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

GA FLEX Health Equity Improvement Project: October Education Session

Rosa Abraha, MPH

October 22, 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.

Health Equity Gap Analysis

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

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

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)

Let's review the results of your gap analysis surveys!

Overview: MBQIP 2025 Core Measure Set

Data Elements ✓	**Domain 1 – Equity is a Strategic Priority** 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): A. Our hospital strategic plan identifies priority populations who currently experience health disparities. B. Our hospital strategic plan identifies healthcare equity goals and discrete action steps to achieving these goals. C. Our hospital strategic plan outlines specific resources which have been dedicated to achieving our equity goals. 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** Please attest that your hospital engages in the following activities (note: attestation of all elements is required in order to qualify for the numerator): 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. B. Our hospital has training for staff in culturally sensitive collection of demographic and/or social determinant of health information. C. Our hospital inputs demographic and/or social determinant of health information collected from patients into structured, interoperable data elements using certified EHR technology. **Domain 3 – Data Analysis** Please attest that your hospital engages in the following activities (note: attestation of all elements is required in order to qualify for the numerator): 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. **Domain 4 – Quality Improvement** Select all that apply (note: attestation of all elements is required in order to qualify for the numerator): A. Our hospital participates in local, regional, or national quality improvement activities focused on reducing health disparities. **Domain 5 – Leadership Engagement** 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): A. Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews our strategic plan for achieving health equity. 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 (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.

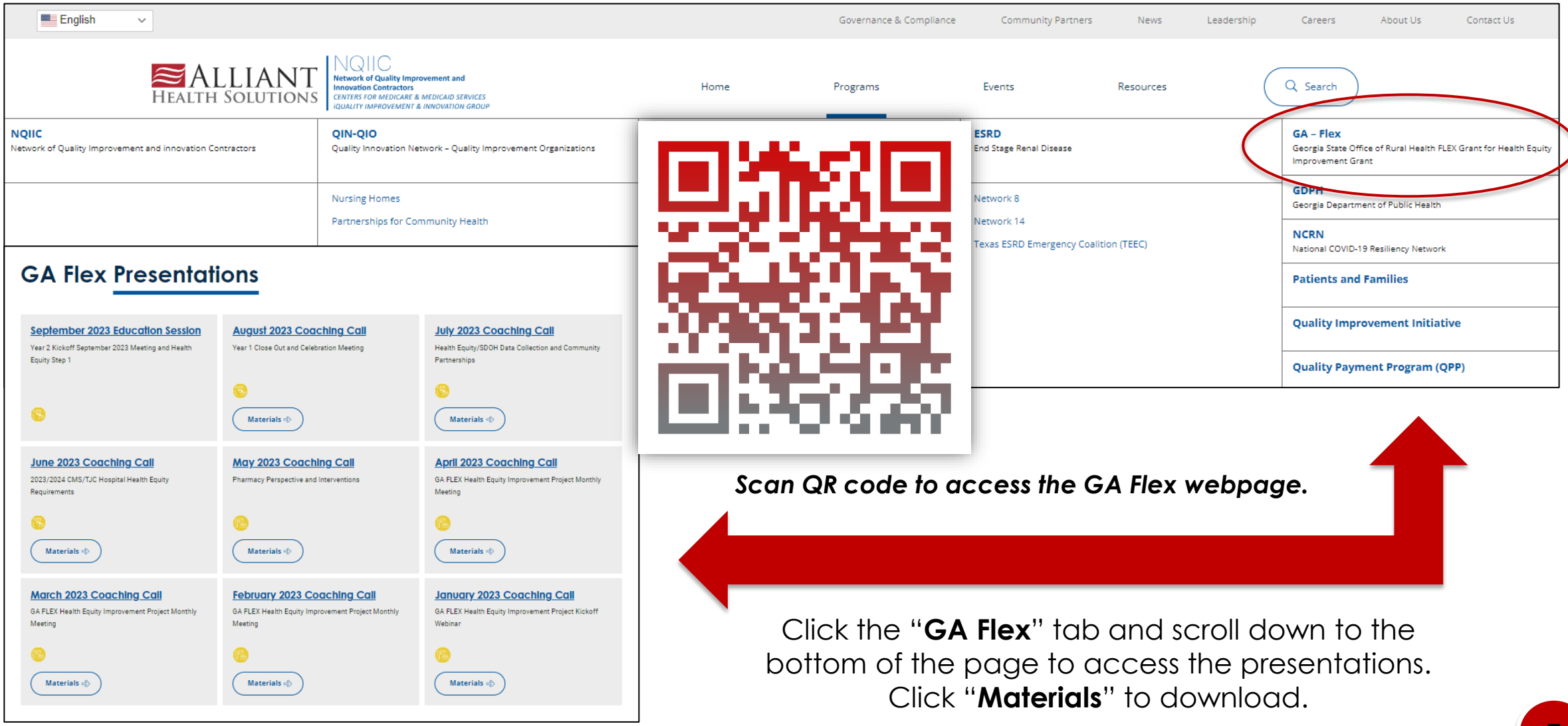
Numerator	The number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, who were screened for all five HSRN, and who screen positive for having a need in one or more of the following five HRSNs (calculated separately): Food insecurity, housing instability, 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.

Join us at 10 a.m EST on Tuesday, November 26th for the next session!

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

Do you or someone from your team need the registration link?

REGISTER HERE!



Scan QR code to access the GA Flex webpage.

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

October is Health Literacy Month!

- **Alliant Health Literacy Bite-Sized Training Video Series:** https://www.youtube.com/playlist?list=PLXWmxni-xNHvBQp3MQt8DXRae06CGF2JI

- **CMS Resources**
  - C2C Roadmap to Better Care and its companion guide for mental health and substance use services, the Roadmap to Behavioral Health. Both resources are available in multiple languages.
  - Share our C2C Prevention Resources, which are available in 8 languages and outline the services that are available at no cost under most health coverage.
  - Review the C2C Enrollment Toolkit, designed to assist community partners and others who help consumers enroll in coverage.
  - Visit our Manage Your Chronic Condition webpage to help those you serve learn more about the chronic care management tools available to them.
  - View our Improving Care for People with Limited English Proficiency infographic to learn more about health disparities among people with limited English proficiency and to find relevant resources.
  - Download Getting the Care You Need – A Guide for People With Disabilities to help people with disabilities understand their rights and get the care they need.
  - Visit the Health Literacy in Healthy People 2030 webpage to find tools and resources the U.S. Department of Health and Human Services is using to help achieve its goal of attaining health literacy to improve health and well-being for all.

Announcement and THANK YOU!

Rosa Abraha, MPH

In my final meeting as the Health Equity Lead for this work, I want to thank you all for the phenomenal opportunity to lead you in this incredible effort and I truly wish you all the best moving forward! Keep up the fantastic work ahead. ☺


Questions?
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