

MVC Health Equity Member Survey Results

Presented by
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AGENDA

01.

Survey Purpose

What are the goals of the survey and how will results be used?

02.

Survey Results

- Quantitative findings
- Select qualitative insights

03.

Next Steps

- MVC activity

The background features a collage of images. On the left, several wooden figures with black and white segments are arranged in a circle, with arrows pointing towards the center. On the right, a hand-drawn sketch of a lightbulb is shown with arrows pointing outwards, and a cloud-like shape containing the text 'BRAIN STORMING'. The central area is a large orange triangle containing the word 'GOALS' in white.

GOALS

Survey Goal #1

Educate sites about the practices and strategies of their peers

Survey Goal #2

Inform future development of equity-focused MVC offerings

How will MVC use the survey data?

Today's update!

Provide a sense of what's happening across the state with examples to take back

Peer Learning

Facilitate member-to-member introductions, share success stories from trailblazers

Tailor MVC's Offerings

Inform decision-making about future MVC report development and meeting topics

What Did We Ask?

(And What Didn't We Ask?)



**CURRENT STRATEGIES
& OPERATIONS**

PRIORITY POPULATIONS

**CURRENT STATE OF
DATA & ANALYTICS**



Survey Results

Quantitative findings and select qualitative insights



Survey Respondents

42

Hospitals

100%

MVC Regions

40%

Of Hospital
Members

9

Systems
Represented

What Are Hospitals Currently Trying?

Most common initiatives or processes in place at hospitals across Michigan to reduce patient access challenges



84%

Greater
Provider
Availability



80%

Translated
Materials &
Services



67%

Financial
Support
Programs



57%

Transportation
Programs



55%

Safety Net
Programs for
Uninsured

65%

**PRIMARY
LANGUAGE**

54%

**RACE &
ETHNICITY**

52%

AGE

38%

**GENDER
IDENTITY**

37%

**DISABILITY
STATUS**

35%

**SEXUAL
ORIENTATION**

Demographics of Focus

Hospitals identified patient subgroups for whom they have specific equity goals

What's Getting in the Way?

The top barriers preventing hospitals from developing and implementing health equity initiatives



49%

Insufficient
Financial
Investment



24%

Insufficient
Data



20%

No Clear
Business
Case



16%

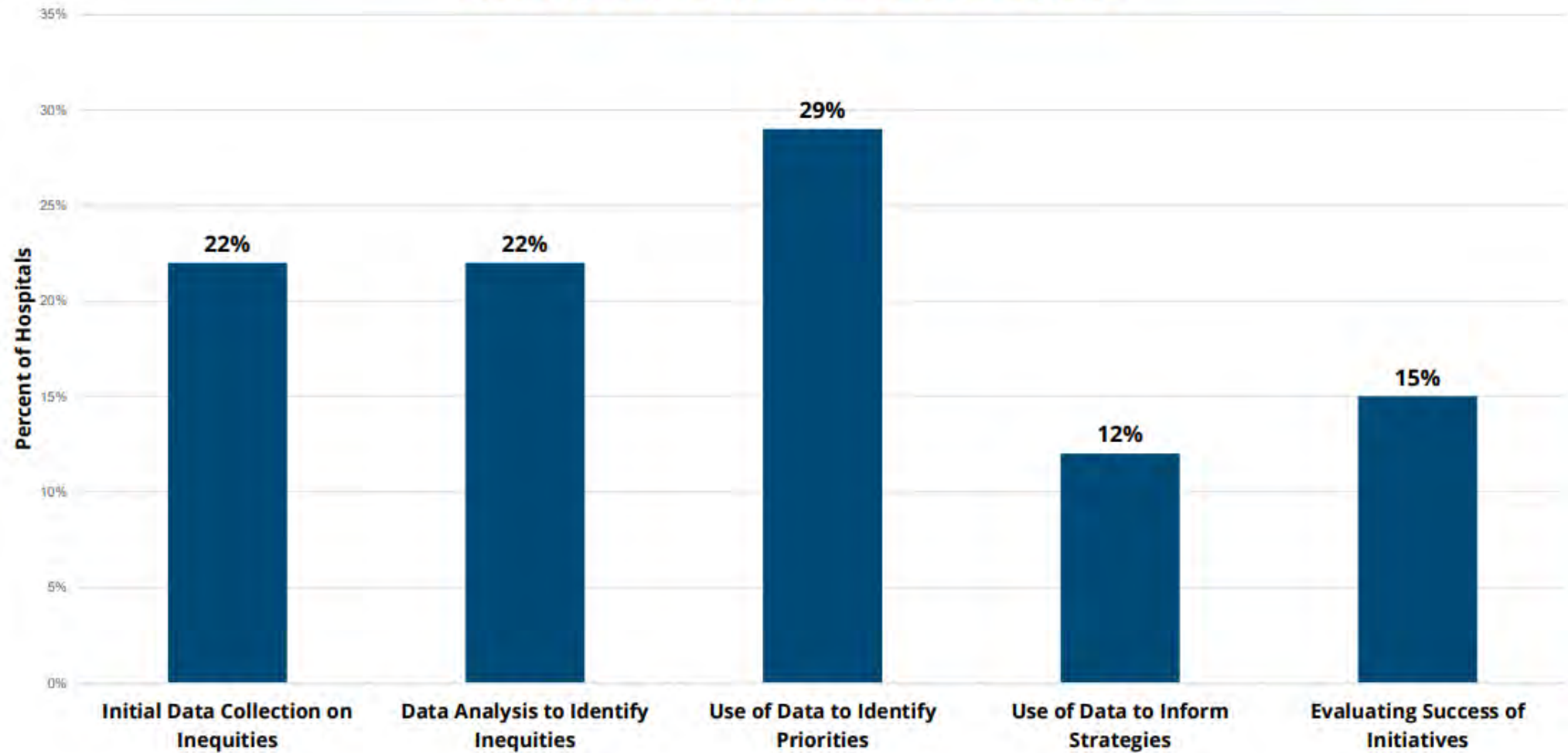
No Defined
Strategy



16%

Lack of
Training &
Expertise

Hospital Self-Reported Current State of Efforts to Support Equity Activity through Data and Analytics



Data Sources

Most common hospital data sources to identify or measure patient health disparities

A donut chart with a dark blue outer ring and an orange inner ring. The orange ring represents 75% of the total, while the dark blue ring represents the remaining 25%.

75%

Readmissions
Data

A donut chart with a dark blue outer ring and an orange inner ring. The orange ring represents 65% of the total, while the dark blue ring represents the remaining 35%.

65%

Clinical Quality
Indicators

A donut chart with a dark blue outer ring and an orange inner ring. The orange ring represents 48% of the total, while the dark blue ring represents the remaining 52%.

48%

Patient
Experience Data

A donut chart with a dark blue outer ring and an orange inner ring. The orange ring represents 44% of the total, while the dark blue ring represents the remaining 56%.

44%

CMS Core
Measures

A donut chart with a dark blue outer ring and an orange inner ring. The orange ring represents 44% of the total, while the dark blue ring represents the remaining 56%.

44%

MVC Push Report
Demographic Tables

Patient Social Need Screenings & Follow-Up



Screening in Place

Processes in place to screen patients for a particular social need

Recorded in EMR

Record results from screening questions in patient's EMR

Connection to CBO/Services

Connect patient with relevant resources

Resolution of Need Evaluated

Evaluate successful resolution of patient's needs

Social Needs



Accessibility

Employment

Food Insecurity

Housing Insecurity

Interpersonal
Violence

Social Isolation

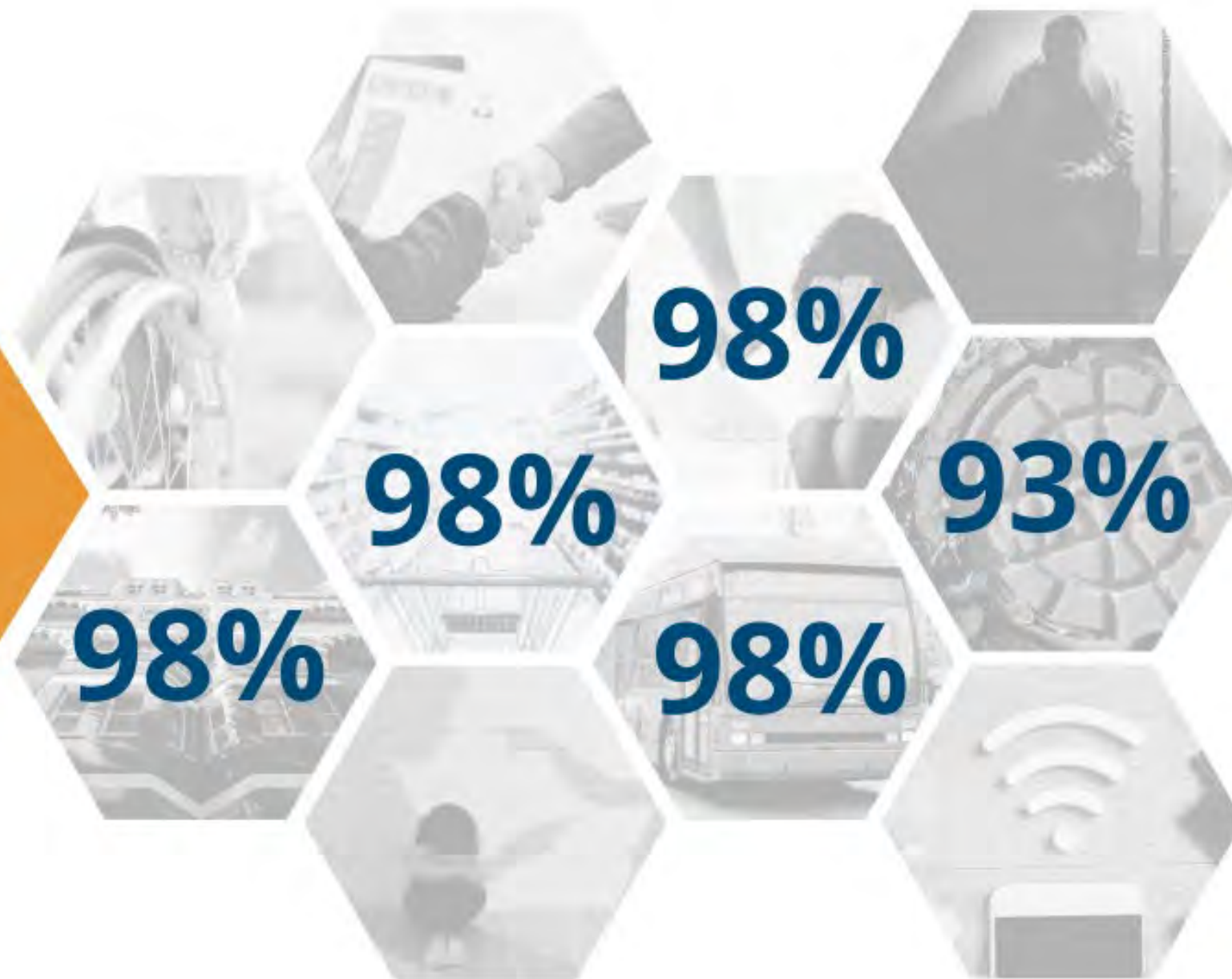
Transportation
Barriers

Trauma

Unreliable
Internet

Utility Needs

Most Common Screenings



Accessibility

Employment

Food Insecurity

Housing Insecurity

**Interpersonal
Violence**

Social Isolation

**Transportation
Barriers**

Trauma

Unreliable
Internet

Utility Needs

Resolution Of Need Evaluated

40%

43%

57%

62%

43%

Accessibility

Employment

Food Insecurity

Housing Insecurity

**Interpersonal
Violence**

Social Isolation

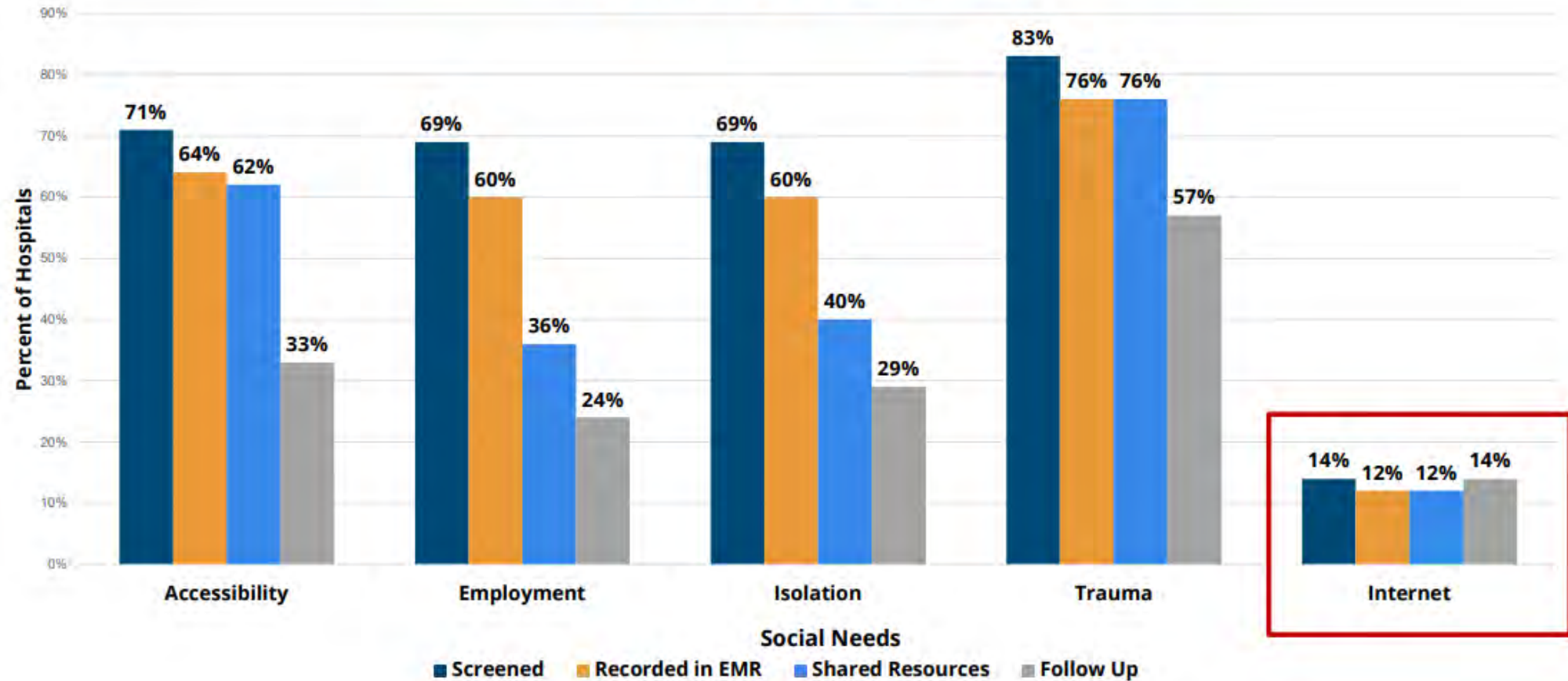
**Transportation
Barriers**

Trauma

Unreliable
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Utility Needs

Percent of Hospitals with Processes in Place to Screen, Record, Support, and Follow Up on Patient Social Needs





Community Partnerships

Working with community-based organizations (CBOs), health departments, and other community representatives



Of respondents have partnerships in place with community organizations

Key Partners & Success Stories

We have had a small but meaningful difference in blood pressure control between our Black and white populations. We have partnered with local barbershops to help increase awareness, refer to primary care services, and are closely tracking response and improvements in blood pressure control (the program is new enough that we do not yet have results on improvement in BP control). The intermediate measures of engagement with the program and referrals to primary care are encouraging.



Key Partners & Success Stories

We partnered with Smiles on Wheels to provide dental hygienist access (cleanings, sealants, and fluoride) once a month in our primary care clinic, regardless of a patient's ability to pay. This approach has helped capture younger than school age children and parents who struggle with access to transportation due to finances. This program has been well received by our patient populations and we had a community member reach out to us to compliment the program.



Key Partners & Success Stories

Region VII Area Agency on Aging began a partnership with McLaren Bay Region and the case management team to launch a care transition program.... to smooth the transition of patients from hospital to home and reduce the risk of readmission to the hospital. The program sends a community health worker (CHW) into the patient's home post discharge to review discharge paperwork, review medications, ensure post-hospitalization doctor's visits are scheduled, and provide the client with any resources that may be needed. A CHW is embedded with the case management team and works closely to ensure all patients in need receive the opportunity for a visit.



26% Community-Based
Organizations

26% Community
Health Needs
Assessments

31% DEI Committee
or Framework

Gathering Diverse
Voices to Inform
Equity Strategies



Next Steps

Support for member priorities and alignment of MVC activity

MVC's Equity Strategy

Supplemental Data Sets

Integrate SDOH data sets, credit data, demographic data, etc. to support members

Meaningful Comparisons

Actionable benchmarking and report measures to emphasize equity opportunities

Future P4P Inclusion

Process and performance measures related to equity in future program cycles

Alignment with CQI Portfolio

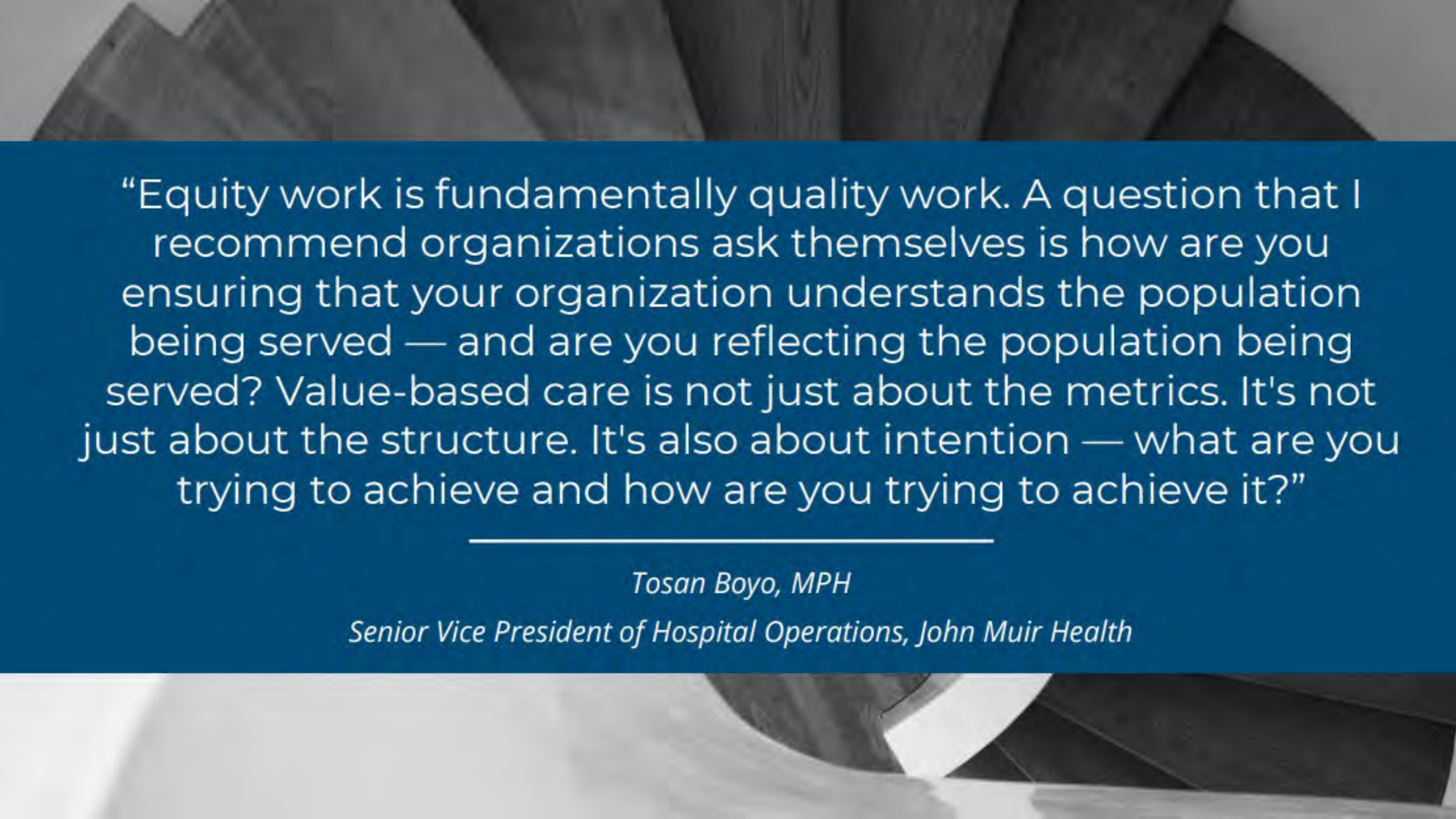
Incorporate expertise of partner CQIs and learn from their successes and challenges

Member Networking & Resource Support

Facilitate opportunities for shared learning and the cultivation of quality improvement resources

Professional Development

Further develop the knowledge and skills of MVC staff contributing to this work



“Equity work is fundamentally quality work. A question that I recommend organizations ask themselves is how are you ensuring that your organization understands the population being served — and are you reflecting the population being served? Value-based care is not just about the metrics. It's not just about the structure. It's also about intention — what are you trying to achieve and how are you trying to achieve it?”

Tosan Boyo, MPH

Senior Vice President of Hospital Operations, John Muir Health



Thank you!

What questions do you have?

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