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

# GA FLEX Health Equity Improvement Project: 2024-2025 Kickoff Meeting

Rosa Abraha, MPH

October 8, 2024

# Meeting Attendance


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

# Featured Speaker

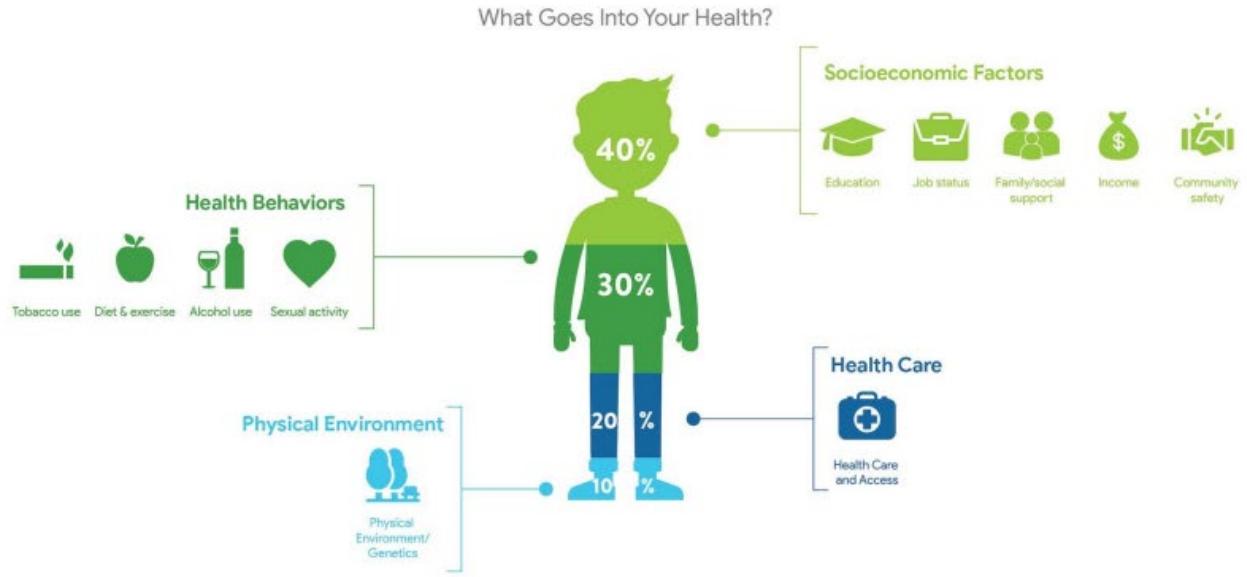
Rosa Abraha, MPH
Health Equity Lead
Alliant Health Solutions
Rosa.Abraha@allianthealth.org

Rosa leads Alliant's health equity strategic portfolio and embeds health equity in the core of Alliant's work. Rosa has 10 years experience in public health advisory for premier agencies, including the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH) and the Food and Drug Administration (FDA). She holds a master of public health in health policy and management from Emory University.

# Health Equity and SDOH

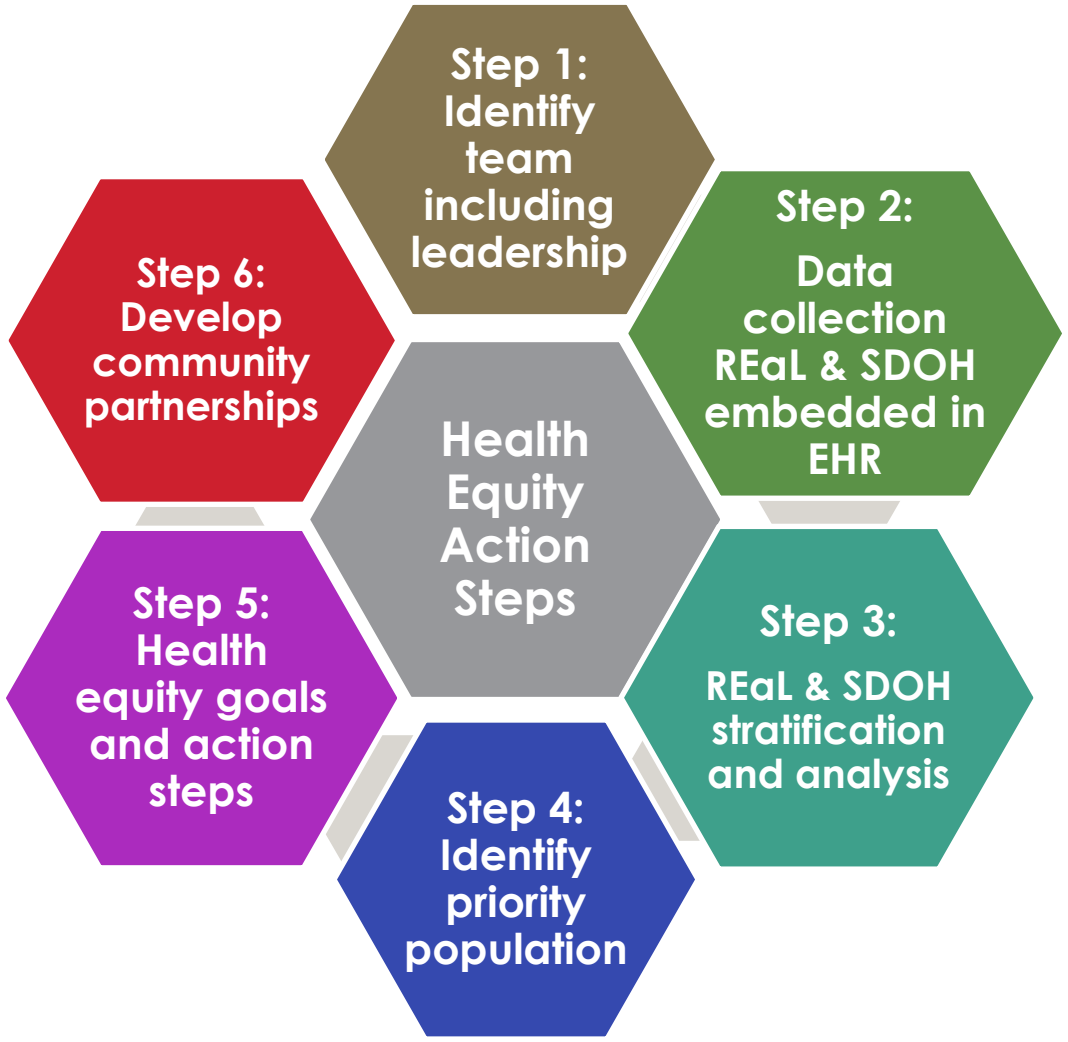
## What are Social Determinants of Health

Non-medical factors that influence the equitable health outcomes of the patient community we serve




Social Determinants of Health - Healthy People 2030 | health.gov

# Six Steps to Health Equity Action Planning




**Congrats on the development of your HE action plan! We've heard phenomenal reviews on all the hard work you put in to develop these plans.**

**Have you shared your HE strategic plan with your leadership teams/board? Have you received any feedback? Share it with us in the chat!**

# Best Practices and Lessons Learned from Past Year

- **Bite-Sized Homework Assignments:** Breaking down larger project goals into manageable, bite-sized assignments allows staff to make incremental progress, reducing overwhelming responses and promoting engagement.
- **Community Engagement:** Actively involving trusted community leaders in planning and decision-making processes helps build trust and ensures that initiatives are culturally relevant and responsive to local needs.
- **Collaborative Partnerships:** Forming partnerships with local organizations, stakeholders, and other healthcare providers enhances resource sharing and strengthens the overall impact of health equity and quality improvement initiatives.
- **Ongoing Training:** Providing regular hands-on training sessions on the intersection of health equity and quality improvement to equip staff with the necessary skills to engage and effectively support diverse patient populations.
- **Resource Sharing Initiatives:** Encouraging collaboration among hospitals to share best practices, tools, and resources can maximize impact and reduce duplication of efforts. Our sharing and presentation on the FindHelp tool was critical for most CAH staff to see where the SDOH resources in their area exist where they previously thought there were none.

# Looking Forward: Health Equity Improvement (HEI) Project

- **Year 3 Project Period:** October 2024 – August 2025

- **Purpose/Focus**: Continuing to build on the HE strategic planning efforts completed in year 1, AHS hopes to support CAHs in the **implementation phase** of their plans and promote an all teach all learn model where peer learning is encouraged.

- **Year 2 Learning Objectives:**
  - To explain the CMS and GA Flex Grant MBQIP mandatory health equity requirements and support understanding around these requirements in rural Georgia hospitals
  - To support rural Georgia critical access hospitals in identifying population health disparities and the impact of the social determinants of health on their patient populations
  - To deliver guidance and training to rural Georgia critical access hospitals that addresses health disparity challenges and promotes health equity best implementation through interactive education sessions and an all teach all learn model

# Overview: MBQIP 2025 Core Measure Set

| Data Elements ✓ | **Domain 1 – Equity is a Strategic Priority**<br>Please attest that your hospital has a strategic plan for advancing healthcare equity and that it includes all of the following elements (note: attestation of all elements is required in order to qualify for the numerator):<br>A. Our hospital strategic plan identifies priority populations who currently experience health disparities.<br>B. Our hospital strategic plan identifies healthcare equity goals and discrete action steps to achieving these goals.<br>C. Our hospital strategic plan outlines specific resources which have been dedicated to achieving our equity goals.<br>D. Our hospital strategic plan describes our approach for engaging key stakeholders, such as community-based organizations. |
|---|---|

**Measure #1- Hospital Commitment to Health Equity (HCHE)**
This measure has 5 main domains outlined on this page that will be reported on annually through the Hospital Quality Reporting (HQR) platform. You are already 1 step ahead because you have completed Domain 1 with your HE strategic plan!

| Data Elements | **Domain 2 – Data Collection**<br>Please attest that your hospital engages in the following activities (note: attestation of all elements is required in order to qualify for the numerator):<br>A. Our hospital collects demographic information, including self-reported race and ethnicity, and/or social determinant of health information on the majority of our patients.<br>B. Our hospital has training for staff in culturally sensitive collection of demographic and/or social determinant of health information.<br>C. Our hospital inputs demographic and/or social determinant of health information collected from patients into structured, interoperable data elements using certified EHR technology.<br>**Domain 3 – Data Analysis**<br>Please attest that your hospital engages in the following activities (note: attestation of all elements is required in order to qualify for the numerator):<br>A. Our hospital strategies key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and includes this information on hospital performance dashboards.<br>**Domain 4 – Quality Improvement**<br>Select all that apply (note: attestation of all elements is required in order to qualify for the numerator):<br>A. Our hospital participates in local, regional, or national quality improvement activities focused on reducing health disparities.<br>**Domain 5 – Leadership Engagement**<br>Please attest that your hospital engages in the following activities. Select all that apply (note: attestation of all elements is required in order to qualify for the numerator):<br>A. Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews our strategic plan for achieving health equity.<br>B. Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews key performance indicators stratified by demographic and/or social factors. |
|---|---|

# Overview: MBQIP 2025 Core Measure Set

## Measure #2 – SDOH Screening

The Screening for Social Drivers of Health Measure assesses whether a hospital implements screening for all patients that are 18 years or older at time of admission for food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety.

| | |
|---|---|
| Improvement Noted As | Increase in the rate. |
| Numerator | The number of patients admitted to an inpatient hospital stay who are 18 years or older on the date of admission and are screened for all of the following five HRSNs: Food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety during their hospital inpatient stay |
| Denominator | The number of patients who are admitted to a hospital inpatient stay and who are 18 years or older on the date of admission. |
| Exclusions | (1) Patients who opt- out of screening; and<br>(2) patients who are themselves unable to complete the screening during their inpatient stay and have no legal guardian or caregiver able to do so on the patient's behalf during their inpatient stay. |

***Reporting: Annual numerator and denominator submission through Hospital Quality Reporting (HQR) platform via web-based data form.*

## Measure #3 - SDOH Screen Positive

This provides information on the percent of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, were screened for an HSRN, and who screen positive for one or more of the following five health related social needs (HSRNs): Food insecurity, housing instability, transportation problems, utility difficulties, or interpersonal safety.

| | |
|---|---|
| Numerator | The number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, who were screened for all five HSRN, and who screen positive for having a need in one or more of the following five HRSNs (calculated separately): Food insecurity, housing instability, transportation needs, utility difficulties, or interpersonal safety. |
| Denominator | The number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission and are screened for all of the following five HSRN (food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety) during their hospital inpatient stay. |
| Exclusions | The following patients would be excluded from the denominator: 1) Patients who opt out of screening; and 2) patients who are themselves unable to complete the screening during their inpatient stay and have no caregiver able to do so on the patient's behalf during their inpatient stay. |

# Overview: Priority SDOH Domains

1. **Food Insecurity**
   Food insecurity is defined as limited or uncertain access to adequate quality and quantity of food at the household level.

2. **Housing Instability**
   Housing instability encompasses multiple conditions ranging from the inability to pay rent or mortgage, frequent changes in residence including temporary stays with friends and relatives, living in crowded conditions, and actual lack of sheltered housing in which an individual does not have a personal residence.

3. **Transportation Needs**
   Unmet transportation needs include limitations that impede transportation to destinations required for all aspects of daily living.

4. **Utility Difficulties**
   Inconsistent availability of electricity, water, oil, and gas services is directly associated with housing instability and food insecurity.

5. **Interpersonal Safety**
   Assessment for this domain includes screening for exposure to intimate partner violence, child abuse, and elder abuse.

# Looking Forward: Year 3 Health Equity Improvement (HEI) Project

**Meeting Registration:** REGISTER HERE!

| | |
|---|---|
| Date & Time | Oct 22, 2024 10:00 AM |
| | Nov 26, 2024 10:00 AM |
| | Dec 17, 2024 10:00 AM |
| | Jan 28, 2025 10:00 AM |
| | Feb 25, 2025 10:00 AM |
| | Mar 25, 2025 10:00 AM |
| | Apr 22, 2025 10:00 AM |
| | May 27, 2025 10:00 AM |
| | Jun 24, 2025 10:00 AM |
| | Jul 22, 2025 10:00 AM |
| | Aug 26, 2025 10:00 AM |

**End Goal:** By August 2025, each CAH will have implemented, tested and promoted **one health equity goal** within the HE action plan that they developed last project year (*hint hint – begin reviewing your **HE strategic plans** to decide which goal you want to work on further!).* Each month you will be guided to work on a particular portion of your goal implementation. This will produce a model for other rural hospitals for how to successfully implement their health equity goals and will be written up as a success story that your facility can continue to build upon. We will tackle this one goal at a time, so we avoid burnout and being too overwhelmed!


# Homework assignment is due **Tuesday, October 15, 2024.**

**Submission Process:** Each hospital must **INDIVIDUALLY** complete an updated gap analysis based on where your facility is currently in the health equity implementation process. Please note this is due next Tuesday!

**Survey Link**: Complete your homework using the following link:

https://www.surveymonkey.com/r/3CZ79ND

# Health Equity Gap Analysis

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

**The following checklist assesses a hospital's incorporation of health equity best practices as part of its overall operations.**

Hospital name: _____

Date: _____

| ELEMENT | BEST PRACTICE RECOMMENDATION | IMPLEMENTATION STATUS | | | ACTION PLAN/ NEXT STEPS List specific activities your team will seek to accomplish to fully implement each practice recommendation |
|---|---|---|---|---|---|
| | | FULLY | PARTIALLY | NONE | |
| **ORGANIZATIONAL LEADERSHIP** | | | | | |
| Health equity is a key strategic priority with established structures and processes in place to elim-inate disparities and ensure equitable healthcare is prioritized and delivered to all patient populations. | Health equity is articulated as a key organization-wide priority (e.g., goals and objectives, strategic plan, policy, protocol, pledges, mission/vision/values, data transparency, leadership buy-in, community partnerships, diverse workforce) supported by a clear business case and plan for operationalizing health equity strategies and interventions that address mul-tiple determinants of health, decrease institutional racism and strengthen community partnerships to improve health and equity. | ○ | ○ | ○ | |
| Hospital has designated a leader(s) or functional area (i.e., health equity committee) responsible for advancing health equity and who actively engages in strategic and action planning activities to reduce disparities. | Health equity leaders are designated and held accountable for disparities reduction with established roles and responsibilities to champion equity and improve quality of care. Designated leaders actively engage hospital staff, patients and families and create linkages with community stakeholders to support health equity improvement activities. | ○ | ○ | ○ | |

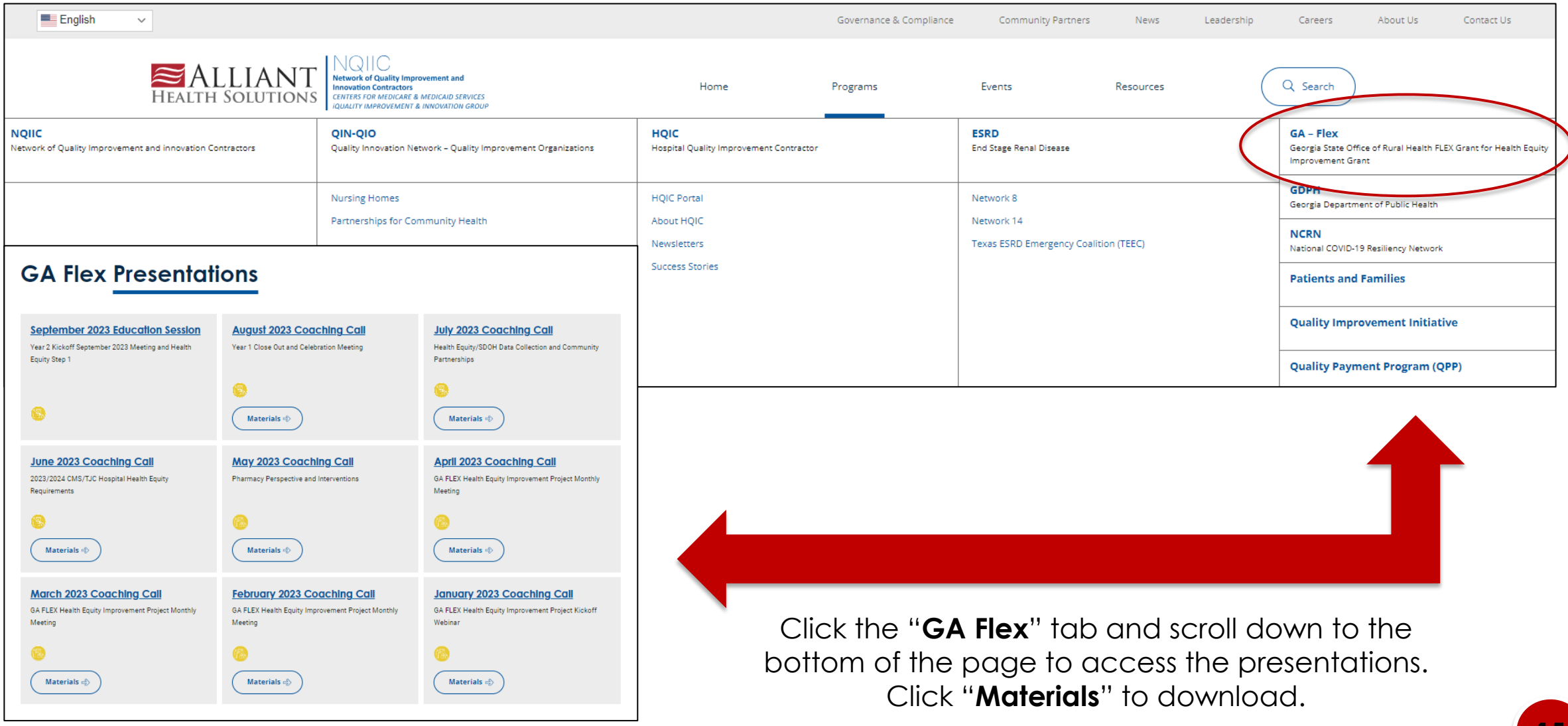
(Source: Eastern US Quality provement Collaborative)

- This HE Gap Analysis aims to help organizations assess the extent to which they have incorporated health equity best practices as part of its overall operations.
- There are *7 major categories* for evaluation in this analysis: organizational leadership, workforce training, data collection, data validation, data stratification, health literacy/cultural competence, community partnerships.
- Each year we will complete this to reevaluate where you are in the health equity process and ideally with each passing year you will progress to full implementation and have corresponding action steps tied to your efforts.

# Join us at 10 a.m EST on Tuesday, October 22, 2024, for our first education session!

*Scan QR code to access the GA Flex webpage.*

**Be prepared to discuss results of the gap analysis submissions before we launch into part 1 of your health equity implementation phase!**




Click the "**GA Flex**" tab and scroll down to the bottom of the page to access the presentations. Click "**Materials**" to download.


Questions?
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