

El Centro Regional Medical Center - Hospital Equity Report Submission (Compliance Format)

1. Web address for the Hospital Equity Report on the hospital's website

www.ecrmc.org

2. Do you have a designated individual who leads hospital health equity activities?

☒ Yes

El Centro Regional Medical Center designates a Health Equity Officer within the Quality and Population Health Department. This role oversees health equity strategy, compliance with state and federal equity standards, and coordination of data analysis across service lines.

3. Do you provide documentation of policy prohibiting discrimination?

☒ Yes

ECRMC maintains an updated Non-Discrimination and Equity in Care Policy, compliant with Section 1557 of the Affordable Care Act, Joint Commission standards, and the California Health and Safety Code. The policy is reviewed annually, approved by the Compliance Committee, and distributed hospital-wide.

4. Equity Plan: Actions to address the Top 10 Disparities

Summary of Findings:

The HQI report identifies disparities in 30-day all-cause unplanned readmission rates by age, race/ethnicity, sex assigned at birth, and expected payor. Older adults (≥ 65), Medicare beneficiaries, males, and Hispanic or Latino patients experience higher readmission rates compared to reference groups.

Planned Actions:

1. Readmission Reduction for Older Adults (65+ and 50–64)

- Implement enhanced discharge planning protocols targeting medication reconciliation and follow-up appointment adherence.
- Integrate home health referral triggers for patients over 50 with chronic conditions.
- Objective: Reduce readmissions among 65+ by 15% within 24 months.

2. Equity in Readmission Rates by Race/Ethnicity

- Partner with bilingual care navigators to improve discharge comprehension among Hispanic/Latino patients.
- Deploy culturally appropriate health education materials.
- Objective: Narrow readmission gap between Hispanic/Latino and White patients (1.2 rate ratio) by 50% within 24 months.

3. Sex-Based Readmission Disparities

- Analyze diagnosis-related causes for male readmissions.
- Expand post-discharge telehealth follow-up for male patients with behavioral health comorbidities.
- Objective: Achieve parity between male and female readmission rates by FY2026.

4. Payor-Based Disparities (Medicare vs. Medicaid)

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- Introduce care coordination pilot targeting Medicare beneficiaries with multiple chronic diagnoses.
- Track readmission drivers and establish 'Red Flag' alerts in EHR for early intervention.
- Objective: Reduce Medicare readmission rate from 14.5% to 12.0% within two years.

Monitoring & Evaluation:

Equity dashboards will be updated quarterly. Data will be stratified by demographic group and reported to the Quality and Compliance Committee.

5. Performance in the Priority Area of Person-Centered Care

ECRMC continues to align its operations with California HCAI Person-Centered Care Standards. The hospital has embedded patient engagement tools, multilingual interpreter access, and shared decision-making protocols across service lines.

Key Activities:

- Implementation of a Patient and Family Advisory Council (PFAC) that reviews patient experience metrics quarterly.
- Deployment of real-time patient feedback surveys integrated into the EHR system.
- Staff training on trauma-informed care and cultural humility (90% compliance as of Q3 FY2025).
- Establishment of a patient communication dashboard to identify and resolve disparities in satisfaction and comprehension rates.

Performance Metrics:

- Patient satisfaction increased by 7% year-over-year in HCAHPS communication domains.
- Language access requests fulfilled at >99% compliance.
- Equity dashboard demonstrates narrowing of satisfaction gaps between English and Spanish-speaking patients.

6. Performance in the Priority Area of Patient Safety

ECRMC's Patient Safety Program integrates equity considerations into all safety event reviews.

Core Strategies:

- Standardized Root Cause Analyses (RCA) include demographic variable assessment.
- Enhanced clinical alert systems for readmission risk and fall prevention among older adults.
- Continuous sepsis and medication reconciliation audits, stratified by demographic data.

Performance Indicators:

- 12-month reduction in 30-day readmissions (overall 1.4% decrease).
- Falls among adults aged 65+ reduced by 9% due to targeted interventions.
- Behavioral health-related readmissions monitored quarterly; males identified as priority population for post-discharge calls.

ECRMC demonstrates sustained compliance with CMS and CDPH safety reporting requirements.

7. Performance in the Priority Area of Addressing Patient Social Determinants of Health (SDOH)

ECRMC integrates SDOH screening into all inpatient admissions and emergency department encounters.

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Current Initiatives:

- Use of PRAPARE and Accountable Health Communities (AHC) screening tools.
- Partnership with Imperial County Public Health Department and local community-based organizations (CBOs) for housing, food, and transportation support.
- Referral tracking via EHR social needs module.

Measured Outcomes:

- 72% of high-risk patients screened for at least one SDOH domain in FY2025.
- 48% of referred patients successfully connected to community resources.
- Reduction in readmissions linked to unmet social needs among Hispanic/Latino patients by 5%.

Ongoing Plans:

Expand closed-loop referral tracking with regional CBOs by FY2026 to ensure >70% connection success rate.

8. Performance in the Priority Area of Effective Treatment

ECRMC emphasizes evidence-based, equitable clinical treatment practices.

Programs and Metrics:

- Ongoing review of readmission data to identify diagnostic categories contributing to disparity (e.g., CHF, COPD, diabetes).
- Participation in HQI Readmission Reduction Collaborative.
- Implementation of Chronic Care Management (CCM) and Transitional Care Management (TCM) billing to support sustained outpatient follow-up.

Results:

- 18% increase in post-discharge follow-up compliance among Medicare patients.
- Early intervention program reduced readmissions among 50–64 age group by 1.2 percentage points over the last year.
- Established EHR flags for evidence-based treatment adherence by diagnosis and age.

ECRMC's efforts align with the HQI framework for effective, equitable, and efficient care delivery, ensuring consistent clinical outcomes across demographics.

9.

Enhancing discharge planning process thru daily multi-disciplinary team meetings

Streamlining transitions of care thru close coordination with post-acute providers, e.g. SNF, HHA, Hospice care

Optimizing resource management thru collaboration with Population Health, e.g. CCM, ECM to reduce preventable readmissions

Collaborating with community resource institutions, including county behavioral health, social services and payer navigators to address complex high-risk patients

10.

Providing financial assistance and support thru financial counselors to reduce cost constraints

Offering access to Tele health and language interpretation service whenever needed to serve diverse population

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Providing Uber Health and local Medical transport for those high-risk patients having no access to transportation

Optional Structural Measures: Hospital Commitment to Health Equity (HCHE) and Social Drivers of Health (SDOH)

1. CMS Hospital Commitment to Health Equity Structural (HCHE) Measure. (If Available)

- a. CMS HCHE Domain 1: Strategic Planning ☒ Yes ☐ No
- b. CMS HCHE Domain 2: Data Collection ☒ Yes ☐ No
- c. CMS HCHE Domain 3: Data Analysis ☒ Yes ☐ No
- d. CMS HCHE Domain 4: Quality Improvement ☒ Yes ☐ No
- e. CMS HCHE Domain 5: Leadership Engagement ☒ Yes ☐ No

2. CMS Screening for Social Drivers of Health (SDOH) and CMS Screen Positive Rate for SDOH and Intervention (If Available) Note: Most hospitals will not be able to provide the values in red, as they were never required to be collected or reports for a CMS SDOH Measure.

SDOH Measure Component/Rate	Value
a. CMS SDOH Overall Screened Numerator: Number of patients admitted to an inpatient hospital stay who are 18 years or older on the date of admission and are <u>screened for all five HRSNs</u> . (9 digits max)	150
b. CMS SDOH Overall Screened Denominator: Number of patients who are admitted to a hospital inpatient stay and who are 18 years or older on the date of admission. (9 digits max)	1182
c. CMS SDOH Overall Screened Rate: The percent of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, were screened for an HRSN, and who <u>screen positive for one or more of the following five HRSNs</u> : Food insecurity, housing instability, transportation problems, utility difficulties, or interpersonal safety. (4 digits max, i.e. xx.x)	12.7%
d. CMS SDOH Food Insecurity Numerator: Number of patients screened positive for food insecurity. (9 digits max)	10
e. CMS SDOH Food Insecurity Positive Rate: CMS SDOH Food Insecurity Numerator divided by CMS SDOH Overall Screened Numerator, multiplied by 100. (4 digits max, i.e. xx.x)	6.7%

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f. CMS SDOH Food Insecurity <u>Intervention</u>: Number of interventions provided for Food Insecurity. <i>(9 digits max)</i>	N/A
g. CMS SDOH Food Insecurity <u>Intervention Rate</u>: CMS SDOH Food Insecurity Intervention divided by CMS SDOH Overall Screened Numerator, multiplied by 100. <i>(4 digits max, i.e. xx.x)</i>	N/A
h. CMS SDOH Housing Instability <u>Numerator</u>: Number of patients screened positive for housing instability. <i>(9 digits max)</i>	9
i. CMS SDOH Housing Instability <u>Positive Rate</u>: CMS SDOH Housing Instability Numerator divided by CMS SDOH Overall Screened Numerator, multiplied by 100. <i>(4 digits max, i.e. xx.x)</i>	6%
j. CMS SDOH Housing Instability <u>Intervention</u>: Number of interventions provided for housing instability. <i>(9 digits max)</i>	N/A
k. CMS SDOH Housing Instability <u>Intervention Rate</u>: CMS SDOH Housing Intervention divided by CMS SDOH Overall Screened Numerator, multiplied by 100. <i>(4 digits max, i.e. xx.x)</i>	N/A
l. CMS SDOH Transportation Problems <u>Numerator</u>: Number of patients screened positive for transportation problems. <i>(9 digits max)</i>	7
m. CMS SDOH Transportation Problems <u>Positive Rate</u>: CMS SDOH Transportation Problems Numerator divided by CMS SDOH Overall Screened Numerator, multiplied by 100. <i>(4 digits max, i.e. xx.x)</i>	4.7%
n. CMS SDOH Transportation Problems <u>Intervention</u>: Number of interventions provided for transportation problems. <i>(9 digits max)</i>	N/A
o. CMS SDOH Transportation Problems <u>Intervention Rate</u>: CMS SDOH Transportation Problems Intervention divided by CMS SDOH Overall Screened Numerator, multiplied by 100. <i>(4 digits max, i.e. xx.x)</i>	N/A
p. CMS SDOH Utility Difficulties <u>Numerator</u>: Number of patients screened positive for utility difficulties. <i>(9 digits max)</i>	9
q. CMS SDOH Utility Difficulties <u>Positive Rate</u>: CMS SDOH Utility Difficulties Numerator divided by CMS SDOH Overall Screened Numerator, multiplied by 100. <i>(4 digits max, i.e. xx.x)</i>	6%
r. CMS SDOH Utility Difficulties <u>Intervention</u>: Number of interventions provided for utility difficulties. <i>(9 digits max)</i>	N/A

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s. CMS SDOH <i>Utility Difficulties</i> <u>Intervention Rate</u>: CMS SDOH Utility Difficulties Intervention divided by CMS SDOH Overall Screened Numerator, multiplied by 100. <i>(4 digits max, i.e. xx.x)</i>	N/A
t. CMS SDOH <i>Interpersonal Safety</i> <u>Numerator</u>: Number of patients screened positive for interpersonal safety. <i>(9 digits max)</i>	6
u. CMS SDOH <i>Interpersonal Safety</i> <u>Positive Rate</u>: CMS SDOH Interpersonal Safety Numerator divided by CMS SDOH Overall Screened Numerator, multiplied by 100. <i>(4 digits max, i.e. xx.x)</i>	4%
v. CMS SDOH <i>Interpersonal Safety</i> <u>Intervention</u>: Number of interventions provided for interpersonal safety. <i>(9 digits max)</i>	N/A
w. CMS SDOH <i>Interpersonal Safety</i> <u>Intervention Rate</u>: CMS SDOH Interpersonal Safety Intervention divided by CMS Overall SDOH Screened Numerator, multiplied by 100. <i>(4 digits max, i.e. xx.x)</i>	N/A