disparities.
3. Describe the identified health disparity your organization will address.

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- a. What is your disparity? Your answer will be based on the disparities you identified in your beneficiary population in Question 1 and should describe the disparity that your organization will address. You will have the opportunity to add an additional disparity later in the HEP.
- b. What category best describes your disparity? Identify one category from the menu options: HRSN, Conditions, or Other Risk Factors. Select the category that best describes the disparity. Then select one specific disparity from the category menu options provided. You do not need to select from more than one category. If the disparity spans multiple categories, choose the category that is most applicable and include additional information about the other categories in the description and rationale sections. Select one disparity from one category:

Category: **Health Related Social Needs (HRSN)**

Disparity:

- Education
- Family and community support
- Financial instability
- Food insecurity
- Health Literacy
- Housing instability
- Interpersonal safety
- Language barrier
- Physical activity
- Social isolation
- Social support
- Transportation barriers
- Other (If you chose “Other”, please specify in the text field)

Category: **Conditions**

Disparity:

- Breast Cancer
- Chronic Leukemia
- COPD/Emphysema
- Diabetes
- Heart Disease
- Hypertension
- Lung Cancer
- Lymphoma
- Multiple Myeloma
- Prostate Cancer
- Small Intestine/Colorectal Cancer
- Other (If you chose “Other”, please specify in the text field)

Category: **Other Risk Factors**

Disparity:

- Accessibility to clinically appropriate levels (or settings) of care
- Cancer Stage
- Decreased Medication Adherence
- ICU Admissions at End-of-Life
- Lower Enrollment in Hospice
- More Frequent Hospitalizations
- Time to Initiation of Treatment
- Underrepresentation/ Access to Clinical Trials
- Other (If you specify “Other”, please specify in the text field)

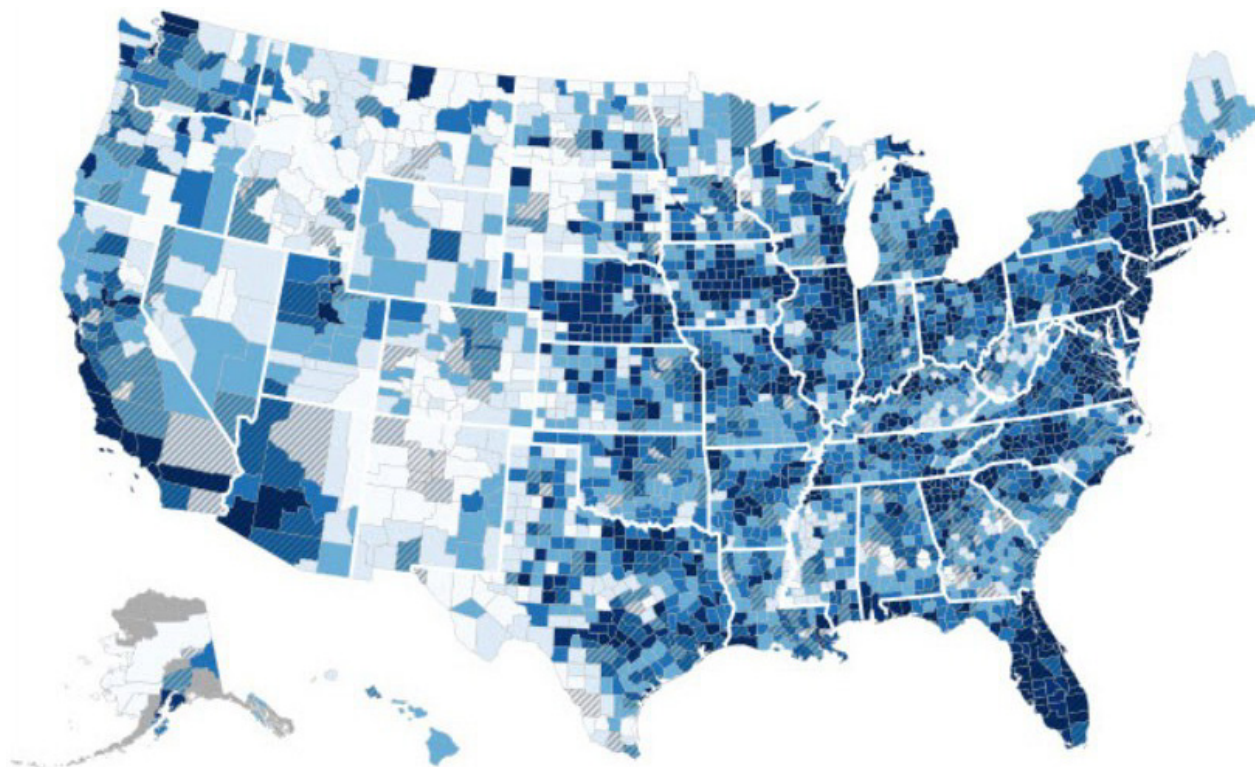
- c. Please provide details and rationale for the selected disparity based on lessons learned from your data sources in Question 1.

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4. List the underserved community(ies) that is/are affected by the identified disparity that your organization will address. Provide the rationale for the selection of the underserved community(ies).

Tip: The [CMS Office of Minority Health](#) (CMS OMH) has designed an interactive map, the [Mapping Medicare Disparities Tool](#), to identify areas of disparities between subgroups of Medicare beneficiaries in health outcomes, utilization, and spending (Figure 1). Users can explore and better understand disparities in chronic diseases to 1) visualize health outcome measures at a national, state, or county level; 2) explore health outcome measures by age, race, ethnicity, and sex; 3) compare differences between two geographic locations (e.g., benchmark against the national average); and 4) compare differences between two racial and ethnic groups within the same geographic area. This tool allows filtering by year, geography, measures, chronic disease, and more. For more information on how to use the Mapping Medicare Disparities Tool, please utilize the [Quick Start Guide](#).

Figure 1: Mapping Medicare Disparities Tool



6.2 Data

It is essential for EOM participants to collect and report to sociodemographic data to CMS to address healthcare inequities.¹² When collecting such data, participants should prioritize the

¹² CMS, Quality Improvement and Interventions, (2023), Retrieved from: [https://www.cms.gov/priorities/health-equity/minority-health/resource-center/health-care-professionals-researchers/quality-improvement-interventions/#%3A%7E%3Atext%3DBuilding%20an%20organizational%20Response%20to%20Health%20Disparities%20%E2%80%93%20Resource%20Guide%20\(PDF\)](https://www.cms.gov/priorities/health-equity/minority-health/resource-center/health-care-professionals-researchers/quality-improvement-interventions/#%3A%7E%3Atext%3DBuilding%20an%20organizational%20Response%20to%20Health%20Disparities%20%E2%80%93%20Resource%20Guide%20(PDF))

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collection of race, ethnicity, and language (REaL) data, align tools to collect self-reported REaL data, and train staff and educate patients to understand that REaL data will be used to identify and reduce health disparities.¹³ *This is currently a requirement for EOM participants, per Sections VII, XI and further described in Appendix C of the PA.*

The following are ways to use data sources to identify health disparities. To support EOM participants in developing their HEPs, we have compiled a list of [Publicly Available Health Equity Data Sources](#) to support EOM participants in developing their HEPs. This document provides a list of publicly available sociodemographic and social determinants of health (SDOH) data sources. EOM participants can also reference the [CMS Health Equity TA: Data Sources Handout](#) for additional sources. The Publicly Available Health Equity Data Sources document, the CMS Health Equity TA handout and the list below are not exhaustive lists. There are other data sources participants may use to support their HEPs. Participants are encouraged to utilize additional national, regional, state-level and practice-level data sources to better identify health disparities within their specific underserved community(ies).

- The International Classification of Diseases, Tenth Revision, Clinical Modification ([ICD-10-CM](#)) psychosocial risk and economic determinant-related codes (Z codes) can be used to document social needs. Useful Z code data include homelessness status, inadequate housing, extreme poverty, waiting admission to adequate facilities elsewhere, unavailability and inaccessibility of health-care facilities, unavailability and inaccessibility of other helping agencies, and respirator dependence during power failure.
- The [National Quality Forum](#) (NQF) has developed a Disparities-Sensitive Measure Assessment Protocol and Process with criteria in two tiers and scored to identify a set of performance measures that highlight inequities across care settings or in specific benchmarks to be used to demonstrate differences between groups. These measures, labeled as disparities-sensitive, are those where disparities in outcomes between subgroups is significant and can be used for stratification.¹⁴
- The [Neighborhood Atlas®](#) website was created in order to freely share measures of neighborhood disadvantage with the public, including educational institutions, health systems, not-for-profit organizations, and government agencies, in order to make these metrics available for use in research, program planning, and policy development.

Should your organization need assistance interpreting Medicare data, please contact the Research Data Assistance Center ([ResDAC](#)).

6.3 Set Health Equity Goals for your Disparity and Monitor Progress

Goal setting is important for any measurement related to performance and quality improvement. This [worksheet](#) provides an illustrative framework that can help you establish SMART goals for your

¹³ Hasnain-Wynia, R., Pierce, D., Haque, A., Hedges Greising, C., Prince, V., Reiter, J. (2007) *Health Research and Educational Trust Disparities Toolkit*. <http://retdisparities.org> accessed on April 11, 2022

¹⁴ National Quality Forum. Healthcare Disparities and Cultural Competency Consensus Standards: Disparities-Sensitive Measure Assessment (2012), Retrieved from: [https://www.cms.gov/priorities/health-equity/minority-health/resource-center/health-care-professionals-researchers/quality-improvement-interventions/#%3A%7E%3Atext%3DBuilding%20an%20Organizational%20Response%20to%20Health%20Disparities%20%E2%80%93%20Resource%20Guide%20\(PDF\)](https://www.cms.gov/priorities/health-equity/minority-health/resource-center/health-care-professionals-researchers/quality-improvement-interventions/#%3A%7E%3Atext%3DBuilding%20an%20Organizational%20Response%20to%20Health%20Disparities%20%E2%80%93%20Resource%20Guide%20(PDF))

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targeted measures and performance improvement plans. Goals should be clearly stated and describe what you intend to accomplish.

The following section provides guidance and examples that EOM participants can utilize to apply continuous quality improvement (CQI) and measure intervention outcomes.

5. What are your SMART Goals for addressing your disparity and how will you make progress towards these goal(s)?
 - a. Establish and describe your immediate or short-term health equity goal(s) and how it will address the identified disparity. The goal(s) should be specific, measurable, achievable, relevant, and time-bound (SMART)?
 - b. What immediate steps do you plan to take to make progress toward the short-term goal(s)?
 - c. How will you continue to make long-term progress toward the identified goal(s)?

6.4 Identify and Select Evidence-Based Interventions

The intervention(s) selected to combat the selected health disparity should be tailored to provide equitable care to the underserved community(ies) selected and improve patient experiences and health outcomes, while potentially reducing cost.

6. What evidence-based intervention will you use to address the health disparity in Question 3? Evidence-based interventions integrate 1) the best available research findings, 2) healthcare expertise and other resources, and 3) characteristics, needs, values, and preferences of those impacted by the intervention.¹⁵
 - a. Select the intervention type for the disparity identified in Question 3. Select from the following menu options:
 - Access to Care
 - Care Planning
 - Address Financial Instability
 - Address Food Insecurity
 - Improve Health Literacy
 - Language Services
 - Patient Navigation
 - Psychosocial Health
 - Quality
 - Strengthen Social Supports
 - Transportation Services
 - Other (If you chose “Other”, please specify in the text field)
 - b. Describe how you will provide the intervention to all affected beneficiaries, including the underserved community(ies). The intervention you select to address the identified health disparity should be tailored to provide equitable care to the underserved community(ies). Examples of evidence-based interventions can be found [here](#).

The Community Preventive Services Task Force provides example interventions by various topics. Additional information can be found at [The Community Guide](#).

Once a health disparity(ies) and underserved community(ies) have been selected, matching interventions to provide quality improvement and equitable healthcare should be identified based on needs, meaningful and actionable impact, resources, and feasibility. Interventions may include

¹⁵ Jacobs JA, Jones E, Gabella BA, Spring B, Brownson RC. Tools for Implementing an Evidence-Based Approach in Public Health Practice. *Prev Chronic Dis* 2012;9. doi: 10.5888/pcd9.110324

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community outreach, provider trainings, increased accessibility to health care facilities, improved communication, and language access for those with limited English proficiency and people with disabilities, increasing the ability of healthcare providers to meet the needs of an underserved community(ies), and other methods of change.

When choosing an intervention, those that address structural drivers (e.g., social, physical, or economic environments), which may constrain health behaviors and outcomes, may have a more lasting, positive impact because they identify the source of the problem.¹⁶ Such interventions may include factors like economic instability, limited education, employment status, systemic discrimination, and limited resources. Research has also found the most successful interventions involve a diverse group of interested parties, such as the criminal justice system, education, transportation, housing, businesses, and other social services, in support of the health care system.¹⁷ It is important to note that interventions in one community may not be appropriate for other underserved community(ies) due to cost and time constraints, geographical and ethical issues, beneficiary reluctance, community and/or other interested parties influence or the evolving nature of the intervention. Interventions should be appropriate to each underserved community(ies) and their unique characteristics.¹⁸ Examples of evidence-based interventions are presented in Table 2.

Table 2: Examples of Evidence-based Interventions

HEP	Applicable Performance Period(s)
Nutrition	Home-delivered; congregate meal services for older adults. ¹⁹
Alleviate Transportation Barriers	Using a virtual transportation hub to address transportation barriers and reduce no-show rates for oncology treatments. ²⁰
ACCURE Program to Reduce Disparities in Lung Cancer	Using real-time EHR warning system, a nurse navigator, and treatment completion rates to improve lung cancer treatment. ²¹
Alleviating Depression Among Patients with cancer (ADAPt-C)	Hospital based program that can be adapted to different care settings to address major depression and dysthymia to improve the health-related quality of life of cancer patients. ²²

¹⁶ Arleen F. Brown, Grace X. Ma, Jeanne Miranda, Eugenia Eng, Dorothy Castille, Teresa Brockie, Patricia Jones, Collins O. Airhihenbuwa, Tilda Farhat, Lin Zhu, and Chau Trinh-Shevrin, 2019: Structural Interventions to Reduce and Eliminate Health Disparities. American Journal of Public Health 109, S72_S78, <https://doi.org/10.2105/AJPH.2018.304844>

¹⁷ Solar O, Irwin A. A conceptual framework for action on the social determinants of health. Commission on Social Determinants of Health, 2010. Retrieved from: <https://www.who.int/publications/i/item/9789241500852> Accessed April 15, 2022

¹⁸ The Community Guide. Methods Manual for Community Guide Systematic Reviews, (2021), Retrieved from: <https://www.thecommunityguide.org/pages/methods-manual.html>

¹⁹ The Community Preventive Services Task Force. Nutrition, Physical Activity, and Obesity: Effectiveness of Home-delivered and Congregate Meal Services for Older Adults, (2021), Retrieved from: <https://www.thecommunityguide.org/media/pdf/methods-manual/Methods-Manual-Community-Guide-Systematic-Reviews.pdf>

²⁰ Marquez R, Manning MA, Mohamed MK. Resolving transportation disparity in cancer care, (2021), Retrieved from, https://ascopubs.org/doi/abs/10.1200/JCO.2020.39.28_suppl.96

²¹ Cykert S, Eng E, Walker P, Manning MA, Robertson LB, Arya R, Jones NS, Heron DE. A system-based intervention to reduce Black-White disparities in the treatment of early-stage lung cancer: A pragmatic trial at five cancer centers (2019), Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6434214/>

²² Alleviating depression among patients with cancer (ADAPt-C). National Cancer Institute (NCI). Retrieved from: <https://ebccp.cancercontrol.cancer.gov/programDetails.do?programId=3551008>

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7. Complete the Health Equity Performance Measures Table to help track, monitor, and evaluate your intervention identified in Question 6. Enter the following data into the table:
 - a. Performance Measure: Enter the metric you will use to measure reductions in the health disparity identified in Question 3 using the intervention identified in Question 6.
 - b. Baseline: Enter the average 2023 data on the underserved community described in Question 4.
 - c. Beneficiary 2023 Average: Enter the average of the total beneficiary population for selected performance data for the prior year.
 - d. PY2024 Desired Outcome for the Measure: Enter the intended performance outcome for 2024 for this measure.
 - e. PY2025 Desired Outcome for the Measure: Enter the intended performance outcome for 2025 for this measure.
 - f. PY2026 Desired Outcome for the Measure: Enter the intended performance outcome for 2026 for this measure.
 - g. PY2027 Desired Outcome for the Measure: Enter the intended performance outcome for 2027 for this measure.
 - h. Please include information on how often your organization intends to conduct this tracking. Progress should be evaluated at least once annually.

The Health Equity Performance Table for question 7 can be found in **Appendix A**.

8. If you would like to add an additional disparity to this HEP, please do so. Note that additional disparities are not required.
 - a. If you are adding an additional disparity, complete the following questions:
 - Is (are) the underserved community(ies) identified in Question 4 also affected by this additional disparity? Yes or No
 - Do(es) the health equity goal(s) identified in Question 5 also apply to this additional disparity?
 - Does the intervention identified in Question 6 also apply to this additional disparity? Yes or No
 - b. If you select an additional disparity, you may be prompted to provide additional details for your selection.
9. Describe the safeguards that you will implement as part of your monitoring plan to ensure all beneficiaries, including the underserved community(ies), obtain equitable care, and that your goals and interventions do not exacerbate health inequities. Describe the safeguards that you will implement as part of your monitoring plan to ensure all beneficiaries, including the underserved community(ies), obtain equitable care, and that your goals and interventions do not exacerbate health inequities.

Include what you will do if your intervention is not achieving your goal(s) (e.g., continuous quality improvement plan, PDSA cycle, routine data monitoring, tracking outcomes, beneficiary feedback/surveys).

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10. Please select additional staff who will be responsible for implementing and monitoring progress on the HEP. Select all that apply from the following menu options:

- Administrator/CEO/CMO
- Care Manager
- Data Analyst
- Nurse Navigator
- Program Manager/Supervisor
- Provider
- Quality Coordinator
- Social Worker
- Other (If you chose “Other”, please specify in text field)

Please describe each staff’s role in the process.

6.5 Identify Engagement Strategies

The following section provides points for EOM participants to consider in their HEP regarding beneficiary, caregiver, and community partner engagement.

11. Please describe your plan to engage beneficiaries and their caregivers in shared decision-making to ensure patient centered intervention(s). Select from the following menu options:

- Actively listen and communicate with beneficiaries in plain language to enhance understanding
- Apply shared decision making by developing treatment plans and goals collaboratively with patient, caregiver, and care team
- Conduct cultural and linguistic needs assessments with patients and caregivers to identify languages spoken, cultural practices, and beliefs that may impact healthcare decision making
- Conduct HRSN screening and resource connection
- Conduct patient surveys and use patient experience survey data to inform change.
- Educate beneficiaries and caregivers on how their involvement can improve their healthcare experiences
- Establish a patient and caregiver Advisory Committee
- Host focus group meetings with beneficiaries and caregivers
- Incorporate beneficiary and/or caregiver input into the development of our goals and the design of our interventions/key activities
- Provide health information, pamphlets, and brochures in patients’ preferred languages
- Provide interpreter services
- Tailor interventions to patients’ individual needs including preferred language, cultural beliefs, and health literacy levels
- Other (If you chose “Other”, please specify in the text field)

Describe how you will ensure a culturally appropriate and linguistically responsive approach to patient and caregiver engagement (e.g., providing training to staff, hiring staff that has experience working with your patient population, translating electronic and written materials into multiple languages).

12. Please describe your plan to engage providers and staff to ensure coordinated, comprehensive patient-centered care. Select from the following menu options:

- Conduct data collection training

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- Conduct health equity trainings including, but not limited to, implicit bias and cultural competency trainings
- Conduct HRSN screening training
- Establish staff and provider sub-committees to develop interventions to improve health equity
- Establish regularly scheduled multi-departmental provider, staff and care team meetings focused on health equity interventions
- Identify provider/staff leaders
- Supply care teams with up-to-date resources to assist patients with addressing HRSNs
- Other (If you chose “Other”, please specify in text field)

13. Identify and describe any potential challenges and barriers to implementing your HEP and your plan for mitigating those challenges and barriers. Select from the following menu options:

- Access to up-to-date resources to assist patients with addressing HRSNs
- Beneficiary awareness/engagement
- Conducting health equity training
- Conducting HRSN screening training
- Cultural/language barriers
- Data analytic capacity/capabilities
- Data collection
- Engaging providers/staff leaders
- Establishing staff and provider sub-committees
- Holding regularly scheduled multi-departmental provider, staff and care team meetings focused on health equity
- Individual provider behavior
- Knowledge of up-to-date resources to assist patients with addressing HRSNs.
- Limited financial resources
- Need for staff training
- Staff availability
- Other (If you chose “Other”, please specify in text field)

Additionally, describe plans to mitigate the identified challenges and barriers.

When approaching beneficiary and caregiver engagement, consider committing to providing culturally responsive and linguistically appropriate care according to the [HHS National Standards for Culturally and Linguistically Appropriate Services \(CLAS\) for Health and Health Care](#).

Person and family engagement goes beyond informed consent. It is about proactive communication and partnered decision making between health care providers and patients, families, and caregivers. It is about building a care relationship that is based on trust and inclusion of individual values and beliefs. More information on this can be found in the [CMS Person & Family Engagement Strategy](#) and the corresponding [toolkit](#).

14. List the community partners that you currently/will engage to support addressing the identified health disparity and how they will help support your intervention(s). Select from the following menu options:

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- Advocacy group
- Cancer support group
- Cancer support services program
- Caregiver support program
- Charity/Foundation
- Community Health Worker
- Community outreach program
- Co-pay assistance program
- Counseling services
- Financial counseling
- Food delivery program
- Food pantry
- Pharmacy assistance program
- Referral system software/platform
- Transportation service
- Tribal community resources
- Other (If you chose “Other”, please specify in text field)

- a. Enter name of Community Partner (optional).
- b. Describe how each partner will support your intervention.

15. As applicable, across which other local, state, or federal programs do you plan to coordinate with to address the identified disparity(ies) within your beneficiary population. Select from the following menu options:

- Death/survivor benefits
- Disability benefits
- Emergency housing
- Housing Choice Vouchers (HCV)
- Utility Assistance (e.g., Low Income Home Energy Assistance Program (LIHEAP))
- Medicaid
- Sections 811 and 202 (HUD Programs)
- Social Security
- State-based services and programs
- Supplemental Nutrition Assistance Program (SNAP)
- Temporary Assistance for Needy Families (TANF)
- None
- Other (If you chose “Other”, please specify in text field)

Working with community resources provides a unique and powerful partnership to build collaborative relationships and trust.²³ Every EOM participant’s community is different, based on demographics and geographic location. Ideas for community resources include state and county public health institutions, area agencies on aging, social services organizations, places of worship, and other agencies and organizations that serve these communities. The [Administration for Community Living](#) funds over 30,000 community-based organizations in every state across the country.²⁴ This national network serves over 10 million older adults each year, with an acute focus on high cost, high need populations and equity. A section of their [website](#) is dedicated to information and resources on advancing partnerships to align health care and social services, with a primary focus on the community care hub model.

²³ Brennan Ramirez LK, Baker EA, Metzler M. Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2008. <https://stacks.cdc.gov/view/cdc/11130>

²⁴ “Advancing Independence, Integration, and Inclusion throughout Life.” ACL Administration for Community Living, <https://acl.gov/>.

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The Centers for Disease Control and Prevention developed the workbook, [Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health](#), to address health care inequities. It provides examples of health disparities and ways to provide equitable care for underserved communities. Community-based case studies are included, as well as examples for developing community initiatives to provide impactful interventions to underserved communities.

Additional tools, resources, and health equity frameworks to consider can be found in Appendix B and Appendix C.

Appendix A: Health Equity Performance Measures Table (Question #7)

7. Please complete the Health Equity Performance Measures table below to help track, monitor, and evaluate your intervention identified in Question 6.

Disparity:

Intervention:

Performance Measure	Baseline	Beneficiary 2023 Average	PY2024 Desired Outcome for the Measure	PY2025 Desired Outcome for the Measure	PY2026 Desired Outcome for the Measure	PY2027 Desired Outcome for the Measure
<i>To measure reductions in health disparity identified in Question 3 using the intervention identified in Question 6.</i>	<i>The average 2023 data on the underserved community described in Question 4.</i>	<i>The average of the total beneficiary population for selected performance data for the prior year.</i>	<i>The intended performance outcome for 2024 for this measure.</i>	<i>The intended performance outcome for 2025 for this measure.</i>	<i>The intended performance outcome for 2026 for this measure.</i>	<i>The intended performance outcome for 2027 for this measure.</i>

Please include information on how often your organization intends to conduct this tracking. Progress should be evaluated at least once annually.

Appendix B: Development Guidance and Framework

Below you will find a few additional resources and health equity frameworks to support EOM participants working to develop HEPs. Included in more detail below are CMS's Framework for Health Equity, other quality improvement frameworks and tools, such as a framework developed by the NCQA, that details key steps that organizations may follow to implement equity-focused quality improvement interventions.

The Department of Health and Human Services (HHS) has identified the following three major implementation strategies to reduce health disparities:

1. Train health care personnel to deliver culturally responsive and linguistically appropriate care for diverse populations;
2. Raise awareness of disparities using research and data; and
3. Form partnerships to identify and test solutions.²⁵

The [CMS Framework for Health Equity \(2022-2032\)](#) draws on these major HHS strategies and other HHS and CMS initiatives, such as [Healthy People 2030](#), the [National CLAS Standards](#), and decades of research and input from interested parties across our communities. The CMS Framework for Health Equity outlines five major areas of focus to operationalize health equity across our health care system. These five priorities will inform CMS' efforts for the next ten years and shape how CMS and our external partners may operationalize each priority to achieve health equity and eliminate disparities. The priority areas reflect key areas of concern where CMS action is needed and critical to advancing health equity as identified by input from interested parties representing underserved and disadvantaged communities. Organizations may take action in any or all of these areas, and by working together to focus interventions and activities on these priority areas, partners across the health care system may have opportunities to move the needle to reduce disparities and advance health equity together.

In late 2022, CMS also released a companion framework focused specifically on meeting the health care needs of members of rural, tribal, and geographically isolated communities²⁶– the CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities. CMS serves the public as a trusted partner and steward, dedicated to advancing health equity, expanding coverage, and improving health outcomes across all its programs to promote high-quality, equitable care, including for rural, tribal, and geographically isolated communities.

In alignment with the CMS Framework for Health Equity 2022–2032, this Framework supports CMS' overall efforts to advance health equity, expand access to quality, affordable health coverage, and improve health outcomes. CMS' approach to operationalizing this Framework over the next five years will be informed by ongoing public engagement as appropriate, and CMS will continue to monitor trends in health and health care that uniquely impact rural, tribal, and geographically isolated areas.

²⁵ Agency for Healthcare Research and Quality (AHRQ), 2014 Annual Progress Report to Congress: National Strategy for Quality Improvement in Health Care (2014), Retrieved from: <https://archive.ahrq.gov/workingforquality/reports/2014-annual-report.html>

²⁶ CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities, supra note 3

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Through the adoption and implementation of the CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities, CMS will continue to work to promote policies and programs that help make high-quality health care in these communities available and affordable.

Section A-1 Quality Improvement Plan

Health disparities are evidence that high quality health care has not been delivered equally to all beneficiaries. Quality improvement (QI) is a way to help remediate some health inequities within an underserved community. Several QI frameworks and tools exist, including a framework developed by NCQA. These frameworks are designed to promote culturally appropriate care and equitable access for individuals with limited English proficiency, as well as reduce overall health disparities.²⁷ In the NQCA framework, there are key steps that organizations may follow to implement equity-focused QI interventions, which are detailed below.

1. **Identify Health Disparities and Priority Populations:** As an organization begins a QI journey, it is important to understand the demographics and health care needs of the specific communities served in order to identify and work to reduce disparities. Stratifying data and measures by available demographics and social determinants of health data is a way to begin to look at outcomes, access, and quality indicators for specific populations in a larger service area. Health care delivery systems data can also be assessed to look at the demographics of the population served and identify locality of community services, cultural competencies among health care personnel and any language barriers, quality performance of care delivery, and information systems. Other sources of qualitative data to assess include surveys, administrative, clinical and program data, race/ethnicity and language preference data, and community or population data.

An organization may start by identifying what data is available, analyzing that data and then identifying a population or area to focus on, and a specific disparity within a measure or aspect of access or quality to tailor resources or an intervention.
2. **Define your goals:** Once data has been analyzed and a specific disparity is identified, an organization can set a goal or goals – there may be a long-term goal and several short-term goals. These goals may include process improvements to get to outcome improvements. If community members were not engaged in the data analysis in the first phase of this quality improvement effort, it is beneficial to engage individuals within the community who may be the focus of an intervention or quality improvement effort at this point. Members of the population most impacted can help set goals and galvanize community support, as well as identify what may be driving a disparity, what the major barriers are, and what local assets such as facilitators might be available for an organization to leverage. All of these aspects can help with goal setting, as well as with the planning stages that follow.

²⁷ National Committee for Quality Assurance and Eli Lilly Company, *Toolkit for Multicultural Health Care: A Quality Improvement Guide* (2007), Retrieved from: <http://online.fliphtml5.com/vzpf/naoo/#p%3D1>.

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3. Establish your organization's health equity strategy: For optimal outcomes, an organization may wish to start listing out what actions need to be taken to meet short term goals, and what actions they will need to take to reach long-term goals. These are action steps that can help an organization move sequentially through their improvement process. Community members and individuals who work directly with the population of focus for an intervention may have valuable insights to share about what steps can be taken in what order, and input from members of an improvement team will help ensure the team creates a plan they can implement together.
4. Determine what your organization needs to implement its health equity strategy: Once specific actions and steps are laid out, community members and members of the organization's improvement team can begin to itemize what resources and assets you already have, and what more is needed to ensure you can reach your goals. Local interested parties, trusted partners, and social support organizations may have resources that can help support or advance the goals of your intervention, and members of the community may be able to help make connections between your organization and other local groups. If additional resources are needed, local partners may be able to pool resources or help your organization identify new opportunities to collaborate and leverage similar efforts. This is also an important time to itemize what resources your organization has that will need to be set aside to support your intervention, including staff, time, funding, or infrastructure support.
5. Monitor and evaluate your progress: Evaluating interventions to reduce health care disparities is critical to understand whether they are successful and how they can be improved. Members of the quality improvement team, an organization's leadership team, and members of the community can agree on specific measures that the quality improvement team will track to assess progress, and assign roles so that it is clear who is collecting, analyzing, and reporting the data, and where information is being shared. An evaluation can identify how well the intervention is running, whether it is successful and what is contributing to the success/challenges of the interventions. One example is comparing the baseline data of a health care disparity within a community before an intervention has been implemented to the available data after the intervention has been implemented. Reporting information on success, progress, and challenges back to community members and partners is also a powerful tool to engage others in the intervention and bring additional support to your work.

It is important to note that changes in disparities can follow many paths over time and are influenced by factors that may not be immediately obvious, so expected changes may not occur or unexpected changes may emerge. Although it is expected that disparities will decrease as quality improves, that is not always the case, especially when quality improves quickly. It is useful to measure changes over time stratified by population groups separate from changes in gaps among different groups – this can help ensure a clear view of changes and trends in disparities. This can also help to ensure that if unintended consequences arise, or new disparities emerge, teams can adapt interventions to be most effective and achieve their end goals of moving the needle on disparities.

Appendix C: Additional HHS and CMS Health Equity Resources: Reports and Toolkits

HHS and CMS have several resources, toolkits, and sources of information on promising practices that organizations may find useful based on their area of focus. Resources are organized below by the CMS Framework for Health Equity priorities, to help guide improvement work in these focus areas.

[CMS Framework for Health Equity 2022–2032](#)

The CMS Framework for Health Equity operationalizes CMS approach to health equity within the Agency, to address health disparities as a foundational element across all our work – in every program and across every community. Using five priority areas, CMS will use this framework to design, implement, and operationalize policies and programs to support health for all people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our beneficiaries need to thrive.

Resources for Collection, Reporting, and Analysis of Standardized Data

[Race, Ethnicity, Language, and Disability Demographic Data Collection Standards](#)

The Race, Ethnicity, Language, and Disability Demographic Data Collection Standards provides data collection standards on demographic categories including: race, ethnicity, disability status, preferred spoken or signed and preferred written language.

[HHS Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status](#)

The purpose of this guidance is to promulgate a set of uniform data collection standards for inclusion in surveys conducted or sponsored by HHS as required by Section 4302 of the Affordable Care Act.

[Race and Ethnicity Data Improvement Toolkit](#)

The Race and Ethnicity Data Improvement Toolkit provides practical guidance and tools for organizations hoping to improve data collection on race, primary language, and ethnicity. Statistics, technical assistance support and software information is provided.

[Best Practices for Asking Questions to Identify Transgender and Other Gender Minority Respondents on Population Based Surveys](#)

The Best Practices for Asking Questions to Identify Transgender and Other Gender Minority Respondents on Population Based Surveys outlines how to improve population-based data collection about transgender and other gender minorities through development of sexual orientation and gender identity-related measures. Includes examples of strategies for creating procedures for collecting data to meet the needs of transgender individuals and other gender minorities.

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[Racial, Ethnic, and Gender Disparities in Health Care in Medicare Advantage \(April 2021\)](#)

The Racial, Ethnic, and Gender Disparities in Health Care in Medicare Advantage describes the quality of health care received in 2019 by Medicare beneficiaries enrolled in Medicare Advantage (MA) plans nationwide (34 percent of all Medicare beneficiaries). The report highlights racial and ethnic differences in health care experiences and clinical care, compares quality of care for women and men, and examines racial and ethnic differences in quality of care among women and men separately. This 2021 report is the sixth in a series of reports that are updated annually.

[Rural-Urban Disparities in Health Care in Medicare \(November 2020\)](#)

The Rural-Urban Disparities in Health Care in Medicare describes rural-urban differences in health care experiences and clinical care received nationally in 2019. In addition to comparing the quality of care delivered to rural and urban Medicare beneficiaries overall, the report looks at how these differences vary by race and ethnicity and by race and ethnicity within rural and urban areas.

[CMS OMH Using Z Codes: The SDOH Data Journey to Better Outcomes](#)

This infographic describes the journey that social determinants of health (SDOH) data takes from the individual through the health system to data reporting as ICD- 10-CM Z codes. It discusses data collection, documentation, coding and reporting. It contains resources to help implement programs to collect and report SDOH data in a manner that can lead to better health outcomes for individuals.

[CMS Health Equity TA: Data Sources Handout](#)

This table lists various data sources that are available to help identify health disparities by level, Health & Health Care and Demographic data.

[University of Wisconsin Neighborhood Atlas®](#)

A website that shares measures of neighborhood disadvantage with the public, including educational institutions, health systems, not-for-profit organizations, and government agencies, in order to make these metrics available for use in research, program planning, and policy development. This includes information based on the Area Deprivation Index (ADI), a measure created by the Health Resources and Services Administration that ranks neighborhoods by socioeconomic disadvantage in a region of interest.

[CDC/Agency for Toxic Substance and Disease Registry \(ATSDR\): Social Vulnerability Index](#)

Social vulnerability refers to the potential negative effects on communities caused by external stresses on human health. Such stresses include natural or human-caused disasters, or disease outbreaks. Reducing social vulnerability can decrease both human suffering and economic loss. The CDC/ATSDR Social Vulnerability Index (CDC/ATSDR SVI) uses 16 U.S. census variables to help local officials identify communities that may need support before, during, or after disasters. This website share information about the CDC/ATSDR Social Vulnerability Index (CDC/ATSDR SVI).

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[United States Census Bureau](#)

Provides thousands of data tables, maps, and more based on 2020 Census data.

Resources for Reducing Disparities

[Health Equity Challenges and CMS Resources to Help Address Them](#)

This infographic outlines various barriers to health equity and related challenges that populations often face. For each barrier, CMS resources are provided to help close the gap in health equity.

[Guide to Reducing Disparities in Readmissions](#)

The Guide to Reducing Disparities in Readmissions provides an overview of key issues related to readmissions for racially and ethnically diverse Medicare Beneficiaries, as well as useful resources for hospitals to take action for addressing readmissions.

Resources for Building Capacity of Health Care Organizations and the Workforce

[Medicare Learning Network](#)

CMS developed and disseminated innovative and promising approaches to support the health care workforce in addressing health disparities and improving the patient experience through provider-focused, accredited trainings supported by the Medicare Learning Network and other platforms. Nearly a dozen provider-focused guides have been produced to help practices take strategic, step-by-step approaches to improving care for vulnerable communities.

[A Guide to Using the Accountable Health Communities Health-Related Social Screening Tool](#)

This document describes the Health-Related Social Needs (HRSN) Screening Tool for the CMS Accountable Health Communities (AHC) Model and promising practices for universal screening.

[Building an Organizational Response to Health Disparities – Five Pioneers from the Field](#)

In the report, five organizations address how they have made a business case for addressing disparities in health care quality and access. Organizations such as hospitals, health plans, health systems, and others may see their own motivations and challenges reflected in these examples. These case studies increase the evidence base for health organizations in support of building a business case to reduce health disparities.

[CMS Improving Health Care Quality for LGBTQ People](#)

A web-based training course to provide education for health care providers and staff that are responsible for collecting Medicare patient data from LGBTQ individuals.

[Improving Health and Well-Being through Community Care Hubs](#)

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A Health Affairs blog highlighting the value of improving health and well-being through establishing community care hubs – community-focused entities supporting a network of community-based organizations providing services that address individuals’ health-related social needs. This blog was co-authored by leaders across the U.S. Department of Health and Human Services.

[Partnership to Align Social Care – Community Care Hub Resources](#)

The Partnership to Align Social Care is a national learning and action network that brings together leaders across health plans, health systems, community-based organizations, national associations, philanthropy, and federal agencies to co- design a multi-faceted strategy to enable successful partnerships among health care organizations and community care hubs. A community care hub centralizes administrative functions and operational infrastructure, including contracting with health care organizations, payment operations, management of referrals, service delivery fidelity and compliance, technology, information security, data collection, and reporting.

[Community Care Hub Contracting Spotlights](#)

These spotlighted examples highlight three community care hubs that have successfully contracted with health plans to offer various services that address health-related social needs. Each spotlight features information on the hub structure, interventions offered, health plan partner(s), and the financial model for the contracted services.

Resources to Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services

[Guide to Developing a Language Access Plan](#)

A language access plan can help ensure that an organization provides high quality and appropriate language services. A language access plan can also help ensure that an organization’s staff members are aware of what to do when an individual with limited English proficiency needs assistance. This Guide identifies ways that providers can assess their programs and develop language access plans to ensure persons with limited English proficiency have meaningful access to their programs.

[Health Literacy Tool Shed: A database of Health Literacy/Assessments](#)

The Health Literacy Tool Shed is a resource to learn more about measurement tools for health literacy. The website includes a list of recommended references and background information for learning about health literacy.

[A Practical Guide to Implementing the National CLAS Standards: For Racial, Ethnic and Linguistic Minorities, People with Disabilities and Sexual Gender Minorities](#)

HHS developed the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health and healthcare. This toolkit provides practical tools and examples of CLAS, in addition to implementation efforts that can be adapted by health care organizations. The

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purpose of this toolkit is for organizations that have decided to pursue CLAS, to improve equity and eliminate health disparities.

[Implementing Multicultural Health Care Standards: Ideas and Examples](#)

The Implementing Multicultural Health Care Standards: Ideas and Examples provides CMS examples of activities to improve cultural and linguistically appropriate services to help organizations reduce disparities in care.

Resources to Increase Accessibility to Health Care Services and Coverage

[Improving Communication Access for Individuals Who Are Blind or Have Low Vision](#)

The Improving Communication Access for Individuals Who are Blind or Have Low Vision describes the different elements organizations may choose to implement to meet the communication needs of the individuals who are Blind or have low vision. As organizations go through the planning process, they can consider the elements discussed in this resource in the context of their organization- and population-specific needs.

[Improving Communication Access for Individuals Who Are Deaf or Hard of Hearing](#)

The Improving Communication for Individuals who are Deaf or Hard of Hearing describes the different elements organizations may choose to implement to meet the communication needs of the individuals who are Deaf and Hard of Hearing. As organizations go through the planning process, they can consider the elements discussed in this resource in the context of their organization- and population- specific needs.

[Modernizing Health Care to Improve Physical Accessibility](#)

The Modernizing Health Care to Improve Physical Accessibility provides guidance on how to increase physical accessibility of medical services, tools to assess accessibility, and tips and training materials to support efforts to reduce barriers and improve quality of care for individuals with disabilities.