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

GA FLEX Health Equity Improvement Project: March 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!

Results from Part 1A of Strategic Plan Submission: **Top Priority Populations**

- Black patients with increased readmissions
- Self-pay uninsured patients
- White patients with increased readmissions
- Black patients who are admitted and diabetic
- Patients with SDOH needs – top ones were food insecurity, housing instability and transportation
- 75+ White female patients with increased readmissions for respiratory diseases
- Patients in our hospital with difficulty accessing prescription medications following hospital stays

Today's Education Session Focus:

Let's focus on step 5!

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.

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.

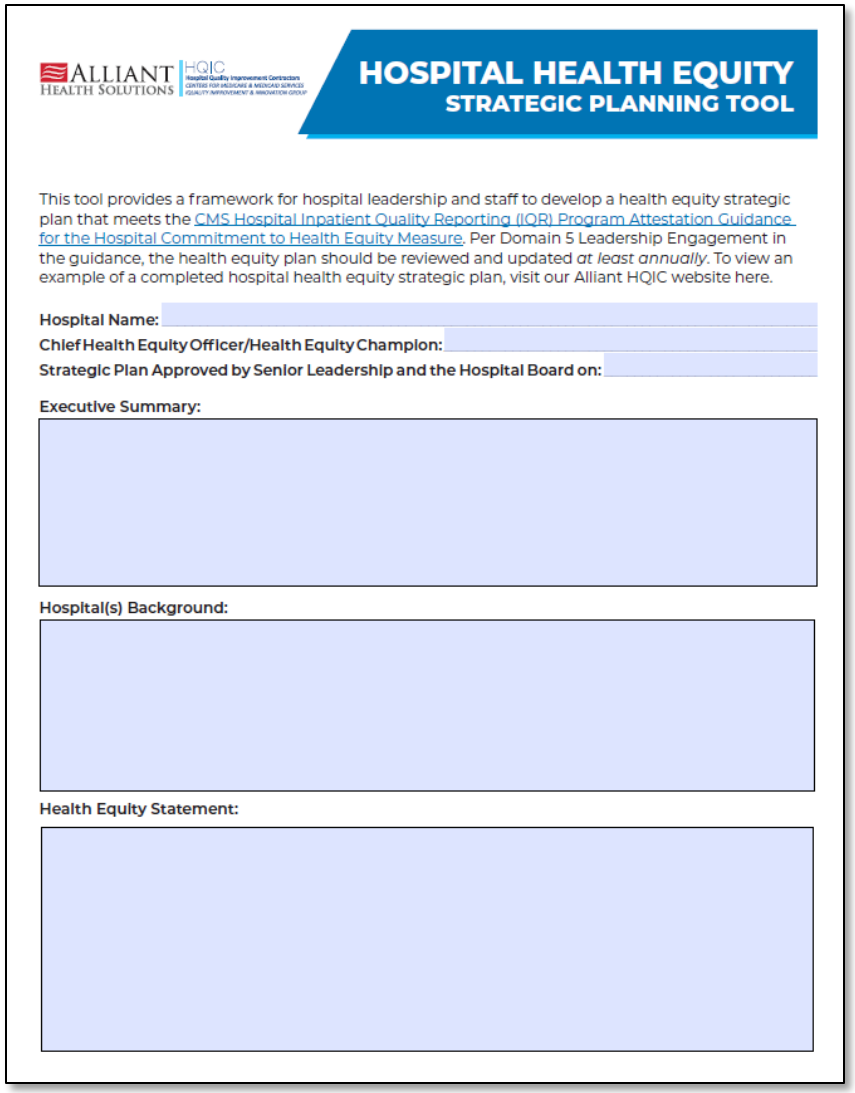
Examples of key stakeholders include but are not limited to community-based organizations and collaboratives, patient and family advisory groups, elected officials, and existing institutional partnerships or coalitions.

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

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 adopt 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 for **DOMAIN1B**

Do not *copy exact language.*

Domain 1B. Our hospital strategic plan identifies health care equity goals and discrete action steps to achieve these goals.

Health Equity Goal(s)	Related Action Steps
Goal #1: Conduct best practice interventions for Black patients in our hospital experiencing increased readmissions	For CY2024, we will conduct monthly data tracking on the rate of readmissions by race/ethnicity to continue identifying root causes for Black patient readmissions and monitor progress in reducing readmission rates for Black patients. By September 2024, we will partner with at least 2 trusted community partner organizations that are well known for representing the Black patient population to identify strategies to address mistrust and gain confidence from Black patients in health equity interventions. We will bring these organizations in for a townhall or training with our case management, nursing and registration staff to promote culturally responsive motivational interviewing of Black patients.
Goal #2: Conduct best practice interventions for patients in our hospital experiencing food insecurity	For CY2024, we will conduct monthly data tracking on the rate of admitted patients who are screening positive for food insecurity and continue to monitor progress in reducing readmission rates for these patients. By June 2024, we will adopt the Alliant SDOH discharge referral checklist in our discharge process to provide referrals to food shelter/banks for patients that screen positive for food insecurity. By September 2024, our hospital will partner with a food pantry/bank or local farmers market to offer a mobile pop up shop of fruits, vegetables or other canned goods to provide for free to patients that screen positive for food insecurity.
Goal #3: Conduct best practice interventions for patients in our hospital lacking appropriate access to transportation	For CY2024, we will conduct monthly data tracking on the rate of admitted patients who are screening positive for inappropriate access to transportation and continue to monitor progress in reducing readmission rates for these patients. By June 2024, we will adopt the Alliant SDOH discharge referral checklist in our discharge process to provide referrals to transportation organizations for patients that screen positive for food insecurity. By September 2024, our hospital will partner with two identified local churches to have a van service available to patients experiencing transportation difficulties.

Alliant Tool for Social Determinants of Health Referral at Discharge

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SOCIAL DETERMINANTS OF HEALTH (SDOH) DISCHARGE REFERRAL LIST

This tool helps your healthcare team address any social challenges that might affect your health and connect you and your caregiver with essential community resources that promote your total well-being.

HEALTH LITERACY – The degree to which individuals have the capacity to obtain, process and understand basic health information and services necessary to make appropriate health decisions.

Primary Language: _____
☐ Needs interpreter
Language Line: _____
Interpreter 1: _____
Phone: _____
Interpreter 2: _____
Phone: _____

SOCIAL ISOLATION – The lack of relationships with others and little to no social support or contact.

Senior Center 1: _____
Contact person: _____
Phone: _____
Senior Center 2: _____
Contact person: _____
Phone: _____
Adult Day Center: _____
Contact person: _____
Phone: _____

HOUSING INSTABILITY – Encompasses multiple conditions ranging from the inability to pay rent or mortgage, frequent changes in residence, including temporary stays with friends and relatives, living in crowded conditions, and lack of sheltered housing in which an individual does not have a personal residence.

☐ Inability to pay rent/mortgage
☐ Frequent changes in residence
☐ Crowded conditions
☐ Lack of sheltered housing

Shelter 1: ☐ Male ☐ Female ☐ Family
Contact person: _____
Phone: _____
Shelter 2: ☐ Male ☐ Female ☐ Family
Contact person: _____
Phone: _____
Shelter 3: ☐ Male ☐ Female ☐ Family
Contact person: _____
Phone: _____

UTILITY DIFFICULTIES – Inconsistent availability of electricity, water, oil and gas services. This is directly associated with housing instability and food insecurity.

☐ Electricity ☐ Water
☐ Oil and/or gas

Electric Company: _____
Contact person: _____
Phone: _____
Water Company: _____
Contact person: _____
Phone: _____
Gas/Oil Company: _____
Contact person: _____
Phone: _____
Faith-Based Organization: _____
Contact person: _____
Phone: _____
Other Organization: _____
Contact person: _____
Phone: _____

FOOD INSECURITIES – Limited or uncertain access to adequate quality and quantity of food at the household level.

Meals on Wheels Program: _____
Contact person: _____
Phone: _____
Local Area Agency on Aging: _____
Contact person: _____
Phone: _____
Food Bank/Food Pantry: _____
Contact person: _____
Phone: _____
Food Bank/Food Pantry: _____
Contact person: _____
Phone: _____
Food Bank/Food Pantry: _____
Contact person: _____
Phone: _____
Other Organization: _____
Contact person: _____
Phone: _____

TRANSPORTATION DIFFICULTIES – Limitations that impede transportation to destinations required for all aspects of daily living.

☐ Medical ☐ Non-emergent

Medical Transport Company 1: _____
Contact person: _____
Phone: _____
Medical Transport Company 2: _____
Contact person: _____
Phone: _____
Medical Transport Company 3: _____
Contact person: _____
Phone: _____
Non-Emergency Transport Company 1: _____
Contact person: _____
Phone: _____
Non-Emergency Transport Company 2: _____
Contact person: _____
Phone: _____
Non-Emergency Transport Company 3: _____
Contact person: _____
Phone: _____
United Way (Local Chapter): _____
Contact person: _____
Phone: _____
Faith-Based Organization with Van: _____
Contact person: _____
Phone: _____
Faith-Based Organization with Van: _____
Contact person: _____
Phone: _____
Faith-Based Organization with Van: _____
Contact person: _____
Phone: _____
Faith-Based Organization with Van: _____
Contact person: _____
Phone: _____
Other: _____
Contact person: _____
Phone: _____

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quality.alliancehealth.org

This material was prepared by Alliant Health Solutions, a Quality Innovation Network – Quality Improvement Organization (QIN – QIO) and a Hospital Quality Improvement Contractor (HQIC) under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. Publication Number: 12SOW-AHS-QIN-QIO-TO1-PCH-TO3-HQIC-4934-12/07/23

https://quality.alliancehealth.org/wp-content/uploads/2023/12/SDOH-Discharge-Referral-List-Fillable_508.pdf

Completed Example for **DOMAIN1C**

Do not *copy exact language.*

Domain 1C: Our hospital strategic plan outlines specific resources for achieving our equity goals.

Type of Resource(s)	Description of Resource(s)
Staffing Resources	John Doe, Health Equity Champion (Health Equity Taskforce Lead) John Doe, Director of Nursing John Doe, Assistant Director of Nursing John Doe, Director of Quality and Safety ED Department Leadership Case Management Team (5) Registration Staff (3) Dietetics/Nutrition Department EMS/Paramedics Team Language Line/Interpreter Team Patient and Family Advisory Council Members (6)
Structural Resources (i.e., technological capabilities/EHR adaptations, integrated model of care etc.)	The PRAPARE Tool has been embedded into our EHR to support SDOH data collection. We have an integrated care patient-centered care model where a case management consult is immediately triggered when a patient screens positive for any of the SDOH. Our case management team provides community resources to the patient through our community partner, FindHelp, and the patient is immediately texted or given a paper lists (if no cell phone) with the names of 2-3 community resources. Post-discharge, we have a feedback loop with FindHelp where we ensure that the patients use SDOH resources within 72-hours post-discharge and then receive a report from our partner on usefulness/utility of the services 10-days post-discharge. We track future readmissions related to this patient in our EHR.
Training Resources	For REaL data collection conducted by our registration staff, the following training was provided from the American Hospital Association: https://ifdhe.aha.org/hretdisparities/collecting-data-nuts-bolts). Additionally, we've conducted in-house trainings for new and existing hospital staff on all the following new tools and processes: SDOH referral process and feedback loop, PRAPARE tool, REaL and SDOH data collection, health equity monthly reporting and more. We also partner with GA SORH and Alliant Health Solutions in the Flex HE Improvement project and participate in monthly education events.
Other Resources (i.e., Funding)	Our hospital recognizes the need for additional funding sources to support our work, including but not limited to the following SORH funding to cover necessary EHR upgrades to meet new health equity screening requirements: Small Rural Hospital Improvement Program (SHIP) Funds – $13,312 - applied to this by 12/29/23 and funding to be effective June 1, 2024 - May 31, 2025 Rural Hospital Stabilization Funds - awards pending in 2024 Rural Hospital Tax Credit Funds - awards pending in 2024

NEW! Homework Assignment due Wednesday, May 1, 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:

Homework Link for Domain 1B and 1C

Join us Tuesday, April 23 at 10 a.m. ET 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:

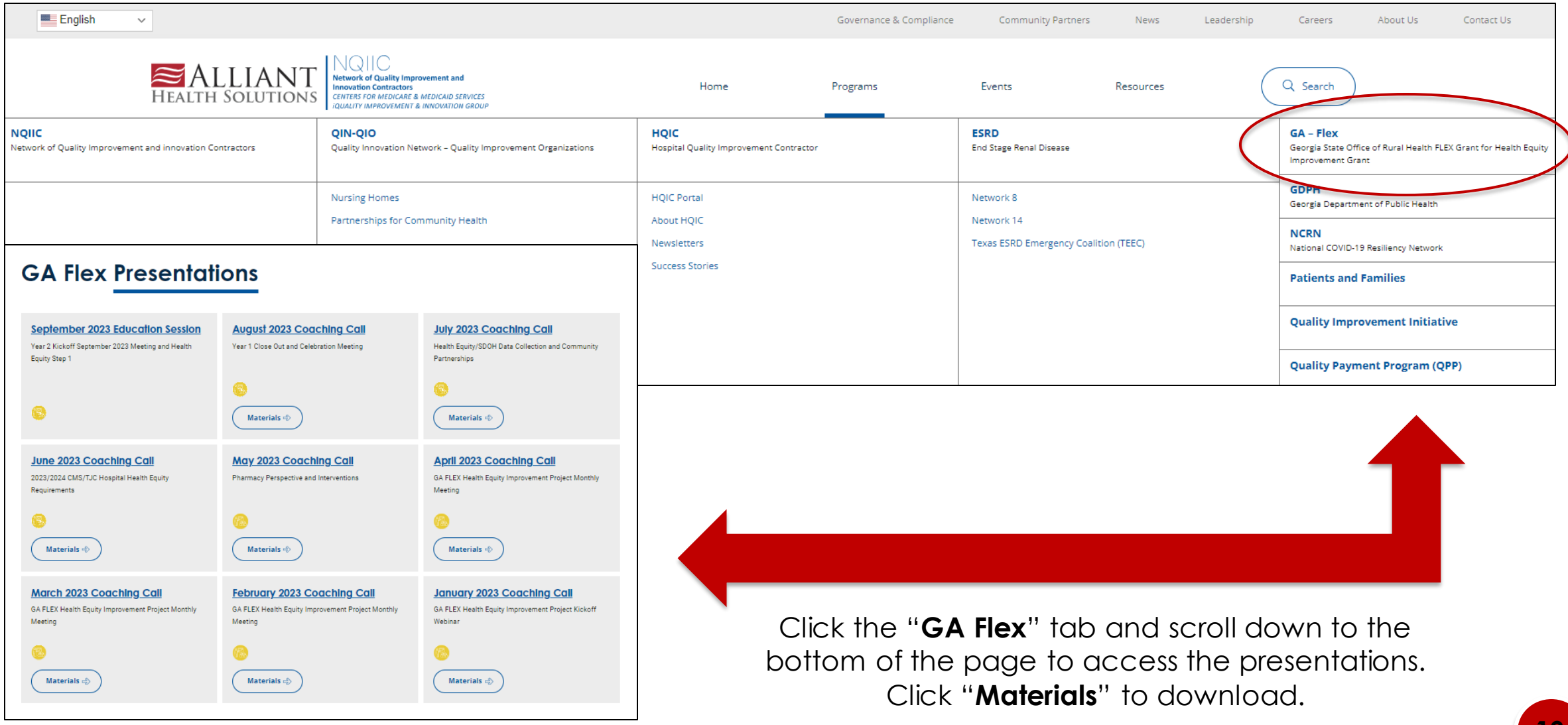
- ~~October 24, 2023~~
- ~~December 19, 2023~~
- ~~February 27, 2024~~
- April 23, 2024
- June 25, 2024

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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