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

GEORIGA STATE OFFICE OF RURAL HEALTH (SORH) FLEX GRANT:

2024 HEALTH EQUITY IMPROVEMENT PROJECT

PLAYBOOK

PROJECT OVERVIEW

Welcome to our playbook on advancing health equity through strategic planning for Georgia's critical access hospitals (CAHs). Alliant Health Solutions developed this playbook with the Georgia State Office of Rural Health (GA SORH). The leadership of the GA SORH partnered with Alliant Health Solutions to develop a health equity improvement project supported by the Medicare Rural Hospital Flexibility (FLEX) Grant. This initiative aims to assess and address health equity needs in Georgia's rural hospitals. It offers voluntary guidance and training to the state's 30 identified CAHs to implement necessary improvements in health disparities and social determinants of health (SDOH) affecting their patients and communities.

Since January 2023, Alliant Health Solutions has actively engaged CAH participants through monthly coaching calls. These sessions aid the CAHs in identifying and addressing health disparities and ensuring equitable health care for rural Georgia's hospital patients.

Building on the success of our initial efforts, the project highlighted the effectiveness of engaging CAH teams and providing educational support crucial to advancing health equity initiatives statewide. In the second phase, Alliant Health Solutions has prioritized the development of health equity strategic plans for CAHs, aligning with forthcoming health equity requirements in the 2024-2029 SORH FLEX grant program. These requirements are derived from the FY 2023 IPPS/LTCH final rule of the Centers for Medicare and Medicaid Services (CMS), particularly Domain 1's emphasis on Equity as a Strategic Priority and the mandate for developing health equity strategic plans.

This playbook offers insights into over two dozen unique health equity strategic plans from CAHs across Georgia. It showcases their health equity data analysis, strategies to address priority disparate populations, and the development of actionable health equity goals. Additionally, it highlights intentional community partnerships at national, state, and local levels to address SDOH affecting CAH patients.

We believe this playbook will serve as a pivotal case study and model for effective health equity planning in CAHs. By collaboratively creating more equitable health care systems, especially in rural and critical access areas, we aim to support the well-being of all communities nationwide.

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Hospital: Archbold Brooks

Health Equity Leader: Julie Dumas/ Kortney Thomas

Executive Summary: The Archbold system developed a process to support the organization's strategy to acknowledge and help reduce disparities and achieve health equity. Early on, the hospital's quality team developed a tool to ensure an effective approach to assess the organization's incorporation of health equity best practices. They identified that its population of patients is median to low-income individuals with chronic illnesses and conditions that require the need for hospitalization and have frequent follow-up appointments and treatments in areas outside the immediate purview of the facility. Therefore, the focus was improving intrahospital transport and collaborating with community stakeholders to help support health equity.

Hospital Background: Archbold Brooks is a nonprofit 25-bed CAH in Brooks County, Georgia, with approximately 100 employees. Core hospital services include inpatient observation, acute and swing bed patients, inpatient and outpatient rehabilitation, laboratory, radiology, and an emergency department.

Health Equity Statement: We are committed to providing safe, patient-centered and equitable care to ensure the best possible outcomes for our patients and their caregivers. In addition, we are focused on evaluating the SDOH affecting our patients and providing them with the necessary guidance to obtain the resources they need to ensure an equal opportunity at a healthy lifestyle.

Domain 1A: Our hospital strategic plan identifies priority populations that currently experience health disparities. The information below provides supporting data evidence for each of these priority populations.

Identified Priority Population 1: Patients admitted to the hospital lack transportation access.

Supporting Data Evidence 1: In reviewing the community health needs assessment (CHNA) and the census bureau for Brooks County, we found that SDOH affects the overall health outcome of our patients. Out of 16,270 residents, only 23.3% have access to transportation. In a review of our 2023 transport invoices, approximately 40% of admitted patients screened positive for lack of transportation and need transportation to and from appointments/treatments.

Domain 1B: Our hospital strategic plan identifies health care equity goals and discrete action steps to achieve these goals. Below are our organization's Health Equity goals and related action steps.

Health Equity Goal 1: To provide safe, patient-centered and equitable care by improving quality and safety to ensure the best possible outcomes for underserved patients and their caregivers who experience health disparities.

Related Action Step 1: The quality team developed a tool to assess the organization's incorporation of best practices in health equity. They started by conducting a health equity gap analysis. After that,

the organization's vice president of quality was appointed as the "health equity officer," a designated leader at the system facilities was assigned the role of "health equity champion." Finally, they utilized the Plan-Act-Do method to outline a process that would involve developing a tool to screen, assess, and continuously monitor the results of the PRAPARE tool after its implementation in mid-2023.

Health Equity Goal 2: To collect and evaluate race, ethnicity, and language (REaL) data in addition to housing insecurities, food insecurities, transportation issues, utilities, and safety needs (SDOH) data to help improve patient overall outcomes.

Related Action Step 2: As of July 2023, the hospital health equity champion designated the case manager and swingbed coordinator as the health-related social needs task force. Using the PRAPARE tool embedded in our electronic health record (EHR), we collect SDOH data from all acute and swing bed admissions. Our quality team can extract this data electronically at any time.

Health Equity Goal 3: To provide patients with a community resource list that will include resources to help aid and assist individuals with specific needs.

Related Action Step 3: As of August 2023, the community resource list was revamped and provided to all patients on admission. This has proven beneficial to patients who screen positive for housing and food insecurities, utility difficulties, and safety needs.

Domain 1C: Our hospital strategic plan outlines specific resources for achieving our equity goals. Below is a description of each resource.

Staffing Resources:
Julie Dumas, Health Equity Officer (system-wide)
Kortney Thomas, Health Equity Champion
June Furney, Administrator
Heather Williams, Case Manager
Raven Brown, Swingbed Coordinator
Hospital Authority-PFAC team
Intrahospital Transport Unit

Structural Resources: The PRAPARE tool supports SDOH data collection, is embedded into our EHR system, and is completed on both acute and swing bed patients on admission. Patients are reevaluated if they are transferred from an acute setting to swing bed status from one of our other facilities to assess for any changes or needs. The questionnaire is completed by the case management/swing bed coordinator. Patients who screen positive for any SDOH are provided with a community resource list to assist with their specific needs.

Training Resources: In-house training was conducted on REaL data and the PRAPARE tool. REaL training data is collected by registration staff with mandatory fields embedded into our EHR and requires the appropriate documentation. The SDOH PRAPARE tool data collection is done by case management/swing bed, and health equity data is reported as requested. We meet with our organization's quality team every other month. We also partner with Alliant Health Solutions for our

Hospital Quality Improvement Contractor (HQIC) program and attend Zoom meetings. In April 2023, our hospital incorporated the Hospital Authority to become our Patient Family Advisory Council (PFAC) team. The Hospital Authority has members who are business leaders, community members, and patients of our hospital. These members share ideas with our staff and bring feedback from the community. This group meets quarterly. HealthStreams education and cultural surveys are completed yearly by all staff.

Other Resources: Our hospital uses funding sources to support our needs. The Small Rural Hospital Improvement Program (SHIP) funds support our education needs to promote quality, safety and other data abstraction, such as readmissions. FLEX funds for 2024 are pending for culture and patient safety. By May 2024, we will have collaborated with revenue integrity to ensure Z-coding is integrated into our new EHR system to help reimburse underserved individuals such as the homeless.

Domain 1D: Our hospital strategic plan describes our approach to engaging key stakeholders, such as community-based organizations. Below is a list of our partners.

National Partner(s):

- National Quality Forum – Collaborates with varied stakeholders to develop and track quality performances that will dramatically improve health care.
- Vizient – Provides expertise in achieving system-wide quality improvement that addresses health disparities and improves overall health and well-being.
- American Hospital Association – Provides educational training and surveys and promotes best practice that focuses on quality improvement in all aspects of health.

State Partner(s):

- Georgia Hospital Association (GHA) provides Small Rural Hospital Improvement Program (SHIP) funding for health information technology to comply with quality improvement activities, such as advancing patient care information to help identify SDOH and other health disparities. Alliant Health Solutions aligns with GHA by providing support through the HQIC. They provide support by networking and sharing viable information that focuses on SDOH.

Local Partner(s):

- The local partners include the involvement of county commissioners, the city's mayor, emergency medical services (EMS), the 911 director, and the emergency management agency (EMA) to discuss the issue of access to transportation for health-related needs.
- The Brooks County Health Department provides the Community Health Needs Assessment. This helps us identify and address health disparities by conducting a community survey, which coincides with our mission to provide safe, innovative, compassionate care for our community.

Hospital-Specific Partner(s): Archbold Brooks implemented a PFAC. Although we are in the beginning stages, we have incorporated Hospital Authority members into our PFAC team. The Hospital Authority has members who are business leaders, community members, and Archbold Brooks patients. These members can share their ideas with our staff and provide feedback from the community. The group meets every other month.

Hospital: Archbold Mitchell

Health Equity Leader: Julie Dumas

Executive Summary: The Archbold system developed a process to support the organization's strategy to help reduce disparities and achieve health equity. Early on, the forefront of quality understood the need to develop a tool to ensure an effective approach to assess the organization's incorporation of health equity best practices. We identified that our population of patients is median- to low-income with chronic illnesses and conditions that require hospitalization and frequent follow-up appointments and treatments in areas outside the immediate purview of the facility. We focused on improving intra-hospital transport and collaborating with community stakeholders to help support health equity.

Hospital Background: We are a nonprofit 25-bed CAH facility in Mitchell County, Georgia, with approximately 130 employees. Core hospital services include inpatient observation, acute and swing bed patients, inpatient and outpatient rehabilitation, laboratory, radiology, and an emergency department.

Health Equity Statement: We are committed to providing safe, patient-centered and equitable care to ensure the best possible outcomes for our patients and their caregivers. In addition, we are focused on evaluating the SDOH affecting our patients and providing them with the necessary guidance to obtain the resources they need to ensure an equal opportunity at a healthy lifestyle.

Domain 1A: Our hospital strategic plan identifies priority populations that currently experience health disparities. The information below provides supporting data evidence for each of these priority populations.

Identified Priority Population 1: Patients admitted to our hospital who -experience food insecurity.

Supporting Data Evidence 1: Reviewing the CHNA 2022-2023 and the Census Bureau 2023 for Mitchell County, SDOH, we found that they affect patients' overall health outcomes. Out of the approximately 21,521 residents, 17.3% lack access to a sufficient quantity of affordable, nutritious food. Our community's top three health challenges are high blood pressure, diabetes and overweight/obesity.

Domain 1B: Our hospital strategic plan identifies health care equity goals and discrete action steps to achieve these goals. Below are our organization's Health Equity goals and related action steps.

Health Equity Goal 1: Collect REaL and SDOH data to identify patients admitted to our hospital with food insecurities within the last year.

Related Action Step 1: Beginning September 2023, our hospital integrated the PRAPARE tool into our EHR. By May 15, 2024, the health equity task force will track REaLand SDOH data to identify which patient population is experiencing health disparities related to food insecurities.

Health Equity Goal 2: Work with community resources to address health-related social needs related to food insecurities.

Related Action Step 2: We work with local and regional resources to identify dates and locations of food bank offerings.

Domain 1C: Our hospital strategic plan outlines specific resources for achieving our equity goals. Below is a description of each resource.

Staffing Resources:
Lynn Buckner, Health Equity Taskforce Lead
Frankie Gibbs, Director of Nursing
Marlie Brown, Med Surg Nurse Manager
Mandy Elmore, Director of Quality and Safety
Mariah Lee, Administration Assistant
Robin Hayes, Case Management Team

Structural Resources: We embedded the PRAPARE tool into our EHR to support SDOH data collection. Our case management team will identify patients who screen positive for food insecurities and provide community resources to patients.

Training Resources: The case management team collects REaL data upon every hospital admission to identify food insecurities using the PREPARE tool. This data will be reported monthly in our health equity team meeting.

Other Resources: Our CAH works closely with our main campus for needed support.

Domain 1D: Our hospital strategic plan describes our approach to engaging key stakeholders, such as community-based organizations. Below is a list of our partners.

National Partner(s): American Hospital Association

State Partner(s): Georgia Hospital Association

Local Partner(s): Kiwanis, Council on Aging and Albany Area Primary Health Care

Hospital: Atrium Health Floyd Polk Medical Center

Health Equity Leader: Dawn Truett

Executive Summary: Atrium Health Floyd Polk Medical Center fully supports providing high-quality and equitable care to all families in our rural community. We are dedicated to addressing the SDOH and promoting equity-based health care to meet our community's unique needs.

Hospital Background: AHFPMC is a CAH in rural Polk County, Georgia, with 25 licensed beds in our medical/swing bed unit and 16-bed emergency department. We also have a very robust Swing Bed Program. Our outpatient services include outpatient therapies, wound care, cardiac rehab, an infusion clinic, a heart failure clinic, and imaging, including CT, MRI, mammography, and lung screening. We are also a Level IV Trauma center.

Health Equity Statement: To improve health outcomes and reduce health care disparities through data-driven health equity interventions and high-quality services for our community.

Domain 1A: Our hospital strategic plan identifies priority populations that currently experience health disparities. The information below provides supporting data evidence for each of these priority populations.

Identified Priority Population 1: 68% of Polk County's adult population have high blood pressure

Supporting Data Evidence 1: 2021 Community Health Needs Assessment for Polk County, Georgia.

Identified Priority Population 2: 42% of our county population is obese.

Supporting Data Evidence 2: 2021 Community Health Needs Assessment for Polk County, Georgia.

Identified Priority Population 3: 14% of our county population experience food insecurity

Supporting Data Evidence 3: 2021 Community Health Needs Assessment for Polk County

Domain 1B: Our hospital strategic plan identifies health care equity goals and discrete action steps to achieve these goals. Below are our organization's Health Equity goals and related action steps.

Health Equity Goal 1: Conduct best practices and interventions for patients with a high blood pressure diagnosis.

Related Action Step 1: In calendar year (CY) 2024, we will conduct monthly data tracking on patients diagnosed with high blood pressure. By July 2024, we will partner with at least two community resources to provide healthy initiatives for those in our population with high blood pressure.

1. A blood pressure machine kiosk in a local hair salon or barber shop for self-checking blood pressure should be installed.

2. Partner again with the local farmers market to provide healthy food to Polk County residents, which will help lower blood pressure, cholesterol, and obesity.

Health Equity Goal 2: Conduct best practices for our patients and families who are considered obese to promote healthy lifestyle changes.

Related Action Step 2: For CY 2024, we will conduct monthly data tracking on patients diagnosed with high blood pressure. By July 2024, we will partner with at least two community resources to provide healthy initiatives for our community's obese residents.

1. Partnering with the local farmers market to provide healthy food to Polk County residents 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.

Health Equity Goal 3: Conduct best practice interventions for our patients and families that experience food insecurities.

Related Action Step 3: 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 two community resources to assist our patients and families with food insecurities.

1. Give lists of referrals to patients and families at discharge who screen positive for food insecurities.
2. Partner with the local farmers market to provide healthy food to patients and families, including those using EBT cards to purchase food.

Domain 1C: Our hospital strategic plan outlines specific resources for achieving our equity goals. Below is a description of each resource.

Staffing Resources:
Dawn Truett, Health Equity Lead/Quality Liaison
Anita Jackson, AVP of Rural Health
Tifani Kinard, Administrator/VP of Rural Health
Marie Kerns, Case Management
Registration Staff
Tiffany Cotton, Social Worker
PFAC members (eight)

Structural Resources: We use the SDOH screening tool embedded in our EMR-EPIC and a Community Resource Hub on our hospital intranet that can be printed and given to patients and families at discharge.

Training Resources: In-house training is provided for registration staff and nursing staff.
We also partner with GA SORH and Alliant Health Solutions in the FLEX HE Improvement project and participate in monthly education sessions.

Other Resources:

- SHIP funding
- Rural Tax credits
- SPIRIT grant funding
- Floyd-Polk Foundation funding through grants

Domain 1D: Our hospital strategic plan describes our approach to engaging key stakeholders, such as community-based organizations. Below is a list of our partners.

National Partner(s):

- Feeding America
- American Heart Association

State Partner(s):

- Feeding Georgia – The Map the Meal Gap shows that food insecurity exists in every county and congressional district in the United States. However, the prevalence of food insecurity varies significantly across populations and places.
- GA State Office of Rural Health – Helping us help our communities
- GA Hospital Association – Participate in the FLEX and SHIP programs

Local Partner(s):

- Local farmer's markets
- Food Pantries at local churches – Victory Baptist Church
- Summer School Lunch Program – Seven days worth of two meals per day per child under 18. This is done every week from June 1- August 1 in Polk County

Hospital-Specific Partner(s):

- PFAC Polk Medical Center – our PFAC sponsors many projects to help our community. We are heavily involved with Live Well Polk, which sponsors local farmer's markets. We also conduct health fairs and provide healthy recipes and ingredients, including fresh vegetables.

Hospital: Atrium Health Navicent Peach

Health Equity Leader: Laura Gentry/Angeline Doh

Executive Summary: Atrium Health Navicent is committed to improving health, elevating hope and advancing healing for all patients and families in Middle Georgia. Health equity and social impact is a strategic priority for our organization. Prioritizing health equity is a strategic investment that can lead to numerous benefits, including improved health outcomes, reduced health care costs, and enhanced community well-being. We pledge to disrupt the root causes of health inequities and promote health equity by addressing SDOH through a collaborative approach with community-based organizations, government agencies, elected officials and other stakeholders. This strategic plan outlines how our hospital will address and demonstrate the five identified 2024-2029 Medicare Beneficiary Quality Improvement Project (MBQIP) health equity commitment requirements.

Hospital Background: Peach County Hospital, now Atrium Health Navicent Peach, opened in September 1953 as a nonprofit acute-care hospital. The 67,500-square-foot facility has 25 spacious private rooms, 14 emergency treatment rooms, two trauma rooms, an extended care program for rehabilitation, a state-of-the-art orthopedic-sized operating room, two endoscopy suites, 64-slice CT Machine with cardiac studies capability, digital mammography for detecting breast cancer, bone density testing, ultrasounds and a mobile MRI, comfortable sleep study lab, state-of-the-art laboratory equipment, IV infusion therapy room, physical, occupational and speech therapy, and pulmonary function lab and bronchoscopy suite.

Health Equity Statement: We are committed to reducing health care disparities through data-driven health equity interventions and quality services. We aim to use the power of data to identify areas of need and target interventions that will have the greatest impact. We believe we can make a real difference in the health and well-being of our communities.

Domain 1A: Our hospital strategic plan identifies priority populations that currently experience health disparities. The information below provides supporting data evidence for each of these priority populations.

Identified Priority Population 1: African American patients in our hospital experience increased readmissions.

Supporting Data Evidence 1: Our hospital's PowerBI data revealed that Black and white patients are admitted at similar rates, 45% and 53%, respectively. However, the readmission rates for Black patients are disproportionately higher than whites at 78% compared to 22%. A root cause analysis is needed to understand why Black patients are readmitted at a higher rate than whites.
Identified Priority Population 2: African American females with red blood cell disorders in our hospital experience increased readmissions.

Supporting Data Evidence 2: Our hospital's PowerBI data revealed that African American females with red blood cell disorders are readmitting at 30% higher than any other DRGs.

Identified Priority Population 3: All patients readmitted to our hospital experience increased utility needs.

Supporting Data Evidence 3: In February 2024, our PowerBI SDOH data showed that patients with readmissions are experiencing utility needs at a disproportionately high rate of 17%, compared to the 8.14% rate for patients without readmissions. Similarly, our 2023 CHNA revealed that only 8% of Peach County residents faced utility needs issues.

Domain 1B: Our hospital strategic plan identifies health care equity goals and discrete action steps to achieve these goals. Below are our organization's Health Equity goals and related action steps.

Health Equity Goal 1: Reduce readmissions for African American females with Red Blood Cell disorders (Sickle Cell).

Related Action Step 1: Increase the use of order sets and the Sickle Cell Clinical Pathway to communicate a plan of care with the patient on Day 1 of admission (i.e., treatment plan, medication, etc.). A community health worker (CHW) from the Georgia Sickle Cell Foundation will provide resources and support at the patient's bedside during a hospital stay. Dr. Lavoie is designated as the Physician Champion. Nursing and physician staff are educated on the clinical pathway for sickle cell. Dr. Patel will assist in monitoring order sets and clinical pathway utilization. We are also increasing education on FindHelp resources in Epic for clinical staff and distributing cards in ED waiting rooms.

Health Equity Goal 2: Increase the rate of SDOH screening and referrals.
Increase the rate of closed-loop referrals accessing resources.

Related Action Step 2: Review current SDOH screening rates and set a goal for screens and closed loops. Monitor rates and discuss with stakeholders during meetings.

Health Equity Goal 3: Increase bias reduction and sensitivity awareness among teammates working with an identified population (sickle cell patients).

Related Action Step 3: Provide education to teammates through the Core Connect learning platform.

Domain 1C: Our hospital strategic plan outlines specific resources for achieving our equity goals. Below is a description of each resource.

Staffing Resources:
Angeline Doh, Health Equity Champion (Health Equity Taskforce Lead)
Laura Gentry, CEO, AHN Peach
Susan Payne, Clinical Operations Director
Carmen Stuckey, VP, Regional Quality
Edna PrimasHarrell, System Quality Manager
Paul Lavoie, MD, Physician Champion
Jill Hancock, Chief Nursing Officer

Kristy Ard, Nurse Manager
Lauren Bray, ED, LPN
Debora Wright, MedSurg, LPN
Rozlynn Wilson, Acute Care Navigator
Megan Chumbley, Clinical Pharmacy Manager
LaShauna Hunt, Community Health Supervisor
Hank Moore, MD, Central GA Cancer Care

Structural Resources:
The CMS SDOH tool has been integrated into our electronic health records system. Clinical staff collect SDOH data at the time of a visit. For patients who screen positive, clinical staff or case management will provide resources or referrals to our community partners and FindHelp.

Central GA Cancer Care is a fill-gap for sickle cell patients discharged from AHN Peach. Dr. Hank Moore will see patients who cannot see their primary care doctor due to appointment availability.

Training Resources:
Training for new and existing hospital staff is conducted through Core Connect, our HR Learning Management system. Training includes using the CMS SDOH tool and FindHelp resources in the EMR database.

We also partner with GA SORH and Alliant Health Solutions in the Flex HE Improvement project and participate in monthly education events.

Domain 1D: Our hospital strategic plan describes our approach to engaging key stakeholders, such as community-based organizations. Below is a list of our partners.

National Partner(s):

- American Hospital Association – Advocates for hospitals at the federal level, including SDOH and health equity.
- Office of Minority Health – Focuses on federal policies that contribute to preventable and unfair differences in health status and outcomes experienced by racial and ethnic minority and American Indian and Alaska Native populations in the United States and provide conclusions and recommendations that identify the most effective or promising approaches to policy change to further racial, ethnic, and tribal health equity (including both promising and evidence-based solutions).
- Centers for Disease Control and Prevention – Provides education and resources.
- Sickle Cell Disease Association of America – Advocates for people affected by sickle cell conditions and empowers community-based organizations to maximize quality of life and raise public consciousness while advancing the search for a universal cure.

State Partner(s):

- Georgia State Office of Rural Health and Alliant Health Solutions – Provides hands-on support through the GA FLEX HEI program and shares resources, training, and networking opportunities focused on addressing health disparities

- The Sickle Cell Foundation – Provides consultation to Providers and CHW support to patients.
- Georgia Hospital Association – Provides information and education on issues ranging from access to health care and clinical care updates to effective hospital management and compliance with high-level accreditation standards.

Local Partner(s):

- Peach County and Crawford County Collaboration (mental health): hospital, law enforcement, judicial system, iHope, local government officials, Middle Flint CSU, DBHDD, EMS, addresses mental health crises, access to health care, housing, SDOH, etc.
- Peach County Family Connection – A partnership of several organizations working with families to research and address the needs of children and families in the community. They are tackling intractable problems such as adult literacy, child abuse and neglect, school dropout, and physical and mental health disparities.
- Middle Georgia Community Action Agency, Inc. (MGCAA) – MGCAA's Home Energy Assistance Program offers short-term help to families in the community to get help with energy assistance when needed.
- Project Share by Salvation Army—Provides financial emergency assistance to individuals and families facing a temporary crisis that threatens their homes. Project Share attempts to target the most urgent need, whether it is a utility bill, part of a rent payment, or an emergency prescription.
- Peach County Health Department – Provides programs and services to protect the health and well-being of everyone in the county. These include disease prevention, environmental protection, health monitoring, health promotion, health care access, and emergency preparedness and response.

Hospital-Specific Partner(s):

- Readmission Committee – The readmissions committee is comprised of representatives from the hospital service lines in areas such as cardiovascular, medicine, neurosciences, general surgery, and women's health. It also includes representation from the ambulatory and care management departments. This committee meets regularly to review data related to readmissions for each service area and discuss activities, programs, or new initiatives in place that address the reduction in readmissions.
- Patient Financial Counseling – This department identifies self-pay patients and conducts interviews prior to discharge. Program eligibility for COBRA or Medicaid services is determined through the interview process. Medicaid-eligible patients receive assistance through the application process all the way to the outcome. This includes assistance with the application, documents, and appeal process if denied. If the patient is still denied after appeal, the financial counselor will guide the patient through charity programs provided by Atrium Health. Cobra-eligible patients are connected to a COBRA specialist to guide them through the application process. Contracted DFCS workers support the financial counselors by assisting with the application process to ensure expediency toward a favorable outcome.
- Healthy Communities – Assists the hospital with readmission reduction efforts through care management and care coordination to solve for SDOH and CMAs who conduct Transitional Care Outreach to assist patients in scheduling post-discharge follow-up appointments.

- Quality Department – Administers the Small Rural Hospital Improvement Program (SHIP), which supports the hospital's data reporting consistency and reliability.
- Rural health clinic (AH Primary Care Fort Valley) (hospital-based) – Designated as underserved or experiencing a shortage of health care services. Delivers health care to rural populations, ensuring residents access essential medical services.

Hospital: Bacon County Hospital and Health System

Health Equity Leader: Jennie Johnson, RN

Executive Summary: The board supports quality and equitable care for all our patients, families and community. We aim to build partnerships within our community to understand and meet the equitable health care needs of our surrounding population.
Our commitment involves building a plan, collecting and analyzing data, and improving quality with leadership involvement. Our strategy aligns with the CMS service and includes annual quality reporting data from the CMS health equity domains."

Hospital Background: Bacon County Hospital is a 25-bed CAH in Bacon County, Georgia. We are a licensed swing bed facility to meet additional rehab needs of patients. Our hospital provides inpatient acute care, an intensive care unit, labor and delivery birthing suits and outpatient services. Bacon County Hospital has 24-hour emergency services, diagnostic imaging, and endoscopy. Bacon County Hospital and Health System also has an 88-bed long-term care facility, daycare and Rual community care clinic.

Health Equity Statement: Bacon County Hospital is committed to delivering quality, equitable health care with data-driven interventions to our community, patients, and families.

Domain 1A: Our hospital strategic plan identifies priority populations that currently experience health disparities. The information below provides supporting data evidence for each of these priority populations.

Identified Priority Population 1: Our hospital includes a highly uninsured patient population, so those who lack insurance coverage are a priority population for us.

Supporting Data Evidence 1: We used our CHNA, Hospital Demographic, State Level Data. In 2022, the CHNA data revealed our total population to be 11,140, with 3,874 households. The health care access data indicated a higher uninsured rate for Bacon County, at 19%, compared to the state of Georgia's uninsured rate of 16%. Bacon County also experiences a significant shortage of health professionals, including dentists and mental health providers, compared to the state. Data collected from hospital records from October 2023 to the present indicates that 12.7% of inpatient admissions are self-pay, uninsured patients. Additionally, our SDOH questionnaire in our EMR shows that 2.2% of the data is collected upon admission.

Identified Priority Population 2: We also have a high population of patients with behavioral health needs.

Supporting Data Evidence 2: The CHNA data collection was completed in 2022 and highlights substance use, behavioral health, and poor mental health outcomes as the top three emerging issues in Bacon County. Based on the SDOH data collected upon admission via our EMR, our patients experience behavioral health and life management difficulties and screen positive for lifestyle choices

that cause limitations and difficulties with housing, transportation, utilities, and food at a rate of 3.7%. Additionally, mental health morbidity is ranked in the top 3, as referenced in our CHNA assessment.

Identified Priority Population 3: Food Insecurity is a top SDOH issue in our admitted patient population.

Supporting Data Evidence 3: The 2022 CHNA assessment reported a poverty rate of 21% and a child poverty rate of 31%. According to the assessment, Bacon County reported an unemployment rate of 4.9%. The county's median household income is around 20,000. Bacon County's food-insecure population is 17%. SDOH questions embedded in our EMR revealed that 5.6% of our patients screened positive for food insecurity.

Domain 1B: Our hospital strategic plan identifies health care equity goals and discrete action steps to achieve these goals. Below are our organization's Health Equity goals and related action steps.

Health Equity Goal 1: High Uninsured Population: Bacon County Hospital and Health System is committed to health equity and is developing and improving processes to meet the needs of our community's high uninsured population. Bacon County has an uninsured rate of 19% and admitted uninsured inpatients a rate of 12%. We are committed to decreasing this rate by 5% by January 1, 2025.

Related Action Step 1: In September 2023, we held a staff meeting with Madison Street Agency. Madison Street is a marketplace insurance broker with multiple resources for the uninsured population. We developed a strategic plan to present self-pay patients with this resource upon admission to the hospital. Bacon County Hospital also provides additional staffing after hours and on weekends to assist with enrollment opportunities for Presumptive Medicaid. Bacon County has a large population of seasonal migrant workers, so we trained registration staff to assist with Emergency Medicaid for Hispanic OB deliveries. Using the language line enables accurate communication with all the needs of the Hispanic population in our area. The resources are listed below:

- Marketplace Referral
- Indigent Care
- Presumptive Medicaid
- Emergency Medicaid, Hispanic OB delivery

Health Equity Goal 2: Behavior/Mental Health: Behavior Health ranks among our community's top three emerging needs. Over the next three months, we will collect baseline data and plan to set a goal after reviewing it.

Related Action Step 2: In February 2024, Bacon County Health System held system-wide mandatory staff education, raising awareness of SDOH and the development of our S.O.S. Samaritans of Society team. Mandatory staff education covered the five domains: food, housing, transportation, utilities, and interpersonal safety. We also educated on how we would capture 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. An employee health fair held in April 2024 provided staff with mental health resources available in our community. Additional education of upcoming education opportunities also being provided for staff as well as community partners are as follows:

- May 2024: Family Resilience Training, Adolescent Behavior Health, staff
- July 2024: Youth Mental Health First Aid, Community Partners

Health Equity Goal 3: Food Insecurity: Bacon County's insecure food population is 17%. Our SDOH data reveals that 5.6% of our patients screened positive for food insecurity. Case manager's/ discharge planner's referrals to Area Agency on Aging to screen for assistance.

Related Action Step 3: Bacon County partnered with our local food banks:

- Fifth Street Food Pantry (provides one box of food per month on Wednesdays)
- Senior Citizen Center (daily meals at the center with transportation and delivered meals)
- Local food bank

Domain 1C: Our hospital strategic plan outlines specific resources for achieving our equity goals. Below is a description of each resource.

Staffing Resources:
Jennie Johnson, RN, Case MGR/Clinical CPL, Health Equity Owner
Connie Tyre, RN, Quality MGT Coordinator(facilitator)
DeAnn Flanders, RN, CIC, Quality Director
Deanna Hoff, RN, Director of Nursing
Rachel Ellis, BS, ADON
Alissa Peacock, HIM Director
Jessica Hancock, LPN, Case MGR
Cherry Beauregard, Admissions/Collections MGR
Carla Wilson, MSN, RN, Informatics
Lisa Cullins, Nutrition Director
Case MGT Team
Registration Team
Daniel Johnson, Board Member
John Sweat, Board Member
Language Line Interpreter Partnership

Structural Resources: CMS questions are embedded in the EMR to support SDOH data collection. Once a patient is screened and meets the SDOH domain, an electronic order is referred to the case managers and uploaded to the nursing staff's work list. Upon admission, every patient is assigned a case manager and given a card with the name and contact of their case manager. The case manager addresses five domains and provides appropriate referrals and resources in our community. Case managers conduct a follow-up phone call with the patient within the first five days of discharge. We perform readmission interviews and reviews and track this data.

Training Resources: Staff is provided a manual upon the hiring date. In-house training is provided for new and current staff on SDOH data collection, the “why” to ensure our patient’s needs are met, and the staff is provided with the tools needed to perform their roles. We recently added a hospital-wide education portal. All staff will have access to training to enable every staff member to receive hospital-wide education in every department. As we continue our journey with SDOH, we are reviewing additional education in this area.

Other Resources: Alliant Health Solutions HQIC, Flex Grant, SHIP, Care Optics

Domain 1D: Our hospital strategic plan describes our approach to engaging key stakeholders, such as community-based organizations. Below is a list of our partners.

National Partner(s): American Hospital Association, Find Help.org

State Partner(s):

- Georgia State Office of Rural Health and Alliant Health Solutions provides hands-on support through the GA FLEX Health Equity program and shared resources, training, and networking opportunities focused on addressing health disparities
- Georgia Hospital Association/SHIP
- Hospital Quality Improvement HQIC- Reliability and Resilience Learning Action Series
- Area Agency on Aging
- Madison Street Agency (Scott Higginbotham)
- Main Street Rural Health
- Georgia Department of Human Services, Adult Protective Services

Local Partner(s):

- Bacon County Senior Center - Daily lunch; Meals delivered to homes if homebound.
- Georgia legal service program, Georgia Cares, Community Resource Guide, Care Fourth/ Structured Family Caregiver.
- Department Family and Children Services
- Fifth Street Food Pantry - Bacon County Family Connection – Serves on Wednesday’s 9-10
- VFW- Alma Food Bank
- Alma Church of God
- Alma Baptist Church
- Chamber of Commerce
- Mayor and City Council of Alma, Georgia
- Breakfast with Bacon- Community Leaders
- Bacon County Commissioners
- Tri-Care Transport
- Alma Taxi
- Pats Taxi Service

Hospital-Specific Partner(s):

- Bacon County Foundation Committee
- Patient Family Advisory Council

Hospital: Bleckley Memorial Hospital

Health Equity Leader: Melissa Belflower

Executive Summary: Bleckley Memorial Hospital is committed to decreasing health disparities tied to the SDOH. We plan to connect with community resources and reach out to agencies and networks to find the resources patients need to help promote health and medical care.

Hospital Background: Bleckley Memorial Hospital is a 25-bed CAH with a 5-bed emergency department, outpatient radiology and laboratory.

Health Equity Statement: Bleckley Memorial Hospital is committed to promoting health equity and reducing patient disparities. Bleckley Memorial Hospital will address health disparities as a quality and safety priority, to ensure equal and fair access to health care services for all patients.

Domain 1A: Our hospital strategic plan identifies priority populations that currently experience health disparities. The information below provides supporting data evidence for each of these priority populations.

Identified Priority Population 1: Identify patients who experience a need for transportation.

Supporting Data Evidence 1: Using SDOH collected by case management to determine the population of patients who experience a lack of transportation to and from medical appointments.

Identified Priority Population 2: Identify patients who experience a lack of nutrition/food.

Supporting Data Evidence 2: SDOH collected by case management is used to determine the population of patients with poor nutrition due to the lack of readily available food.

Identified Priority Population 3: Identify patients who are homeless/have nowhere to go when discharged.

Supporting Data Evidence 3: Using SDOH collected by case management to determine the population of patients who are either homeless/or have nowhere to return to after being in hospital for several days (maybe losing bed at PCH/NH).

Domain 1B: Our hospital strategic plan identifies health care equity goals and discrete action steps to achieve these goals. Below are our organization's Health Equity goals and related action steps.

Health Equity Goal 1: To increase opportunities for patients to live as healthy as possible.

Related Action Step 1: Bleckley Memorial Hospital developed a team for SDOH. This team includes the quality director, case manager, nurse manager and ER nurse manager, along with the CNO/COO.

The team collaborated with networking with other agencies and developed an electronic form for the case manager to complete on admission.

Health Equity Goal 2: Collect SDOH data and develop patient-friendly resources to improve health disparities, such as transportation, food, housing and other social support services.

Related Action Step 2: Quarterly data will be reported on SDOH screenings and the number of positives of those screenings. This will be reported to Quality, and Quality will report to the required agencies.

Health Equity Goal 3: Improving cultural competencies among employees.

Related Action Step 3: Educating employees on new hires and annually on the SDOH and meeting the health equity needs of all patients.

Domain 1C: Our hospital strategic plan outlines specific resources for achieving our equity goals. Below is a description of each resource.

Staffing Resources:
Melissa Belflower, quality director health equity champion
Beth Berryhill, case manager
Alaina Dykes, ED nurse manager
Kristine Lawson, M/S nurse manager
John Roland, COO, CNO

Structural Resources: The AHC Health-Related Social Needs Screening electronic form was created and integrated into the case management admission assessment.

Training Resources: Employees take a cultural competency test at the time of hire and then annually. Employees are presented with videos and handouts about cultural competency.

Domain 1D: Our hospital strategic plan describes our approach to engaging key stakeholders, such as community-based organizations. Below is a list of our partners.

National Partner(s): American Medical Association (AMA)- A health care advocacy with delegates and trustees working to improve health care.

State Partner(s):

- Georgia Hospital Association programs with resources and contacts who share resources. Georgia Hospital Association also offers education and training.
- Hometown Health offers resources, training, and education in different areas. Georgia Hospital Association and Hometown Health offer many networking contacts to support our patients' health equity needs.

Local Partner(s): Our local health department is a strong partner. We also partner with local churches, which have food banks for those in need. They also help with hotel costs for those who have been displaced until other arrangements can be made.

Hospital-Specific Partner(s): We are establishing a Patient and Family Advisory group. Starting in January 2024, we are screening for SDOH. We are also conducting performance improvement for individuals who screen positive on the SDOH questionnaire. This process has revealed disparities and helped us identify areas of primary focus for health equity.

Hospital: Candler County Hospital

Health Equity Leader: Kimberly Williams

Executive Summary: Acknowledging the pivotal role of SDOH in shaping health care outcomes, this strategic plan focuses on addressing disparities by integrating SDOH considerations into care delivery. By prioritizing initiatives such as community partnerships, culturally competent care, and targeted interventions for underserved populations, this plan aims to enhance patient outcomes, reduce disparities, and ensure alignment with CMS mandates. Implementation strategies include robust data collection on SDOH metrics, staff training on equity-centered care, and continuous monitoring and evaluation to gauge effectiveness and drive improvement. Through proactive measures to address health equity, the hospital aims to meet regulatory requirements and foster a more inclusive and equitable health care environment for all patients.

Hospital Background: Candler County Hospital is a 25-bed CAH owned by the county and governed by the Candler County Hospital Authority. CCH operates as a nonprofit facility, and its operations are completely funded by revenues generated through patient services, including inpatient, outpatient, radiology, respiratory, laboratory and physical therapy services.

Health Equity Statement: To promote equitable access to exceptional health care services, address our diverse community's unique requirements and obstacles, and foster a nurturing atmosphere that extends compassionate care to all individuals regardless of their background or circumstances.

Domain 1A: Our hospital strategic plan identifies priority populations that currently experience health disparities. The information below provides supporting data evidence for each of these priority populations.

Identified Priority Population 1: Black patients in our hospital are experiencing increased admission of diabetes diagnosis.

Supporting Data Evidence 1: Out of the 11,000 residents in Candler County, 22% identify as Black. However, the collection of REaL data revealed that 42% of diabetes-associated admission are Black patients.

Identified Priority Population 2: Patients in our hospital lacking appropriate access to transportation.

Supporting Data Evidence 2: Statistics show that 7.9% of the population does not own a vehicle, which is more than the 6.3% average for the state. Moreover, Candler County has a walkability score of 4.8 as opposed to the state average of 7.5, making it clear that our citizens face substantial obstacles due to inadequate transit infrastructure.

Domain 1B: Our hospital strategic plan identifies health care equity goals and discrete action steps to achieve these goals. Below are our organization's Health Equity goals and related action steps.

Health Equity Goal 1: By December 2024, ensure equitable access to diabetes education for patients, families, and the community, with a focus on our identified high-risk population.

Related Action Step 1: Our hospital will collaborate with the University of Georgia Cooperative Extension and a diabetes nurse educator. Our action steps include conducting a needs assessment, developing culturally sensitive education materials, and training health care professionals. We will organize community workshops and utilize technology for outreach, establish peer support groups, and implement follow-up and monitoring systems.

Health Equity Goal 2: Integrate SDOH tracking into the CPSI EHR system by the third quarter of 2024.

Related Action Step 2: Conducted Health Equity Gap Assessment and appointed our social worker as health equity champion in March 2024. Collaborated with the clinical nurse informaticist to develop an e-form for social worker, specific to identifying SDOH. Plan to further develop the E-form with SDOH Z-codes, train staff, pilot test, and implement a tracking system for SDOH data by Q3 2024. Plan establishing reporting mechanisms for ongoing monitoring and quality improvement by December 2024.

Health Equity Goal 3: Reduce rural hospital readmissions by addressing transportation barriers through collaboration with community resources.

Related Action Step 3: Utilize community programs offering chronic disease management and transportation assistance to eligible patients by the third quarter of 2024. Resources include groups such as Amerimed for chronic disease management and other organizations for transportation services and educating patients about available support. Monitor program effectiveness, gathering feedback for continuous improvement and sustainability. This initiative aims to improve patient outcomes, lower health care costs, and enhance access to care in our rural community.

Domain 1C: Our hospital strategic plan outlines specific resources for achieving our equity goals. Below is a description of each resource.

Staffing Resources:
Kimberly Williams, social worker - health equity champion
Shannon Hart, quality assurance nurse- health equity task force lead
Registration Staff Leadership
Nurse Informatics Staff
Linda Coleman, chief nursing officer
Nursing Leadership Staff (Alex Farlow, Denese Callaway, Sally Powell)
Discharge Planning Staff (Kimberly Williams, Kym Bowman, Kate McClendon)

Structural Resources: The PREPARE tool was used to build an electronic form in our EHR system for case management/social workers, including SDOH data. Our EHR system, CPSI, has limited ability to pull reports for tracking, so our nurse informatics staff will continue to build our e-form to include

Z-codes. We will seek further assistance from an outside system, Sunlink, to help track and run reports.

- Follow-up will be conducted via phone call, post-discharge, by discharge planning staff.
- Collaboration with local clinics and staff to ensure transition of care and further reduce readmissions.

Training Resources: Alliant Health Solutions monthly health equity office hours and education events.

Other Resources: Diabetes educator at a local health clinic.

Domain 1D: Our hospital strategic plan describes our approach to engaging key stakeholders, such as community-based organizations. Below is a list of our partners.

National Partner(s): Our partnership with the Health Resources & Services Administration (HRSA) significantly enhances our ability to provide equitable health care in our rural community. HRSA's support and resources enable us to improve access to quality care, address health care disparities, and ensure that all individuals, regardless of their background or circumstances, receive the care they need.

State Partner(s): Our partnership with Georgia Hospital Association and Alliant Health Solutions enhances our care quality, improves patient outcomes, and optimizes operational efficiency. Their support, resources and training ensure that our hospital remains a vital resource for our community, addressing health disparities and supporting the population we serve.

Local Partner(s):

- The Area of Advanced Aging provides essential services to the impoverished elderly, ensuring they receive the care and support they need to live with dignity and independence.
- Our collaboration with the Candler County Health Department focuses on their program to reduce the cost of mammograms, making these critical screenings more accessible to those in need.
- Our partnership with East Georgia Health Care supports the uninsured and underinsured population, ensuring everyone in our community can access necessary medical services by providing reduced-cost colonoscopy screenings, medications, and more.

Hospital-Specific Partner(s):

- Through collaborations with Augusta University Hospital, we offer telehealth services in neurology, infectious disease, cardiology, intensivist care, emergency medicine, and more, ensuring expert consultations locally.
- The University of Georgia Extension supports educational programs on nutrition, diets, and diabetes management.
- Pineland Behavioral Health provides essential psychiatric services.
- Partnerships with Candler Medical Group and our rural clinic offer a sliding fee scale, ensuring accessible health care for all.

Hospital: Chatuge Regional Hospital

Health Equity Leader: Laura Ng

Executive Summary: Chatuge Regional Hospital promotes quality and equitable care for patients and families. Health equity is a chief component of our strategic plan to better promote holistic health in our community. Chatuge Regional Hospital understands this endeavor involves comprehensive and purposeful interests to address SDOH in our community. Our hospital will collaborate with consortiums in the area to assist us in advancing this system to meet the needs of our community. This plan summarizes Chatuge Regional Hospital's intention to demonstrate to the community our pursuits within the five identified 2024-2029 MBQIP health equity commitment requirements.

Hospital Background: Chatuge Regional Hospital is a nonprofit CAH in Hiawassee, Georgia, in Towns County. We are licensed for 25 beds for acute care or swing bed services. We also have a six-bed emergency department with 24-hour physician coverage. Other services include radiology, laboratory, outpatient, rehab, and pain management. We are also working on becoming a certified rural stroke center with an anticipated certification in early 2025.

Health Equity Statement: Chatuge Regional Hospital will strive to improve patient outcomes and reduce disparities through data-driven health equity interventions and high-quality services.

Domain 1A: Our hospital strategic plan identifies priority populations that currently experience health disparities. The information below provides supporting data evidence for each of these priority populations.

Identified Priority Population 1: Our patients express concerns about access to adequate food resources.

Supporting Data Evidence 1: Obtaining data gleaned from DATAUSA for Towns County for 2022, we discovered that food insecurity was 11.2% in 2019 and 14.8% in 2022, an increase of almost 4%. In addition, the number of school-aged children eligible for reduced or free lunches is 53%, much higher than in our three surrounding counties.

Identified Priority Population 2: Our patients express concerns about the ability to afford utility basics.

Supporting Data Evidence 2: Data obtained from DATAUSA for 2022 revealed that our residents' median income was $51,000, which is lower than surrounding counties. In addition, data from our SDOH questionnaire revealed that some of our patients were willing to express concerns about utility issues.

Identified Priority Population 3: Our patients who express concerns with access to transportation.

Supporting Data Evidence 3: Data was obtained from County Health Rankings for 2023- 2024 for Towns County, and the number of people aged 64 and older was 37%, higher than any of our three

surrounding counties. In addition, our county is designated as rural. This, along with data collected from our SDOH questionnaire, inspired us to work on transportation concerns.

Domain 1B: Our hospital strategic plan identifies health care equity goals and discrete action steps to achieve these goals. Below are our organization's Health Equity goals and related action steps.

Health Equity Goal 1: Organize procedural interventions for our patients who are having problems accessing adequate food resources.

Related Action Step 1: In 2024, Chatuge Regional Hospital will trace the number of our patients who communicate issues with food insecurities and monitor progress on our efforts to reduce admission rates for this group of patients.

By July, we will incorporate discharge referral information in the patient discharge handbook, providing advice on contacting local food banks for those patients.

By the end of this year, we will have attempted to partner with at least one of our local food banks to offer groceries at a reduced cost or for free to our identified patients in this group.

Health Equity Goal 2: Organize procedural intercessions for our patients who are having issues with utility insecurities.

Related Action Step 2: During 2024, Chatuge Regional Hospital will trace the number of patients communicating issues with utility insecurities and monitor progress on our efforts to reduce admission rates for this group of patients.

By July, we will incorporate discharge referral information in the patient discharge handbook, providing advice on contacting local resources for those patients.

By the end of this year, we will have attempted to partner with at least two local churches that can offer assistance to our identified patients in this group.

Health Equity Goal 3: Organize procedural intercessions for our patients experiencing transportation concerns.

Related Action Step 3: In 2024, Chatuge Regional Hospital will trace the number of our patients who communicate issues with lack of transportation and monitor progress on our efforts to reduce admission rates for this group of patients.

By July, we will incorporate discharge referral information in the patient discharge handbook, providing advice on contacting local transportation services for those patients.

By the end of this year, we will have attempted to partner with at least two of our local churches to offer a potential transportation service to our identified patients in this group.

Domain 1C: Our hospital strategic plan outlines specific resources for achieving our equity goals. Below is a description of each resource.

Staffing Resources:
Laura Ng, Health Equity Champion
Ryan Snow, Hospital Administrator
Tanya Long, Director of Nursing
Dexter Shook, Director of Risk/ Quality
Krystal Young, Director of Emergency Services
Emily Henry-Lewalski, Director of Nutrition Services
Case Management Team
Registration Staff
Language Line Interpretation Services

Structural Resources: Chatuge Regional Hospital uses the PREPARE tool for SDOH data collection. As a member of our patient-centered care team, the case manager, during their initial discussion with the admitted patient, will enter the PREPARE data into our EHR system. The case manager will provide the patient with a list of community resources based on the interview results. This list will also be included in the patient's discharge handbook. After discharge, we partnered with JLM Solutions to give each discharged patient a 72-hour post-discharge phone call to assess their perception of the hospital visit and their current health status at home. Readmission data are reviewed every 30 days to track and trend the effectiveness of our SDOH interventions as necessary.

Training Resources: Chatuge Regional Hospital leads initial staff training as appropriate on items such as REaL data collection, the SDOH collection and referral routine, the PRAPARE model, and health equity reporting. This training is provided via our online Lippincott Learning modules and periodic in-services.

Chatuge Regional Hospital associates with GA SORH and Alliant Health Solutions in their Flex HEI endeavor. We also participate in their monthly calls for continuing education.

Other Resources: Chatuge Regional Hospital knows that additional funding to enhance our efforts with this project is necessary for continual upgrades to our EHR system. Funding sources include, but are not limited to, the following:

SHIP Funds applied to this project for the 2023 calendar year from June 1, 2024, through May 31, 2025.

Domain 1D: Our hospital strategic plan describes our approach to engaging key stakeholders, such as community-based organizations. Below is a list of our partners.

National Partner(s):

- The National Quality Forum (NQF) is a nonprofit, nonpartisan, membership-based organization that works to improve health care outcomes, safety, equity, and affordability. NQF offers programs and guidance on integrating health care and community services to address health-related social needs.
- Pan Foundation: By participating with the Pan Foundation, financial assistance can be provided to patients who need it most. In addition, the Pan Foundation partners with those organizations that work toward health equity.
- Patient Activation Measure (PAM): Assists in measuring individuals' ability to manage their health by measuring their knowledge about medications and preventive health, skills to maintain lifestyle changes and participate in health decisions, and confidence in communication with their physician and following up.

State Partner(s):

- Georgia Hospital Association Center for Rural Health: Works with various internal and external stakeholders to explore challenges for rural hospitals and rural health care, identify future trends, and raise awareness of rural health issues to include in the GA FLEX HEI project, which offers multiple resources for support and training in response to health disparities.
- Feeding Georgia: Cooperate with this institution to attain community food banks for appropriation and administering necessary food items for those lacking proper nourishment access.

Local Partner(s):

- Meals on Wheels: Partner with this local organization to provide home-delivered meals to qualified seniors in the area.
- Towns County Food Pantry: Food will be provided to county residents in need and qualify for the program.
- McConnell Memorial Baptist Church: Collaborate with this religious institution to procure a van to transport residents who lack transportation to their health care appointments.

Hospital-Specific Partner(s):

- Community Needs Assessment Committee: Taps into the varied overview of our CNAC to garner more information on the varied confrontations experienced by our patients in this rural and mountainous area, such as transportation needs, access to proper food sources, and other initiatives to focus on precise necessities of Chatuge Regional Hospital's service area to address local health disparities.

Hospital: Clinch Memorial Hospital

Health Equity Leader: George Johnson

Executive Summary: Clinch Memorial Hospital, a CAH in Homerville, Georgia, partnered with the Center for Public Health Practice and Research, Georgia Southern University, to conduct a community health needs assessment as required under the Affordable Care Act based on Internal Revenue Section (IRS Section 501(r)(3)(A)(i)) to strengthen nonprofit hospital organizations, identify and document community needs and efforts to address as well as enhance community engagement.

The Georgia Southern University team applied a mixed-method approach to this assessment. The team gained input from the hospital stakeholders and the general community through focus group discussions and surveys. Data from secondary sources were also used to assess the community's needs. Based on the results, the CHNA Steering Committee, in concert with local health department representatives, determined the priority areas for the next three years.
Goals, objectives, and actions were chosen to address the priority areas that would be meaningful and achievable.

The results from the secondary data analyses suggest that the county's population is slightly contracting and aging. From 2015 to 2020, the overall population decreased in Clinch County, while Georgia's population increased (-4.5% vs. +4.8%). Over this period, Clinch County experienced a decrease in the population under age 65 and an increase in the proportion of the population 65 and over. The proportion of the white, non-Hispanic population decreased, but at a slower rate than African Americans or Hispanics. The population is expected to decrease from 2020 to 2025 but at a slower rate. By 2025, the proportion of African Americans and Hispanics is expected to increase, while the proportion of white, non-Hispanics is expected to decrease. It is also important to note that demographics, including income, education, and age, vary by census tract. Furthermore, specific communities experience greater challenges due to a lagging economy, limited employment, and lack of transportation. Secondary data agreed with survey and focus group findings in several areas of community health challenges, including, but not limited to, nutrition, obesity, inactivity, drugs, access to specialists, transportation, preventative screening utilization, and senior care.

Hospital Background: Located in Southeast Georgia, Clinch Memorial Hospital is a 25-bed CAH serving Homerville, Clinch County, and surrounding counties.

Clinch Memorial Hospital is accredited under the NIAHO® Hospital Accreditation Program. Under the authority granted to DNV GL Health Care USA, Inc. by the U.S. Department of Health and Human Services, CMS, Clinch Memorial Hospital is deemed in compliance with the Medicare Conditions of Participation for Critical Access Hospitals (42 C.F.R. §485).

Clinch Memorial was founded in 1957 as a 48-bed rural community hospital and moved to a new facility in Homerville in 2007.

Health Equity Statement: To Inspire Hope, Invest in Others, Promote Wellness

Domain 1A: Our hospital strategic plan identifies priority populations that currently experience health disparities. The information below provides supporting data evidence for each of these priority populations.

Identified Priority Population 1: Lack of Adequate Physical Activity

Supporting Data Evidence 1: Obesity, Inactivity, and Diabetes Worse Than State

Identified Priority Population 2: Nutrition and Prescription Compliance

Supporting Data Evidence 2: High diabetes -21% of residents experiencing food insecurity.

Identified Priority Population 3: Mental Health and COVID-19-related impacts

Supporting Data Evidence 3: Mental Health Provider Ratio Lower than State-Days of Poor Mental Health in Last 30 Comparable to State, but Higher than the United States.

Domain 1B: Our hospital strategic plan identifies health care equity goals and discrete action steps to achieve these goals. Below are our organization's Health Equity goals and related action steps.

Health Equity Goal 1: Re-start Community Farmers Market

Related Action Step 1: Gain concurrence from Homerville Mainstreet to revitalize the market, using Homerville Depot as the venue.

- Engage with farmers using contact information from the Chamber of Commerce and Farm Bureau.
- Engage with downtown business organizations.

Health Equity Goal 2: Develop a healthy eating campaign

Related Action Step 2:

- Create/locate content for social media.
- Modify social media content for newspapers to target the older population.
- Sponsor a table at farmers' markets.

Health Equity Goal 3: Create a more active Clinch County population

Related Action Step 3: Create a recurring walk session around town (in conjunction with Biggest Loser).

Domain 1C: Our hospital strategic plan outlines specific resources for achieving our equity goals. Below is a description of each resource.

Staffing Resources:
Angela Handley, Chief Executive Officers
Beth Jones, Clinch Memorial Hospital Board Member
Kellie Register, Chief Nursing Officer
Nancy K Strickland, Accounts Payable Supervisor
George Johnson, Compliance Officer
Lily Blitch, Director of Organizational Development
Nicole Raffield, Respiratory Therapy Manager

Structural Resources: EHR adaptations, Interoperability Solutions, Collaborative Care Teams, Community Partnerships, Facility Adaptations

Training Resources:

- Annual Review Workshop
- GHA trainings and/or webinars
- CMS trainings and/or webinars
- DNV trainings and/or webinars
- Georgia Southern University trainings and/or webinars
- SORH trainings and/or webinars

Domain 1D: Our hospital strategic plan describes our approach to engaging key stakeholders, such as community-based organizations. Below is a list of our partners.

National Partner(s): American Hospital Association, Hometown Health University,

State Partner(s): Alliant Health Solutions, Georgia Department of Community Health, State Office of Rural Health, Georgia Hospital Association

Local Partner(s): Unison Behavioral Health, ResCare Normal Life, River Brook Nursing Home, Pearl Cancer Center, Clinch County Family Connections, Babies Can't Wait, Clinch County DFACS, Children's 1st, Clinch County Head Start, Children's Medical Services, Clinch County Health Department, DaVita Satilla River Dialysis, Dr. Benjamin Tanner (Clinch Dental Care), Dr. Varnedoe & Jackson, Mckinney Health Center, Morrison Dental Clinic, Morton & Peavey D.D.S., Hope Ministries, Clinch County Concerted Services, Jesus and Jam of Clinch County Inc.

Hospital: Early Medical Center

Health Equity Leader: Rhonda Cross

Executive Summary: This hospital board values and welcomes every patient, provider, employee, volunteer and visitor regardless of age, socioeconomic status, race, or ethnicity. Our goal is to build and grow a health care system in Early County that provides equitable care to everyone we serve. Early Medical Center and the community it serves share a remarkable bond. To us, that bond is a living commitment that we take very seriously. We understand that each day, this community puts its trust in our hands. It's our job to earn, confirm and strengthen that trust through the care experiences of patients and their loved ones.

Hospital Background: This hospital is a 25-bed CAH in Early County, Georgia. It is licensed for Acute Care and Swing Bed patients. Our services include outpatient behavioral health, radiology, laboratory, and a four-bed ER department.

Health Equity Statement: To CMS, health equity means the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

Domain 1A: Our hospital strategic plan identifies priority populations that currently experience health disparities. The information below provides supporting data evidence for each of these priority populations.

Identified Priority Population 1: Patients admitted to our hospital who lack access to transportation.

Supporting Data Evidence 1: October-December 2023 data from our SDOH questionnaire shows that 50% of patients admitted to our hospital do not have appropriate transportation.

Domain 1B: Our hospital strategic plan identifies health care equity goals and discrete action steps to achieve these goals. Below are our organization's Health Equity goals and related action steps.

Health Equity Goal 1: Our goal at Early Medical Center is to establish transportation for all people admitted to the facility.

Related Action Step 1: A list of available transportation services is located in the ER and on the Medical-Surgical floor at the Early Medical Center. We have in-house transportation during the weekdays. We can also utilize a community pastoral association as needed.
Health Equity Goal 2: Obtain and compare data for REaL and SDOH for patients admitted to this facility

Related Action Step 2: A position has been filled to aid in compiling all SDOH data obtained from patients on admission and to intervene as needed on those who screen positive.

Health Equity Goal 3: Focus on mental health disparities among the elderly.

Related Action Step 3: We are in the process of opening a new outpatient behavioral health program that will provide two levels of care to the senior population experiencing mental health issues: standard outpatient services and intensive outpatient services.

Domain 1C: Our hospital strategic plan outlines specific resources for achieving our equity goals. Below is a description of each resource.

Staffing Resources:
Rhonda Cross, RN
Michelle Mock, RN, Health Equity Champions
Susan English, RN, Nurse Manager
Heather Nobles, RN, Case Management
Darby Godfrey, Activities Director
Kristy Atterberry, BO Manager

Structural Resources: Information is gathered through our EHR (M-Systems) during the initial nursing assessment and admission process.

Training Resources: Staff is educated through orientation and annual training.

Other Resources: Grant through the SHIP Program.

Domain 1D: Our hospital strategic plan describes our approach to engaging key stakeholders, such as community-based organizations. Below is a list of our partners.

State Partner(s):
- Georgia Hospital Association
- Alliant Health Solutions

Local Partner(s): Early County Health Department assists in recognizing health disparities in our community and provides education and resources to this population.

Hospital-Specific Partner(s): Our PFAC is available to provide insights into our community's health equity and assist us with information to better serve this population.

Hospital: Effingham Health System

Health Equity Leader: Tina Browning/Shaundese Duncan

Executive Summary: Effingham Health System (EHS) is committed to health equity, aligning with CMS's strategic plan. Our board and staff focus on inclusive leadership, data-driven approaches, community engagement, culturally competent care, and expanded access. We aim to monitor progress through a health equity dashboard, enhance workforce diversity, establish PFACs, and ensure diverse clinical trial participation. EHS strives to deliver equitable health care and improve outcomes for all patients. EHS is dedicated to addressing the SDOH to enhance community well-being. With robust support from its board members, physicians, and staff, EHS actively works to reduce health disparities and promote equitable health care access. The organization prioritizes comprehensive care, including social, economic, and environmental factors that impact health outcomes. EHS collaborates with local partners to implement initiatives targeting housing, nutrition, education, and employment, ensuring a holistic approach to health care. This commitment reflects EHS's mission to foster a healthier, more inclusive community, leveraging collective expertise and resources to drive meaningful change.

Hospital Background: Effingham Health System in Springfield, Georgia, is a 25-bed CAH with a 106-bed extended care nursing facility. It has been a health care cornerstone since its founding, providing exceptional services through its modern hospital, advanced care center, and outpatient facilities. Renowned for its state-of-the-art technology and dedicated health care professionals, the hospital offers emergency care, surgical procedures, diagnostic imaging, and specialized treatments, including cardiology, orthopedics, and women's health. Emphasizing preventive care and community wellness, Effingham Health System conducts educational programs and screenings. Committed to continuous improvement and innovation, it ensures optimal patient outcomes and satisfaction, remaining a trusted health care provider for Springfield and the surrounding communities.

Health Equity Statement: The committee shall assess patient health-related social needs and identify opportunities and community resources to reduce health care disparities within the community with a focus on access to quality and safe delivery of care for all patients, including populations who have historically lacked access to care because of sociodemographic characteristics such as race and ethnicity, age, and preferred language.

Domain 1A: Our hospital strategic plan identifies priority populations that currently experience health disparities. The information below provides supporting data evidence for each of these priority populations.

Identified Priority Population 1: Patients admitted to our hospital who lack access to transportation.

Supporting Data Evidence 1: Due to the lack of transportation resources to Effingham County and beyond, our community health assessment. With the use of our EHR, EHS will be able to identify those individuals who need these resources.

Identified Priority Population 2: Patients admitted to our hospital who face food insecurity.

Supporting Data Evidence 2: EHS will use our EHR to identify individuals who need this resource.

Identified Priority Population 3: Patients admitted to our hospital who face interpersonal safety issues.

Supporting Data Evidence 3: EHS will use our EHR to identify individuals who need this resource.

Domain 1B: Our hospital strategic plan identifies health care equity goals and discrete action steps to achieve these goals. Below are our organization's health equity goals and related action steps.

Health Equity Goal 1: Reduce health disparities. Address and diminish the health disparities experienced by marginalized and underserved populations.

Related Action Step 1:

- Data Collection and Analysis: Collect comprehensive data on health outcomes across different populations. Analyze data to identify specific areas where health disparities are most pronounced.
- Community-Based Programs: Develop community health programs targeting specific at-risk populations. Partner with local organizations to implement health education and outreach initiatives.
- Tailored Health care Interventions: Design and implement health care interventions tailored to the unique needs of different populations. Utilize patient navigators to help individuals from underserved communities access care and services.
- Address Social Determinants of Health: Collaborate with organizations that address housing, education, and employment to tackle the underlying causes of health disparities.

Health Equity Goal 2: Improve Access to Quality Care: Ensure equitable access to high-quality health care services for all individuals, regardless of socioeconomic status, race, ethnicity, or geographic location.

Related Action Step 2:

- Expand Health care Coverage: Advocate for policies that expand health care coverage. Provide resources and assistance to help individuals navigate and enroll in insurance programs.
- Increase Availability of Primary Care Services: Support establishing and expanding community health centers in underserved areas. Implement telehealth services to reach patients in remote or underserved locations. Remove Financial Barriers.
- Transportation and Accessibility: Implement programs that provide transportation assistance to health care facilities. Ensure health care facilities are accessible to individuals with disabilities.

Health Equity Goal 3: Enhance Workforce Diversity: Increase diversity and cultural competence within the health care workforce to better reflect and serve diverse populations.

Related Action Step 3:

- Diverse Recruitment Strategies: Develop targeted recruitment campaigns to attract candidates from diverse backgrounds. Partner with educational institutions to create pathways for groups into health care careers.
- Cultural Competency Training: Integrate cultural competency training into all medical and health care education levels. Offer continuous professional development opportunities focused on cultural awareness and sensitivity.
- Mentorship and Support Programs: Establish mentorship programs to support the professional growth of minority health care workers and create a supportive and inclusive work environment that values diversity and promotes equity.

Domain 1C: Our hospital strategic plan outlines specific resources for achieving our equity goals. Below is a description of each resource.

Staffing Resources: EHS offers a robust staffing framework to deliver comprehensive care to the community. EHS includes a diverse team of health care professionals such as physicians, nurses, allied health professionals, and administrative staff. The system emphasizes continuous professional development, ensuring staff are well-trained and up-to-date with the latest medical advancements. They also focus on maintaining optimal staffing levels to ensure quality patient care and operational efficiency. Effingham Health System promotes a collaborative work environment with a commitment to enhancing its health care services' overall effectiveness and responsiveness.

Structural Resources: EHS boasts advanced structural resources, including cutting-edge technology and comprehensive EHR adaptation for streamlined patient data management. EHS utilizes an integrated model of care, fostering collaboration among multidisciplinary teams to provide holistic and coordinated services. The system has modern diagnostic and treatment technologies, ensuring high-quality care. EHS also emphasizes telehealth services, enhancing access to care for remote patients. Their infrastructure supports continuous improvement in patient outcomes and operational efficiency, reflecting a commitment to leveraging technology and integrated care models to meet the diverse needs of their community.

Training Resources: EHS offers extensive training resources to ensure its staff remains skilled and knowledgeable. This includes regular professional development programs, workshops, and continuing education opportunities tailored to various health care roles. New employees undergo comprehensive orientation and onboarding programs to familiarize them with the organization's policies, procedures, and culture. EHS also supports staff with mentorship programs and leadership development initiatives, fostering a culture of continuous learning and growth. These efforts ensure high standards of patient care and professional excellence across the organization.

Domain 1D: Our hospital strategic plan describes our approach to engaging key stakeholders,

such as community-based organizations. Below is a list of our partners.

National Partner: American Hospital Association, National Quality Forum

State Partner: Alliant Health Solutions, Georgia State Office of Rural Health, Georgia Hospital Association

Hospital-Specific Partner: Effingham Health System Board of Directors

Hospital: Elbert Memorial Hospital

Health Equity Leader: Elberton-Elbert County Hospital Authority

Executive Summary: Elbert Memorial Hospital's (EMH's) executive and physician leaders are passionate about serving EMH's patients and the community. A committee consisting of EMH's leaders will be formed to lead activities to reduce health care disparities for EMH's patients. The committee shall identify opportunities and community resources to reduce health care disparities within the community, focusing on fostering relationships through engagement.

Hospital Background: EMH is a nonprofit 25-bed CAH in Elberton, Georgia. Core hospital services include inpatient, outpatient, swing bed, laboratory, radiology, infusion, and surgical services. Therapy services include physical, occupational, and speech, including our new cardiac/pulmonary rehab program.

Health Equity Statement: EMH is committed to prioritizing the reduction of health care disparities for its patients, with a focus on access to quality and safe care delivery.

Domain 1A: Our hospital strategic plan identifies priority populations that currently experience health disparities. The information below provides supporting data evidence for each of these priority populations.

Identified Priority Population 1: Children and persons of color

Supporting Data Evidence 1: Our community health needs assessment (CHNA) was completed from (August 2023- January 2024) for Elbert County. Community data, hospital data, and secondary data sources were analyzed. It was revealed that 26% of people under age 18 are in poverty, which is greater than the state (17%) and national (16%) average.

Identified Priority Population 2: Patients lacking commitment to overall well-being.

Supporting Data Evidence 2: Our CHNA was completed from (August 2023- January 2024) for Elbert County. Community data, hospital data, and secondary data sources were analyzed. It was revealed that 23% of adults reported fair or poor health, greater than the national (14%) and state (18%) average.

Identified Priority Population 3: Patients in our community lack access to healthcare.

Supporting Data Evidence 3: Our CHNA was completed from (August 2023- January 2024) for Elbert County. Community data, hospital data, and secondary data sources were analyzed. It was revealed that limited access to exercise opportunities, limited access to healthy foods, and an uninsured population under 65 were all higher than the state and national average.

Domain 1B: Our hospital strategic plan identifies health care equity goals and discrete action steps to achieve these goals. Below are our organization's Health Equity goals and related

action steps.

Health Equity Goal 1: EMH will identify effective approaches to enhance safety measures for children and persons of color.

Related Action Step 1: EMH will assess monthly data identified by our SDOH assessments for our children and persons of color that reflect a positive screening.

Health Equity Goal 2: EMH will identify interventions for patients in our hospital who lack commitment to overall well-being.

Related Action Step 2: EMH will collect and assess monthly data identified by our SDOH assessments for patients who lack commitment to overall well-being. We have been collecting data since June 2023.

Health Equity Goal 3: EMH will identify methods and interventions involving our patients that lack health care accessibility.

Related Action Step 3: EMH will collect and assess monthly data identified by our SDOH assessments for patients who lack health care accessibility. We have been collecting data since June 2023.

Domain 1C: Our hospital strategic plan outlines specific resources for achieving our equity goals. Below is a description of each resource.

Staffing Resources:
Elberton-Elbert County Authority
Health Equity Committee
Nursing Leadership
Case Management Team
Quality/Safety Team
Dietary/Nutrition Department
Wellness Center Team
Human Resources

Structural Resources: EMH integrated our SDOH assessment into our CPSI EHR. Registration and Nursing Staff have implemented these assessments upon admission since 06/2023. Any patient with a (+) screening reflexes to our case management department.

Training Resources: Our in-house clinical informatics director and nursing leadership team provide our training. We also partner with Alliant Health, Georgia Hospital Association, and GA SORH.

Other Resources: EMH acknowledges the need for continued resources to improve the health of our community. We have a generous foundation that supports this facility and our community. We also

participate in Georgia Heart.

National Partner(s): American Hospital Association

State Partner(s):

- Georgia Hospital Association
- State Office of Rural Health
- Hometown Health
- Rob Leverette, Ga. State House Representative District 33
- Georgia Rural Health Innovation Center

Local Partner(s):

- Elbert Senior Center
- Elbert County Chamber of Commerce
- Elbert Partners for Health
- Community Partnership of Elbert County, Inc.
- Department of Family and Children Services
- Elbert County Health Department
- Elbert County Board of Education

Hospital-Specific Partner(s):

- Elbert County Auxiliary
- Elbert Memorial Hospital Wellness Center
- Elbert Memorial Hospital Foundation

Hospital: Jasper Memorial Hospital

Health Equity Leader: Robin Carey, RN

Executive Summary: The Jasper Health Services Board of Directors fully supports efforts to provide high-quality and equitable care for all patients/families of Jasper Memorial Hospital. Equity is a critical organizational priority and, thus, an essential component of our strategic plan for our community. We recognize that this effort requires long-term, dedicated investments and vital partnerships with community-based organizations to address the SDOH and help us promote an equity-focused health care delivery system designed to meet the unique needs of our rural community. In alignment with the Medicare Beneficiary Quality Improvement Project (MBQIP), the CMS will require hospitals participating in the MBQIP program to report annually on the Hospital Commitment to Health Equity Measure. This strategic plan outlines Jasper Memorial Hospital's efforts to address and attest to activities within the five identified CMS health equity commitment domains: strategic planning, data collection, data analysis, quality improvement, and leadership engagement.

Hospital Background: Jasper Memorial is a CAH in Monticello, Jasper County, Georgia. The hospital is licensed for 17 beds and has 12 operational beds that can be used interchangeably as swing beds. Core services include inpatient, outpatient, swing bed, lab, radiology, and therapy services.

Health Equity Statement: Jasper Memorial Hospital will utilize data-driven health equity strategies and quality services to enhance patient health outcomes and reduce health care disparities.

Domain 1A: Our hospital strategic plan identifies priority populations that currently experience health disparities. The information below provides supporting data evidence for each of these priority populations.

Identified Priority Population 1: Black female patients in our hospital experience increased readmissions.

Supporting Data Evidence 1: Using REaL data collected by registration staff, Black females made up 9.3% of our total admissions for CY 2023 but 20% of the readmitted population. This disparity led us to focus on why Black females are readmitting more than other populations.

Identified Priority Population 2: Patients in our hospital lack access to transportation for out-of-town specialist appointments.

Supporting Data Evidence 2: CHNA was completed in 2022, identifying transportation and access to specialists as a community need. However, no exact data was given. It was noted that Jasper County is designated by the Department of Health and Human Services as a Medically Underserved Area (MUA). None of our patients have reported transportation as an issue on the SDOH screening form.

Identified Priority Population 3: Patients in our hospital experience food insecurity due to the lack of access to nutritious, diet-appropriate foods.

Supporting Data Evidence 3: CHNA, completed in 2022, identified poor nutrition as a priority for our community. 35% of Jasper County residents are obese, and fewer than 1 in 10 eat sufficient fruits and vegetables. None of our patients have reported food insecurities as an issue on the SDOH screening form.

Domain 1B: Our hospital strategic plan identifies health care equity goals and discrete action steps to achieve these goals. Below are our organization's Health Equity goals and related action steps.

Health Equity Goal 1: Promote health equity by adequately training hospital staff in collecting race, ethnicity, and language data and SDOH to ensure proper data collection for analysis of patient outcomes.

Related Action Step 1: By September 30, 2024, all nursing and registration staff will complete the applicable Relias training courses related to HEI, SDOH and REaL data collection.

The Quality leader will compile the data by December 31, 2024, and the QAPI committee will use it to extrapolate patient outcomes in relation to SDOH and REaL data.

Health Equity Goal 2: Improve access to care by building on outreach efforts to enroll eligible patients in appropriately available health plans such as Georgia Access, Medicaid, Medicare, or other marketplace plans

Related Action Step 2: By December 31, 2024, the percentage of indigent and self-pay patients will decrease by 50%.

Health Equity Goal 3: Identify community resources to address the five CMS domains, focusing on food insecurities and transportation needs.

Related Action Step 3: By December 31, 2024, establish a quarterly farmers market utilizing Eat Right Atlanta. Provide fresh foods to low-income families at a reduced rate and accept SNAP and EBT benefits.

By December 31, 2024, we will provide the SDOH discharge referral checklist for patients who screen positive on any SDOH domains to provide patients with access to community resources.

Domain 1C: Our hospital strategic plan outlines specific resources for achieving our equity goals. Below is a description of each resource.

Staffing Resources:
Robin Carey, Chief Compliance Officer, Health Equity Champion, Director of Quality
Kelly Raney, Director of Nursing, Case Manager, PFAC Team Leader
Samantha Mashburn, Assistant Director of Nursing, Case Manager
Dr. Nataliya Kubasova, Chief of Staff
Tina Smith, Registration Supervisor

Sonya Rivers, Marketing and Outreach, Director of Human Resources and Ancillary
Robert Cumbie, CEO
Alison Hildebrandt, JHS Board of Directors Chairman

Structural Resources: The ACH SODH questionnaire is now integrated into every admission to the inpatient/swing bed unit and every ED patient triage. We review these screenings daily, but beginning in May 2024, Cerner will incorporate an automatic notification to case management if a patient screens positive. We track readmissions through GHA Care Optics and internally through our EHR. Case management makes follow-up calls with patients at discharge to ensure their needs are being met.

Training Resources: We have two modules of required training in Relias. “An Overview of Population Health,” and “An Overview of Social Determinants of Health.”

We use the training for AHA for our registration staff on REaL data collection.

We are partnered with Alliant Health Solutions as our HQIC program and receive training on Health Equity.

Other Resources: Rural Hospital Tax Credit Funds - pending for 2024

Domain 1D: Our hospital strategic plan describes our approach to engaging key stakeholders, such as community-based organizations. Below is a list of our partners.

National Partner(s): Agency for Healthcare Research and Quality: A wide variety of resources available for education, training, data and analytics, tools to address health disparities, and links to community resources.

Department of Health and Human Services: Healthy People 2030 –Evidence-proven resources for addressing health disparities

National Committee for Quality Assurance: Resources to design and implement strategies to address meeting health disparities.

State Partner(s): Georgia Hospital Association: Provides education, training, and leadership to address health disparities in the rural community.

Alliant Health Solutions: The HQIC program provides support and resources for developing and implementing a strategic plan to address health disparities.

State Office of Rural Health: Provides funding resources for education and training on addressing health disparities in the rural community.

Local Partner(s): Eat Right Atlanta provides fresh vegetables to those with food insecurities through

an EBT and income-based payment scale. They come onsite monthly to serve the community.

Jasper County Health Department: Provides health services to the uninsured and underinsured, including access to diagnostic testing and medications. Participates in our community health assessment.

Jasper County Food Bank: Provides a wide variety of food distribution, including pantry items and fresh vegetables, to patients with food insecurities. It also participates in the community health needs assessment.

Hospital-Specific Partner(s): Jasper Memorial Hospital Auxiliary: This organization provides community engagement and raises funds on behalf of the hospital to provide needed resources. It also participates in the community health needs assessment.

Jasper Memorial Hospital Patient Family Advisory Council: Provides feedback to help improve patient safety and quality. It also provides unique insight into community resources available to those who screen positive for health disparities.

Hospital: Jeff Davis Hospital

Health Equity Leader: Joni Powell, RN/Case Manager

Executive Summary: Jeff Davis Hospital is fully committed to ensuring high-quality and fair health care for all patients and their families within our community. Equity is a central priority within our organization, forming a vital part of our strategic vision for building a healthy community. We understand that achieving this goal necessitates sustained investment and collaborative partnerships with community organizations to tackle the SDOH. These efforts aim to establish an equitable health care delivery system tailored to the specific needs of our rural community. Our strategic plan outlines our hospital's endeavors to meet and exceed the five designated 2024-2029 MBQIP health equity commitment criteria: food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

Hospital Background: The Jeff Davis County Hospital Authority was established in 1959 because the community saw the need for a hospital in Jeff Davis County. There have been many changes over the years within the hospital. In 2004, we became a CAH with 25 beds. We offer many services, including med/surgery, intensive care, endoscopy, 24-hour emergency department, CT, 3D mammography, dexa, ultrasound, diagnostic radiology, 24-hour respiratory Care, Dietary Counseling, Blood Bank, 24-hour laboratory coverage, respite care, swing bed, hospice care, wound care center, behavior intensive outpatient therapy. Our medical staff includes family practice, internal medicine, surgery, cardiology, pathology, radiology, emergency medicine, and pulmonary rehabilitation.

The Jeff Davis Hospital is dedicated to providing the best quality of care to all and meeting the community's health care needs. We strive to be the health care provider of choice for Jeff Davis and surrounding counties.

Being part of the community has been an important goal throughout the years, and with your help and loyalty, we can continue to provide health services that you can depend on.

Health Equity Statement: Jeff Davis Hospital strives to enhance patient well-being and health outcomes across all populations by implementing data-informed health equity interventions and partnering with community resources.

Domain 1A: Our hospital strategic plan identifies priority populations that currently experience health disparities. The information below provides supporting data evidence for each of these priority populations.

Identified Priority Population 1: Substance Abuse

Supporting Data Evidence 1: CHNA for Jeff Davis County was completed in 2022, and respondents identified drug and or alcohol abuse as the most significant factor affecting the quality of life in the community. Prescription drugs or pills were identified as the most abused substance, followed by methamphetamine and alcohol.

Identified Priority Population 2: Food Insecurity

Supporting Data Evidence 2: The University of Wisconsin's County Health Rankings and Roadmaps identified Jeff Davis County as a food desert. This report also shows that 29% of the county's children live in poverty, compared to 17% in Georgia and 16% in the United States.

Identified Priority Population 3: Obesity

Supporting Data Evidence 3: CHNA for Jeff Davis County was completed in 2022. The adult obesity rate had increased by 7% from the previous report to 38%, unfavorably compared to the state of Georgia's average of 32%. The adult diabetes rate is 20% for Jeff Davis County, with the state average of 12%. Diabetes has also increased by 7% in Jeff Davis County since the last report. Obesity/overweight, substance abuse, and physical inactivity were identified as the top three negative influencers of health. EMR BMI Report.

Domain 1B: Our hospital strategic plan identifies health care equity goals and discrete action steps to achieve these goals. Below are our organization's Health Equity goals and related action steps.

Health Equity Goal 1: To build a healthy community by identifying populations experiencing health disparities.

Related Action Step 1: Our hospital has training for staff in culturally sensitive collection of demographic and/or SDOH information.

Collect demographic information, including self-reported race and ethnicity and SDOH data, on inpatients using the PRAPARE tool embedded within our Cern.

Social Services consults are triggered for patients who screen positive for any of the 5 Social Determinants of Health. Case management visits these patients and provides them with resources to assist with these needs.

Health Equity Goal 2: Promote drug abuse prevention and substance abuse treatment within the community.

Related Action Step 2:

- The Project Manager for the Drug-Free Community Grant is active in our school system, working to prevent and reduce substance use among youth. Working with 50 surrounding school counselors to identify mental health and substance abuse concerns.

- Partnering with Emory University on a grant for drug treatment. By August 2024, patients with substance abuse disorders will be able to receive an initial dose of Suboxone from JDH ED with a follow-up visit to a local provider for continued assistance. Narcan is also provided in the ED.
- Establish connections with local drug treatment centers

- Outback & Freedom Living - A bulletin board with resources will be provided
- Patients receiving treatment can receive a gas voucher.
- Starting Point Outreach Counseling - Resources bulletin board and gas voucher for drug treatment.

Health Equity Goal 3: Increase the availability of food to citizens in need.

Health Equity Goal 4: To educate the community on healthy eating/healthy living to decrease obesity

Related Action Step 3:
- Offer free produce at a drive-through farmer's market. The first event was held on June 13, 2024.
- Feeding America/Savannah: Food bank sponsored by Jeff Davis Hospital
- Shop & Serve: Citizens shop for food and buy by the pound.
- Case management provides resources to patients who screen positive for food insecurities.

Related Action Step 4:
- JDH Nutritionist will provide nutrition education to the community.
- Health and wellness classes are offered live and on social media, focusing on weight loss, exercise and flexibility, and personal finance to help budget for healthy foods.
- Healthy eating/healthy living information will be streamed/looped on TV monitors in waiting rooms throughout the hospital.
- Healthy eating/healthy living education provided at Jeff Davis Senior Center.

Domain 1C: Our hospital strategic plan outlines specific resources for achieving our equity goals. Below is a description of each resource.

Staffing Resources:
Joni Powell, RN, Case Management/Social Services (Health Equity Champion)
Bonnie Saunders, BSN, RN, Director of Quality & Accreditation
Barry Bloom, CEO
Cindy McKinnon, RN, CNO
Ivey Grace Churchwell, JDSAC Project Coordinator
Landon Chavis, Director of Public & Govt. Relations
Emily Taylor, RN

Structural Resources: The PRAPARE Tool has been integrated into our Cerner EMR to facilitate the collection of SDOH data. A case management consult task is automatically initiated when a patient screens positive for any SDOH factors. In our patient-centered integrated care model, our case management team connects patients with the appropriate community resources to address their needs.

Training Resources:
- In-house education and training are provided to collect patient information on the PRAPARE Tool.

- REaL data collection education is provided to admission staff from the American Hospital Association. https://ifdhe.aha.org/hretdisparities/collecting-data-nits-bolts
- Additional staff education on Health Equity and SDOH is provided through the hospital education platform Healthstream.
- Partnered with Alliant Health Solutions for our HQIC Program and attended monthly health equity office hours and related learning and education events.

Other Resources:
- Drug-Free Communities Grant
- Rural Hospital Stabilization Funds - Awards Pending in 2024
- Rural Hospital Tax Credit Funds - Awards Pending in 2024

Domain 1D: Our hospital strategic plan describes our approach to engaging key stakeholders, such as community-based organizations. Below is a list of our partners.

National Partner(s): Robert Wood Johnson Foundation - provides funding, research, and strategic guidance that promotes community engagement.

American Hospital Association's Institute for Diversity and Health Equity offers educational training, toolkits, and best practices in health equity.

State Partner(s):
- Georgia Hospital Association and Alliant Health Solutions: Provides hands-on support through the HQIC program and shares resources, training, and networking opportunities focused on addressing health disparities within the state
- Feeding America/Savannah

Local Partner(s):
- Healthy eating/healthy living education provided at Jeff Davis Senior Center
- Southeast Health District
- First Baptist Church - provides meal boxes for citizens
- Hillcrest Baptist Church - food boxes for citizens
- Family Connections
- Jeff Davis County School System - to provide meals to school-age children
- Established connections with local drug treatment centers
- Outback & Freedom Living - bulletin board with resources will be provided
- Patients receiving treatment can get a gas voucher

Hospital-Specific Partner(s): Jeff Davis Hospital is developing a PFAC to collect ideas and improve hospital processes to best meet patients' needs while enhancing health equity and the quality of patient care.

Hospital: Jenkins County Medical Center

Health Equity Leader: Antoine Poythress

Executive Summary: Jenkins County Medical Center strives to be the community leader in health equity and increase access to health care for all groups.

Hospital Background: Our CAH was built in 1974. Currently, 10 of the beds are dedicated to IP behavior health services.

Health Equity Statement: Jenkins County Medical Services strives to ensure all individuals have equal and equitable access to all health care services provided at the facility.

Domain 1A: Our hospital strategic plan identifies priority populations that currently experience health disparities. The information below provides supporting data evidence for each of these priority populations.

Identified Priority Population 1: Outreach program to minority groups.

Supporting Data Evidence 1: Meeting with local minority groups to educate them on accessing hospital services, behavioral health treatment, and minority males' access to health care.

Domain 1B: Our hospital strategic plan identifies health care equity goals and discrete action steps to achieve these goals. Below are our organization's Health Equity goals and related action steps.

Health Equity Goal 1: Increase minority access to ED services.

Related Action Step 1: Community engagement meetings

Health Equity Goal 2: Improve relationships with minority groups

Related Action Step 2: Interaction with minorities while in the facility

Health Equity Goal 3: Hospice education

Related Action Step 3: Community engagements

Domain 1C: Our hospital strategic plan outlines specific resources for achieving our equity goals. Below is a description of each resource.

Staffing Resources: CEO and one support staff

Training Resources: Community Education

Other Resources: Hospital operations

Domain 1D: Our hospital strategic plan describes our approach to engaging key stakeholders, such as community-based organizations. Below is a list of our partners.

National Partner(s): AHA

State Partner(s): Georgia Hospital Association

Local Partner(s): County Commissioners
NAACP

Hospital-Specific Partner(s): Local community groups

Hospital: Liberty Regional Medical Center

Health Equity Leader: Donna M. Crosby, Compliance Officer and Director of Quality

Executive Summary: The Hospital Authority of Liberty County fully supports providing innovative, high-quality care to all our patients and their families at Liberty Regional Medical Center (LRMC). We understand that achieving this goal requires long-term effort, dedicated investments, and key partnerships with our community-based organizations to address SDOH and promote an equity-focused health care delivery system tailored to our rural community's unique needs. In line with the FY2023 IPPS/LTCH final rule, the CMS requires hospitals participating in the Hospital Inpatient Quality Reporting program to annually report on the Hospital Commitment to Health Equity Measure. Our Quality Strategic Plan outlines LRMC's efforts to address and demonstrate activities within the five identified. CMS health equity commitment domains:

- Strategic planning
- Data collection
- Data analysis
- Quality improvement
- Leadership engagement.

The SDOH committee at LRMC is comprised of the following members: Donna Crosby, RN, compliance officer/director of quality; Donna Cochrane, CNO, utilization management; John Dekle, director of emergency department; Prandalyn Scurles, director of medical practices; Kim Coetzee, director of the medical surgical department; Heather Daniels, director of perinatal services; Mary Pizzino, director of HIM and informatics; Heather Dyer, director of patient financial services/patient access; and Sakina Pennywheel, financial services.

Hospital Background: LRMC is a nonprofit CAH in Hinesville, Georgia. LRMC is licensed for 25 beds that are fully staffed and operational. We offer swing beds, a medical-surgical unit, and a perinatal unit. Our core hospital services include observation, inpatient care, swing bed services, labor and delivery, an 18-bed with three trauma rooms, an emergency department (seeing over 30,000 patients per year), surgical services, laboratory, radiology, cardiac and respiratory rehabilitation, as well as speech, occupational, and physical rehabilitation. LRMC also owns Liberty Family Medical Practices, Liberty Obstetrics and Gynecology, and Liberty Surgical Associates. Liberty Family Medical Practice has campuses in Hinesville and Midway. LRMC also has a walk-in clinic with a separate front entrance at the hospital. In partnership with St. Joseph/Candler, LRMC offers medical oncology and infusion services. Furthermore, LRMC operates a 108-bed skilled nursing facility in Ludowici, Georiga, which provides 24-hour nursing services, rehabilitation therapy (including physical, occupational, and speech therapy), daily activity programs, and a specialty care unit (SCU) for Alzheimer's/dementia care with secure indoor and outdoor areas.

Health Equity Statement: LRMC is dedicated to improving our patients' health outcomes and reducing health disparities through data-driven health equity interventions and quality services.

Domain 1A: Our hospital strategic plan identifies priority populations that currently experience health disparities. The information below provides supporting data evidence for each of these priority populations.

Identified Priority Population 1: Transportation: Patients admitted to the hospital state they have no transportation.

Supporting Data Evidence 1: When inpatients were admitted to the hospital, two out of 12 mentioned that they had no means of transportation, which affected their ability to receive adequate care. The patients were asked SDOH questions from April 9, 2024, through April 30, 2024. The patients who reported transportation issues were African American and white, and their ages ranged from 48 to 82.

Identified Priority Population 2: Food: Patients admitted to the hospital stated it was difficult to prepare food.

Supporting Data Evidence 2: When inpatients were admitted to the hospital, two out of 12 mentioned having difficulty affording and preparing food. The patients were asked SDOH questions from April 9, 2024, through April 30, 2024. Patients who reported transportation issues were African American, and their ages ranged from 69 to 82.

Identified Priority Population 3: Utilities: Patient stated that paying for his utilities was difficult.

Supporting Data Evidence 3: When inpatients were admitted to the hospital, one out of 12 mentioned they had difficulty affording utilities. The patients were asked SDOH questions from April 9, 2024, through April 30, 2024. The patients who reported transportation issues were of African American race, with an age of 69.

Domain 1B: Our hospital strategic plan identifies health care equity goals and discrete action steps to achieve these goals. Below are our organization's Health Equity goals and related action steps.

Health Equity Goal 1: Provide innovative, ethical, and respectful health services for underserved populations and those experiencing health disparities.

Related Action Step 1: On August 9, 2023, LRMC held its first SDOH meeting, which involved the compliance officer/director of quality, chief nursing officer, director of the emergency department, director of health information management/informatics, and the director of medical practices. In the meeting, the team introduced SDOH data and health equity requirements and discussed the steps for implementing the data collection process, educating on SDOH/health equity, identifying the participants involved in the process, and determining the data capture points.

A team was formed that included the director of financial services, case manager/utilization management, director of the medical surgical department, director of perinatal services, director of the emergency department, financial counselor, director of medical practices, chief nursing officer, director of him/informatics, and the compliance officer/director of quality. On September 15,

2023, the SDOH/Health Equity Committee convened to review the progress of the data collection implementation and education.

In December 2023, LRMC incorporated health equity and SDOH into the Quality Strategic Plan, with Donna Crosby, the compliance officer/director of quality, appointed as the leader.

Health Equity Goal 2: LRMC will collect, evaluate and educate using the REaL data. The data collected will include race, ethnicity, and language, along with the SDOH questions. LRMC will develop evidence-based interventions using all the data collected.

Related Action Step 2: In April 2024, we began collecting data manually for inpatients on the medical-surgical and perinatal floor. Electronic data collection also started in the emergency department and medical practices. Upon reviewing the collected data, we noticed a need for more education in the emergency department regarding the importance of collecting health equity data correctly. The emergency department director included this education in the department staff meeting agenda. Data collection in the medical practices, medical-surgical, and perinatal services was at 100%.

Health Equity Goal 3: The SDOH/Health Equity Committee will develop resources for any necessary interventions to promote health equity and provide holistic healthcare to patients.

Related Action Step 3: We created a list of resources for SDOH insecurities. Our case management team identifies any SDOH insecurities and helps to obtain the necessary resources. We also provide a resource list to patients. Additionally, our financial counselor meets with private-pay patients daily to assist with indigent care applications and explore other helpful resources, such as Medicaid or Medicare.

In the perinatal department, a program called Moms Heart Matters provides home blood pressure monitoring for mothers with hypertension during pregnancy, pre-eclampsia or eclampsia. It allows nurses to monitor the readings and contact a physician if necessary to adjust medications or arrange for the patient's return to the hospital if needed. We collaborate with a cardiologist group to schedule follow-up appointments for these mothers upon discharge.

Domain 1C: Our hospital strategic plan outlines specific resources for achieving our equity goals. Below is a description of each resource.

Staffing Resources: Donna Crosby, compliance officer/director of quality; Donna Cochrane, chief nursing officer; Kim Coetzee, director of medical surgical department; John Dekle, director of emergency department; Heather Daniels, director of perinatal department; Heather Dyer, director of patient financial services; Mary Pizzino, director of HIM/informatics, Seimitsu IT, Stratus Video language interpretation services; Jessica Dutter, case management; Leigh Freeman, utilization management; Prandalyn Scurles, director of medical practices; Sakina Pennywell, patient financial.

Structural Resources:

- REaL data collection is completed by Donna M. Crosby, compliance officer/director of quality. The training used was CMS and CMMI Accountable Health Communities (AHC) Health-

Related Social Needs (HRSN) Screening tool. These tools were used to incorporate the questions into our EHR. Additionally, we placed the health equity questions in the Medical Practices EHR. The questions are a hard stop, so they have to be answered before the patient can move forward with their registration process. We are working with Centricity, Tsystems, and CPSI to get the data collection electronic.

- We completed the Health Equity Gap Analysis.

- We also partner with Alliant Health Solutions for our HQIC program and attend monthly health equity-related learning and education events.

Training Resources:
- Health Quality Innovation Network (HQIN) REaL Data Collection Script and Definition
- CMS/CMMI/AHC/HRSN Screening Tool
- Alliant Health Solutions slide on SDOH and involving Community Partnerships

Other Resources: There is a need for more funds to help with the upgrade of the EHR, however, we receive the following funds:
- GA SORH Flex Grant.
- Small Rural Hospital Improvement Program (SHIP) Funds

Domain 1D: Our hospital strategic plan describes our approach to engaging key stakeholders, such as community-based organizations. Below is a list of our partners.

National Partner(s):
- American Hospital Association: Education and resources
- United Way: Provides assistance in education, economic mobility, and health resources.
- United Healthcare's Healthy at Home program: Offers assistance to eligible patients for 30 days following all inpatient and skilled nursing facility discharges. Participants may receive the following benefits:
    - 28 meal deliveries through Mom's Meals. To access this benefit, individuals must be referred by a United Healthcare Advocate. The contact number for this referral is 1-866-204-6511.
    - 12 one-way rides to medically related appointments and the pharmacy. To access this benefit, individuals must be referred by a United Healthcare advocate. The contact number for this referral is 1-833-219-1182, or visit www.modivcare.com/BookNow.
    - Six hours of in-home personal care provided through a CareLinx professional caregiver. This includes preparing meals, bathing, medication reminders, and more. To access this benefit, the contact number is 1-844-383-0411 or visit www.carelinx.com/UHC-retiree-post-discharge.U.S. Public Health Department: promotes health, medicine, public health, and social services.
- Family Promise: A nonprofit organization that offers assistance to homeless families.
- Representative Buddy Carter: Provides advocacy

State Partner(s):

- Georgia Hospital Association provides additional funding support and helps us target SDOH resources unique to rural communities.
- Georgia Hospital Association and Alliant Health Solutions offer hands-on support through the HQIC program and provide resources, training, and networking opportunities focused on addressing health equity disparities within the state.
- Georgia Department of Public Health provides various programs focusing on women's and newborns' health, including WIC, First Steps, Family Connections, TANF, and assistance from a Medicaid nurse to help with Medicaid application. Job Training: Georgia Department of Labor
- https://findhelpga.org for assistance as needed.
- Ben Watson, Georgia State Representative: Advocacy
- A.L. Williams, Georgia State Representative: Advocacy
- Georgia Perinatal Quality Collaborative (GaPQC) provides funding to improve the health outcomes for mothers and babies.

Local Partner(s):

- America's Second Harvest of Coastal Georgia: Provides a community distribution list with the food distribution location.
- City of Hinesville Homeless Coalition: Provides temporary housing for discharged homeless patients.
- Safe Harbor Children's Coalition CARES Homeless Prevention Emergency Shelter: Provides clothing, meals, transportation, counseling, psychiatric services, school support, independent living skills, medical, dental, and onsite visitation.
- Coastal Georgia Area Commission Action Authority CARES Homeless Prevention: Provides Low-Income Heating and Energy Assistance Program (LIHEAP), Emergency Food and Shelter Program (FEMA), Volunteer Income Tax Assistance Program (VITA), Senior Center Program (MCC), Community Action Youth Leadership Initiative (C.A.Y.L.I.), and the Meals-On-Wheels Program (MOW).
- Park Place Outreach, Inc. CARES Rapid Rehousing Street Outreach: Provides youth emergency shelter, meals, and counseling to at-risk youth and their families.
- Grocery/Food/Rent/Utilities Assistance: A resource list of the churches in our area that can help.
- Emergency Shelter: American Red Cross, Liberty County DFACS, and Next Step.
- Military Only: Army Community Service, Army Emergency Relief, and Fort Stewart Red Cross.
- Job Training: Liberty Adult Education
- Clothing Assistance: American Red Cross, Liberty County Manna House, and a church list.
- Health Assistance: Babies Can't Wait, Care South/St. Joseph Candler, Diversity Health, Liberty County Health Department, Liberty County WIC, and some churches.
- Housing: Homeless Prevention Program
- Health Care Alliance: Resources
- Liberty County Commissioners: Donald Lovette; Marion Stevens, Sr., Justin Fraiser, Connie Thrift, Maxie Jones IV, Gary Gillard, Eddie Walden
- City of Hinesville: Mayor Karl Riles, Diana Reid, Jason Floyd, Vicky Nelson, Dexter Newby, Jose Ortiz, Jr., City Manager Kenneth Howard, and Assistant City Manager Ryan Arnold.
- Transportation: Coastal Regional Coaches has a stop in our parking lot with an affordable fee.

Hospital-Specific Partner(s):

- Financial Assistance: A patient financial representative visits each morning to provide indigent applications to privately pay patients. We initiate the iVita medical health care line of credit application process at our facility. If the patient is approved, they make payments based on their ability to pay. Ameris Bank sends the hospital the approved sum, and the patient makes payments directly to Ameris Bank.
- Transportation: The hospital has acquired a non-emergency vehicle for patient transportation.
- Financial/Transportation/Housing/Food/Interpersonal safety/Readmissions: The Care Plan Committee and Case Manager talk with any admitted patient with SDOH insecurities. They make referrals, research assistance, and provide a resource list.
- “Mom’s Heart Matters” is an internal program developed to address health disparities in high-risk populations for maternal morbidity and mortality. Patients at risk for high blood pressure after delivery, pre-eclampsia, or eclampsia are provided with education and a blood pressure cuff before being discharged. The blood pressure readings are then sent to a nurse who can identify and communicate any abnormal readings to the physician. The physician can then adjust the patient’s blood pressure medications, prescribe new medications, or request the mother return to the hospital as needed. Additionally, the program refers any patient diagnosed with pre-eclampsia or eclampsia for follow-up. The data from our program is collected and compiled by Mercer University.

Hospital: Miller County Hospital

Health Equity Leader: Ashley Ward

Executive Summary: Miller County Hospital strives to provide safe, quality, equitable care to all patients and families in our facility. This effort requires teamwork with community organizations to address the SDOH and to provide equity-focused health care to our community.

Hospital Background: Miller County Hospital is a non-profit general acute care hospital in Colquitt, Georgia. In addition to inpatient medical and behavioral health services, the hospital offers a nursing home, a pharmacy, and outpatient services.

Health Equity Statement: To improve patient health outcomes and reduce health disparities through safe, quality, effective patient care.

Domain 1A: Our hospital strategic plan identifies priority populations that currently experience health disparities. The information below provides supporting data evidence for each of these priority populations.

Identified Priority Population 1: Patients in our hospital experiencing food insecurity.

Supporting Data Evidence 1: CHNA completed in 2022 for Miller County showed that 15% of the population in Miller County experienced food insecurity. The state average is 13%.

Identified Priority Population 2: Patients in our community have relatively worse health outcomes than the rest of the state.

Supporting Data Evidence 2: According to the CHNA completed in 2022, many county residents report poor physical and mental health.

Identified Priority Population 3: 75+ White females have a higher admission rate for respiratory disorders.

Supporting Data Evidence 3: Analyzed claims data with different diagnoses and discovered that more older white females are admitted with respiratory disorders than any other population.

Domain 1B: Our hospital strategic plan identifies health care equity goals and discrete action steps to achieve these goals. Below are our organization's Health Equity goals and related action steps.

Health Equity Goal 1: Implement interventions in our hospital for patients experiencing readmissions.

Related Action Step 1: Collect and track data on readmissions throughout the year and stratify by race/ethnicity. Try to drill down, find a cause, and implement interventions to reduce readmissions.

Health Equity Goal 2: Implement interventions for patients experiencing transportation access issues.

Related Action Step 2: Collect monthly PREPARE data and track the number of patients screened positive for experiencing transportation difficulties. Continue to work with community resources to assist patients with transportation.

Health Equity Goal 3: Implement interventions to help alleviate food insecurities for patients

Related Action Step 3: Collect and trend data for patients screening positive for experiencing food insecurities. Educate patients and the community about the resources available and how to access those resources.

Domain 1C: Our hospital strategic plan outlines specific resources for achieving our equity goals. Below is a description of each resource.

Staffing Resources:
Ashley Ward, Quality and Risk Management Manager
Shawn Whittaker, Chief Nursing Officer
Bobby Grubbs, Med Surg Nurse Manager
ED Department Leadership
Case Management Team
Registration Staff
Dietary Team
Transportation Team
Language Line

Structural Resources: Our EHR has the PRAPARE assessment to help collect SDOH data. Our social workers administer the questionnaire and can provide resources to a patient and the case management team if a patient screens positive. On discharge, patients are given a folder with resources available throughout the community and are made a follow-up appointment with their physician.

Training Resources: We conduct in-house training on using the PREPARE tool, referring patients to resources, collecting REaL and SDOH data, and reporting health equity.

Education is also received through GA SORH and Alliant Health Solutions through the FLEX grant.

Other Resources:

Domain 1D: Our hospital strategic plan describes our approach to engaging key stakeholders, such as community-based organizations. Below is a list of our partners.

National Partner(s): American Hospital Association extends education on Health Equity and provides training, toolkits, and patient education.

National School Lunch Program: This program helps provide free or reduced-cost lunches at school for children and often provides bags of food or lunches during the summer.

State Partner(s):

- Georgia Office of Rural Health and Alliant Health: Offers training through the GA Flex Grant and provides training, resources, and best practices on health equity.
- Southwest Georgia Community Action Council: Provides programs that help ease the burden of some insecurities community members may face.

Local Partner(s):

- Colquitt United Methodist Church: Provides a food pantry to the community that is open on Saturdays.
- Southwest Georgia Regional Transit: Provides affordable and accessible transportation to the community for errands, doctors appts, etc.

Hospital: Monroe County Hospital

Health Equity Leader: Logan Duncan

Executive Summary: Health equity is a journey taken with empathy, attention, and commitment. Our community's care has been unceasing and unwavering to ensure all patients have an equitable opportunity for optimal outcomes. Our facility will acquire data on admitted patients to analyze our patient population for any health disparities. Our Utilization Review Committee will review this data, and trending data will be taken to our Quality Management Oversight Committee.

Hospital Background: Our hospital is a 25-bed critical access with a 9-bed emergency department in Forsyth, Georgia. We service inpatient, observation, swing bed, emergency department, outpatient surgery, and outpatient populations in our community and surrounding communities that do not have a hospital. Most of our med/surg unit patients are swing bed patients.

Health Equity Statement: We aim to screen and evaluate all admitted patients for health disparities or SDOH. We also aim to improve patient's clinical outcomes by providing resources to help them overcome any health disparities they may be encountering.

Domain 1A: Our hospital strategic plan identifies priority populations that currently experience health disparities. The information below provides supporting data evidence for each of these priority populations.

Identified Priority Population 1: White patients in our hospital experience an increased readmission rate.

Supporting Data Evidence 1: Our hospital's internal data, combined with GA Notify data, revealed that African American and white patients are admitted at similar rates. However, the readmission data showed that the white population is readmitted more than the African American population. We are still working to get the root cause analysis and statistical data to support this theory.

Identified Priority Population 2: White female patients with a diagnosis of respiratory illness such as CHF and/or Pneumonia were at a higher rate of readmission.

Supporting Data Evidence 2: Our hospital's internal data and GA Notify data revealed that white females with respiratory-related illnesses have higher readmission rates than all admitted patient populations and diagnoses. CHF was observed at a rate of 23%, and Pneumonia at a rate of 10%.

Identified Priority Population 3: White females with respiratory-related illnesses who have Medicare are at a higher rate of readmission than other patient populations and are patients who are discharged to home.

Supporting Data Evidence 3: Our hospital's internal data, combined with GA Notify data and the facility's most recent CHNA, revealed that white females with respiratory-related illnesses who

have Medicare as their insurance have a higher readmission rate than the overall admitted patient population.

Domain 1B: Our hospital strategic plan identifies health care equity goals and discrete action steps to achieve these goals. Below are our organization's Health Equity goals and related action steps.

Health Equity Goal 1: Conduct best practice interventions for white patients with respiratory-related illnesses who are experiencing an increase in readmissions.

Related Action Step 1: For CY 2024 (starting 02/2024), we will conduct monthly data tracking, trending, and aggregating data by race/ethnicity, and diagnosis.

Health Equity Goal 2: Identify and trend all five categories of SDOH and pick the top two health disparities among the MCH patients.

Related Action Step 2: For CY 2024 (starting 02/2024), we will conduct monthly data tracking and trending for all patients who screen positive for any social health determinates in the five categories of transport, housing, utilities, food insecurity, and social insecurity.

Health Equity Goal 3: Conduct best practices for interventions/resources for patients who screen positive for health disparities.

Related Action Step 3: For CY 2024 (starting 02/2024), we will aggregate the data from SDOH questions to determine our top priority areas and patients at high risk for readmission.

By July 2024, we will have completed the Alliant SDOH discharge referral checklist and adopted it into our discharge planning process for patients needing any identified areas of concern regarding social determinants of health.

By October 2024, our hospital will have identified resources for patients in the top two categories and will continue to work towards identifying additional resources for all categories of SDOH. Grant opportunities will also be explored.

Domain 1C: Our hospital strategic plan outlines specific resources for achieving our equity goals. Below is a description of each resource.

Staffing Resources:
Patient Access Manager
Case Manager
Quality Coordinator
Med/Surg manager
All Med/Surg nursing staff

Structural Resources: The PRAPARE Toolkit questionnaire has been embedded into our EHR via an electronic form. This electronic form allows us to aggregate data every month. The five SDOH questions are also embedded into the nursing assessment discharge plan and are asked upon admission to the unit.

Our case manager provides resources to any patients who screen positive for the SDOH questions via a paper document. Readmissions are tracked by our quality coordinator. Data is reviewed and trended in our utilization review committee and escalated to our QMS structure as necessary.

Training Resources: We will conduct in-house data collection training for our registration, nursing, quality, and case management teams. In addition, we will partner with GA SORH and Alliant Health Solutions in the FLEX HIE Improvement project and participate in monthly training sessions.

Other Resources:

- Our hospital recognizes the need for additional funding sources to support our efforts in this project, including, but not limited to, community meals, food/housing vouchers, etc.
- Rural Hospital Tax Credit Funds can be utilized.
- Rural Stabilization Grant Funds – awards pending 2025
- HRSA Grant – awards pending 2025

Domain 1D: Our hospital strategic plan describes our approach to engaging key stakeholders, such as community-based organizations. Below is a list of our partners.

National Partner(s):

- American Hospital Association's Institute for Diversity and Health Equity- Offers training, toolkits, and best practices for health equity.
- American Public Transport Association—We will contact them to see what they can do to help develop transportation solutions and advocate for improving access to transportation for patients facing transport challenges in rural Georgia.

State Partner(s):

- Georgia Hospital Association
- Georgia State Office of Rural Health and Alliant Health Solutions: Provides hands-on support through the GA FLEX HEI program and shares resources, training, and networking opportunities to address health disparities.
- Georgia Food Bank Association: Collaborate with the association to access local food banks and distribution networks to address patient food insecurity.
- Rural Transit Authorities: Working with the rural transit authorities to develop affordable and accessible transportation options for patients who lack transportation to their follow-ups.
- Area Agency on Aging: Helps provide resources for all areas of health disparities for the geriatric population.
- Georgia LIHEAP: Assist families in need of heating and cooling.

Local Partner(s):

- Forsyth Methodist Church: Collaborating with them to assist patients with food insecurities.
- New Providence Baptist Church: Provides funding to families in need.
- Kingdom Builders: Provides housing and building ramps for needy families.
- Older American's Council (OAC): Provides many resources for the geriatric population.
- UGA extension office: Provides resources for fitness and nutritional programs.
- Middle Georgia Community Action Agency: Assists with cooling to those that meet criteria.
- Salvation Army Macon Emergency Shelter and Rescue Mission of Middle Georgia: Provides temporary housing and shelter

Hospital-Specific Partner(s):

- Morrisons: Provides balanced nutritional meals to our patients and our communities. Meals can be made for the community to purchase that are balanced based on their dietary restrictions.
- Food, Fitness, First: Our dietician consulting company.

Hospital: Morgan Medical Center

Health Equity Leader: Caitlin Gibson

Executive Summary: The board of Morgan Medical Center is committed to delivering high-quality and equitable care to all patients and their families. Emphasizing equity as a core organizational goal, our strategic plan aims to serve our communities effectively. We understand the need for sustained investment and strong partnerships with local organizations to tackle health disparities and cultivate an equity-driven health care system tailored for our rural area. In line with recent requirements by the CMS, Morgan Medical Center is dedicated to annually reporting on its Health Equity Commitment, reflecting our ongoing efforts in strategic planning, comprehensive data collection and analysis, quality improvement initiatives, and leadership engagement. This executive summary underscores Morgan Medical Center's dedication to these principles, showcasing our proactive approach to meeting and exceeding the standards set forth for health equity.

Hospital Background: Morgan Medical Center, formerly Morgan Memorial Hospital, is a 25-bed CAH. It is owned and operated by the community of Morgan County. A nine-member Hospital Authority governs it. The hospital is designated as a level IV trauma center and is certified as a remote treatment stroke center. Hospital services include swing beds, inpatient, outpatient, radiology, laboratory, and surgery.

Health Equity Statement: Morgan Medical Center commits to continuously improving health equity in our facility. Facility leadership, Ralph A. Castillo, CPA, CEO and Karen Young, RN, CNO, are dedicated to implementing the Joint Commission and CMS standards regarding eliminating disparities and ensuring equitable health care to all patient populations. Our administration will identify a health equity leadership team at our facility. This leadership team will include key personnel responsible for advancing health equity and actively engaging in strategic planning activities to reduce disparities.

Domain 1A: Our hospital strategic plan identifies priority populations that currently experience health disparities. The information below provides supporting data evidence for each of these priority populations.

Identified Priority Population 1: African American patients in our hospital are experiencing increased readmissions.

Supporting Data Evidence 1: Using the REaL data collected by our registration department, we observed that the African American population accounts for only 19% of our inpatient admissions but 27% of our 30-day readmissions. This finding encouraged our organization to focus on the root-cause analysis for the reason behind the higher re-admission ratio.

Identified Priority Population 2: Patients in our hospital experiencing housing instability.

Supporting Data Evidence 2: The CHNA report for Morgan County, completed in 2022, showed that 23.26% of residents reported homelessness as a factor affecting the quality of life in the community.

The SDOH questionnaire information collected for admitted patients showed housing instability as a reported problem.

Identified Priority Population 3: Patients in our hospital with difficulty retrieving prescription medications following hospital stays.

Supporting Data Evidence 3: 16 patients reported difficulty retrieving their medications following hospital encounters from January to April 2024. None reported difficulty during the SDOH assessment.

Domain 1B: Our hospital strategic plan identifies health care equity goals and discrete action steps to achieve these goals. Below are our organization's Health Equity goals and related action steps.

Health Equity Goal 1: Implement evidence-based interventions to improve outcomes for African American female hospital patients facing readmissions.

Related Action Step 1: In CY 2024, the case management office will regularly analyze data on readmission rates by race/ethnicity, specifically focusing on African American female patients. The goal is to identify underlying reasons for readmissions and track progress in reducing readmission rates for this demographic.

In CY 2024, all inpatient admissions will be assessed using the LACE scoring tool. Patients with a score of 10 or more are classified as high risk for readmissions and will receive a follow-up phone call within 48 to 72 hours.

Health Equity Goal 2: Implement evidence-based interventions for patients in our hospital who are facing housing insecurity.

Related Action Step 2: In CY 2024, we will regularly track data on the admission rate of patients who screen positive for housing insecurity and closely monitor our progress in reducing readmission rates for these patients.

By October 2024, MMC will contact surrounding shelters for additional information regarding the length of stay limits and requirements to stay.

Starting in May 2024, our hospital will incorporate the Alliant Social Determinants of Health (SDOH) discharge referral checklist into our discharge procedures. This checklist will facilitate shelter referrals for patients identified as experiencing housing insecurity.

Health Equity Goal 3: Implement evidence-based strategies to assist patients in our hospital who face challenges receiving medications after discharge.

Related Action Step 3: In CY 2024, we will regularly track data on the admission rate of patients who screen positive for difficulty receiving medications. Additionally, we will closely monitor our progress in reducing readmission rates for these patients.

By May 2024, MMC will enhance the existing indigent care form for medication requests. Additionally, we will introduce MMC insurance cards to simplify the medication process for patients after admission.

As part of the indigent care program, patients with challenges accessing medications will be directed to our pharmacy and patient financial services. This will ensure they receive the necessary medications before discharge.

Domain 1C: Our hospital strategic plan outlines specific resources for achieving our equity goals. Below is a description of each resource.

Staffing Resources:
Caitlin Gibson, Case Management Manager, Health Equity Champion
Susan Jackson, Director of Quality
Vincent Cavaliere, Pharmacy Manager
Laura Hays, Dietary Manager
Rosenda Bretz, Supervisor of Patient Access Services
Medical Staff Executive Team

Structural Resources: The PRAPARE Tool has been embedded into our EHR to support SDOH data collection. The nursing staff completes the SDOH form on all patients on the Med-Surg floor. Case management audits all forms for positive responses and provides appropriate resources and follow-up calls to the patient.

Training Resources: In-house training has been provided to the nursing staff regarding collecting SDOH data, the PRAPARE tool, and the referral process to case management. Case management attends monthly meetings with Alliant Health Solutions regarding the Georgia State Office of Rural Health Flex Grant for Health Equity Improvement. By June 2024, registration staff will be trained to collect REaL data. Furthermore, we will organize internal training sessions for new hires and existing hospital staff. These sessions will cover implementing several new tools and processes, including the SDOH referral process, PRAPARE tool, REaL, and SDOH data collection. Additionally, we focus on health equity by providing monthly reporting.

Other Resources: Small Rural Hospital Improvement Program (SHIP) Funds
Rural Hospital Tax Credit Fund

Domain 1D: Our hospital strategic plan describes our approach to engaging key stakeholders, such as community-based organizations. Below is a list of our partners.

National Partner(s):

- The American Hospital Association provides educational resources to advance health equity for minority groups.
- National Quality Forum specializes in implementing quality metrics targeting health disparities and monitoring performance improvement.

State Partner(s):

- Georgia Hospital Association provides additional funding support and education to promote health equity.
- Alliant Health Solutions provides numerous resources and training to achieve a strategic plan to combat health equity disparities.

Local Partner(s):

- Morgan County Health Department conducts community health assessments, offers health education and initiates local efforts to address health disparities.
- Morgan Community Food Pantry provides food distribution services to our community.
- MMC is also partnered with the Rotary Club, Kiwanis, Morgan Co. Family Connections Collaborative, and Morgan Co. Chamber of Commerce.

Hospital-Specific Partner(s):

- Action, Inc. can provide rental, mortgage and utilities assistance for families or individuals who are unable to pay their bills.
- Morgan County Transit can provide transportation assistance to patients for follow-up appointments.

Hospital: Mountain Lakes Medical Center

Health Equity Leader: Cynthia Boulden

Executive Summary: Mountain Lakes Medical Center aims to achieve equitable health care access and outcomes for all individuals and communities, regardless of race, ethnicity, socioeconomic status, disability, or other social determinants of health.

Hospital Background: We are a for-profit CAH in Rabun County, Georgia. Mountain Lakes is licensed for 25 beds, and we are currently staffing 16 beds, including swing beds.

Health Equity Statement: We will identify and address the root causes of health care disparities through a multi-faceted approach that focuses on data analysis, community engagement, policy advocacy, and culturally competent care delivery.

Domain 1A: Our hospital strategic plan identifies priority populations that currently experience health disparities. The information below provides supporting data evidence for each of these priority populations.

Identified Priority Population 1: Uninsured low-income residents experiencing high readmission rates due to a lack of resources for chronic disease management.

Supporting Data Evidence 1: According to the U.S. Census Bureau, an estimated 22.1% of residents under 65 in Rabun County lacked health insurance in 2022, and 14.5% live below the national poverty line. This is about 20% higher than the national average. This can cause delays in seeking preventive care and treatment for chronic conditions and limited access to ongoing care and medication adherence that can worsen existing chronic conditions like diabetes, heart disease, and asthma, causing frequent hospital admissions for chronic condition exacerbation.

Identified Priority Population 2: Patients in our hospital who do not speak English or speak it as a second language.

Supporting Data Evidence 2: According to the U.S. Census Bureau, 8.3% of Rabun County residents spoke a language other than English at home in 2022. This population is expected to increase. Access to appropriate translation services can prevent miscommunication with health care providers, which can lead to misdiagnoses and misunderstandings.

Identified Priority Population 3: Patients in our hospital with low education levels and poor health literacy.

Supporting Data Evidence 3: Lower education levels and poor health literacy can make understanding health information difficult and navigating the health care system difficult. 28.3 % of the population in Rabun County is 65 or older (US Census Bureau). Due to rural areas' social and economic disadvantages, this population is less likely to have obtained a college degree or, in some

cases, a high school diploma. This leads to difficulty understanding instructions given by health care providers and obtaining the needed services to prevent readmission.

Domain 1B: Our hospital strategic plan identifies health care equity goals and discrete action steps to achieve these goals. Below are our organization's Health Equity goals and related action steps.

Health Equity Goal 1: Foster a culture prioritizing health equity by improving access to quality, safe, and effective health care services for underserved communities and populations facing health disparities.

Related Action Step 1: In May 2024, our hospital took a significant step toward health equity. We appointed our Compliance Officer as the health equity champion and established a task force focusing on case management. This task force will conduct a comprehensive health equity gap analysis for our hospital, identifying areas where underserved populations may face disparities in care. By December 2024, the task force will dedicate key personnel within our facility to drive these efforts. Additionally, we plan to utilize CPSI to track hospital inpatient admissions and align them with the appropriate SDOH measures. This tool allows us to track relevant SDOH data, enabling us to better connect patients with the resources they need after discharge.

Health Equity Goal 2: We are committed to understanding why some patients experience different health care outcomes. By collecting data on race, ethnicity, language, and social factors, we aim to identify and address these disparities. This will lead to the development of personalized interventions that improve the health of all our patients.

Related Action Step 2: To streamline the collection of SDOH data, our hospital is implementing an integrated process by December 2024. This process will involve nursing and case management staff utilizing the health equity tool embedded within our CPSI EHR. This initiative will enable us to:

- Gather vital SDOH data every month.
- Stratify and track this data alongside key CMS quality metrics, such as chronic disease management and readmission rates.
- Display these insights on our hospital performance dashboards for ongoing monitoring and improvement.

Health Equity Goal 3: To bridge health equity gaps, we will develop culturally and linguistically appropriate health care interventions. We will then equip our hospital staff with comprehensive training on these best practices, ensuring they can deliver culturally sensitive and effective patient care.

Related Action Step 3: Our hospital is committed to advancing health equity. Here are some key initiatives we're implementing:

- Mandatory Health Equity Training: All nursing, case management staff, and relevant personnel will undergo comprehensive health equity training through Hometown Health. This training will equip them with the knowledge and skills to deliver culturally sensitive and equitable care.

- Enhanced Discharge Planning: We are adopting the Alliant SDOH discharge referral checklist. This will allow us to identify patients with unmet social needs, such as transportation, housing, or food insecurity, and connect them with critical community resources upon discharge.
- Z-Code Implementation and Training: In collaboration with the billing department, we will integrate Z-coding into our system. We will also train medical and registration staff on proper Z-code charting to ensure accurate billing for our health equity services.

Domain 1C: Our hospital strategic plan outlines specific resources for achieving our equity goals. Below is a description of each resource.

Staffing Resources:
Cynthia Boulden, Health Equity Taskforce Lead
Molly Lovett, Infection Prevention
Cynthia Gray, CNO
Kristy Wright, ADON
Stephen Wheeler, ADON
Walt Wilburn, ADON
Laura Quinn, Educator
Susan Fisher, Case Management
Mandy Kuntz, Lifecare Specialist
Megan Cassada, Patient Access Director
Kim Terrell, Dietician
Team Language Line

Structural Resources: Our hospital is committed to addressing SDOH and improving patient outcomes.
Here's how we achieve this:

- Seamless SDOH Data Collection: We've embedded the Health Equity tool within our EHR, streamlining the process of identifying patients with social needs during their visits.
- Integrated Care Model: Positive SDOH screenings trigger a case management consult. This could include transportation assistance, housing support, or food banks. We provide these resources via paper lists to ensure accessibility.
- Proactive Discharge Planning: We will implement a feedback loop to track patient resource utilization within 72 hours of discharge. Additionally, we will develop a report on the service's usefulness 10 days later.
- Monitoring Outcomes: By tracking future readmissions in our EHR, we can assess the impact of our interventions and continuously improve our approach.

Training Resources: Our hospital is dedicated to fostering a culture of health equity through ongoing training and collaboration.

- REaL Data Expertise: Hometown Health will provide comprehensive training to our registration staff on accurately collecting REaL data.
- Staff Training: We will equip all staff with the knowledge and skills for our new health equity initiatives. This includes training on the SDOH referral process, the Health Equity tool, REaL and SDOH data collection, and monthly health equity reporting.

- Partnership and Learning: We leverage partnerships with organizations like Alliant Health Solutions' HQIC program to enhance our health equity efforts. We actively participate in their monthly Health Equity Office Hours and other learning opportunities to stay updated on best practices.

Other Resources: To strengthen our health equity efforts further, we are seeking additional funding sources. These resources will allow us to invest in crucial upgrades to our EHR system, ensuring we meet the latest health equity screening requirements. We are involved with the Small Rural Hospital Improvement Program (SHIP).

Domain 1D: Our hospital strategic plan describes our approach to engaging key stakeholders, such as community-based organizations. Below is a list of our partners.

National Partner(s):

- CMS and Alliant Health Solutions: Through the HQIC program, they provide hands-on support to hospitals while offering valuable resources, training, and networking opportunities. This collaborative effort empowers hospitals to address health care inequities within the state.
- Georgia Health Initiative: provides a wealth of information on health issues in Georgia, including data reports, policy briefs, and resources for different community organizations.
- The American Hospital Association's Institute for Diversity and Health Equity: Provide educational trainings, toolkits, and best practices that equip hospitals with the knowledge and strategies to address health disparities within their patient populations.

State Partner(s):

- Georgia Department of Public Health: This agency works to address health disparities across the state. It offers resources, grant programs, and initiatives focused on improving health outcomes for underserved populations.

- Project SHARE: Lends a helping hand to individuals and families during tough times. They offer financial emergency assistance to those facing a temporary crisis that could lead to losing their home.
- Georgia Rural Health Innovation Center: This center works to improve health and health care delivery in rural Georgia, focusing on addressing disparities faced by rural communities. It offers technical assistance, research, and advocacy efforts.

Local Partner(s):

- Ninth District Opportunity's Community Services Department: This local partner is vital in strengthening our community. They work directly with low-income families in North Georgia, providing programs and resources designed to reduce the impact of poverty. Their efforts help families achieve greater stability and self-sufficiency.
- Foodbank of NE Georgia and other food banks in the surrounding area: This partnership allows us to offer patients a convenient resource. A list of nearby food banks with their operating hours, making it easier for them to find healthy and affordable food options.

Hospital-Specific Partner(s):

- The Christopher Wolf Crusade (CwC): Provides opioid education, resources and mental wellness skills training to hospital inpatients and outpatients to ensure they are well supported during recovery. This support is provided by CwC's Life Care Specialist, a Care Coach who personally sees the patient through to recovery. In addition, CwC's Be Well Program provides patients and their families with the resources necessary to ensure a substance-free future post-recovery.
- The Hispanic Alliance of Georgia: This nonprofit organization based in Gainesville, Georgia, is dedicated to improving the lives of Latinos in the state. It provides opportunities and services focusing on education, financial stability, health, and immigration support.

Hospital: Optim Medical Center Tattnall

Health Equity Leader: Lisa Waters

Executive Summary: The Medical Executive Committee and the Governing Board support the plan to provide quality and equitable care to Optim Medical Center Tattnall patients. The Governing Board recognizes the importance of providing equity to all patients, which is crucial for healing and well-being. This project will include working with the community and local organizations to assist with providing the services that are needed to our patients. In alignment with the FY2023 IPPS/LTCH final rule, the CMS requires hospitals to participate in the hospital inpatient quality reporting program annually. This strategic plan outlines Optim Medical Center Tattnall's plan to address and attest to activities within the five identified CMS domains: Strategic planning, data collection, data analysis, quality improvement and leadership engagement and support.

Hospital Background: Optim Medical Center Tattnall is a 24-bed CAH specializing in orthopedic surgery. Its services include inpatient, outpatient and swing beds, as well as radiology, laboratory, respiratory, physical therapy and an emergency department.

Health Equity Statement: To continue to improve our patient outcomes and to monitor and reduce health care disparities through data-driven interventions through quality.

Domain 1A: Our hospital strategic plan identifies priority populations that currently experience health disparities. The information below provides supporting data evidence for each of these priority populations.

Identified Priority Population 1: White males in our hospital have the highest percentage of readmissions.

Supporting Data Evidence 1: Using REaL data in our HIDI report, we noted that our white male population is having readmissions to a hospital with DVT. We will focus on the root-cause analysis of why white males are having readmissions with DVTs.

Identified Priority Population 2: Patients in our hospital experiencing food insecurity

Supporting Data Evidence 2: The data collected from our SDOH questionnaire for the admitted patients 18 years of age or older and on Medicare showed that out of the seven patients who stated they had disparities, the largest number were males. Out of these, four white males and one Black male stated that they had food insecurity.

Identified Priority Population 3: Patients in our hospital experiencing utilities (gas, water, electric) insecurity

Supporting Data Evidence 3: The data collected from our SDOH questionnaire for admitted patients 18 years or older and on Medicare showed that out of the seven patients who stated they had disparities, the largest number were males. Two Black males stated they had utility insecurities.

Domain 1B: Our hospital strategic plan identifies health care equity goals and discrete action steps to achieve these goals. Below are our organization's Health Equity goals and related action steps.

Health Equity Goal 1: Collect and evaluate SDOH data to conduct root-cause analysis and create interventions based on the data.

Related Action Step 1: By July 2024, Optim Medical Center Tattnall (OMCT) will have an integrated process for collecting SDOH data using the PREPARE tool within EHR.
Since January 2023, our hospital has used a more manual system to collect the data for SHOH. Each quarter, we track the data, report it through our hospital performance dashboard, and discuss it during our quality team meetings.

Health Equity Goal 2: Promote a culture of health equity that improves health services' quality, safety, and effectiveness for underserved populations and those experiencing health disparities.

Related Action Step 2: As of April 2024, OMCT approves the designation of the Quality director to serve as the health equity champion and create a health equity team (especially case management) to conduct a gap analysis for our hospital and address potential solutions for our population.

By December 2024, the health equity team will have dedicated resources in case management to identify health equity gaps and ways of improvement.

Health Equity Goal 3: Train the hospital staff regarding health equity.

Related Action Step 3: By December 2024, OMCT will provide mandatory health equity training to our nursing and case management staff via HealthStream.

Domain 1C: Our hospital strategic plan outlines specific resources for achieving our equity goals. Below is a description of each resource.

Staffing Resources:
Lisa Waters, Quality Director and Health Equity Lead
Lora Duncan, CNO
Teal Jeffers, Risk Manager, Infection Preventionist
Karen Blackmon, Case Management Lead
Charla Nail, Discharge Planner
Vanita Mosley, Case Management
Linda Vasquez, Clinical Director

Structural Resources: The PRAPARE Tool has been embedded into our EHR to support SDOH data collection. When case management identifies a patient who screens positive for any SDOH, they will provide them with community resources.

Training Resources: We've conducted in-house training for new and existing hospital staff on all the following new tools and processes: SDOH referral process and feedback loop, PRAPARE tool, and SDOH data collection, health equity monthly reporting and more. Additionally, OMCT partners with Alliant Health Solutions for our HQIC program and attends monthly health equity office hours.

Other Resources: Our hospital recognizes the need for additional funding sources to support our work, including but not limited to the following SORH funding to cover necessary EHR upgrades to meet new health equity screening requirements

Domain 1D: Our hospital strategic plan describes our approach to engaging key stakeholders, such as community-based organizations. Below is a list of our partners.

National Partner(s): American Hospital Association

State Partner(s): Alliant Health Solutions, Georgia Hospital Association

Local Partner(s):

- Action Pact – Provides home-delivered meals to Seniors, Senior Day Care, and application for the LIHEAP program.
- St Joseph's SOURCE – Provides nurse aides, home-delivered meals and an emergency response button.
- Seasons of Life palliative care – Assists with in-home services.
- Local food pantries – Bread of Heaven, HIS Works and Southeast Communities, Springfield Missionary Church
- The Refuge – Domestic violence
- Walmart Drug plan - $4 drug plan
- United Way – Relocation due to fire; assist with homelessness

Hospital: Optim Medical Center - Screven

Health Equity Leader: Drucilla McBride

Executive Summary: The Board of Optim Medical Center – Screven ensures that resources are provided to promote efforts for equitable care to its patients and families. The provision of equitable care is one of this organization's priorities. This Board recognizes that partnerships within our rural community are key factors in the hospital's ability to sustain an equitable care system based on SDOH factors. In alignment with the FY2023 IPPS/LTCH final rule, the CMS requires hospitals that participate in the Hospital Inpatient Quality Reporting program to report on the Hospital Commitment to Health Equity Measure annually. Our strategic plan outlines Optim Medical Center-Screven's plans to address and attest to implementing activities within the five CMS-defined domains of health equity commitment, including strategic planning, data collection, data analysis, quality improvement and leadership engagement.

Hospital Background: This for-profit CAH is in Screven County, Georgia. It is licensed for 25 beds; however, 16 beds are staffed for medical-surgical patients under observation or inpatient status and swing bed patients. The hospital provides inpatient, observation, swing bed, emergency, outpatient therapy, radiology, laboratory, cardiopulmonary, and surgical services.

Health Equity Statement: Optim Medical Center Screven's goal is to improve patient health outcomes by reducing health care disparities by implementing data-driven interventions that increase the quality of care.

Domain 1A: Our hospital strategic plan identifies priority populations that currently experience health disparities. The information below provides supporting data evidence for each of these priority populations.

Identified Priority Population 1: Patients in our hospital experiencing issues with obtaining prescription medications due to monetary strain.

Supporting Data Evidence 1: Data from the SDOH questionnaire from 2023 has revealed that 10% of our patients had recently struggled with and/or worried about paying for their prescription medications.

Identified Priority Population 2: White patients in our hospital experiencing readmissions.

Supporting Data Evidence 2: The REaL data collected for each patient admission between 2022 and 2023 show that our white patients account for 67% of all readmissions.

Identified Priority Population 3: Patients in our hospital readmitted with respiratory issues.

Supporting Data Evidence 3: The REaL data collected for each patient admission between 2022 and 2023 shows that 75% of our readmitted patients have returned to the hospital with cardiopulmonary issues, specifically respiratory issues.

Domain 1B: Our hospital strategic plan identifies health care equity goals and discrete action steps to achieve these goals. Below are our organization's Health Equity goals and related action steps.

Health Equity Goal 1: Implement interventions for patients expressing issues paying for medications and obtaining them.

Related Action Step 1: In CY 2024, we will continue to track SDOH data obtained from our patients admitted to the med surg unit and use the data to identify potential secondary variables contributing to the discrepancy. By the end of the year (2024), we will partner with at least one local pharmacy or community organization to develop a plan to help patients unable to pay for their medications.

Health Equity Goal 2: Implement interventions for white patients in our hospital experiencing readmissions.

Related Action Step 2: In CY 2024, we will collect and trend readmission information monthly regarding race/ethnicity to continue identifying possible readmission causes.

Health Equity Goal 3: In CY 2024, we will collect and trend readmission information monthly by race/ethnicity to continue identifying possible causes of readmission.

Related Action Step 3: During calendar year 2024, we will continue to track readmissions to our facility from skilled nursing facilities and trend variables that may be contributing to the number of readmissions from the local skilled nursing facility. By the end of 2024, we will partner with our local skilled nursing facility to implement actions that will help reduce the need for admission/readmission to the hospital from this facility.

Domain 1C: Our hospital strategic plan outlines specific resources for achieving our equity goals. Below is a description of each resource.

Staffing Resources:
Drucilla McBride, Health Equity Champion
Kathy Waters, Med Surg Nursing Manager
Brenda Waters, Case Manager
Heather Thompson, ED Nursing Manager
Registration Staff
Nursing Staff

Structural Resources: The PRAPARE Tool has been added to the patient profile in our EHR to aid in collecting SDOH data. Nursing completes this tool upon admission. When a patient screens positive for any SDOHs, nursing alerts case management staff to provide resources about the patient's needs.

Training Resources: The American Hospital Association trained our registration staff for REaL data collection. The health equity champion educated the nursing staff on completing SDOH screening and taking action when a patient screens positive.
Our case manager has also received education and resources to aid patients who screen positive for an SDOH.

Domain 1D: Our hospital strategic plan describes our approach to engaging key stakeholders, such as community-based organizations. Below is a list of our partners.

State Partner(s): Georgia Hospital Association, Alliant Health Solutions

Local Partner(s): Screven County Board of Commissioners, Screven County Health Department, Pineview Nursing and Rehabilitation Center

Hospital-Specific Partner(s): Department of Nursing, OMCS Pharmacy, OMCS Case Management

Hospital: Phoebe Worth Medical Center

Health Equity Leader: Tonya Vaughn

Executive Summary: The board supports efforts to provide high-quality and equitable care for all patients/families in this facility. Equity is an organizational priority and, thus, an important component of our strategic plan for our community. We understand that this effort requires long-term investments and key partnerships with community-based organizations to address the SDOH and help our facility promote an equity-focused health care delivery system designed to meet the unique needs of our rural community. In alignment with the FY2023 IPPS/LTCH final rule, the CMS requires hospitals participating in the Hospital Inpatient Quality Reporting program to report annually on the Hospital Commitment to Health Equity Measure. This strategic plan outlines our efforts to address and attest to activities within the five identified CMS health equity commitment domains: strategic planning, data collection, data analysis, quality improvement and leadership engagement.

Hospital Background: Phoebe Worth Medical Center is a nonprofit CAH in Sylvester, Georgia. It is licensed for 25 beds, which are 25 staffed and operational beds. Core hospital services include inpatient and outpatient departments, including the emergency center, radiology, and laboratory.

Health Equity Statement: To improve patient health outcomes and reduce health care disparities through data-driven health equity interventions and quality services.

Domain 1A: Our hospital strategic plan identifies priority populations that currently experience health disparities. The information below provides supporting data evidence for each of these priority populations.

Identified Priority Population 1: Patients in our hospital lacking appropriate access to transportation.

Supporting Data Evidence 1: This geographic region is rural, which exacerbates the issues of access to health care providers and services, especially for low-income populations and older adults who already experience barriers to access

Domain 1B: Our hospital strategic plan identifies health care equity goals and discrete action steps to achieve these goals. Below are our organization's Health Equity goals and related action steps.

Health Equity Goal 1: Mental health and mental disorders

Related Action Step 1: Continue to track the number of tele-behavioral health visits and on-site ASPIRE visits and sessions, and increase access to and utilization of mental health services and care through telemedicine and in-person counselor sessions.

Health Equity Goal 2: Diabetes management and prevention

Related Action Step 2: Continue supporting the local community garden and promoting eating fresh fruits and vegetables. Construct a demonstration kitchen to provide education on the preparation and treatment of local vegetables in the garden. Continued support of the Worth County Health Department's Diabetes Program, which provides education, screening, and treatment to low-income individuals and assists them with their health supplies and medications.

Health Equity Goal 3: Access to and quality of health care services

Related Action Step 3: Establish urgent care services in our rural health clinic. Expand access to care for specialty health care services such as oncology, cardiology, pulmonary, and orthopedic.

Domain 1C: Our hospital strategic plan outlines specific resources for achieving our equity goals. Below is a description of each resource.

Staffing Resources:
Gina Connell, RN, Public Health
Grace Davis, Pediatrician
Fred Dent, Chairman, Worth County Board of Commissioners
Dianna Grant, M.D., Phoebe Health System Corporate Medical Director, Executive Sponsor
Atron Hayes, City Manager, City of Sylvester
Lisa Oosterveen, Deputy Director, Aspire Behavioral Health & Developmental Disability
Harold Proctor, Mayor, City of Sylvester
Karen Rackley, President, Sylvester Worth County Chamber of Commerce & Economic Development Authority
Sam X. White, Project Manager, The Village Community Garden

Structural Resources: The SDOH evaluation tool is embedded into our EMR to support data collection. The case manager team provides community resources through our community partner, FindHelp. The patient is either given a list, or the needed information is texted to the individual patients, which triggers a positive screening.

Training Resources: We have conducted in-house training with all new and existing hospital staff on the following new tools: the SDOH referral process, FindHelp, SDOH evaluation and data collection. We also partner with Alliant Health Solutions for our HQIC program and attend monthly health equity office hours and related learning and education events.

Other Resources: Rural Hospital Tax Credit Funds - awards pending in 2024

Domain 1D: Our hospital strategic plan describes our approach to engaging key stakeholders, such as community-based organizations. Below is a list of our partners.

National Partner(s): American Hospital Association

State Partner(s):

- Georgia Hospital Association
- Alliant Health Solution provides support through the HQIC program and shares resources, training and networking opportunities.

Local Partner(s):

- Worth County Health Department supports our community health assessments and education.
- Local food bank
- Local community garden-The Village

Hospital-Specific Partner(s): Phoebe Health Systems

Hospital: Putnam General Hospital

Health Equity Leader: Pam Douglas

Executive Summary: Putnam General Hospital supports all families and patients by providing equitable care throughout the hospital. We partner with the community to address SDOH to address the needs of our community. We recognize this is a long-term partnership that will require extra resources for staff, funds, and training.

Hospital Background: Putnam General Hospital is a 25-bed CAH in Putnam County that serves Eatonton and the surrounding areas. It has over 50 years of excellence in rural health care. Our services include inpatient, outpatient, swing bed, radiology, laboratory, therapy, sleep center, emergency department, pulmonary rehab, cardiac rehab, and surgery.

Health Equity Statement: To improve patient outcomes by identifying and reducing health disparities through interventions at discharge.

Domain 1A: Our hospital strategic plan identifies priority populations that currently experience health disparities. The information below provides supporting data evidence for each of these priority populations.

Identified Priority Population 1: Patients experiencing food insecurities.

Supporting Data Evidence 1: SDOH data collection in the hospital

Domain 1B: Our hospital strategic plan identifies health care equity goals and discrete action steps to achieve these goals. Below are our organization's Health Equity goals and related action steps.

Health Equity Goal 1: Partner with our local food bank to support those experiencing food insecurities.

Related Action Step 1: Set up a meeting with the food bank to discuss direct referrals from the hospital and get feedback on how many people take advantage of the resources.

Domain 1C: Our hospital strategic plan outlines specific resources for achieving our equity goals. Below is a description of each resource.

Staffing Resources: Case management

Structural Resources: EHR form created to capture data

Training Resources: Webinars and one-on-one training sessions

Domain 1D: Our hospital strategic plan describes our approach to engaging key stakeholders, such as community-based organizations. Below is a list of our partners.

National Partner(s):

- Alliant QIO
- Flex grant
- Webinars and workgroups
- HQIC
- Monthly coaching calls

State Partner(s):

- Georgia Hospital Association
- Webinars
- In-person meetings

Local Partner(s):

- Food Bank – Sending referrals based on screenings
- Fire Department – Working on a fall prevention program by doing assessments in the patient's home, helping with referrals, and installing fall prevention items after an emergency call for someone who has fallen. This was identified based on the increased number of ED patients presenting to the ED after an in-home fall.
- Putnam County Family Connections and Faith and Rural Health – Annual community health fairs

Hospital-Specific Partner(s):

- SDOH team – Creating forms to collect data and training nurses on the importance of SDOH assessments.

Hospital: SGMC Health Lanier

Health Equity Leader: Geoff Hardy

Executive Summary: SGMC Health Lanier is committed to ensuring patients and their families receive high-quality and equitable care. Every aspect is crucial in providing the safest, highest-quality care, from skilled medical professionals to efficient processes and compassionate communication. Patient safety, effective treatment, and personalized attention are cornerstones of quality care in a hospital setting, ultimately leading to improved outcomes and patient satisfaction.

Hospital Background: SGMC Health Lanier is a 25-bed critical access facility in Lakeland, Georgia. We operate a swing bed unit and a seven-bed emergency department. Core services include inpatient and outpatient rehab, lab, and radiology services.

Health Equity Statement: To enhance patient outcomes, and promote health equity as a fundamental principal of the hospital's operations.

Domain 1A: Our hospital strategic plan identifies priority populations that currently experience health disparities. The information below provides supporting data evidence for each of these priority populations.

Identified Priority Population 1: Patients lacking access to appropriate transportation.

Supporting Data Evidence 1: The percentage of households in Lanier County without access to reliable transportation is higher than the state average, which is unfavorable. The community lacks local transportation services. The DPH website shows the average travel time to employment is >23 minutes.

Identified Priority Population 2: Patients lacking access to primary/urgent care services.

Supporting Data Evidence 2: As identified as the top priority in the CHNA (2024), greater access to primary/urgent care is a key focus for improving health care equity within our local community, ranking 42% higher than the #2 need.

Domain 1B: Our hospital strategic plan identifies health care equity goals and discrete action steps to achieve these goals. Below are our organization's Health Equity goals and related action steps.

Health Equity Goal 1: Encourage a culture of health equity that enhances health care services' quality, safety, and effectiveness for marginalized communities and individuals facing health disparities.

Related Action Step 1: Increase awareness among health care providers and staff about disparities in health outcomes and the social determinants of health. Provide training on cultural competence, implicit bias, and trauma-informed care to enhance sensitivity and understanding.

Health Equity Goal 2: Create culturally and linguistically appropriate health care interventions to improve health equity and properly train hospital employees in best practices.

Related Action Step 2: Developing culturally responsive interventions.

Cultural Competence Training: Implement mandatory training programs for hospital staff at all levels. This should include cultural competence, humility, and sensitivity modules, focusing on understanding diverse cultural backgrounds and communication styles.

Language Access: Ensure language access services, such as professional interpreters, translated materials, and technology-assisted language services, are readily available. Train staff on how to effectively utilize these resources.

Cultural Tailoring: Adapt health care practices and communication to align with cultural norms and preferences. This may involve adjusting care protocols, dietary options, religious accommodations, and rituals surrounding health and illness.

Health Equity Goal 3: Analyze opportunities for transportation services as rural communities often face unique challenges due to sparse population density, limited infrastructure, and geographic barriers.

Related Action Step 3: Explore opportunities in the following areas.

Ridesharing and Carpooling Programs:

- Community-Based Ridesharing: Facilitate platforms or programs that connect drivers with passengers for shared rides within rural areas.
- Carpooling Initiatives: Encourage residents to organize carpools for commuting to work, medical appointments, and other essential services.

Public-Private Partnerships (PPPs):

- Subsidized Transportation Services: Collaborate with private transportation companies to offer subsidized rides for rural residents, particularly for medical appointments, grocery shopping, and social activities.
- Transportation Vouchers: Provide vouchers or subsidies that residents can use with local taxi services or rideshare companies.

Microtransit and Demand-Responsive Transport (DRT):

- Microtransit Solutions: Implement flexible, on-demand transit services using smaller vehicles, such as vans or minibusses, that can more efficiently navigate rural roads.
- DRT Systems: Develop systems that allow residents to request transportation via phone apps or call centers, optimizing routes based on real-time demand.

Volunteer Driver Programs:

- Senior and Community Centers: Establish programs where volunteers use their vehicles to transport elderly residents or those with mobility challenges to appointments and social events.

Bike Sharing and Walking Initiatives:

- Bike Sharing Programs: Introduce bike-sharing programs in rural towns for short-distance travel, providing affordable and environmentally friendly transportation options.
- Pedestrian Infrastructure: Improve sidewalks and pedestrian paths to make walking safer and more accessible within rural communities.

Telehealth and Mobile Services:

- Telehealth Services: Expand telehealth options to reduce the need for physical travel to health care facilities, particularly for routine check-ups and consultations.
- Mobile Health Units: Deploy mobile clinics or health care units to visit rural communities, providing essential medical services closer to residents.

Cross-Sector Collaboration:

- Education and Employment Partnerships: Coordinate with educational institutions and employers to provide transportation solutions for students, workers, and job seekers in rural areas.
- Community Engagement: Involve residents in planning and decision-making to ensure transportation solutions meet local needs and preferences. These alternative solutions can be tailored to rural communities' specific challenges and characteristics, promoting accessibility, affordability, and sustainability in transportation services.

Domain 1C: Our hospital strategic plan outlines specific resources for achieving our equity goals. Below is a description of each resource.

Staffing Resources: NDNQI Staffing Model, Department Leadership, Social Services, Medical Director, Advisory Council

Structural Resources: EPIC (system-wide), telehealth, GRITS, Syndromic Surveillance, SENDSS

Training Resources: SGMC Health Education (Net Learning), MyChart, Lippincott, Up To Date (Medical Resource)

Domain 1D: Our hospital strategic plan describes our approach to engaging key stakeholders, such as community-based organizations. Below is a list of our partners.

National Partner(s): Press Ganey, American Health Association, EPIC, National Rural Health Association

State Partner(s): Georgia Hospital Association, Alliant Health Solutions, Hometown Health, Vizient Southeast

Local Partner(s): DPH, Lanier Family Connection, Lakeland Drug, Dr. Bruce Herrington, Southside Baptist Church, Lakeland-Lanier Chamber of Commerce, Lakeland Development Authority, Partnership For Health, Faith Hope and Love Clinic

Hospital-Specific Partner(s): SGMC Health Lanier Advisory Council

Hospital: Warm Springs Medical Center

Health Equity Leader: Daniel McBride, RN

Executive Summary: Health equity is an organizational priority at Warm Springs Medical Center. We have formulated a policy that addresses health care equity and developed a committee tasked with reviewing trends in the populations we serve. Our policy provides guidelines for identifying, analyzing, addressing, and monitoring health care disparities to minimize inequities and increase quality and patient safety for all patients. Our overarching goal is to provide safe, quality health care where no patient is prevented from achieving it. We especially focus on preventable differences in disease, injury, or violence burden in socially disadvantaged populations.

Hospital Background: Our facility is a 25-bed nonprofit CAH in Meriwether County in Warm Springs, Georgia. Our core services include inpatient, outpatient, swing bed, Emergency Department, radiology, and laboratory.

Health Equity Statement: Regarding health equity, we wish to examine the various components that are barriers to a patient's access to health care at Warm Springs Medical Center and work to resolve these barriers by reaching out to outside resources and services that we can provide.

Domain 1A: Our hospital strategic plan identifies priority populations that currently experience health disparities. The information below provides supporting data evidence for each of these priority populations.

Identified Priority Population 1: Patients experiencing food insecurity.

Supporting Data Evidence 1: We have had two patients who screened positive for food but did not last until more income was achieved. Case management provides these individuals with resources at discharge.

Identified Priority Population 2: Patient experiencing a lack of adequate transportation.

Supporting Data Evidence 2: Six patients have expressed that transportation to health care is an issue for them. Case management provides these individuals with resources at discharge.

Identified Priority Population 3: Patients experiencing utility difficulties.

Supporting Data Evidence 3: Seven patients have been triggered for difficulty with utilities, expressing that they have been threatened with disconnection. Case management provides these individuals with resources at discharge.

Domain 1B: Our hospital strategic plan identifies health care equity goals and discrete action steps to achieve these goals. Below are our organization's Health Equity goals and related action steps.

Health Equity Goal 1: Patients lacking adequate transportation to the facility will be assisted in getting back and forth using hospital-provided transportation.

Related Action Step 1: Warm Springs Medical Center has applied for a senatorial grant to provide two vans for our underserved populations, as lack of transportation is a health equity need.

Health Equity Goal 2: Patients experiencing food vulnerability receive information from case management at discharge on resources in our area that may assist them, such as Meals on Wheels.

Related Action Step 2: Case management provides various resources on obtaining needed food items at discharge. The case management Department lists resources such as Meals on Wheels and other sources of potentially obtaining food needs.

Health Equity Goal 3: Case management provides information on working with various utility companies for patients vulnerable to having their electricity, water, or other utilities cut off.

Related Action Step 3: Case management provides contact information for various regional utility companies for patients who need to communicate with them to avoid service interruption.

Domain 1C: Our hospital strategic plan outlines specific resources for achieving our equity goals. Below is a description of each resource.

Staffing Resources: We are adequately staffed and are currently hiring for RN, LPN, and CNA positions.

Structural Resources: We use CPSI as our EHR and have on-site IT support for technological issues.

Training Resources: One RN and the over-house day and night shift supervisors are responsible for training clinical staff providers, and the chief nurse officer also shares this responsibility.

Other Resources: As stated above, we have applied for grants from Senators Warnock and Ossoff's offices to obtain assistance with funding two transportation vans for our underserved populations.

Domain 1D: Our hospital strategic plan describes our approach to engaging key stakeholders, such as community-based organizations. Below is a list of our partners.

National Partner(s): We are currently investigating national-level entities that could assist in formulating Social Determinants of Health plans for our patient population.

State Partner(s): We are working with Alliant Health Solutions to compose a list of resources for our underserved populations. We are also working with Senator Rafael Warnock's office to get a grant to purchase two vans to alleviate some pressure on individuals with transportation issues.

Local Partner(s): We work with several long-term care facilities to secure housing, when appropriate, for individuals with housing needs. Case management also secures appropriate housing for individuals needing nursing home placement. The case management department also has several printed resources on topics such as food availability, transportation, and utility aid that are given out before discharge. The case management department also works with Adult Protective Services or DFACS if we ever have a case where the patient's safety in the home is an issue.

Hospital-Specific Partner(s): We are investigating resources for food insecurity that are more local to our area, such as the I-58 Mission Food Pantry. We have not used their services yet, but they are located in Senoia, Georiga, about 28 miles from our facility. This resource may or may not be of assistance to many of our population because we service primarily Meriwether County, and patients may not be willing or able to travel that far. We seek to develop a patient and family advisory group to assist with SDOH information.

Hospital: Wellstar Sylvan Grove

Health Equity Leader: Terry Horsch

Executive Summary: Health equity is when everyone can be as healthy as possible. To achieve health equity, multi-sectoral efforts are needed to address the severe and far-reaching health disparities that plague our state by expanding access and removing the social and economic obstacles that lead to poor health outcomes. These barriers include, but are not limited to, poverty, poor housing and unsafe or unhealthy environments, lack of access to good jobs, quality education and comprehensive, high-quality health care. Driven by structural racism, discrimination, stigma and longstanding disenfranchisement, these obstacles overwhelmingly impact underserved communities, including communities of color, people with disabilities, women, people who are incarcerated or without homes and those who live in rural or frontier settings. These inequities do not just affect those groups that are hardest hit. They affect us all. The COVID-19 pandemic is the most recent and glaring example. By diminishing the economic, health, educational and overall human potential of millions of people in Georgia, health inequities and disparities weaken our entire society and leave us unprepared for public health threats.

Hospital Background: The Wellstar Community Health Collaborative (WCHC) is now expanded to encompass all Wellstar hospital communities after the April 2016 acquisition of six hospitals in Georgia, five of which were converted to not-for-profit in 2017, including Wellstar Health System. This cross-functional task force enables Wellstar to better implement community benefit initiatives and measure outcomes of collaborative efforts to improve community health.

Health Equity Statement: At Wellstar Health System, we strive and commit to achieving health care equity and eliminating health care disparities across the diverse communities we serve.

Domain 1A: Our hospital strategic plan identifies priority populations that currently experience health disparities. The information below provides supporting data evidence for each of these priority populations.

Identified Priority Population 1: Pediatric patients who need social service support.

Supporting Data Evidence 1: Wellstar Pediatric service line to track the programs benefiting the pediatric community. Provide comprehensive screening of pediatric patients to gain valuable insight into the child's family life, safety, education and social capital, and opportunities for physical activity.

Identified Priority Population 2: Patients participating in our Doula program.

Supporting Data Evidence 2:

- Number of doula training hours contributed
- Number of doula referrals
- Profile and number of community partners engaged
- Sociodemographic profile of participants and high-risk zip codes served

Clinical outcomes of doula clients: Pre-term birth, low birth weight, NICU admission, unplanned/ planned cesarean and breastfeeding initiation at six months.

Identified Priority Population 3: Patients experiencing housing difficulties and involved in our housing learning community.

Supporting Data Evidence 3: Engage in collaborative professional learning to strengthen one's working knowledge of the housing crisis in Georgia. Identify team members in the housing learning community to identify the system's shared health equity goals.

Domain 1B: Our hospital strategic plan identifies health care equity goals and discrete action steps to achieve these goals. Below are our organization's Health Equity goals and related action steps.

Health Equity Goal 1: Workforce diversity to optimize talent management to achieve a diverse leader and health professional pipeline.

Related Action Step 1: Senior leadership supports and ensures an environment that promotes an organizational culture that requires annually disclosing conflicts of interests, actively participating in compliance-related activities, including quarterly risk assessments, promoting a Just Culture of non-retaliation, encouraging a culture of transparency by leading open discussions about identified areas of opportunity, unanticipated outcomes, and errors, requiring annual compliance and ethics training, and establishing and enforcing policies related to patient's rights and breaches in ethical behavior.

Health Equity Goal 2: To help prevent disease and injury, promote health and well-being, assure conditions in which people can be healthy, and provide timely, effective and coordinated health care.

Related Action Step 2: A Wellstar Graduate Medical Education clinic opened in 2021. This clinic has helped Sylvan Grove as a resource for uninsured or underinsured patients to follow up after an ED visit. In addition, it has helped meet the needs of patients who have not been able to find a local physician due to a lack of financial resources.

Health Equity Goal 3: Public health activities that target populations and individual health behaviors. Sylvan Grove's key communities include underserved communities in defined six zip codes, the bulk of which are in Butts and Spalding counties.

Related Action Step 3: Butts County provides meals to the students in the county at no cost. It was discovered that for some students in the county, this was the main meal they ate. It was noted that some students could not be provided with three meals a day during breaks and summer. Sylvan Grove partnered with local churches and the school district to help provide meals for those students during breaks and summer. Sylvan provided grocery items, and team members volunteered their time to help prepare and distribute the meals.

Domain 1C: Our hospital strategic plan outlines specific resources for achieving our equity goals. Below is a description of each resource.

Staffing Resources:
Senior Vice President
CNO
Director Of Operations
Center of Health Equity
Dietetics/Nutrition Department
Institute of Healthcare Improvement

Structural Resources: Wellstar continually demonstrates the mission, value, and vision as the community's leading investor in facilities, services, and programs to achieve the Institute of Healthcare Improvement's (IHI) "Triple Aim" framework to 1) Improve the patient care experience 2) improve the health of a population, and 3) reduce health care costs. The IHI framework provides the criteria for actionable community benefit services to address priority health needs and for collaboration with vital community partners whose assets enhance and broaden the scope of Wellstar and its hospitals' capacity and expertise.

Training Resources: Wellstar established the Center of Health Equity to reduce disparities in incidence, prevalence, mortality, and burden of disease experienced by disadvantaged and underserved populations by developing, implementing, evaluating, and disseminating effective and efficient system-wide strategies to address inequities.

Domain 1D: Our hospital strategic plan describes our approach to engaging key stakeholders, such as community-based organizations. Below is a list of our partners.

National Partner(s): LeapFrog, CMS, Vizient, Noble, NHSN, Medicare, Epic, AHA, NRC, Apollo, American College of Radiology, College of American Pathologists, Dept. of Labor, EEOC, EPA, HIPAA, IRS, and OSHA, American Organization of Nurse Leaders, American College of Physicians, National Healthcare Safety Network, National Institute of Standards and Technology

State Partner(s): Georgia Hospital Association, Georgia Dept of Health and Human Services, JHA, LifeSouth, Health Management Academy, GEMA, Ga. State Office of Rural Health

Local Partner(s): Butts County Leadership, Butts County Chamber of Commerce, Butts County Rotary, Butts County Hospital Authority

Hospital-Specific Partner(s): Butts County Leadership, Butts County Chamber of Commerce, Butts County Rotary, Butts County Hospital Authority, HICS, Eat Right Atlanta, WellStar Board of Trustees, WellStar Executive Capital Committee, WellStar Medical Group.

Hospital: Wills Memorial Hospital

Health Equity Leader: Angela Radford

Executive Summary: Wills Memorial Hospital strives to provide high-quality and equitable care for all the patients and families we serve. Equity is a key component and organizational priority of our strategic plan for our community. To promote an equity-focused health care system that will meet the unique needs of our rural community, we will provide long-term dedication and develop key partnerships with our community-based organizations. SDOH will be addressed in our strategic plan to attest to health equity commitment requirements.

Hospital Background: Wills Memorial Hospital is a 25-bed CAH staffed with 19 beds, including inpatient, observation, and swing beds. We have an emergency department and outpatient services, including physical, occupational and speech therapy, radiology, laboratory, and respiratory rehab. We also operate two rural health clinics in our three-county service area.

Health Equity Statement: To improve overall patient health outcomes and reduce health care disparities through data-driven health equity interventions and quality service.

Domain 1A: Our hospital strategic plan identifies priority populations that currently experience health disparities. The information below provides supporting data evidence for each of these priority populations.

Identified Priority Population 1: Black patients in our hospital experiencing readmissions.

Supporting Data Evidence 1: In CY 2023, six patients experienced readmission. 83% of the readmissions were of the Black race, and only 17% were of the white race.

Identified Priority Population 2: Black patients with a readmission rate and a respiratory diagnosis.

Supporting Data Evidence 2: Four of the five readmitted Black patients had a respiratory disease diagnosis. 80% of Black readmissions were related to respiratory Issues.

Identified Priority Population 3: Readmitted patients Impacted by experiencing transportation difficulties.

Supporting Data Evidence 3: Of the six patients who experienced readmission, all six screened positive for the lack of transportation. SDOH's lack of transportation causes 100% of our readmissions. The formal ACH Screening did not take place until January 2024, but there is documentation in each EHR stating there were transportation issues for each patient readmitted in calendar year 2023.

Domain 1B: Our hospital strategic plan identifies health care equity goals and discrete action steps to achieve these goals. Below are our organization's Health Equity goals and related action steps.

Health Equity Goal 1: Focus on readmissions of Black patients and conduct best practices to prevent readmissions.

Related Action Step 1: We will track all readmissions monthly to identify the root causes in CY 2024. We will focus on the identified priority populations of Black readmissions to ensure this is our continued priority population due to the low volume of readmissions in our facility.

All inpatients will be monitored monthly for SDOH screening, and any correlation between positive screenings and readmissions will be evaluated.

Health Equity Goal 2: Focus on transportation issues and develop best practice interventions by evaluating available options and resources.

Related Action Step 2: SDOH will be tracked monthly, with a focus on positive screenings for transportation issues. Local resources for transportation will be explored and communicated to patients with positive screenings for SDOH- transportation before discharge.

Health Equity Goal 3: Determine any other correlation between positive screenings of SDOH and readmissions.

Related Action Step 3: Review all readmissions monthly to determine if any screened positive for SDOH. Evaluate any trends to determine future focus on causes of readmissions. PFAC and social work should collaborate to complete a list of local resources for all five SDOHs that can be shared with patients who screen positive for SDOH at discharge before the end of CY 2024.

Domain 1C: Our hospital strategic plan outlines specific resources for achieving our equity goals. Below is a description of each resource.

Staffing Resources:
Angie Radford, Health Equity Lead Director of Nursing
Tonia Ryll, Director of Quality
Jan Long and Taaliyah Booker, Social Services
Tara Rodriguez, Registration
Ashlyn Rogers, PFAC and PFAC Lead
Lisa Echols, HIM Director
Tanner Bridges, Clinical Informatics
Debbie King, Nursing Educator/Infection Prevention

Structural Resources: We currently use the CMS ACH screening tool for all patients admitted to WMH. We are currently focusing on our Inpatient population and collecting data via our EHR to determine the most prevalent SDOH in our inpatient population. We are developing a list of resources within our community with the help of Social Services and our PFAC. By the end of CY 2024, we will

provide patients who screen positive for SDOH with a list of resources. At this time, we are evaluating on a case-by-case basis. We are working with our EHR to get a social work consult to fire when a patient screens positive for SDOH. Our Social Services team is currently consulted on all inpatients, whether they screen positive or negative.

Training Resources: We participate in monthly education events with GA SORH and Alliant Health Solutions in the FLEX HE Improvement project. We have completed in-house education for current registration staff on collecting REaL data. We have also completed in-house education for nursing staff regarding the collection of data on the ACH Screening Tool within the EHR and have it firing a task for every patient admitted to WMH.

Other Resources: Small Rural Hospital Improvement Program (SHIP) - Professional services for regulatory compliance, including health equity and rural hospital tax credit.

Domain 1D: Our hospital strategic plan describes our approach to engaging key stakeholders, such as community-based organizations. Below is a list of our partners.

National Partner(s): The American Hospital Association Institute for Diversity and Health Equity offers educational training, best practices in health equity, and toolkits.
Feeding America identified food security options in our rural Georgia three-county service area, which are used as a resource for local food bank options.

State Partner(s): The GA FLEX HEI program has provided hands-on training for Wills Memorial Staff on developing a hospital strategic plan that will help identify and address health disparities. It has been a great opportunity to collaborate with other Georgia Hospitals and share resources. Source and DFCS are resources the Social Work team at Wills Memorial has been able to use to help identify SDOH regarding food resources. The Salvation Army, Rental Assistance @dcaga.gov, CSRA Area on Aging, United Way of the CSRA, and the Wilkes County Health Department have also been resources for patients experiencing social determinants of health.

Local Partner(s): Wills Memorial collaborates with Wilkes, Lincoln, and Taliaferro County Transits to provide transportation for patients in our three-county service area. BK Transportation and Delivery is a local resource that Wills Memorial uses to help with transportation issues and food delivery. Local transport companies, such as Hulin and Hampton Transportation, have also provided transport for patients. Wills Memorial has a volunteer chaplain service made up of six chaplains from multiple denominations in our service area. There are scheduled visits that include collaboration with social services and any identified needs. Athens and Augusta Salvation Army shelters are used for shelter needs, and Wills Memorial collaborates with the local Sheriff's Department to provide transportation to shelters via bus vouchers. We also collaborate with the Housing Authority to meet any low-income housing needs. Food assistance in our area includes Sanctuary Church, Lincoln County Food Bank, and the Meals on Wheels Program, which is based out of Wills Memorial Hospital.

Hospital-Specific Partner(s): The population health committee has been developed to include the director of nursing, case management, infection prevention, social services, HIM, lab director, registration, IT, and RHC director. The purpose of this committee is to help ensure that health equity is a focus for Wills Memorial Hospital, which has a developed strategic plan.

Thank You

Thank you for exploring our playbook for advancing health equity through strategic planning for Georgia's CAHs. This initiative would not have been possible without the collaboration and support of many dedicated individuals and organizations.

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- **Community Partners and Stakeholders** for their collaboration and contributions to addressing SDOH and promoting health equity.

We hope this playbook is a valuable resource and inspiration for advancing health equity initiatives in CAHs across Georgia and beyond.

Alliant Health Solutions
400 Perimeter Center Terrace NE
Suite 250, Atlanta, GA 30346
OFFICE: 678.527.3100
FAX: 404.982.7591

www.allianthealth.org