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

GA FLEX Health Equity Improvement Project Monthly Meeting

February 25, 2025

Agenda

- Welcome
- Quick Review: Data Validation and SDOH Maps
- Workgroup Discussion and Debrief
  - Domain 2 Data Collection
  - Homework Assignment (survey)
- Domain 3 Data Analysis
- Project Timeline Updates
- Resources
- Q&A/Wrap Up

GA FLEX Health Equity Leads

Karen Holtz, MT (ASCP), MS, CPHQ
Education Lead
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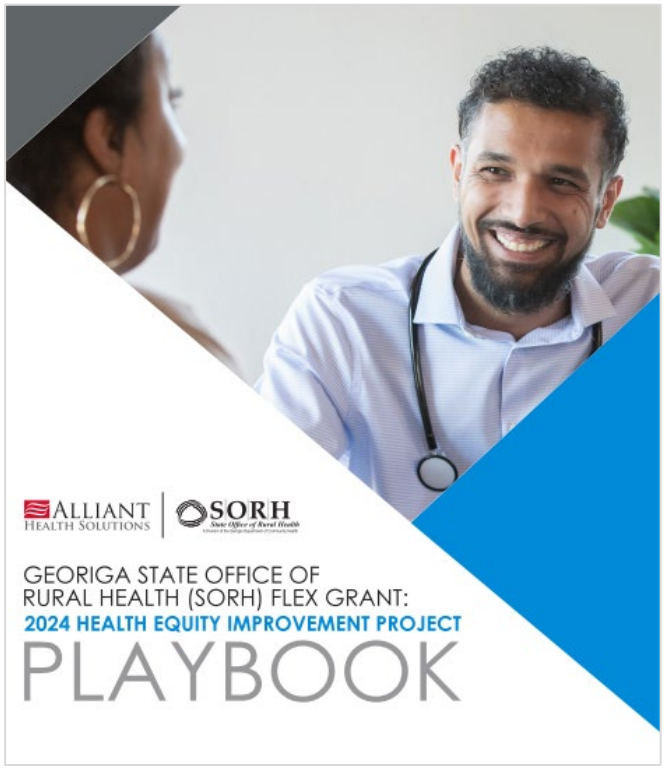
Karen has over 20 years experience in leading performance improvement programs as well as providing advisory services to hospitals. She recently led the Learning and Action Networks (LANs) in the Hospital Quality Improvement Contractor (HQIC) program. Karen holds a master's degree in healthcare management 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.

GA Flex Health Equity Improvement Project Playbook

- Aligns with Hospital Inpatient Quality Reporting Program Attestation Guidance for the Hospital Commitment to Health Equity Measure (Domain 1 Equity is a Strategic Priority)
- Insights into 28 unique **health equity strategic plans** from CAHs across Georgia
- Showcases health equity data analysis, strategies to address priority disparate populations, and the development of actionable health equity goals
- Highlights intentional community partnerships at national, state, and local levels



https://quality.allianthealth.org/wp-content/uploads/2024/08/GA-FLEX-Playbook-FINAL_508.pdf

CMS Attestation on HCHE Measure Domain 1

Domain 1: Hospital commitment to reducing healthcare disparities is strengthened when equity is a key organizational priority.

Under Domain 1, a strategic plan is defined as a *written* plan to address health equity that is shared across the hospital. Domain 1's sub-domains of 1a, 1b, 1c and 1d are defined further in Text Box 1.

- This domain falls under the CMS Hospital Commitment to Health Equity (HCHE) measure.
- **CAHs that DO NOT participate in the CMS Hospital Inpatient Quality Reporting are not subject to completing this for CMS.**
- The purpose of showing this slide is to explain what language might be pulled and adapted into the MBQIP Flex Funding requirements for 2024-2029.

1A. Our hospital strategic plan identifies priority populations who currently experience health disparities.

Examples of "priority populations" include but are not limited to:

- Persons belonging to minority racial or ethnic groups
- Persons living with a disability
- Being a member of a religious minority
- Living in a rural area
- Being near or below the poverty level
- Populations impacted by drivers of health, such as social determinants (e.g., language proficiency, housing or food insecurity, low literacy, difficulty with access to transportation, or other factors unique to a hospital's patient community)
- Any other populations that have been underserved and/or historically marginalized by the healthcare system

1B. Our hospital strategic plan identifies healthcare equity goals and discrete action steps to achieving these goals.

No additional clarification is provided for this attestation sub-domain.

1C. Our hospital strategic plan outlines specific resources which have been dedicated to achieving our equity goals.

Examples of specific resources include but are not limited to dedicated staffing, structural resources, funding, and trainings.

1D. Our hospital strategic plan describes our approach for engaging key stakeholders, such as community-based organizations.

Examples of key stakeholders include but are not limited to community-based organizations and collaboratives, patient and family advisory groups, elected officials, and existing institutional partnerships or coalitions.

Source: Attestation Guidance Hospital Commitment to Health Equity

2024-2029 MBQIP Health Equity Requirements for CAHs

Hospitals will attest to the Hospital Commitment to Health Equity measure via the Hospital Quality Reporting (HQR) system.

Figure 1: Hospital Commitment to Health Equity Measure Attestation Domains

- Each domain is worth one point and hospitals must attest to ALL subcomponent elements of each domain to receive the full point.

CMS Attestation on HCHE Measure Domain 2

Domain 2: Collecting valid and reliable demographic and social determinant of health data on patients served in a hospital is an important step in identifying and eliminating health disparities.

Hospitals are encouraged to collect social drivers of health data electronically and use tools that have undergone validity and reliability testing. Domain 2's sub-domains of 2a, 2b, and 2c are defined further in Text Box 2.

2A. Our hospital collects demographic information (such as self-reported race, national origin, primary language, and ethnicity data) and/or social determinant of health information on the majority of our patients.

A wide range of demographic and social drivers of health information qualifies for data collection, including but not limited to:

- Self-reported race and ethnicity
- Socioeconomic status
- Being a member of a religious minority
- Living with a disability
- Living in a rural area
- Language proficiency
- Health literacy
- Access to primary care/usual source of care
- Housing status or food security
- Access to transportation

2B. Our hospital has training for staff in culturally sensitive collection of demographics and/or social determinant of health information.

The purpose of this question is to ensure hospitals provide guidance or training to staff on how to collect this information in a patient-centered manner.

2C. Our hospital inputs demographic and/or social determinant of health information collected from patients in structured, interoperable data elements using a certified EHR technology.

No additional clarification is provided for this attestation sub-domain.

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

MBQIP 2025 Core Measure Set and CMS Attestation on SDOH Screening

SDOH-1		SDOH-2	
Screening for Social Drivers of Health Measure		**Screen Positive Rate for Social Drivers of Health Measure**	
• Food insecurity • Housing instability • Transportation needs • Utilities difficulties • Interpersonal safety		• Food insecurity • Housing instability • Transportation needs • Utility difficulties • Interpersonal safety	
Numerator	Number of patients who were screened for **one or all** social drivers	Numerator	Number of patients who screened positive for each driver
Denominator	Number of patients 18 or older admitted as an inpatient	Denominator	Number of patients 18 or older admitted as an inpatient and screened for social drivers

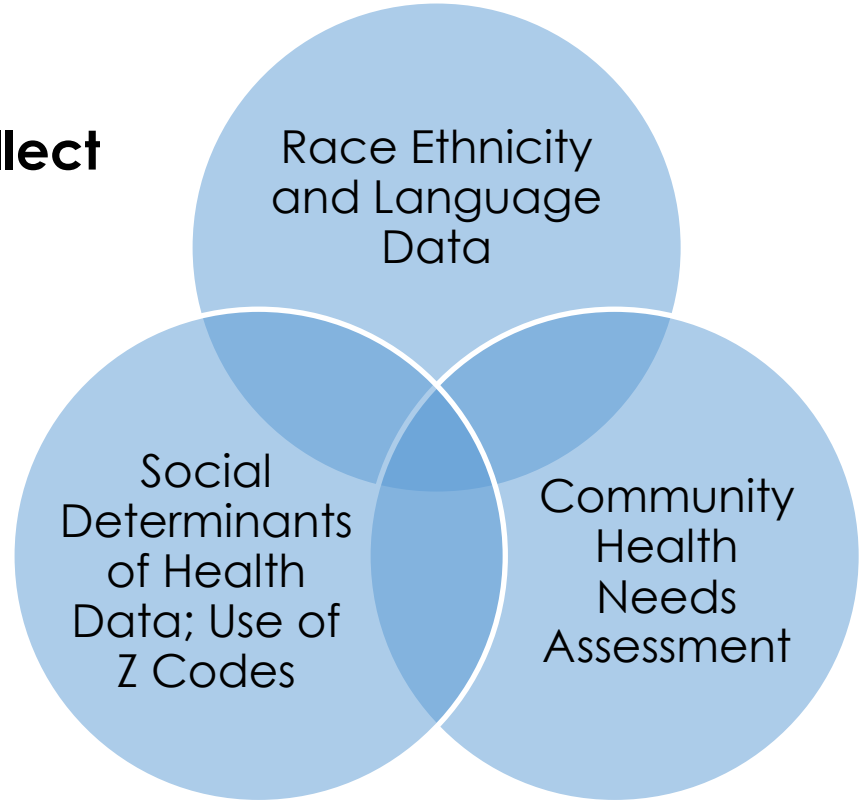
- The screening rate (*in blue*) is one rate, but the screen positive rate (*in green*) will result in five unique rates for each of the five categories of social drivers of health.
- Exclusion Criteria:
  - Patients who opt out of screening
  - Patients unable to complete the screening and have no legal guardian or caregiver to do the screening on their behalf or patients who died during admission.
- Reporting period for this data:
  - **Voluntary for the CY 2025 reporting period. Mandatory beginning with the CY 2026 reporting period.**
  - CY 2028 Payment Determination

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

Data Collection/Validation before Data Analysis

Collect

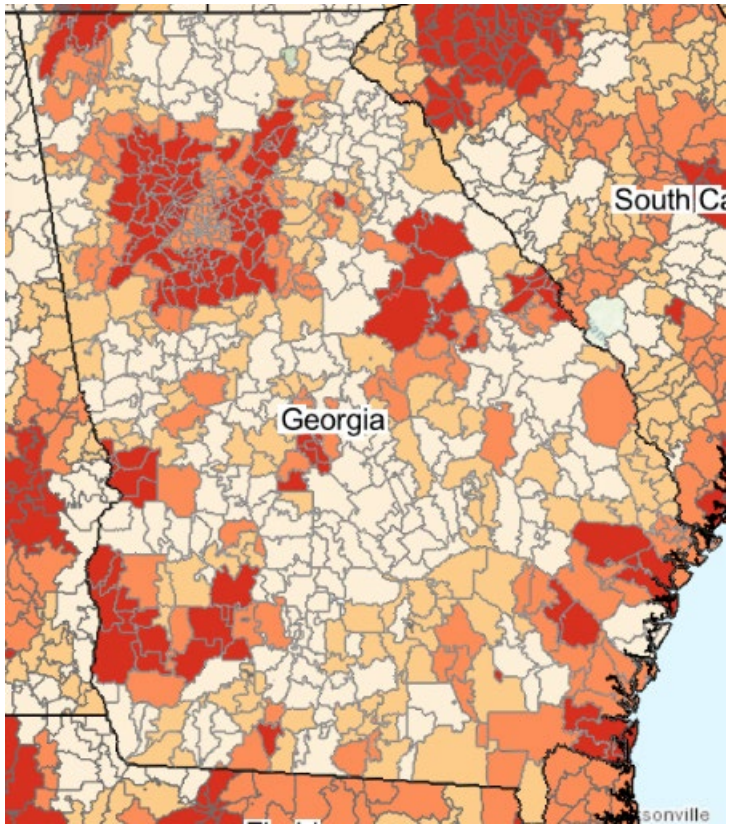
Collect



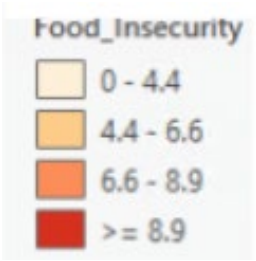
Validate

Other sources:
County Health Rankings
U.S. Census

Alliant Data Map for Georgia: Food Insecurity by Zip Code

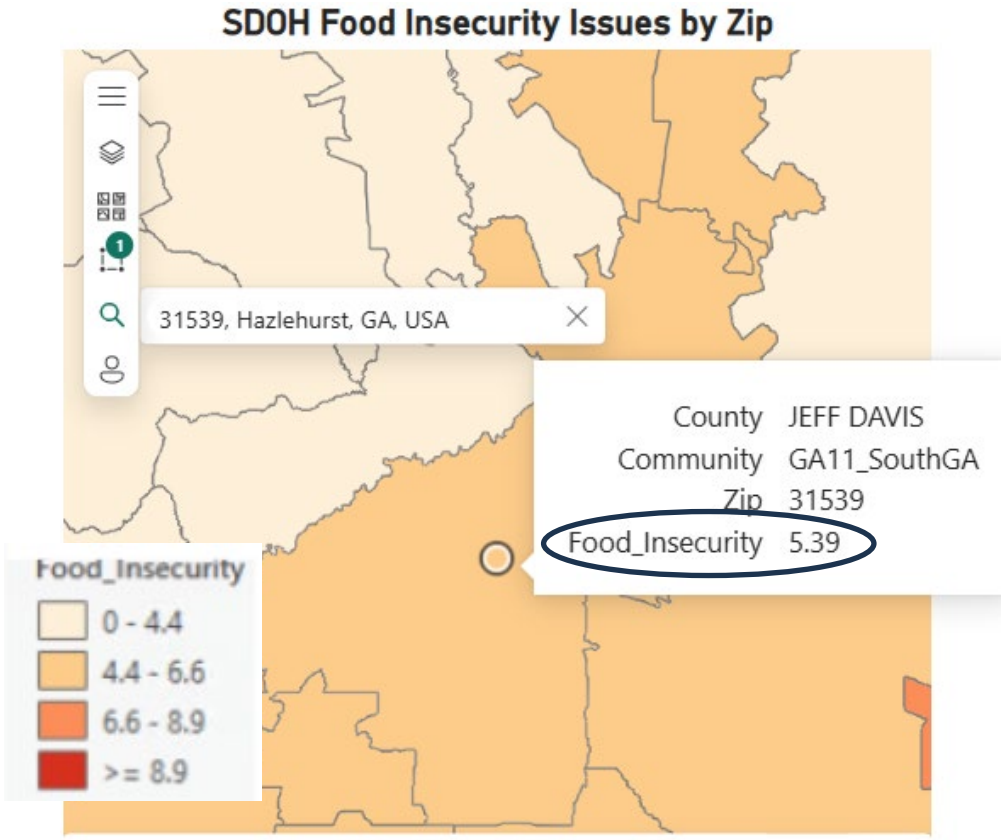


- Scores do not display % of people with X condition
- Higher scores (dark orange areas) represent higher disparities
- Last updated 09/2020



4) Food Insecurity: USDA Food Environment Atlas (https://www.ers.usda.gov/data-products/food-environment-atlas/data-access-and-documentation-downloads/)
   a. Measure: PCT_LACCESS_POP15 (%of population with low access to stores)
   b. Level: County-Level

Hospital: Jeff Davis Hospital in Hazlehurst, GA
Health Equity Leader: Joni Powell



Zip	County	Community	Food_Insecurity
31532	JEFF DAVIS	GA11_SouthGA	4.65
31539	JEFF DAVIS	GA11_SouthGA	5.39

Goals:

- Increase the availability of food to citizens in need
- Educate the community on Healthy Eating/Healthy Living to decrease obesity

Action Steps:

- Free produce with drive-through farmer's market
- Feeding America food bank
- Shop and Serve; buy by the pound
- Case Management provides resources
- Nutritionist will provide education to community Health and Wellness classes
- Information about Healthy Eating/Healthy Living streamed/looped on TV monitors in waiting room

Polling Question #1

1. Are you responsible for submitting the attestation information into Hospital Quality Reporting (HQR)System?

   - ❑ Yes
   - ❑ No, someone else submits. Optional to share name or department.

Breakout Rooms

Hospitals completed as of 02/18/25:
Putnam General Hospital
Optim Medical Center Tattnall
Atrium Health Navicent (AHN) Peach
Warm Springs Medical Center
Elbert Memorial Hospital

Discussion

- You will randomly be placed into a breakout room led by a facilitator
- Discuss questions to 2A, 2B, 2C
- Peer-to-peer networking

Debrief

- Facilitators and/or hospitals can report out
- Discuss any challenges or barriers

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

CMS Attestation on HCHE Measure 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.

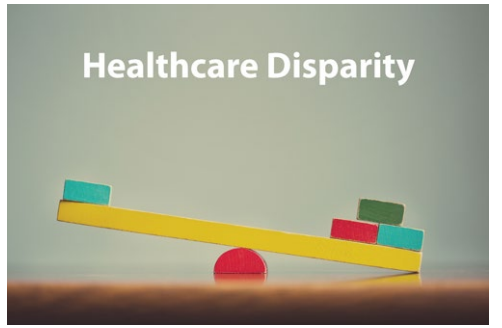
Hospitals may develop stratification metrics for priority populations (as defined by your organization e.g., by race and ethnicity, economic burden, etc.) and monitor results on these metrics using existing internal quality dashboards.

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

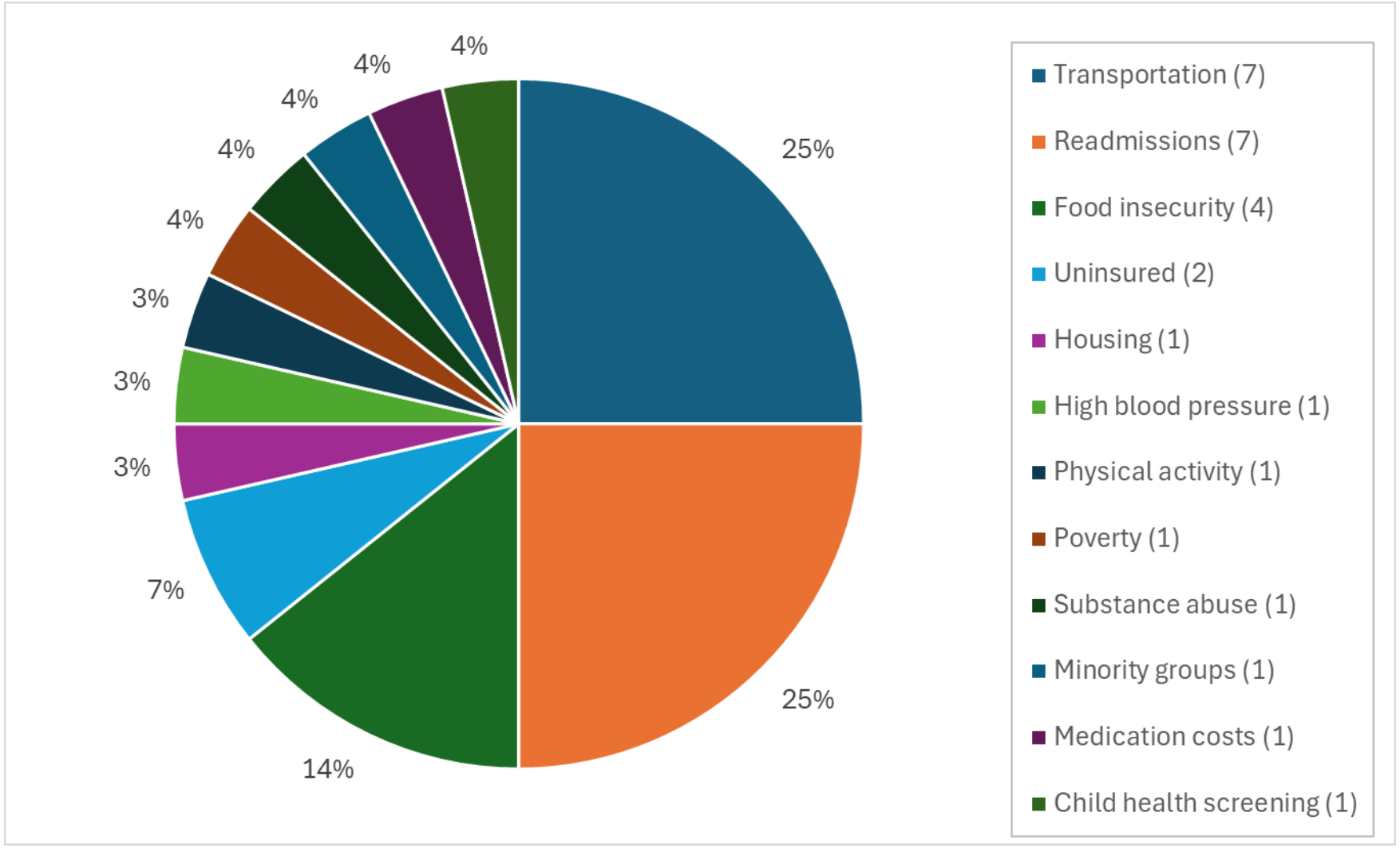
Data Analysis Components

1. Key performance outcome (or process of care measure), e.g., 30-day readmissions
2. **Stratify priority population**
    1. REaL, e.g., race
    2. SDOH, e.g., transportation
3. Display equity gaps in dashboard or current way of internal review of quality measures
4. What's currently on your hospital Quality dashboard?
5. Use charts and graphs



Show the Health Disparity

Strategic Plans – Identified Priority Population 1



Hospital Action Plan Sharing

- Your time to shine!
- Review your health equity strategic plans
- Reference Domain 1B in your Strategic Plan (Playbook)
- Each hospital will report out on at least one health equity goal and action steps
- Use PPT template plus any data analysis graphs
- Select date to share with others

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* *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* *2. Can you align with performance indicator such as readmissions?*	

Polling Question #2

- Please select date to share at least one health equity goal and action steps:
  - ❑ March 25
  - ❑ April 22
  - ❑ May 27
  - ❑ June 24
  - ❑ July 22

Project Timeline

Date	To-Do List
February 25	□ Complete survey (Domain 2 Data Collection) by March 31 □ Communicate and share with appropriate staff if necessary □ Access available resources to validate data if needed
March 25	□ Learning session on Domain 3 Data Analysis □ Discuss MBQIP Reports for GA Flex CAHs □ Discuss plans for technical assistance □ Complete survey (Domain 2 Data Collection) by March 31
April 22	□ Discuss reporting period for Attestation □ Workgroup discussion of Hospital Action Plans (Success Stories)

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

Call for Success Stories

- Are you interested in sharing your hospital's improvement journey in health equity?
- Do you have an example of how your hospital addressed a social driver of health for a patient? For example, food insecurity and food bank as a community resource.
- Please reach out to karen.holtz@allianthealth.org

Alliant Health Website and GA Flex Resources

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

GA Flex Resources

Hospital Health Equity

- Health Equity Coaching Package
- Strategic Planning Tool

Social Determinants of Health (SDOH)

- Discharge Referral List
- Improving the Collection of Social Determinants of Health (SDOH) Data with ICD-10-CM Z Codes
- Social Determinants of Health Setup and Support Guide
- PRAPARE Social Determinants of Health in the EHR

Show More

Health Equity Improvement Project

- Georgia State Office of Rural Health (SORH) Flex Grant: 2024 Health Equity Improvement Project Playbook

2024 Presentations

GA FLEX Health Equity Improvement Project Meetings: December 2024

Thank you for registering for the the 2024-2025 GA FLEX Health Equity Improvement Project, and welcome back! Last year's efforts in developing your health equi...

Materials

GA FLEX Health Equity Improvement Project Meetings: November 2024

Thank you for registering for the the 2024-2025 GA FLEX Health Equity Improvement Project, and welcome back! Last year's efforts in developing your health equi...

Materials

Resources

USDA Economic Research Service
U.S. DEPARTMENT OF AGRICULTURE

- State fact sheets - Georgia
- https://ers.usda.gov/data-products/state-fact-sheets

Household-level Food Insecurity and Very Low Food Security	2011–13 avg.	2018–20 avg.	2021–23 avg.
Percent			
Food insecure households	16.6	10.0	12.8
Very low food secure households	6.0	3.8	5.1

Resources

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

Key Resources and Tools

Global Measures

Hospital Commitment to Health Equity

Here you will find resources to assist with Hospital Commitment to Health Equity Measures.

- Data Submission Guide for Hospital Commitment to Health Equity
- Measure Specifications, Attestation Guidance, and Frequently Asked Questions
- How to submit HCHE and SDOH
- Rural Health Disparities Overview – Rural Health Information Hub

Care Coordination

Social Drivers of Health

Here you will find resources and information regarding the Screening for Social Drivers of Health Measure used for MBQIP.

- Data Submission Guide for Screening for Social Drivers of Health
- Data Submission Guide for Screen Positive Rate for Social Drivers of Health
- Measure Specifications and FAQs
- How to Submit SDOH Measures
- Social Needs Screening Tool Comparison Table | SIREN (ucsf.edu)
- Guide to Social Needs Screening (aafp.org)
- Rural Health Disparities Overview – Rural Health Information Hub
- National Resource Assistance to Address Social Drivers of Health
- How to Leverage MBQIP Data for Improvements – Social Drivers of Health and Health Equity Webinar

Building Resilient Leadership Teams in Rural Healthcare

Georgia Rural Health Association

Webinar Details:

- **Date:** February 27th
- **Time:** 10 AM EST
- **Location:** Online (Zoom – Registration Required)
- **Link to register:** https://bit.ly/4hlbycI


Questions?
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