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

# GA FLEX Quality Improvement Project Monthly Meeting

March 25, 2025

# Agenda

- Welcome
- MBQIP Updates and Reports
- Domain 2 Follow Up
- Domain 3 Data Analysis
- Hospital Action Plan (Morgan Medical)
- Project Timeline Updates
- Resources
- Q&A/Wrap Up

# GA FLEX Improvement Project Leads

**Karen Holtz, MT (ASCP), MS, CPHQ**
Education Lead
karen.holtz@allianthealth.org

Karen has over 20 years experience in leading performance improvement programs as well as providing advisory services to hospitals. She recently led the Learning and Action Networks (LANs) in the Hospital Quality Improvement Contractor (HQIC) program. Karen holds a master's degree in healthcare management from the University of Pittsburgh.

**Melody "Mel" Brown, MSM**
State Quality Manager - Georgia
melody.brown@allianthealth.org

Melody has over 40 years of health care experience, including varied roles at Alliant Health Solutions, where she works on the CMS contract for the Quality Innovation Network-Quality Improvement Organization (QIN-QIO). As Georgia's State Quality Manager, her focus is on quality improvement processes and interventions for health care entities throughout the state.

# MBQIP Updates

- Hospital Commitment to Health Equity (HCHE) measure will be removed in FY 2025 (September 1, 2025-August 31, 2026); no longer annual submission
- Alliant | SORH will replace HCHE project with a Safe Use of Opioids Project in FY 2025
- RQITA has updated *MBQIP 2025 Measure Core Set Information Guide, find full version at:* https://www.telligen.com/wp-content/uploads/2025/03/MBQIP-2025-Information-Guide_v2.2_508.pdf
- SDOH-1 (screen) and SDOH-2 (screen positive rate) will remain
- Two genders male and female when screening for REaL/gender demographic information

# MBQIP Reports SDOH-1 Screening for Social Drivers of Health

## Percent GA Hospitals (12%) compared to National (25%) for CY2023

**SDOH-1: Screening for Social Drivers of Health**

**Table 9: SDOH-1 Performance in Georgia**

| | State Performance by Calendar Year | State Current Year | | National Current Year | | Benchmark |
|---|---|---|---|---|---|---|
| | CY 2023 | # CAHs Reporting | Current Year % | # CAHs Reporting | Current Year % | |
| Patients Screened for Social Drivers of Health | 12% | 6 | 12% | 133 | 25% | N/A |
| Number of Patients | N=3,225 | N=3,225 | | N=47,464 | | |

"DNR" indicates that CAHs in the state did not submit any measure or submitted data was rejected/not accepted.

Source: MBQIP Measure State Report, 2024, Georgia

# MBQIP Reports SDOH-2 Screen Positive Rate for Social Drivers of Health

## Percent GA Hospitals (2 - 8%) compared to National (2 - 5%) for CY2023

**SDOH-2: Screen Positive Rate for Social Drivers of Health**

**Table 10. SDOH-2 Performance in Georgia**

| | State Performance by Calendar Year | State Current Year | | National Current Year | | Bench-mark |
|---|---|---|---|---|---|---|
| | CY 2023 | # CAHs Reporting | Current Year % | # CAHs Reporting | Current Year % | |
| Patients Screening Positive for Food Insecurity | 6% | 6 | 6% | 133 | 5% | N/A |
| Patients Screening Positive for Housing Instability | 4% | 6 | 4% | 133 | 5% | N/A |
| Patients Screening Positive for Interpersonal Safety | 2% | 6 | 2% | 133 | 2% | N/A |
| Patients Screening Positive for Transportation Needs | 8% | 6 | 8% | 133 | 5% | N/A |
| Patients Screening Positive for Utility Difficulties | 6% | 6 | 6% | 133 | 5% | N/A |
| Number of Patients | N=401 | N=401 | | N=11,634 | | |

Source: MBQIP Measure State Report, 2024, Georgia

# Workgroup Networking: Homework Assignment Domain 2A, 2B, 2C

survey link

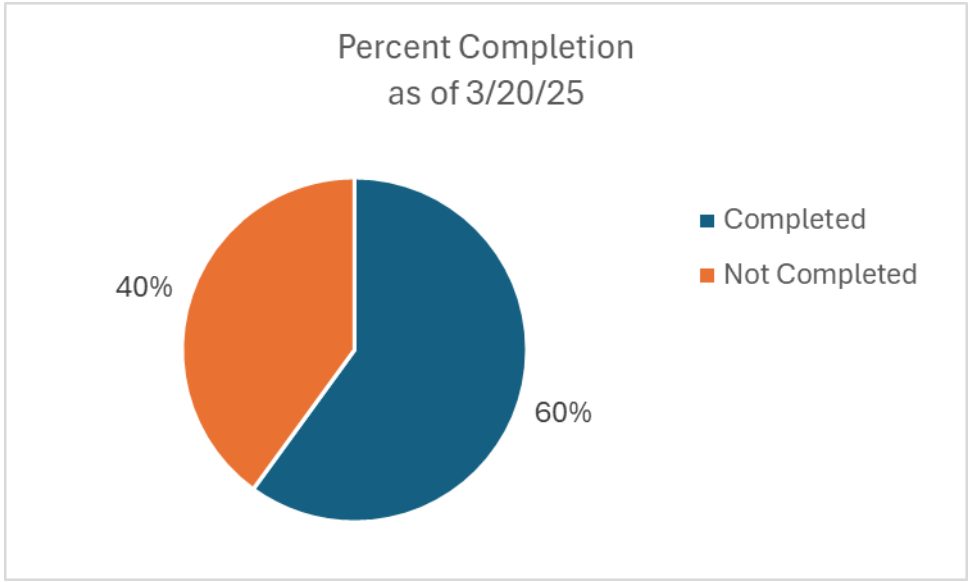
**Due date: March 31, 2025**

- Briefly describe in 2-3 sentences in what ways the following were completed in calendar year 2024, e.g., include who, what, where, when, and how.
  - ❑ 2A Demographic information (self-reported race, ethnicity data, primary language) was collected for the majority, i.e., more than half, of patients
  - ❑ 2A Social determinants of health information (food insecurity, housing instability, transportation needs, utilities difficulties, interpersonal safety) was collected for the majority, i.e., more than half, of patients
  - ❑ 2B Training for staff was provided for culturally sensitive collection of demographics and/or social determinant of health information
  - ❑ 2C Hospital inputs demographic and/or SDOH information collected from patients in structured, interoperable data elements using a certified EHR technology

# Survey Completion: Homework Assignment 2A, 2B, 2C

Hospitals completed as of 03/20/25:

1. Archbold Brooks
2. Atrium Navicent Peach
3. Bacon County
4. Chatuge Regional
5. Egffingham Health System
6. Elbert Memorial
7. Jeff Davis
8. Miller County
9. Monroe County
10. Morgan Medical Center
11. Mountain Lakes Medical Center
12. Optim Medical Center Tattnall
13. Putnam General Hospital
14. Warm Springs Medical Center
15. Early Medical
16. Atrium Health Floyd Polk
17. Wills Memorial
18. Candler County




**What can we do to help you?**

Denominator = 30 CAHs

# CMS Attestation for Domain 3


**Domain 3: Effective data analysis can provide insights into which factors contribute to health disparities and how to respond. Please attest that your hospital engages in the following activities.**

Domain 3 has only one sub-domain (3a) which is defined further in Text Box 3 below.

*Text Box 3: Guidance for Attesting to Domain 3 Data Analysis*

**3A. Our hospital stratifies key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and includes this information on hospital performance dashboards.**

The purpose of measure stratification is to understand if certain patient groups are receiving better care. Stratification in this case refers to examining quality measure results by subgroups of patients to identify important gaps in quality between patient groups.

Hospitals may develop stratification metrics for priority populations (as defined by your organization e.g., by race and ethnicity, economic burden, etc.) and monitor results on these metrics using existing internal quality dashboards.

CMS expects hospitals to identify equity gaps by providing stratified measure information based on either outcome quality measures or process of care measures; this means providing measure scores for priority populations or the gap in score between two groups.

https://qualitynet.cms.gov/files/6481de126f7752001c37e34f?filename=AttstGdnceHCHEMeas_v1.1.pdf

# Frequently Asked Questions - Domain 3

**11. Does CMS require results to be reported on a specific "performance dashboard"?**
CMS does not require reporting on a specific performance dashboard for this measure. Hospitals can utilize their existing internal quality dashboards. The evolution and maturity of a hospital's data collection tools and processes may lead to new and or enhanced dashboards. As with any strategic initiative, results should be available in the same fashion that hospital staff, leaders, clinicians and quality experts are currently reviewing quality measures and performance internally.

**12. Do hospitals need to stratify all key performance indicators or just some?**
The purpose of measure stratification is to understand if certain patient groups are receiving better care. Stratification in this case refers to examining quality measure results by subgroups of patients to identify important gaps in quality between patient groups. Hospitals may develop stratification metrics for priority populations (as defined by your organization) and monitor results on internal quality dashboards. CMS expects hospitals to identify equity gaps by providing stratified measure information based on either outcome quality measures or process of care measures; this means providing measure scores for priority populations or the gap in score between two groups.



https://qualitynet.cms.gov/inpatient/iqr/measures#tab2

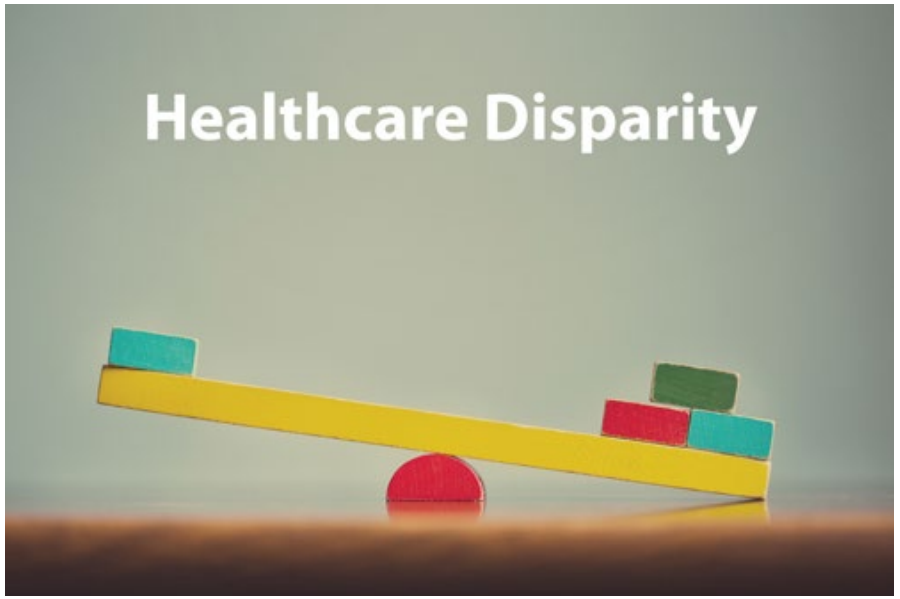
# Hospital Quality Reporting (HQR) Data Submission and Timeline

| Program | Performance Period | Data Submission Deadline | Potential Public Reporting | Payment Determination |
|---|---|---|---|---|
| IQR | January 1, 2024 – December 31, 2024 | May 15, 2025 | October 2025 | FY2026 |
| IQR | January 1, 2025 – December 31, 2025 | May 15, 2026 | October 2026 | FY2027 |

https://qualitynet.cms.gov/inpatient/iqr/measures#tab2

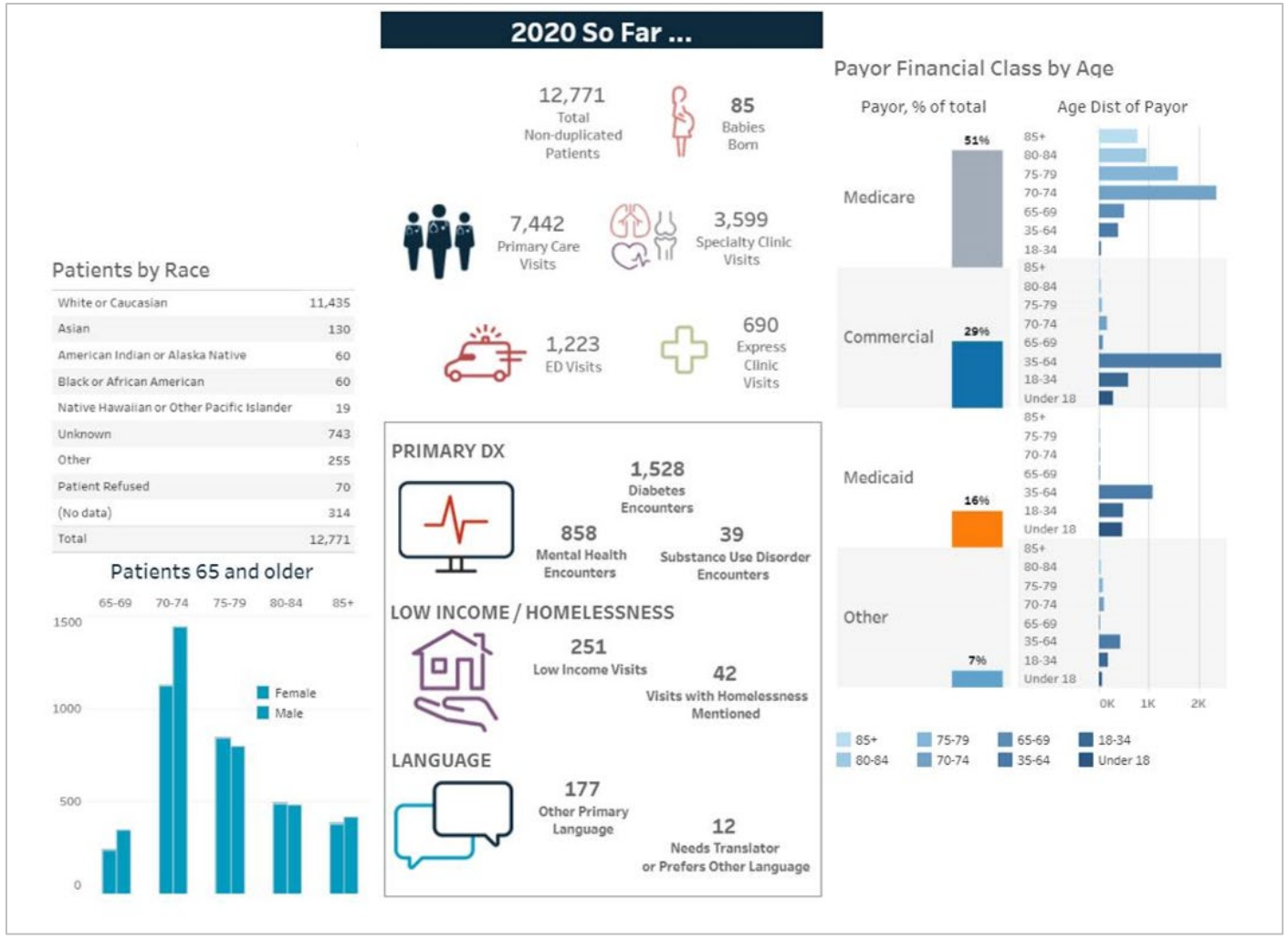
# Data Analysis Components

1. Key performance outcome (or process of care measure), e.g., 30-day readmissions, mortality
2. **Stratify priority population**
    1. REaL, e.g., race
    2. SDOH, e.g., transportation
3. Display gaps in dashboard or current way of internal review of quality measures
4. What's currently on your hospital Quality dashboard? Readmissions, mortality, length of stay
5. Active quality improvement teams
6. Use charts and graphs
7. Benchmarking against industry standards

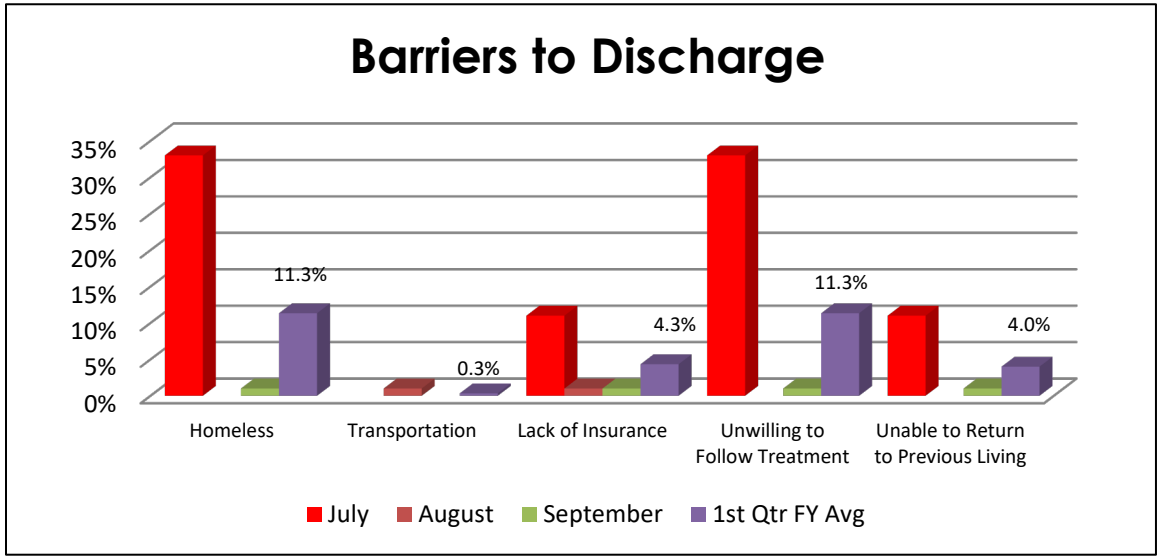



Show the Health Disparity

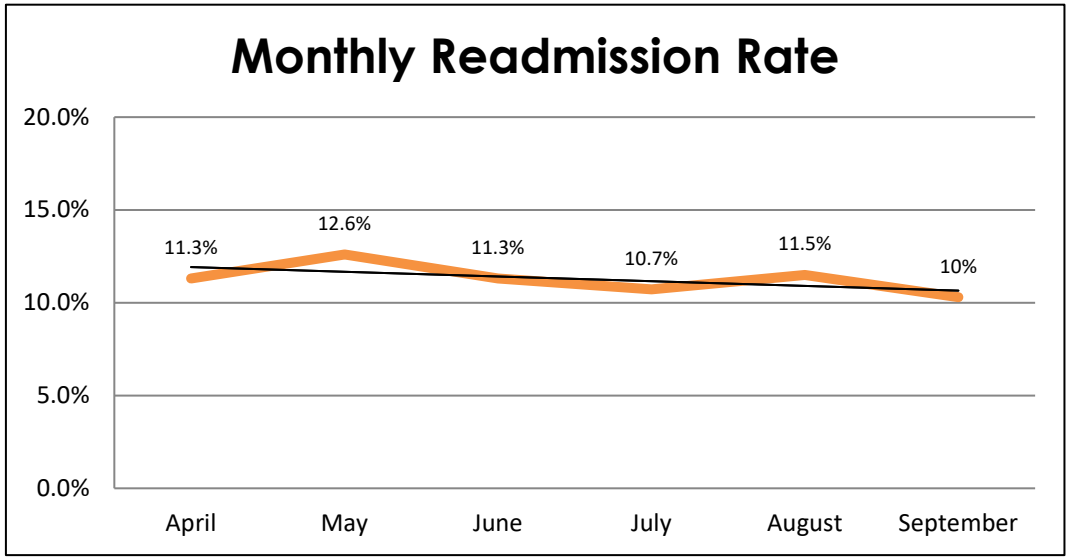
# Hospital Example 1



# Hospital Example 2




Top SDOH barriers identified were homelessness and unwillingness to follow treatment (compliance)




Focused on addressing those two barriers and decreased 30-day readmissions rate from 12.6% to 10%

PRO TIP

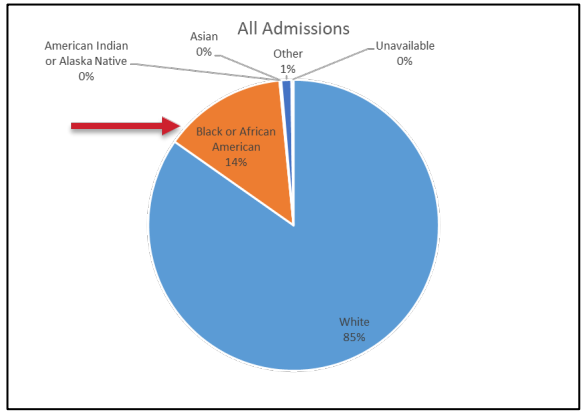
**Focus on addressing one or two social needs at a time and identify community partners to provide resources for those areas.**

# Hospital Example 3

## Process for Health Care Equity Data Analysis by Quality Measures

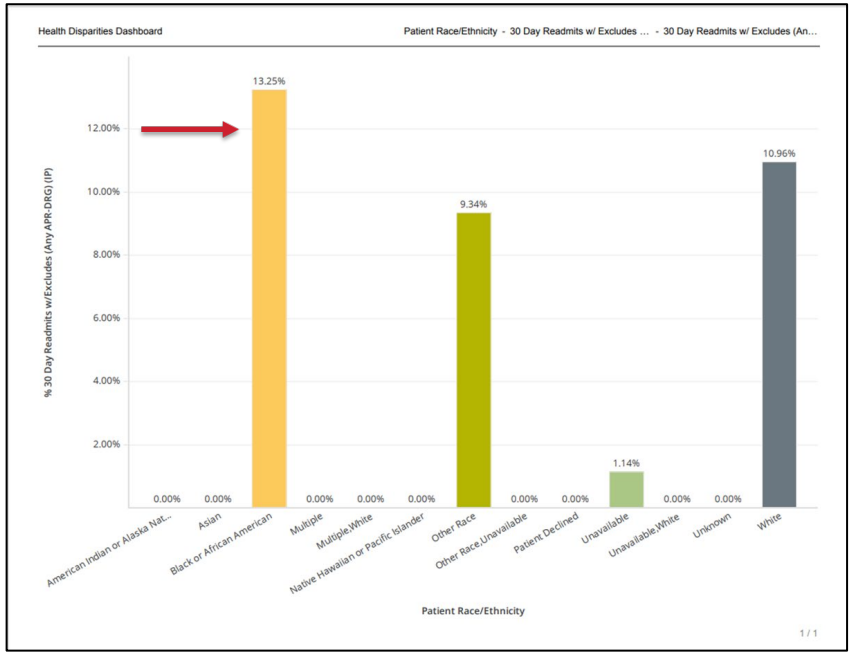
### 1. All Admissions by Race/Ethnicity

Black/African American



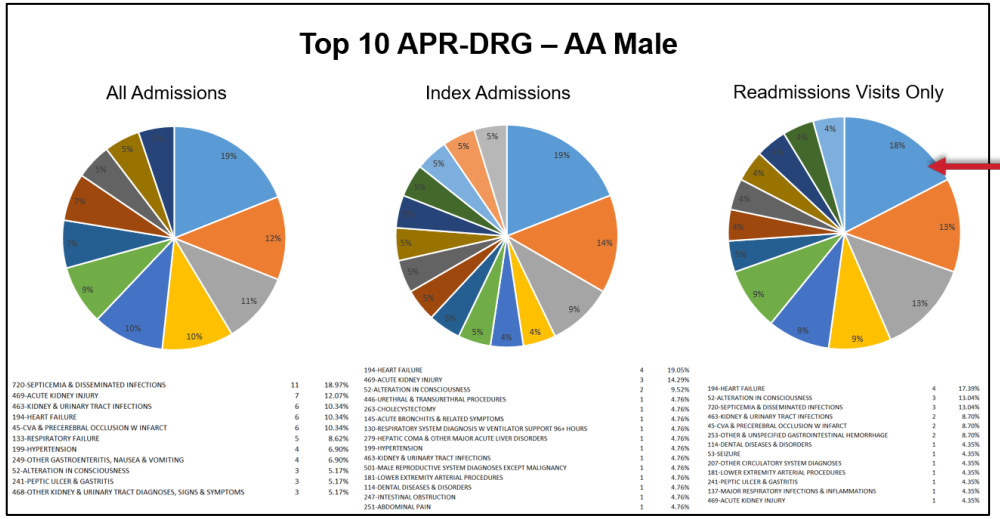

### 2. All Readmissions by Race/Ethnicity

Black/African American

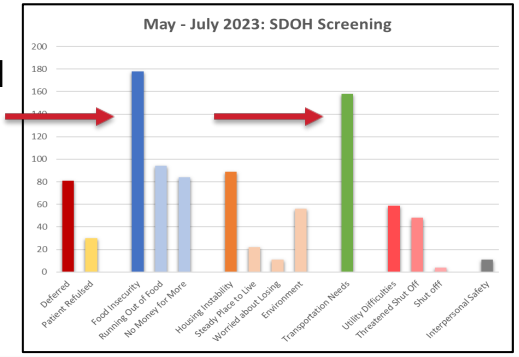



### 3. Black/African American Males Readmissions, Heart Failure

Heart failure




### 4. All Readmissions SDOH Food Insecurity and Transportation Needs



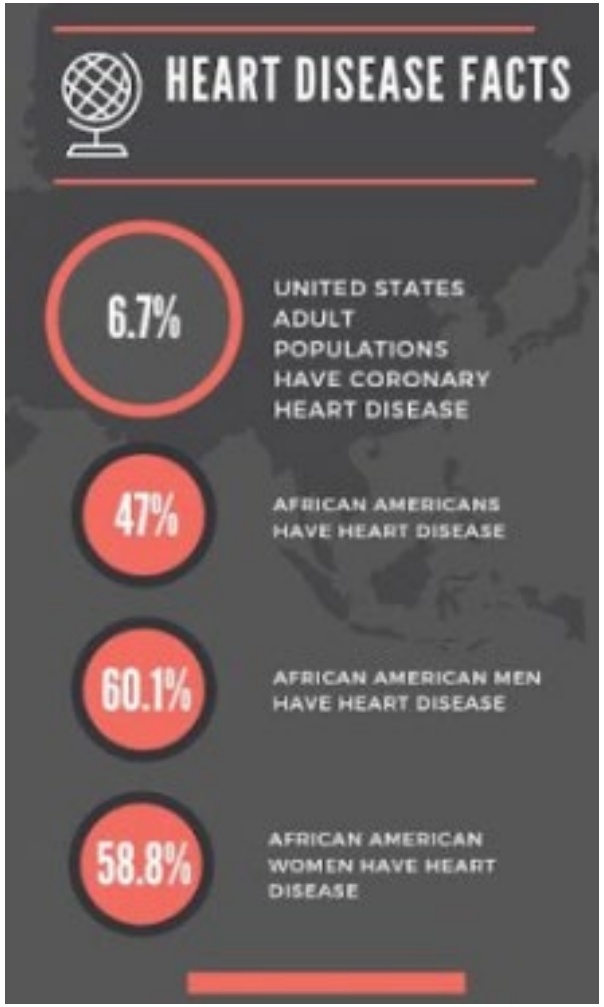
# Additional Insights

- Data may shift and change
  - Example: Baseline data shifted as a result of mortality in older Black men. New finding of younger and sicker Black men with cardiac failure diagnosis.
  - Know the related national statistics

- Continue to ask why to identify root causes
  - Cultural and linguistic barriers that impact community reach
  - What can you learn from our HCAPHS analysis?

- Develop a plan, goals, and interventions that target real improvement – It will take time to identify root causes!

- Go to the source (patients in priority population)



# Hospital Action Plan Sharing

- Your time to shine!
- Review your strategic plans.
- Reference Domain 1B in your Strategic Plan (Playbook). We can Email you the Playbook if needed.
- Each hospital will report out on at least one goal and action steps by July 22, 2025.
- Use PPT template plus any data analysis graphs.
- Select date to share with others.

# Schedule

| Feb 25/Mar 25 | Apr 22 | May 27 | Jun 24 | Jul 22 |
|---|---|---|---|---|
| *Jeff Davis presented Feb 25 | Candler County | Effingham Hospital | SGMC | BCHSI (Jennie Johnson) |
| Morgan Medical | Bleckley Memorial | Jasper Memorial | Monroe Hospital | Archbold (Lynn Buckner) |
| | Chatuge Regional | Atrium Health (Angie Doh) | | Warm Springs |
| | Clinch Memorial | Archbold (K Thomas) | | |
| | Early Medical Center | Atrium Health (Lashauna Hunt) | | |
| | Jenkins County | | | |
| | | | | |

Hospital names in black signed up for date.
Hospital names in red were added.

# Hospital Action Plan

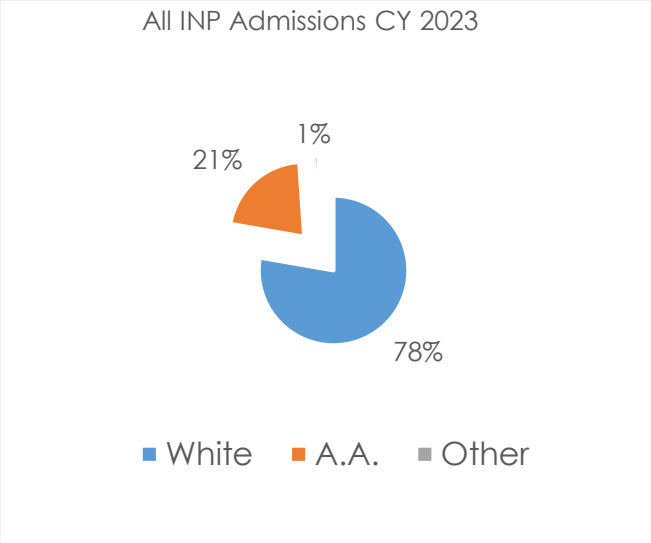
## Morgan Medical Center

## Caitlin Gibson, RN Case Management Manager

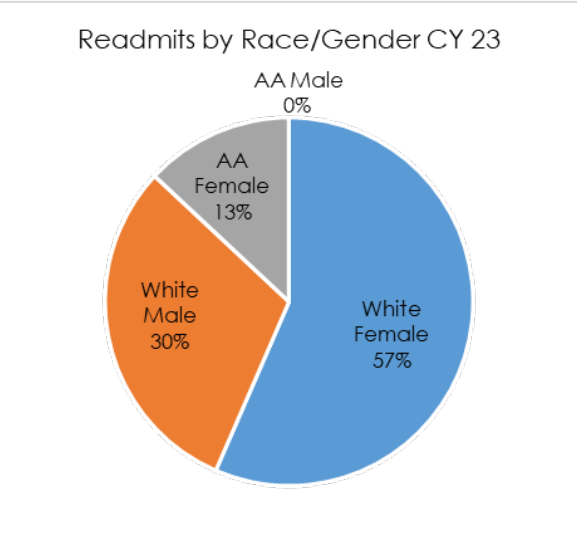
**Goal:** Implement evidence-based interventions to improve outcomes for African American female hospital patients facing readmissions.

| Action Plan/Steps | Status | Performance Outcomes (baseline, trending, or target goal) | Lessons Learned |
|---|---|---|---|
| 1. Analyze readmission data<br>2. High-risk for readmissions contacted within 48-72hrs from discharge<br>3. Optimize d/c planning process to provide additional nurse to patient time<br>4. Provide enhanced support to vulnerable populations that trigger SDOH questionnaire | In progress | 1. Reduction in AA female readmissions from CY 2023-3 to CY 2024-0.<br>2. Directly contacting patients after discharge has helped address potential issues more quickly, such as difficulties obtaining medications, challenges in attending appointments, and confusion about instructions.<br>3. Allocating extra time with the nurse has reinforced discharge instructions and given patients more opportunity to ask questions and gain a clearer understanding.<br>4. Offering resources to patients who identify a need improves discharge outcomes and alleviates stress. | Analysis of readmission data revealed a new trend: Caucasian females with respiratory illnesses are readmitting at a higher rate. This prompted us to collaborate with our respiratory DME company to offer additional support to patients with respiratory issues. By providing resources, we discovered that our rural community has limited access to assistance. We are actively working to partner with more organizations to enhance support for our patient population. |

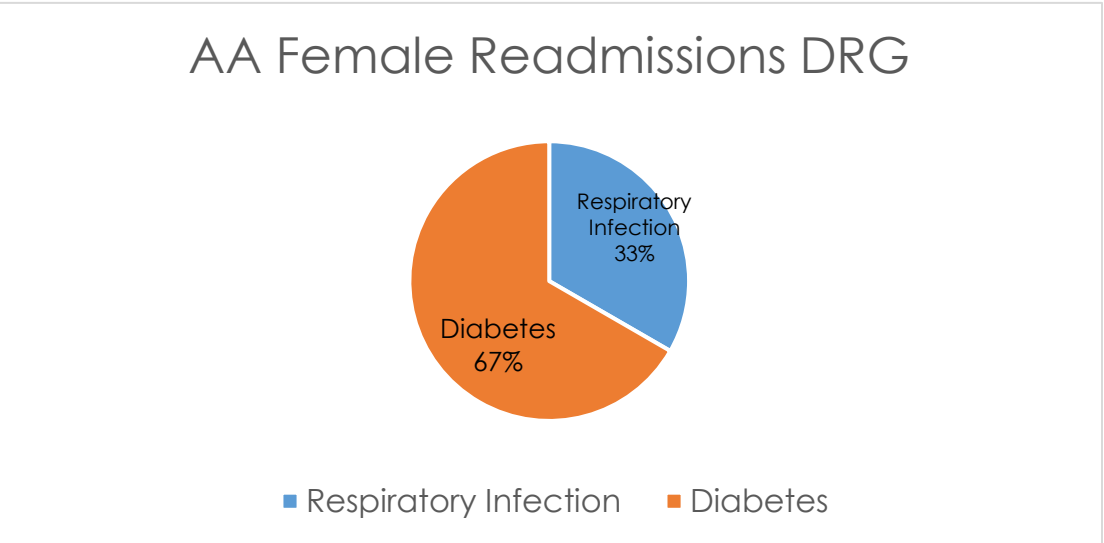
# Data Analysis




- A.A. account for 21% of INP admissions

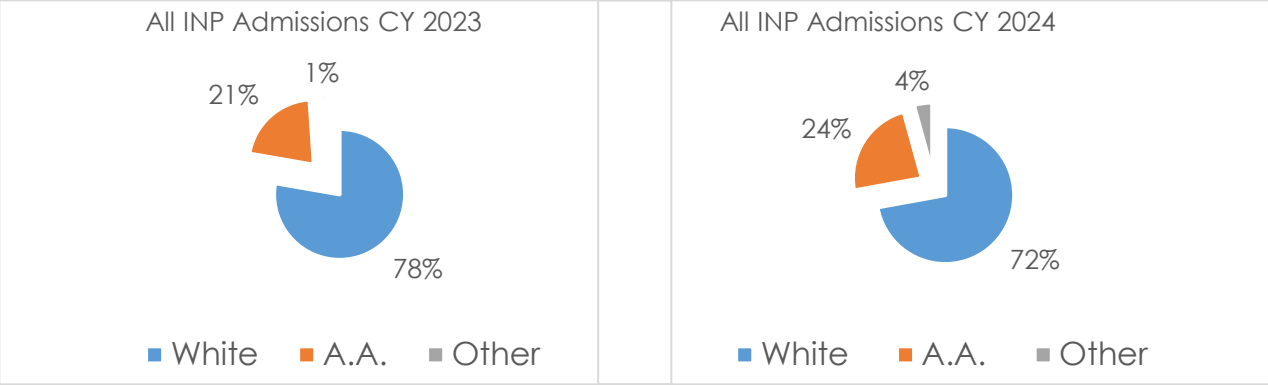



- 13% of readmissions were A.A. females




- Diabetes accounts for 67% of readmissions DRG
- Additional teaching time provided to patients with admissions related to Diabetes

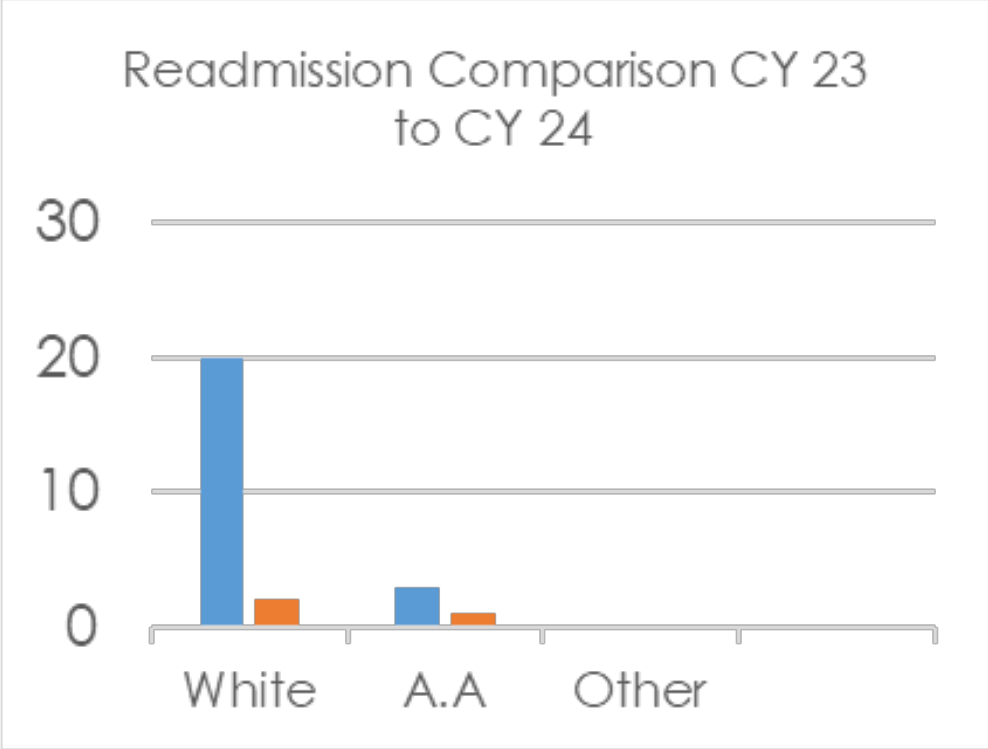
# Comparison 2023 to 2024



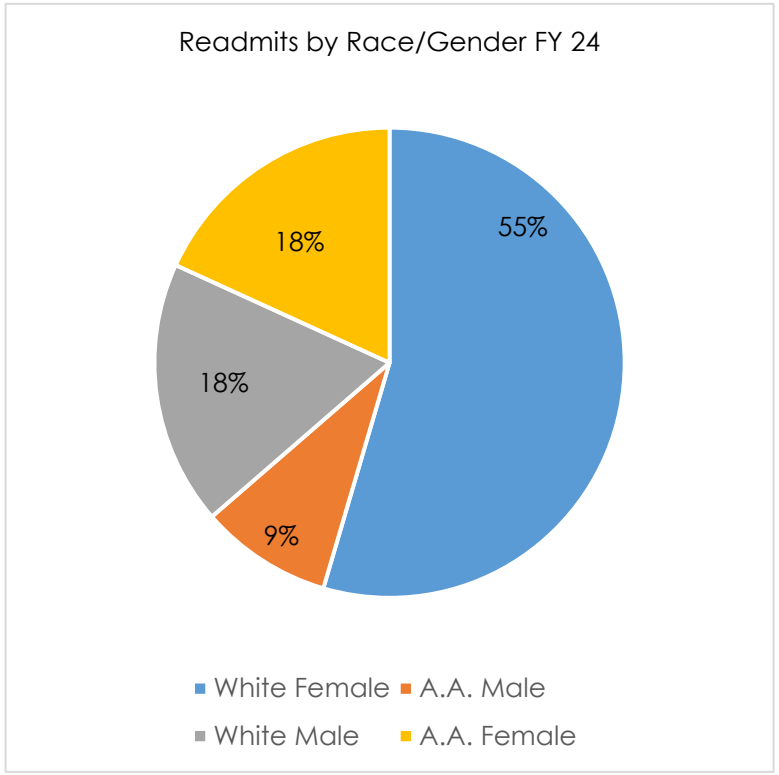


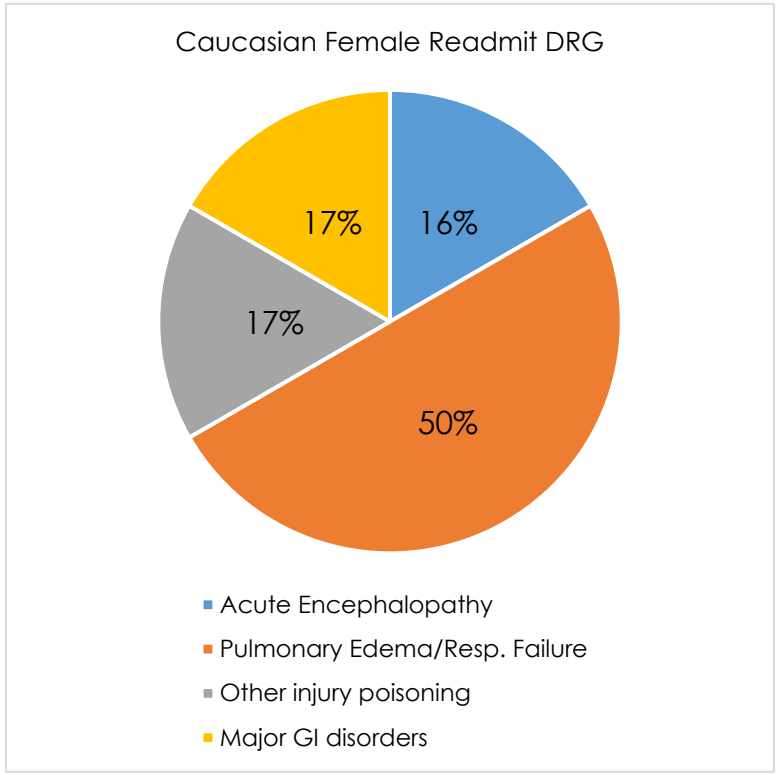


| | CY 2023 | CY 2024 |
|---|---|---|
| Total Readmissions | 23 | 3 |
| African American Readmissions | 3 | 1 |
| African American Female Readmissions | 3 | 0 |



# New Focus




- 55% of readmits are Caucasian female
- 50% are related to Pulmonary edema/ Respiratory failure
- Focus on providing additional resources to this group

# Project Timeline

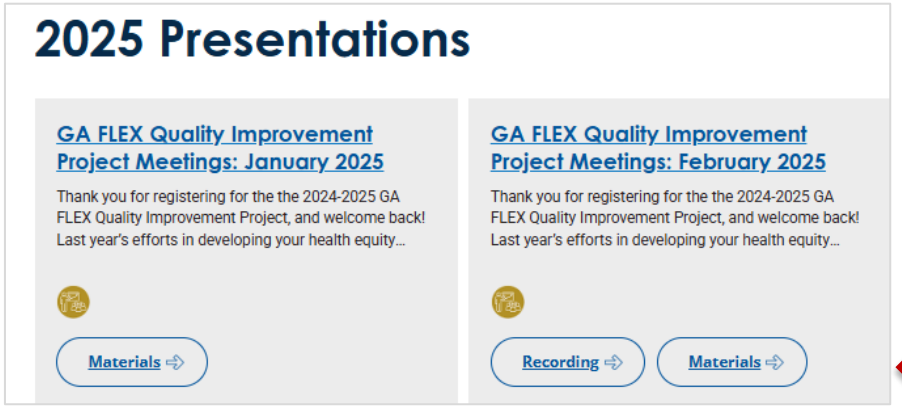
| Date | To-Do List |
|---|---|
| March 25 | □ Learning session on Domain 3 Data Analysis<br>□ Discuss MBQIP updates and reports for GA Flex CAHs<br>□ Complete survey (Domain 2 Data Collection) by March 31 |
| April 22 | □ Workgroup discussion of Hospital Action Plans (Success Stories) |
| May 27 | □ Begin to add Success Stories to the GA Flex webpage<br>□ Workgroup discussion of Hospital Action Plans (Success Stories) |


Email karen.holtz@allianthealth.org or melody.brown@allianthealth.org to schedule a meeting.

# Alliant Health Website and GA Flex Resources

https://quality.allianthealth.org/ga-flex/


Materials (slides) reposted.
Past recordings deleted.




Moving forward, you will see both the materials and recordings as of February 25 session.

# Resources

1. The Rural Quality Improvement Technical Assistance (RQITA) Resource Center: https://www.telligen.com/rqita/

2. Rural Health Information Hub website: https://www.ruralhealthinfo.org/

3. Rural Health Research Gateway: https://www.ruralcenter.org/


Questions?
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Insert individual or team photo

# Hospital Action Plan
# Name of Hospital
# Health Equity Lead Name

Goal: *Insert health equity goal from action plan (Domain 1B) in Playbook*

*Example 1: Increase the availability of food to citizens in need*

| **Action Plan/Steps** | **Status** | **Performance Outcomes** (baseline, trending, or target goal) | **Lessons Learned** |
|---|---|---|---|
| 1. Offer free produce with drive-through farmer's market; first event 06/24 | Ongoing | 1. Target: 50% increase in number of cars<br>2. Can you align with performance indicator such as readmissions, diabetes? | 1. Avoid blocking hospital parking lot |
| | | | |

Insert individual or team photo

# Hospital Action Plan
# Name of Hospital
# Health Equity Lead Name

Goal: *Insert health equity goal from action plan (Domain 1B) in Playbook*

*Example 2: Implement interventions for patients experiencing transportation issues*

| **Action Plan/Steps** | **Status** | **Performance Outcomes** (baseline, trending, or target goal) | **Lessons Learned** |
|---|---|---|---|
| 1. Collect monthly PREPARE data and track the number of patients screened positive for experiencing transportation difficulties | In progress | 1. Baseline and trending: screen positive rate<br>2. Can you align with performance indicator such as readmissions? | |
| | | | |