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

GA FLEX Health Equity Improvement Project: April Workgroup 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!

Polling Question:

Have you completed the Part 1 homework assignment for your health equity strategic plan?

1. Yes, we have!
2. No, not yet but we plan to do so.
3. No and we need more support completing it.

Polling Question:

Have you completed the Part 2 homework assignment for your health equity strategic plan?

1. Yes, we have (and before the deadline woohoo)!
2. No, not yet but we are good to go to submit it by May 1st.
3. We need more support to complete this section.

Current 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 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.

Source: Attestation Guidance Hospital Commitment to Health Equity

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.

Polling Question:

Do have your three health equity goals identified?

1. Yes, we do!
2. No, not yet but we have what we need to create them.
3. No and we need more support identifying our 3 goals.

Breakout Rooms: 20 Minutes

You have been randomly assigned to a breakout room. In your breakout room, take turns sharing your health equity goals. As others present, please be sure to provide encouragement on their goals and action steps. If needed, please share helpful feedback with one another on how to enhance your goals and/or make them clearer.

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 Domain 1B and 1C sections.

Survey Link: Complete your homework using the following link:

Homework Link for Domain 1B and 1C

Join us at 10 a.m. ET on Tuesday, May 28 for our next learning session!

Training and assigned workgroups meet monthly -
every 4th Tuesday from 10 - 11 a.m. EST.

~~**February 27, 2024:** Workgroup~~

~~**March 26, 2024:** Learning Session~~ - ***CE available for real-time attendees**

~~**April 23, 2024:** Workgroup~~

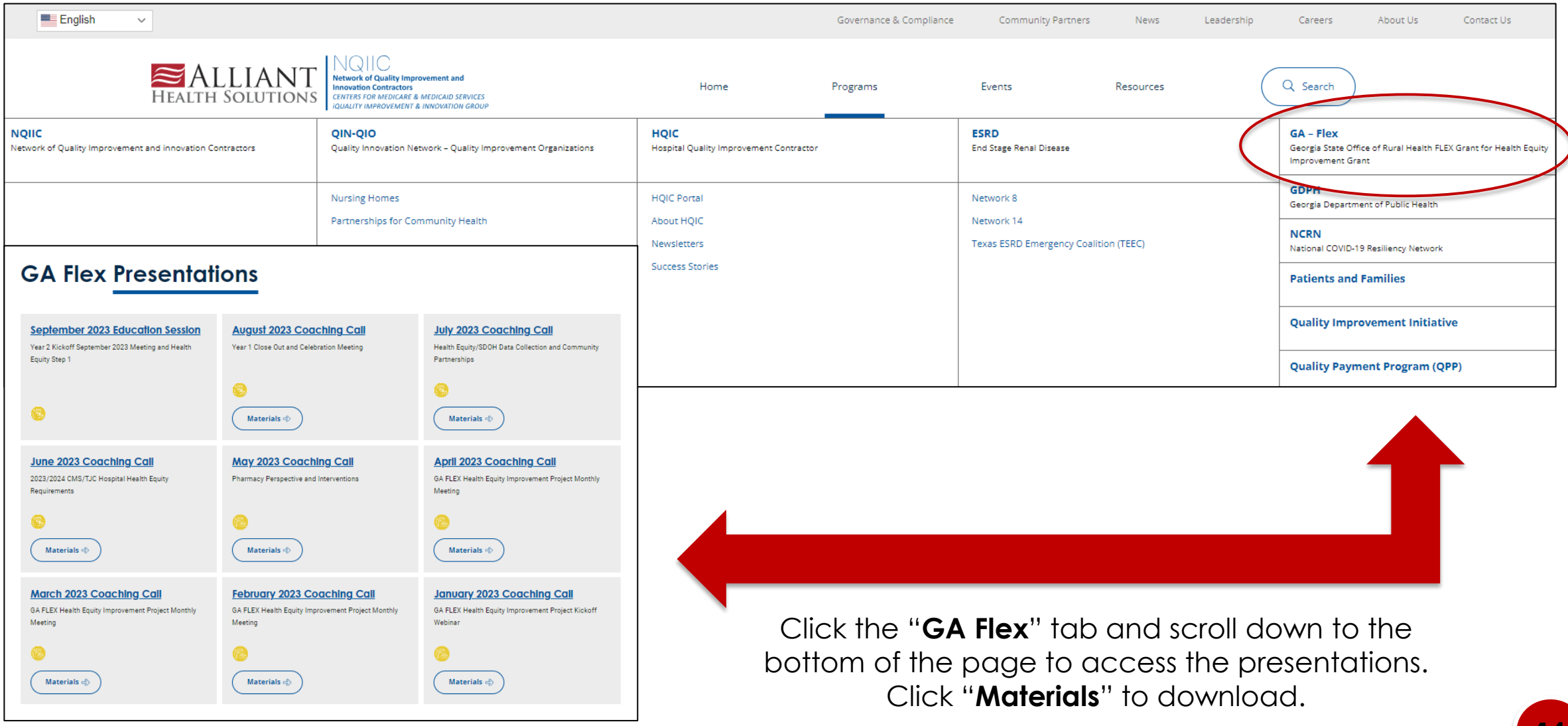
May 28, 2024: Learning Session - ***CE available for real-time attendees**

June 25, 2024: Workgroup

July 23, 2024: Learning Session - ***CE available for real-time attendees**

August 27, 2024: Celebration! - ***CE available for real-time attendees**

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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