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

GA FLEX Health Equity Improvement Project: May Education Session

Rosa Abraha, MPH

May 28, 2023

Featured Speaker

Rosa Abraha, MPH
Health Equity Lead
Alliant Health Solutions
Rosa.Abraha@allianthealth.org

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!

Hospital Highlight: Atrium Health Floyd Polk, HE Champion Dawn Truett

Supporting Data/ Evidence Base	Health Equity Goals	Related Action Steps
68% of Polk County's adult population have high blood pressure	Conduct best practices and interventions for those patients with a diagnosis of high blood pressure	For CY 2024, we will conduct monthly data tracking on patients with a diagnosis of high blood pressure. By July 2024 we will partner with at least 2 community resources to provide healthy initiatives for those in our population with high blood pressure 1. Placing a blood pressure machine kiosk in a local hair salon/barber shop for self checking of blood pressure 2. Partnering again with the local farmers market to provide healthy food for our residents of Polk County to help lower blood pressure, lower cholesterol, and decrease obesity.
42% of our county population are obese	Conduct best practices for our patients and families who are considered obese to promote healthy lifestyle changes	For CY 2024, we will conduct monthly data tracking on patients with a diagnosis of high blood pressure. By July 2024, we will partner with at least 2 community resources to provide healthy initiatives for those in our community that are considered obese. 1. Partnering again with the local farmers market to provide healthy food for our residents of Polk County to help lower blood pressure, lower cholesterol, and decrease obesity. 2. Providing a safe place on our campus to walk and exercise for a healthier lifestyle. We have a small walking track with exercise equipment along the trail for public and patient use.
14% of our county population experience food insecurity	Conduct best practice interventions for our patients and families that experience food insecurities.	For CY 2024, we will conduct monthly data tracking on patients and families who experience food insecurities. We will use our SDOH screening tool to gather this data. By July 2024 we will partner with at least 2 community resources to provide assistance with food insecurities for our patients and families. 1. Give lists of referrals to patients and families at discharge who screen positive for food insecurities 2. Again, partner with the local farmers market to provide healthy food for these patients and families while using their EBT cards to purchase this food

Today's Education Session Focus:

Let's focus on step 6!

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.

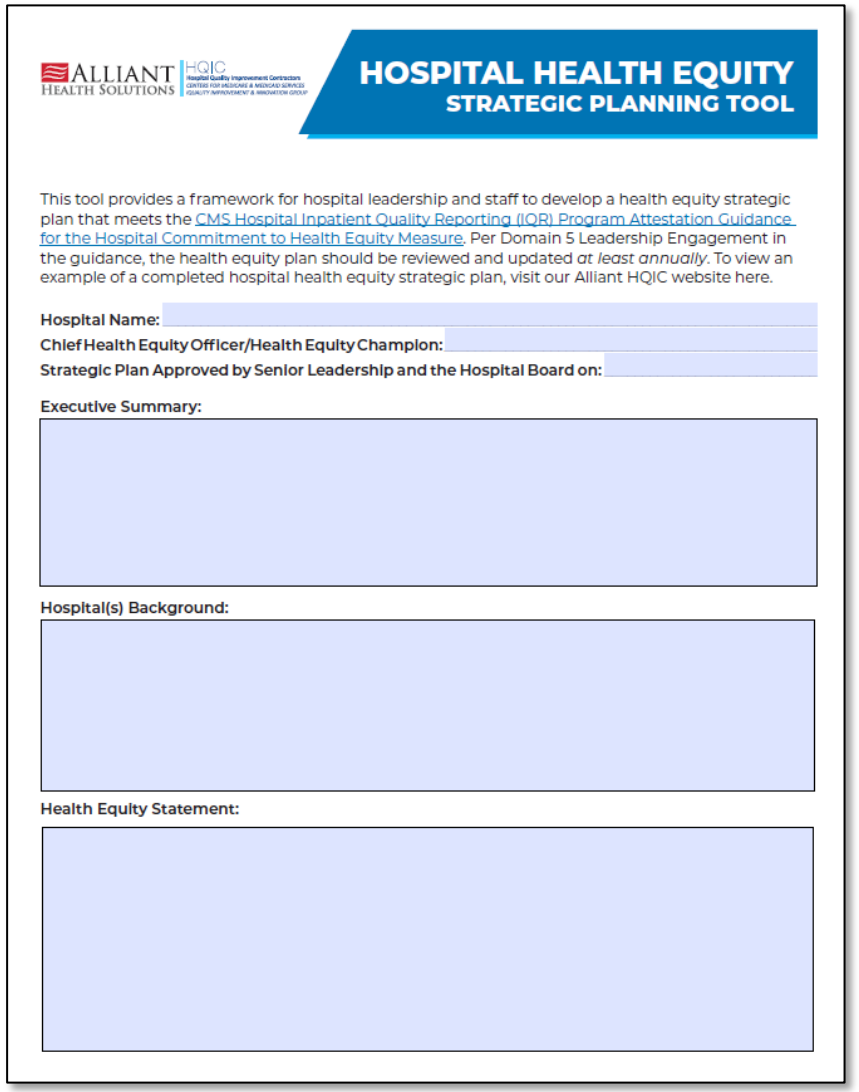
Examples of key stakeholders include but are not limited to community-based organizations and collaboratives, patient and family advisory groups, elected officials, and existing institutional partnerships or coalitions.

Source: Attestation Guidance Hospital Commitment to Health Equity

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*).



ALLIANT HEALTH SOLUTIONS | HQIC

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 **DOMAIN1D**

Do not *copy exact language.*

***Focus on new or existing partnerships that promote support that help you achieve your goals for your selected priority populations (i.e., Black men lacking transportation or food insecurity issues).*

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

Type of Partnership	Name of Partner Organization and Description of Partnership
National Partner (i.e., National Quality Forum, American Hospital Association etc.)	American Hospital Association's Institute for Diversity and Health Equity: offers educational trainings, toolkits, and best practices in health equity Feeding America: Collaborating with Feeding America to implement food security programs and initiatives aimed at addressing food insecurity among patients in our rural Georgia setting. American Public Transportation Association (APTA): Working with APTA to develop transportation solutions and advocate for improved access to transportation for patients facing mobility challenges in rural Georgia.
State Partner (i.e., Hospital Association, Alliant Health Solutions, Elected Officials,	Georgia State Office of Rural Health and Alliant Health Solutions: provide hands-on support through the GA FLEX HEI program and shares resources, training, and networking opportunities focused on addressing health disparities. Georgia Food Bank Association: Collaborate with the association to access local food banks and distribution networks to address food insecurity among patients. Rural Transit Authorities: Working with the rural transit authorities to develop affordable and accessible transportation options for patients who lack transportation to their primacy care/follow-up appointments.
Local Partner (i.e., City Council Officials, Community Coalitions, Community-Based Organizations to Address SDOH, etc.)	XYZ Community Food Pantry: Collaborating with our local food pantry to provide food assistance and nutritional education programs on Tuesdays and Thursdays to patients experiencing food insecurity. First Baptist Church: Working with a local Church to identify and mobilize 1-2 of their vans for weekly transport of patients who lack transportation to their primacy care/follow-up appointments. Black Barbershops: Partnering with 3 black barbershops to host health education workshops and fairs focused on chronic disease management and prevention.
Hospital-Specific Partner (i.e., Patient and Family Advisory Groups)	PFAC: Utilize the diverse perspectives in our PFAC to understand the transportation challenges faced by patients in rural areas. Collaborate with PFAC members to identify transportation options such as volunteer driver programs, shuttle services, or telehealth initiatives that can address the specific needs of patients in our hospital's catchment area.

Alliant Tool for Social Determinants of Health Referral at Discharge

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:
_____

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: _____

Other: _____
Contact person: _____
Phone: _____

https://quality.allianthealth.org/wp-content/uploads/2024/04/GA-FLEX-Social-Determinants-of-Health-SDOH-Discharge-Referral-List_508.pdf

NEW! PART 3 (FINAL PART) of HE Strategic Plan due Monday, July 1, 2024.

Submission Process: Each hospital must **INDIVIDUALLY** complete the survey for their facility.

Survey Link: Complete your homework using the following link:

Homework Link for Part 3 (Domain 1D)

Reminders for Submission of Part 1 and Part 2!

Emails have been sent to hospital leadership teams and selected HE Champions if you're missing Part 1 and/or Part 2!

Part 1 Submission: HOSPITAL HEALTH EQUITYSTRATEGIC PLANNING TOOL - Part 1 (smartsheet.com)

Part 2 Submission: HOSPITAL HEALTH EQUITYSTRATEGIC PLANNING TOOL - Part 2 (smartsheet.com)

Join us Tuesday, June 25 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:

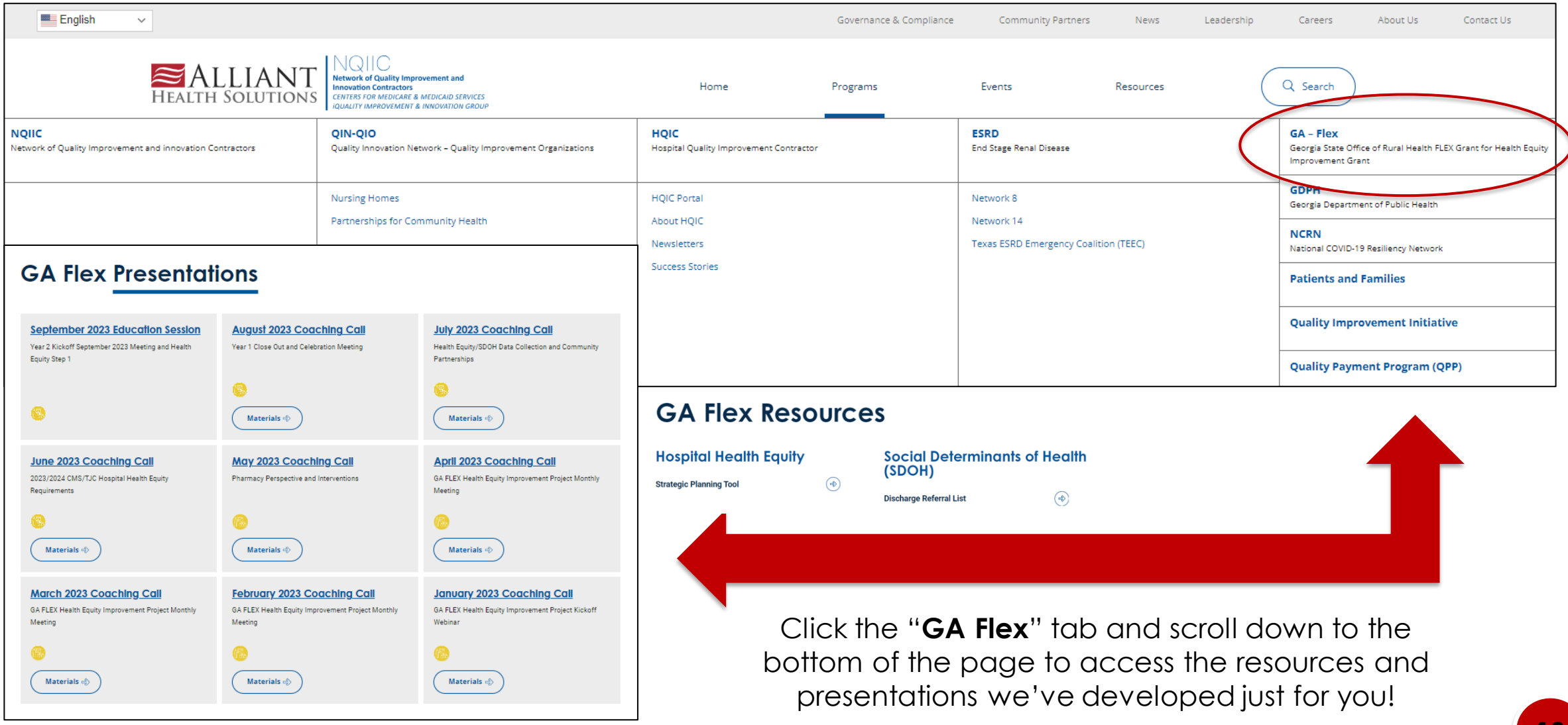
- ~~October 24, 2023~~
- ~~December 19, 2023~~
- ~~February 27, 2024~~
- ~~April 23, 2024~~
- June 25, 2024

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 resources and presentations we've developed just for you!

Questions?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