ALLIANT HEALTH SOLUTIONS | SORH State Office of Rural Health
A Division of the Georgia Department of Community Health

GA FLEX Health Equity Improvement Project: January Education Session

Rosa Abraha, MPH

January 23, 2023

Featured Speaker

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Rosa leads Alliant's health equity strategic portfolio and embeds health equity in the core of Alliant's work. Rosa has 10 years experience in public health advisory for premier agencies, including the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH) and the Food and Drug Administration (FDA). She holds a master of public health in health policy and management from Emory University.

Meeting Attendance

In the chat, please type the name(s) of the representative(s) for your hospital who are present on today's call.
Please be prepared with your cameras on!

Race, Ethnicity, and Language (REaL) Data Collection
(21 survey participants)

- **100%** of participants indicated that their hospital collects REaL data.

- **95%** of participants indicated that REaL questions are currently integrated in their hospital's EHR.

- **52%** of participants indicated that they can pull reports from their hospital's EHR on REaL data.

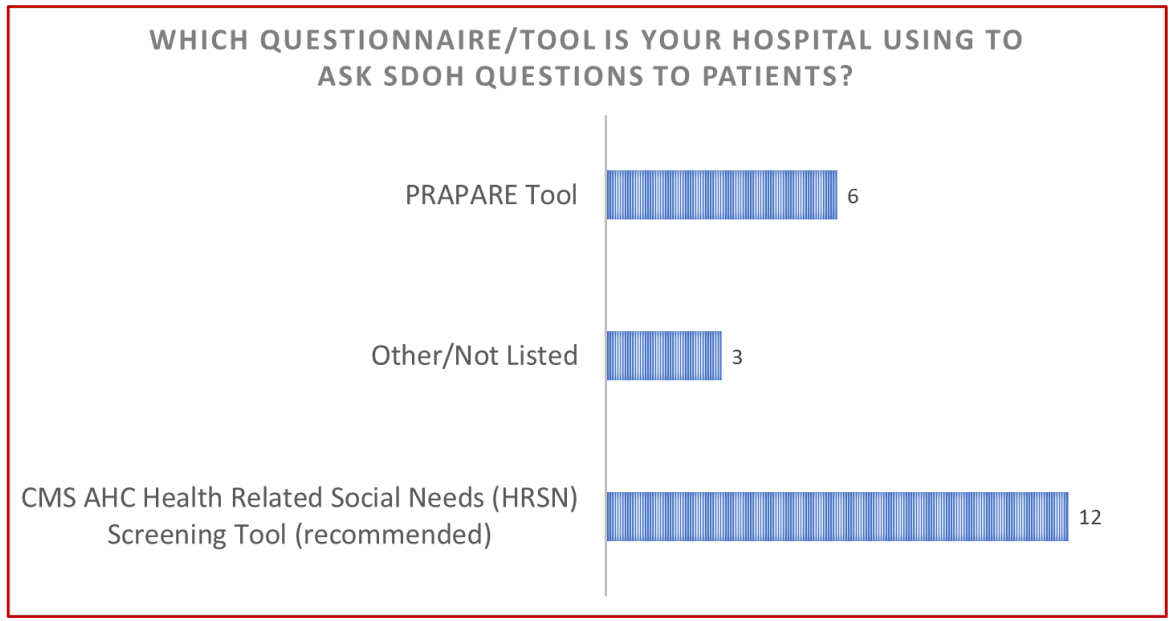
Social Determinants of Health (SDOH) Data Collection

(21 survey participants)

- **95%** of participants indicated that their hospital collects SDOH data.
- **100%** of participants indicated that SDOH questions are currently integrated in their hospital's EHR.
- **48%** of participants indicated that they can pull reports from their hospital's EHR on SDOH data.

Social Determinants of Health (SDOH) Data Collection cont.

(21 survey participants)



Which of the SDOH categories does your hospital ask patients to answer?

Category	Count
Housing instability	20
Food insecurity	19
Transportation problems	20
Utility help needs	19
Interpersonal safety	19
Financial strain	9
Employment	14
Family and community support	12
Education	12
Physical activity	10
Substance use	14
Mental health	12
Disabilities	11

Today's Education Session Focus:

Let's focus on steps 3 & 4!

CMS Attestation on HCHE Measure Domain 3

- This domain falls under the CMS Hospital Commitment to Health Equity (HCHE) measure.
- **CAHs that DO NOT participate in the CMS Hospital Inpatient Quality Reporting are not subject to completing this for CMS.**
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Domain 3: Effective data analysis can provide insights into which factors contribute to health disparities and how to respond. Please attest that your hospital engages in the following activities.

Domain 3 has only one sub-domain (3a) which is defined further in Text Box 3 below.

Text Box 3: Guidance for Attesting to Domain 3 Data Analysis

3A. Our hospital stratifies key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and includes this information on hospital performance dashboards.

The purpose of measure stratification is to understand if certain patient groups are receiving better care. Stratification in this case refers to examining quality measure results by subgroups of patients to identify important gaps in quality between patient groups.

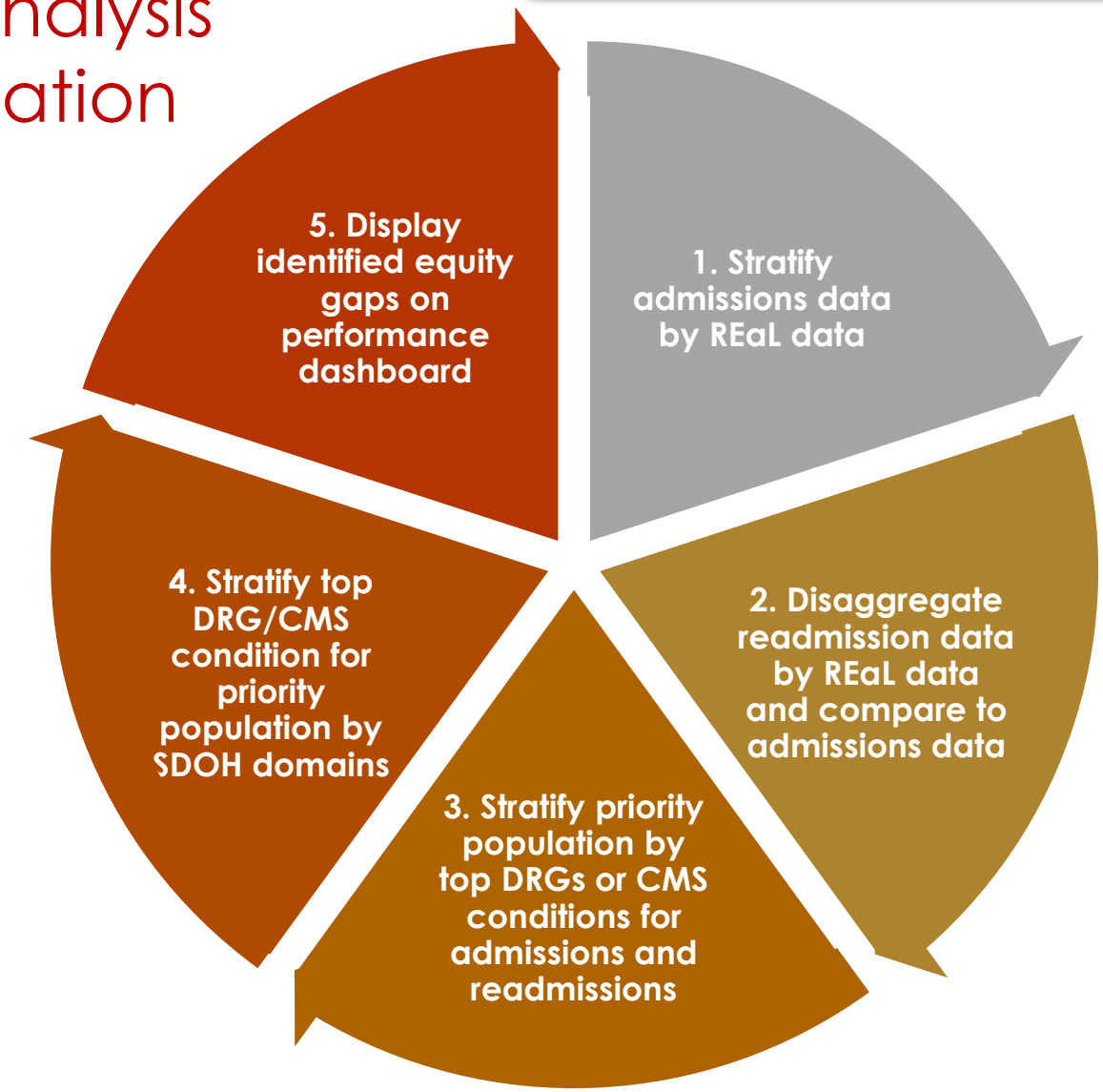
Hospitals may develop stratification metrics for priority populations (as defined by your organization e.g., by race and ethnicity, economic burden, etc.) and monitor results on these metrics using existing internal quality dashboards.

CMS expects hospitals to identify equity gaps by displaying stratified measure information based on either outcome quality measures or process of care measures; this means providing measure scores for priority populations or the gap in score between two groups.

https://qualitynet.cms.gov/files/6481de126f7752001c37e34f?filename=AttstGdnceHCHEMeas_v1.1.pdf

Model for Health Equity Data Analysis and Priority Population Identification

- These steps exist to ensure the removal of medical bias and selection bias.
- **The main goal is to eliminate assumptions about who your priority populations are and what the root cause of their disparities might be**.
- Instead, we want to allow the data to drive hospitals' priority populations of focus and, in turn, the interventions, resources and community partnerships necessary to provide the best and most trusted care to those patients.



Tift Regional Medical Center – Southwell Campus

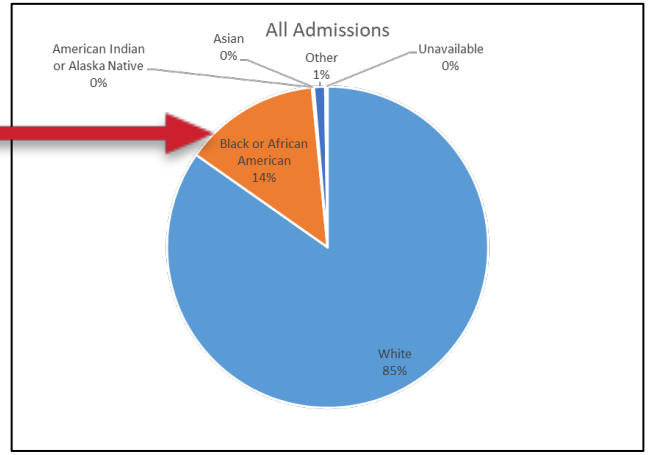
LeAnn Pritchett, MSN RN CPHQ
System Director of Quality & Safety
Tift Regional Medical Center - Southwell

- AHS has partnered with one of HQIC's health equity superstars, Tift Regional Medical Center in Georgia. The main medical center has a 181-bed regional referral hospital located in Tifton.
- The Southwell Medical location is an acute care facility in Cook County with a 12-bed geriatric psychiatric unit and a 95-bed skilled rehabilitation facility.

Tift Regional Medical Center Identifies Inequities in Readmissions

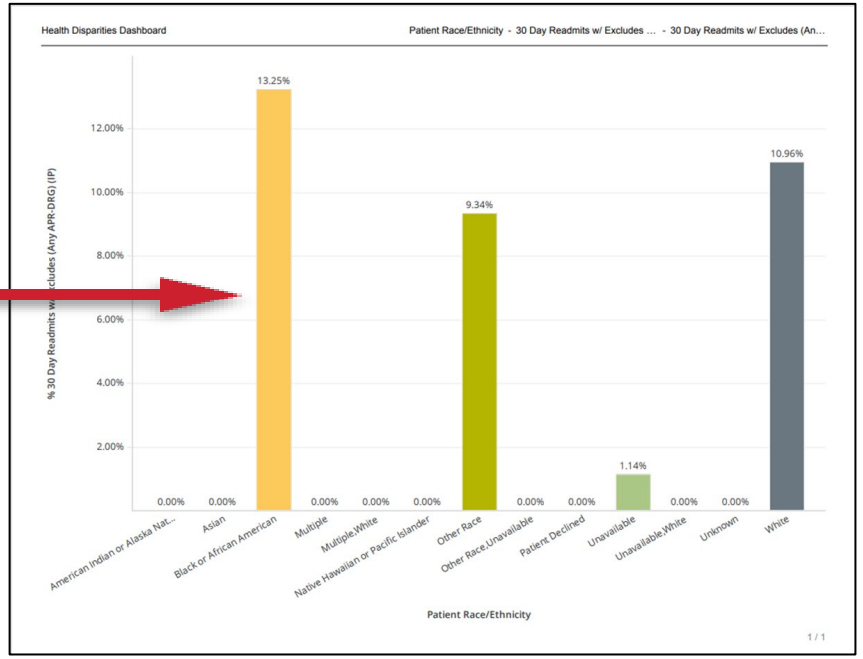
1. All Admissions by Race/Ethnicity

Black/AA patients only make up 14% of all admissions

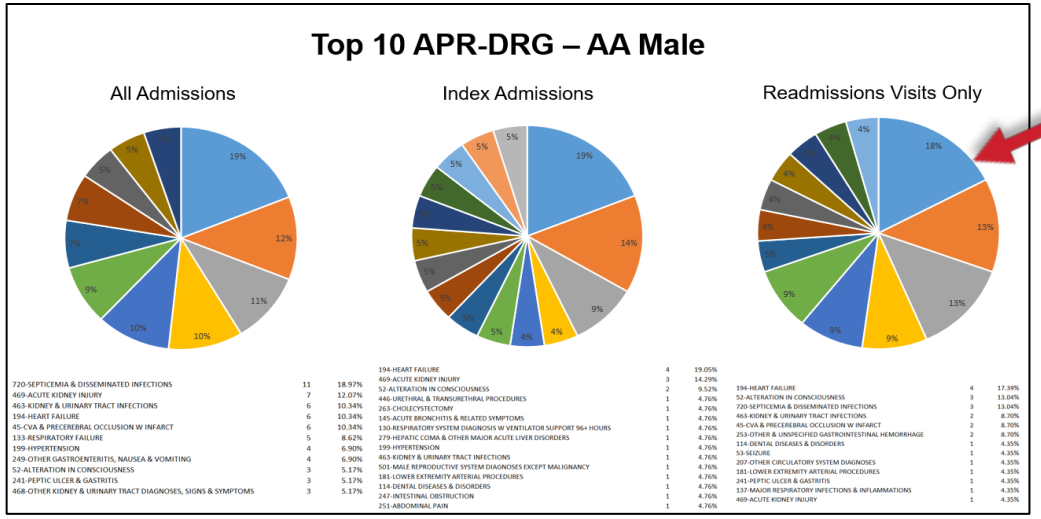


2. All Readmissions by Race/Ethnicity

However, Black/AA patients disproportionately make up the largest % of readmissions at 13%

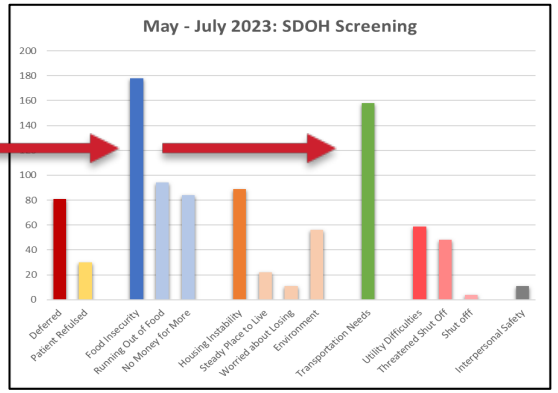


3. Black/African American Males Readmissions, Heart Failure



Heart failure is the top recurring diagnosis in readmissions among Black/AA males

4. Food Insecurity and Transportation are the top two SDOH needs in all readmissions



CMS Attestation on HCHE Measure Domain 1

Domain 1: Hospital commitment to reducing healthcare disparities is strengthened when equity is a key organizational priority.

Under Domain 1, a strategic plan is defined as a *written* plan to address health equity that is shared across the hospital. Domain 1's sub-domains of 1a, 1b, 1c and 1d are defined further in Text Box 1.

- This domain falls under the CMS Hospital Commitment to Health Equity (HCHE) measure.
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1A. Our hospital strategic plan identifies priority populations who currently experience health disparities.

Examples of "priority populations" include but are not limited to:

- Persons belonging to minority racial or ethnic groups
- Persons living with a disability
- Being a member of the lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community
- Being a member of a religious minority
- Living in a rural area
- Being near or below the poverty level
- Populations impacted by drivers of health, such as social determinants (e.g., language proficiency, housing or food insecurity, low literacy, difficulty with access to transportation, or other factors unique to a hospital's patient community)
- Any other populations that have been underserved and/or historically marginalized by the healthcare system

1B. Our hospital strategic plan identifies healthcare equity goals and discrete action steps to achieving these goals.

No additional clarification is provided for this attestation sub-domain.

1C. Our hospital strategic plan outlines specific resources which have been dedicated to achieving our equity goals.

Examples of specific resources include but are not limited to dedicated staffing, structural resources, funding, and trainings.

1D. Our hospital strategic plan describes our approach for engaging key stakeholders, such as community-based organizations.

Examples of key stakeholders include but are not limited to community-based organizations and collaboratives, patient and family advisory groups, elected officials, and existing institutional partnerships or coalitions.

https://qualitynet.cms.gov/files/6481de126f7752001c37e34f?filename=AttstGdnceHCHEMeas_v1.1.pdf

CMS Attestation on HCHE Measure Domain 5

Domain 5: Leaders and staff can improve their capacity to address disparities by demonstrating routine and thorough attention to equity and setting an organizational culture of equity.

Domain 5 sub-domains of 5a and 5b are defined further in Text Box 5.

5A. Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews our strategic plan for achieving health equity.

CMS defines "hospital senior leadership" as the C-suite and board of trustees, and not just quality committees or sub-committees of the board, as well as the Chief Medical Officer and senior leaders among hospital medical staff.

5B. Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews key performance indicators stratified by demographic and/or social factors.

See above CMS definition of "hospital senior leadership."

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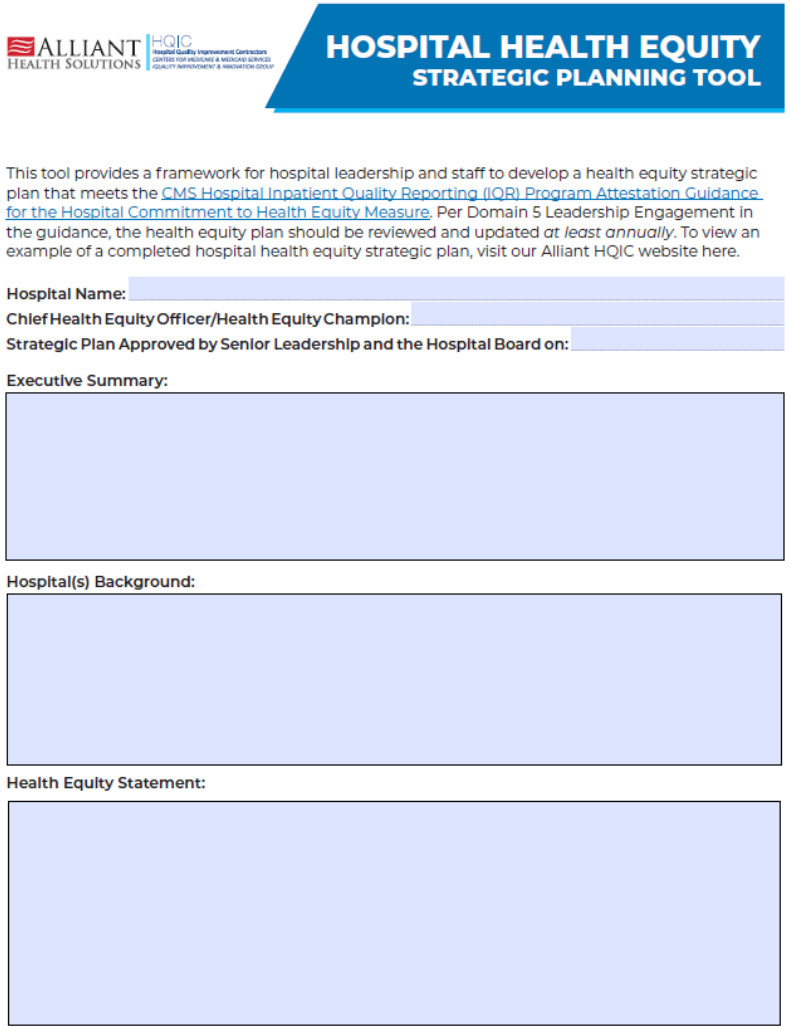
Tool for Hospital Health Equity Strategic Planning

- The purpose of this tool is to provide a framework for hospital leadership and staff in the development of a health equity strategic plan that meets the CMS health equity requirements.

- The GA Flex Program will be adopting these same requirements in the 2024-2029 MBQIP so the goal is for you to have your plan in place by the end of year 2 (*August 2024*).



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HOSPITAL HEALTH EQUITY STRATEGIC PLANNING TOOL

This tool provides a framework for hospital leadership and staff to develop a health equity strategic plan that meets the CMS Hospital Inpatient Quality Reporting (IQR) Program Attestation Guidance for the Hospital Commitment to Health Equity Measure. Per Domain 5 Leadership Engagement in the guidance, the health equity plan should be reviewed and updated *at least annually*. To view an example of a completed hospital health equity strategic plan, visit our Alliant HQIC website here.

Hospital Name:

Chief Health Equity Officer/Health Equity Champion:

Strategic Plan Approved by Senior Leadership and the Hospital Board on:

Executive Summary:

Hospital(s) Background:

Health Equity Statement:

Completed EXAMPLE – *Do Not Copy Exact Language*

Executive Summary:

Our hospital fully supports efforts to provide high-quality and equitable care for all patients and families in our hospital. Equity is a key organizational priority, and thus an important component of our strategic plan for our communities. We recognize that this effort requires long-term, dedicated investments and key partnerships with community-based organizations to address the social determinants of health (SDOH) and help us to promote an equity-focused health care delivery system designed to meet the unique needs of our rural community. This strategic plan outlines our hospitals efforts to address and attest to activities within the five identified 2024-2029 MBQIP health equity commitment requirements.

Hospital(s) Background:

This hospital is a not-for-profit Short-Term Acute Care Facility located in Escambia County in Alabama. It is licensed for 49 beds. There are 33 staffed and operational beds and 10 Swing Beds. Core hospital services include inpatient, outpatient department, radiology, laboratory and a level III trauma center.

Health Equity Statement:

To improve patient health outcomes and reduce healthcare disparities through data-driven health equity interventions and quality services.

Completed EXAMPLE – *Do Not Copy Exact Language*

Domain 1A. Our hospital strategic plan identifies priority populations who currently experience health disparities.

Identified Priority Population(s)	Supporting Data Evidence (i.e., REaL, SDOH, CHNA, Hospital Demographic and/or State Level Data)
Black patients in our hospital experiencing increased readmissions	Using the REaL data collected by our registration team, we have noted that our Black patient population is only 16% of our admitted population but makes up 40% of our readmitted population. This revealed the need for focus on root-cause analysis for why Black patients are readmitting higher than any other population.
Patients in our hospital experiencing food insecurity	CHNA was completed in 2022 for Escambia County (data from County Health Rankings) that revealed that 18.8% of the population in our county experience food insecurity, which is unfavorable compared to the state average of 16%. The December 2023 data from our SDOH questionnaire has revealed that 30% of our admitted patients screened positive for food insecurity.
Patients in our hospital lacking appropriate access to transportation	CHNA was completed in 2022 for Escambia County (data from County Health Rankings) that revealed that 6.47% of households in our county have no motor vehicle, which is unfavorable compared to the state average of 5.92%. The December 2023 data from our SDOH questionnaire has revealed that 20% of our admitted patients screened positive for lack of transportation.

NEW! Homework Assignment due March 5, 2024

Submission Process: Each hospital must **INDIVIDUALLY** complete the survey filling out the *executive summary, hospital background, health equity statement and Domain 1A portions*.

Survey Link: Complete your homework using the following link

https://bit.ly/HQICStrategicPlanningTool

Join us at 10AM EST on February 27th for our Workgroup Office Hour!

Also, join us for the **GA SORH FLEX HEI Project Workgroup Sessions** at 10 a.m. on the 4th Tuesday of every other month on following dates:

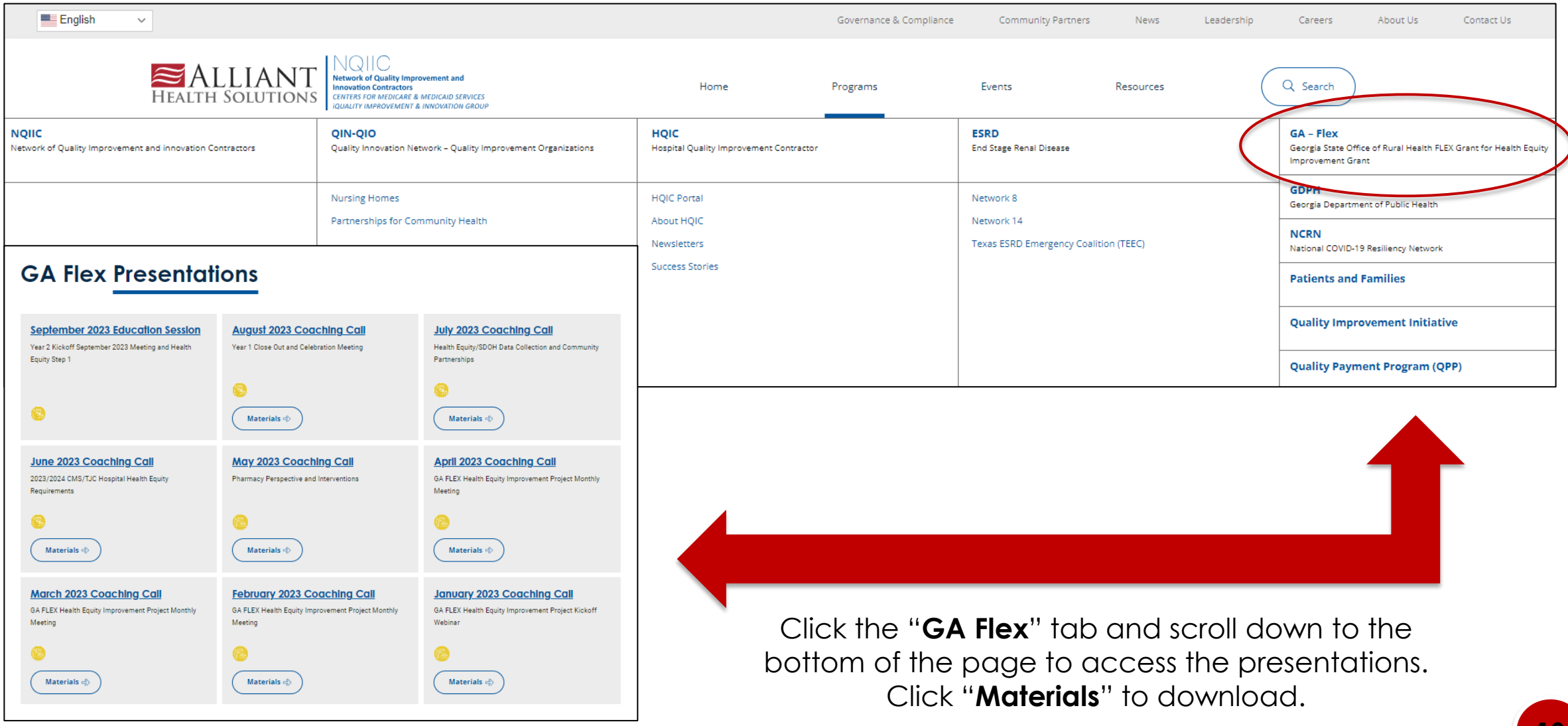
- ~~October 24, 2023~~
- ~~December 19, 2023~~
- February 27, 2024
- April 23, 2024
- June 25, 2024

The registration link will allow to you register for multiple upcoming sessions.

CLICK HERE TO REGISTER FOR THE PROJECT WORKGROUP SESSIONS

For any HEI project questions/concerns, please contact Alliant Health Solutions health equity lead, Rosa Abraha at rosa.abraha@allianthealth.org.

Scan QR code to access the GA Flex webpage



Click the "**GA Flex**" tab and scroll down to the bottom of the page to access the presentations. Click "**Materials**" to download.


Questions?
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