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

GA FLEX Health Equity Improvement Project: June Workgroup Session

Rosa Abraha, MPH

June 25, 2024

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 of 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: Bacon County, HE Champion Jennie Johnson

Supporting Data/ Evidence Base	Health Equity Goals	Related Action Steps
2022 CHNA showed 19 % uninsured for Bacon County compared to state of Georgia uninsured rate of 16%. Data recorded from hospital data Oct 2023-current, revels a rate of 12.7 % of inpatient admissions are self-pay, uninsured patients. Data collected upon admission SDOH questions in EMR 2.2%	Committed to decrease the uninsured rate by 5 % January 1, 2025.	• Sept. 2023: held a staff meeting with Madison Street Agency, a marketplace Insurance broker with multiple resources for the uninsured population. We developed a strategic plan and put it in place to present self-pay patients with this resource upon admission to the hospital. Providing additional staffing after hours and on weekends to assist with enrollment opportunities of Presumptive Medicaid. • Bacon County has a large population of seasonal migrant workers, so we also have trained registration staff to assist with Emergency Medicaid for Hispanic OB deliveries. The use of the language line enables accurate communication with all the needs of the Hispanic population in our area. Listed below are resources provided: Marketplace Referral, Indigent Care, Presumptive Medicaid, Emergency Medicaid, Hispanic OB delivery
2022 CHNA highlights substance use, behavioral health, and poor mental health outcomes as the top three emerging issues for Bacon County. EMR SDOH questions on behavior health, life management difficulties revealed 3.7% of patients screen positive for lifestyle choices that cause limitations and difficulties with housing, transportation, utilities and food.	Over the next three months, we will collect baseline data and plan to set a goal after reviewing this data.	• Feb. 2024: system-wide mandatory staff education raising awareness on SDOH and the development of our S.O.S. Samaritans of Society Team. Mandatory staff education included education covering the 5 SDOH domains: food, housing, transportation, utility difficulties and interpersonal safety. We also educated how we would be capturing the data upon all inpatient admissions via recommended CMS questions built into our admission nursing assessment and upon discharge resources given according to the patient's needs. • April 2024: Employee Health fair provided staff with Mental Health Resources available in our community with their contact information. • May 2024: Family Resilience Training, Adolescent Behavior Health, staff • July 2024: Youth Mental Health First Aid, Community Partners
Bacon County insecure food population is 17%. SDOH questions embedded in our EMR reveal that 5.6% of our patients screened positive for food insecurity.	Support patients and families that experience food insecurities with referrals by case management and discharge planners.	Bacon County has partnered with our local food banks as follows for addressing food issues: • Fifth Street Food Pantry (provides 1 box food per month on Wednesday's) • Senior Citizen Center (Daily meals at center with transportation as well as delivered meals) • Local Food Bank

Today's Workgroup 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 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.

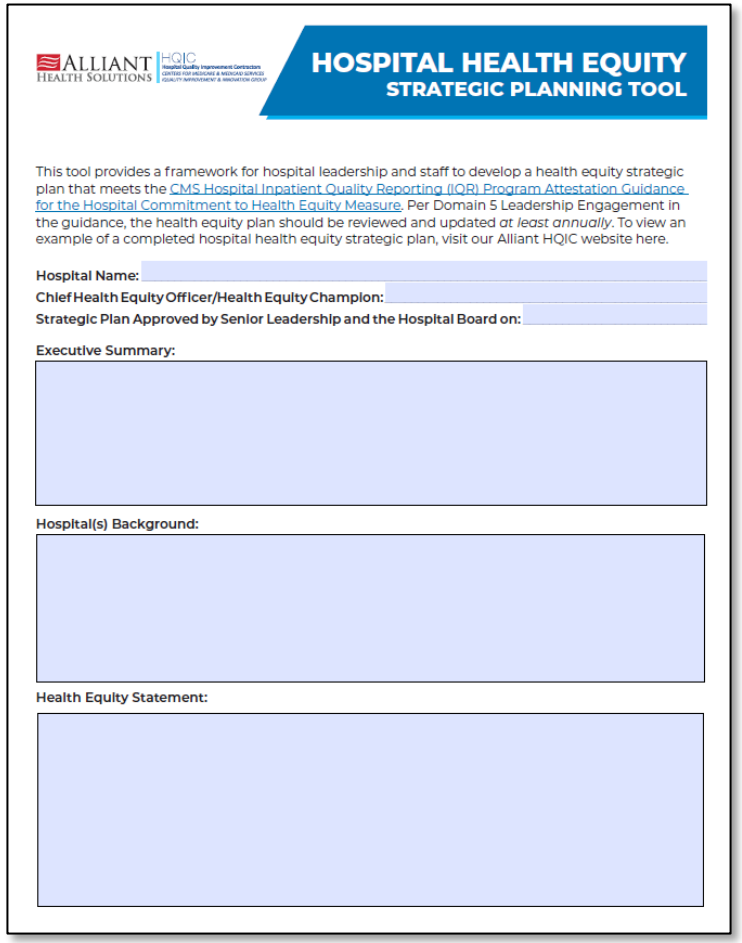
Examples of key stakeholders include but are not limited to community-based organizations and collaboratives, patient and family advisory groups, elected officials, and existing institutional partnerships or coalitions.

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

Tool for Hospital Health Equity Strategic Planning

- This tool provides a framework for hospital leadership and staff to develop a health equity strategic plan that meets 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.

Breakout Rooms: 20 Minutes

We will now proceed to breakout rooms, where hospitals with similar goals can collaborate. Choose one of the following focus areas for your facility and ***brainstorm together potential national, state, local and hospital partners that you can work with to achieve your goals:***

1. Readmissions
2. Food insecurities
3. Transportation
4. Housing instability
5. Other (if none of your goals are listed above)

Identify someone in your group to conduct a report out at the end.

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 were 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 at 10 a.m. ET on Tuesday, July 23, 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~~

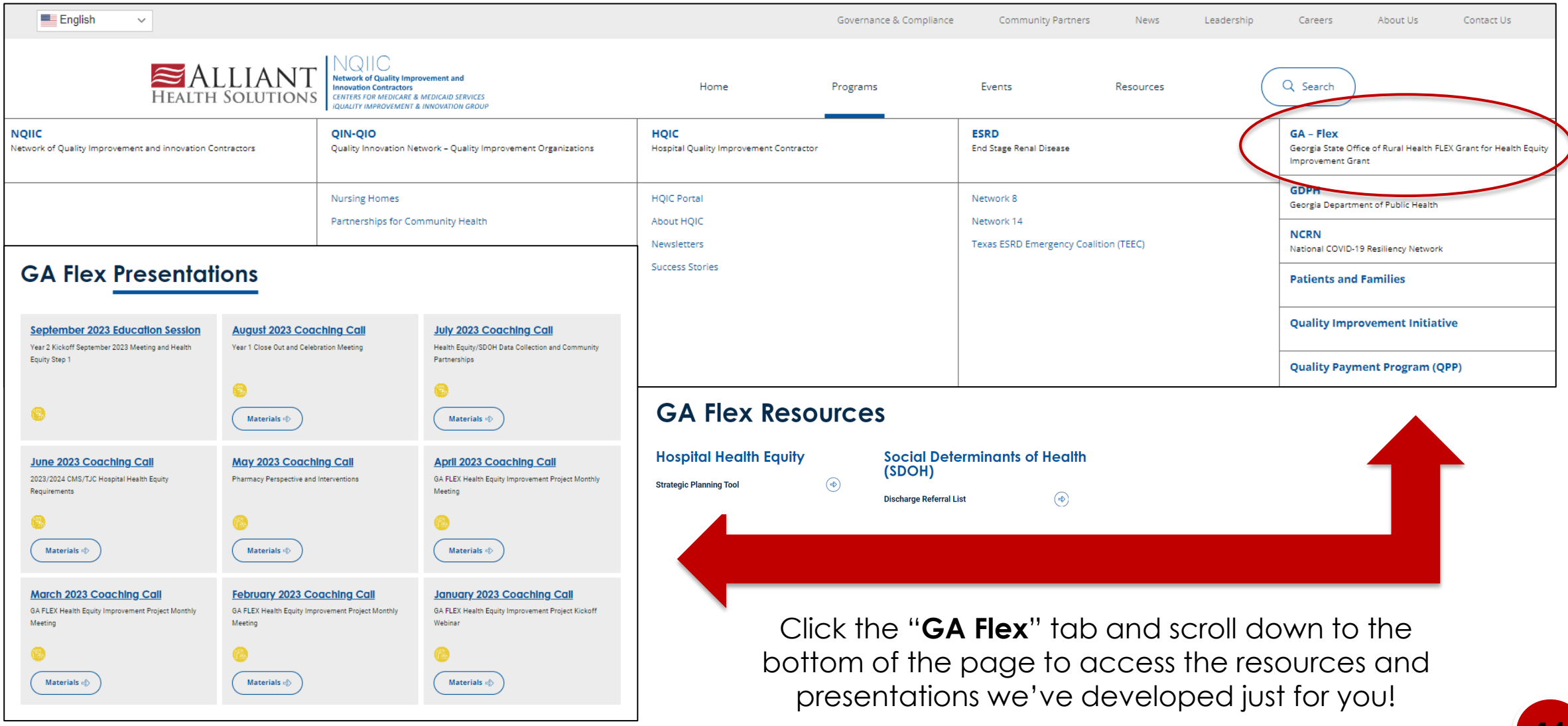
~~**May 28, 2024:** Learning Session~~ - ***CE available for real-time attendees**

~~**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 resources and presentations we've developed just for you!


Questions?
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