



GA FLEX Health Equity Improvement Project: August Closing Meeting

Rosa Abraha, MPH August 27, 2024



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 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



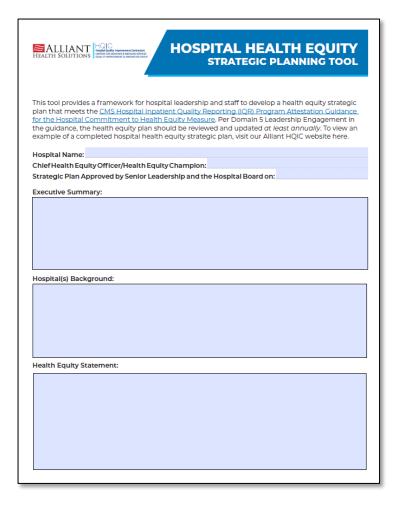
In the chat, please type the name(s) of the representative(s) for your hospital who are present on today's call.

Please be prepared with your cameras on!





Hospital Health Equity Strategic Planning



- Congratulations on completing your hospital HE strategic plan over the last year!!
- This tool provides a framework for hospital leadership and staff to develop a health equity strategic plan that meets the CMS health equity requirements **Domain 1** (shown on the right).



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.

 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.





We Value Your Feedback!

We've transitioned to the Padlet platform to host our feedback survey. Please take a few minutes to share your thoughts on the training. Your input will help us improve and better serve you in the future.

Click the **LINK** in the chat to get started.

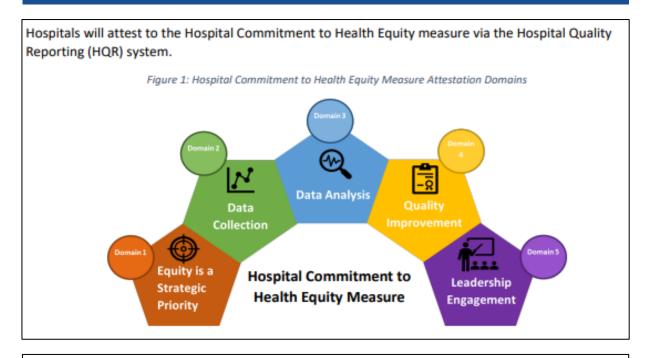
- 1. What aspects of the training sessions did you find most valuable, and why?
- 2. What areas or topics would you like to see improved or addressed differently in future training sessions?
- 3. Have there been any changes or improvements in your hospital practices or patient outcomes as a result of these trainings?





Upcoming 2024-2029 MBQIP Health Equity Requirements for CAHs

Part 1: Hospital Commitment to Health Equity (HCHE) Measure



• Each domain is worth one point and hospitals must attest to ALL subcomponent elements of each domain to receive the full point.

Part 2: Screening for Social Drivers of Health (SDOH-1 in blue and SDOH-2 in green)

Screening for Social Drivers of Health Measure

- Food insecurity
- Housing instability
- Transportation needs
- Utilities difficulties
- Interpersonal safety

Numerator	Number of patients who were screened for one or all social drivers
	Number of patients 18

Number of patients 18
Denominator or older admitted as an inpatient

Screen Positive Rate for Social Drivers of Health Measure

- Food insecurity
- Housing instability
- Transportation needs
- Utility difficulties
- Interpersonal safety

Numerator Number of patients who screened positive for each driver

Denominator

Number of patients 18 or older admitted as an inpatient and screened for social drivers





