GA FLEX Health Equity Improvement Project: January Education Session
Rosa Abraha, MPH
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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?

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing instability</td>
<td>20</td>
</tr>
<tr>
<td>Food insecurity</td>
<td>19</td>
</tr>
<tr>
<td>Transportation problems</td>
<td>20</td>
</tr>
<tr>
<td>Utility help needs</td>
<td>19</td>
</tr>
<tr>
<td>Interpersonal safety</td>
<td>19</td>
</tr>
<tr>
<td>Financial strain</td>
<td>9</td>
</tr>
<tr>
<td>Employment</td>
<td>14</td>
</tr>
<tr>
<td>Family and community support</td>
<td>12</td>
</tr>
<tr>
<td>Education</td>
<td>12</td>
</tr>
<tr>
<td>Physical activity</td>
<td>10</td>
</tr>
<tr>
<td>Substance use</td>
<td>14</td>
</tr>
<tr>
<td>Mental health</td>
<td>12</td>
</tr>
<tr>
<td>Disabilities</td>
<td>11</td>
</tr>
</tbody>
</table>

Which Questionnaire/Tool is your hospital using to ask SDOH questions to patients?

- **PRAPARE Tool**: 6
- **Other/Not Listed**: 3
- **CMS AHC Health Related Social Needs (HRSN) Screening Tool (recommended)**: 12
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.**
- The purpose of showing this slide is to explain what language might be pulled and adapted into the MBQIP Flex Funding requirements for 2024-2029.

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.

1. Stratify admissions data by REaL data
2. Disaggregate readmission data by REaL data and compare to admissions data
3. Stratify priority population by top DRGs or CMS conditions for admissions and readmissions
4. Stratify top DRG/CMS condition for priority population by SDOH domains
5. Display identified equity gaps on performance dashboard
• 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.
- CAHs that DO NOT participate in the CMS Hospital Inpatient Quality Reporting are not subject to completing this for CMS.
- The purpose of showing this slide is to explain what language might be pulled and adapted into the MBQIP Flex Funding requirements for 2024-2029.

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.

- 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.
- The purpose of showing this slide is to explain what language might be pulled and adapted into the MBQIP Flex Funding requirements for 2024-2029.

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).
Completed EXAMPLE – Do Not Copy Exact Language
Domain 1A. Our hospital strategic plan identifies priority populations who currently experience health disparities.

<table>
<thead>
<tr>
<th>Identified Priority Population(s)</th>
<th>Supporting Data Evidence (i.e., REaL, SDOH, CHNA, Hospital Demographic and/or State Level Data)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black patients in our hospital experiencing increased readmissions</td>
<td>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.</td>
</tr>
<tr>
<td>Patients in our hospital experiencing food insecurity</td>
<td>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.</td>
</tr>
<tr>
<td>Patients in our hospital lacking appropriate access to transportation</td>
<td>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.</td>
</tr>
</tbody>
</table>
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
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 you to 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?