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

January 28, 2025

Agenda

- Welcome
- Domain 2 Data Collection
  - Recap from Dec 17 session
  - Homework Assignment
- Domain 3 Data Analysis
- Community Health Needs Assessment (CHNA)
- Project Timeline Updates
- Resources
- Q&A/Wrap Up

GA FLEX Health Equity 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.

GA Flex Contact List

- Currently updating our contacts.
- Pre-event and post-event emails are sent from **Alliant Health Solutions.**
- You may see karen.holtz@allianthealth.org as sender.
- Check your junk email folder.

GHA Patient Safety Summit

Congratulations to the
Critical Access Hospitals (CAHs) winners!

optimhealth SYSTEM

Optim Screven

Effingham HEALTH SYSTEM

MORGAN MEDICAL CENTER

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.

Homework Assignment Domain 2A, 2B, 2C

- Name
- Email address
- Hospital name
- Date
- 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

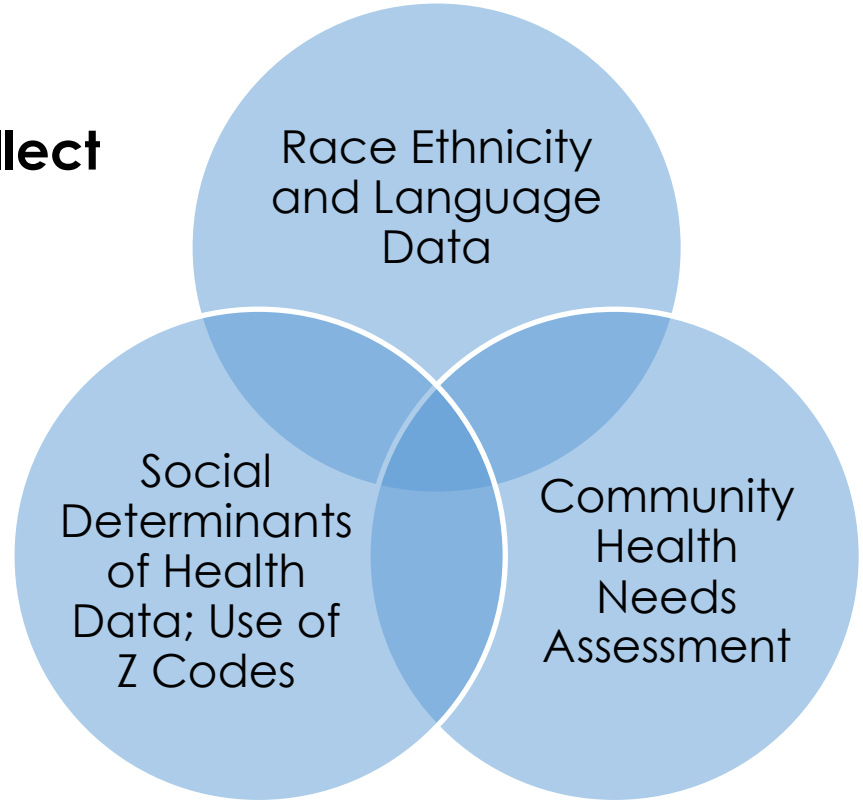
Due date: March 31, 2025

survey

Data Collection/Validation before Data Analysis

Collect

Collect



Validate

Other sources:
County Health Rankings
U.S. Census

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.

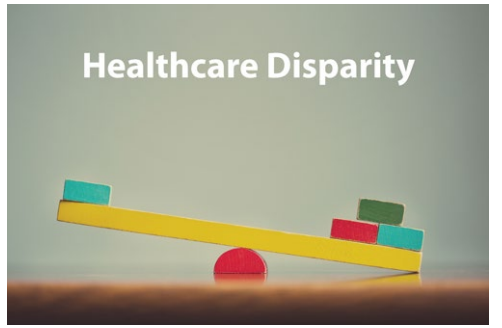
Hospitals may develop stratification metrics for priority populations (as defined by your organization e.g., by race and ethnicity, economic burden, etc.) and monitor results on these metrics using existing internal quality dashboards.

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

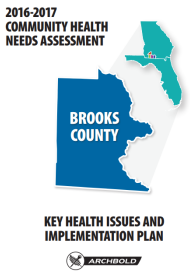
Data Analysis Components

- Key performance outcome (or process of care measure), e.g., 30-day readmissions
- Stratify priority population
  - REaL, e.g., race
  - SDOH, e.g., transportation
- Display equity gaps in dashboard or current way of internal review of quality measures and performance

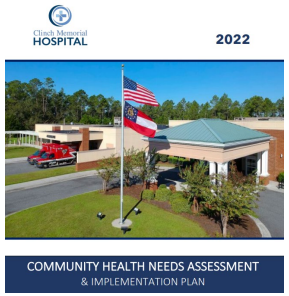


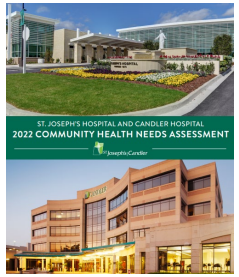
Show the Health Disparity

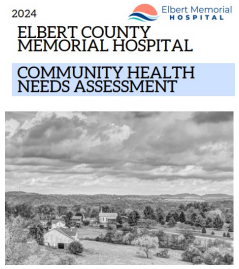
Community Health Needs Assessments
Non-Profit Hospitals

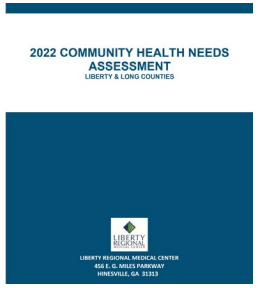


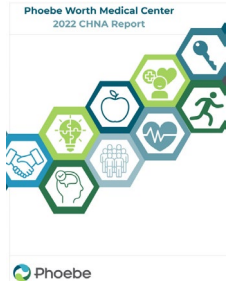
Sponsored by
Atrium Health Navicent Peach
Atrium Health
Navicent

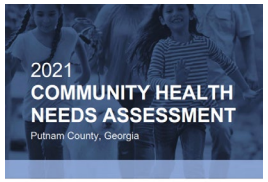




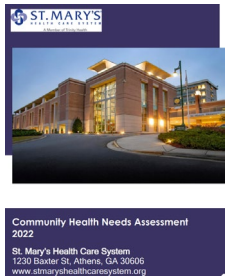


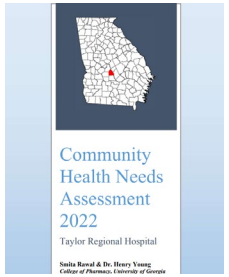


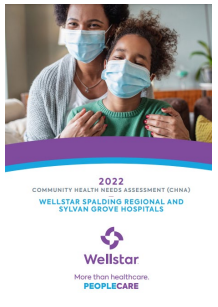


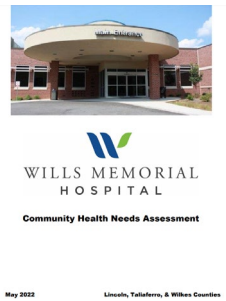


Sponsored by
PGH









Gwendolyn A. Williams, HomeTown Health, LLC

Gwendolyn A. Williams, DHA(c), MBA, MHA
Director of Research & Grants Management
HomeTown Health, LLC

Gwendolyn A. Williams, DHA(c), MBA, MHA, has over twenty years of experience in Medicare quality improvement and has collaborated with various healthcare providers, including hospitals, nursing homes, and home health agencies.

Notably, she piloted the Centers for Medicare and Medicaid Services' Everyone with Diabetes Counts project, a strategic initiative on priority, underserved, minority, and rural populations, launched nationally in 2014.

In her role as the director of research & grants management at HomeTown Health LLC, Gwen leads key Georgia Flex initiatives, including the Diabetes Self-Management Collaborative, the Colorectal Cancer Screening Awareness Project, and the Community Health Needs Assessment Project. Currently, Gwen is a defense away from earning her doctor of health administration degree, specializing in rural healthcare.

HOMETOWN HEALTH | SORH State Office of Rural Health
A Division of the Georgia Department of Health

GA Flex Program

COMMUNITY HEALTH NEEDS ASSESSMENT Project

The Importance of Community Health Needs Assessments in Advancing Health Equity

Understanding and Addressing Community Health Disparities

GA Flex Program
COMMUNITY HEALTH NEEDS ASSESSMENT PROJECT

Objectives

- Define CHNA and highlight the importance of CHNA
- Promote community engagement
- Showcase data utilization
- Demonstrate implementation
- Discuss evaluation methods
- Encourage advocacy
- Identify challenges
- Explore future directions

HOMETOWN HEALTH

Introduction to CHNA

American Hospital Association. (2023). Community Health Assessment Toolkit.

- A systematic process
- Purpose and significance of conducting a CHNA
- Overview of the process

Legislative Background

- Overview of the Affordable Care Act (ACA) requirement for non-profit hospitals
- Community input and stakeholder engagement

Identifying Health Disparities

- What are health disparities?
- How CHNA helps identify specific needs within the community
- Examples of disparities in areas such as race, income, and geography
- Using data to improve health equity for IA
  - County Health Rankings
  - Census Bureau
  - Data USE

Census Data


http://www.census.gov/#
U.S. Department of Commerce
United States Census Bureau
Business
Geography
YOUR RESPONSE MAKES A DIFFERENCE FOR YOUR COMMUNITY


GA Flex Program
COMMUNITY
Health Needs
Assessment
WORKSHOP

County Health Rankings

County Health Rankings & Roadmaps

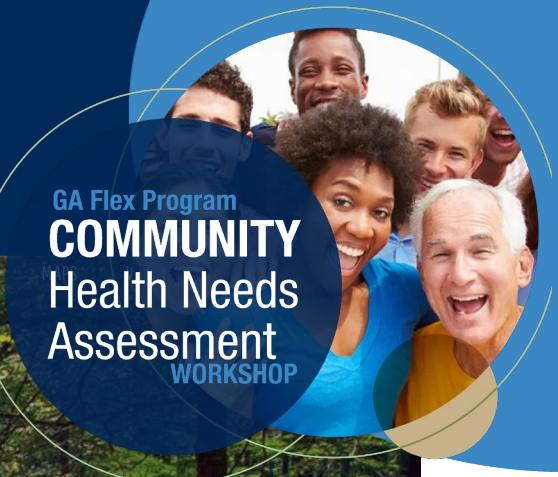
What Impacts Health | Health Data | Strategies and Solutions | Findings and Insights | About Us

Creating thriving communities through civic participation

Creating community spaces where everyone can engage, be informed and have a say is key to healthy communities and to our democracy. This requires attention to policies and practices that exclude people and communities from participating.

Read the report →

Data USA



DATA USA: REPORTS

MILLER COUNTY, GA

COUNTY

ADD COMPARISON

2022 POPULATION
5,923
1.02% 1-YEAR DECLINE

US SENATOR
Jon Ossoff
DEMOCRATIC PARTY

US SENATOR
Raphael Warnock
DEMOCRATIC PARTY

2022 MEDIAN AGE
43.2
0% 1-YEAR CHANGE

2022 POVERTY RATE
24.5%
7.74% 1-YEAR INCREASE

2022 MEDIAN HOUSEHOLD INCOME
$52,132
0.287% 1-YEAR GROWTH

2022 MEDIAN PROPERTY VALUE
$119,400
12.5% 1-YEAR GROWTH

POPULATION & DIVERSITY | ECONOMY | CIVICS | EDUCATION | HOUSING & LIVING | HEALTH

About

In 2022, Miller County, GA had a population of 5.92k people with a median age of 43.2 and a median household income of $52,132. Between 2021 and

Hispanic) (1.15%), and Two+ (Non-Hispanic) (0.912%).

None of the households in Miller County, GA

GA was $119,400, and the homeownership rate was 66.7%.

UNITED STATES \ GEORGIA

GA Flex Program
COMMUNITY HEALTH NEEDS ASSESSMENT PROJECT

Data Collection & Analysis

- Methods of data collection (surveys, focus groups, public health data)
- Importance of quantitative and qualitative data
- Tools and resources for effective analysis

SURVEYS

Most common method for collecting quantitative data. Distributed online, via mail or in person.

FOCUS GROUPS

Valuable for exploring perceptions, beliefs, and attitudes regarding health issues within the community.

PUBLIC HEALTH DATA

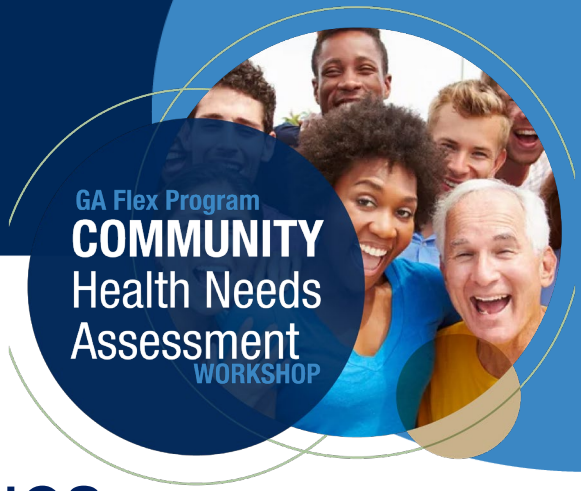
Provide historical context and identify trends in disease prevalence, demographics, and healthcare access.

HOMETOWN HEALTH

Community Engagement

- Involving community members in the assessment process
- Building trust and collaboration with stakeholders
- Examples of successful community partnerships

Prioritization of Health Needs



- Criteria for prioritizing health issues
  - Impact
  - Feasibility
  - Community input
- Strategies for addressing the most pressing health needs
- Case study/example of prioritized health issues

Implementation Strategies

- Inform the development of health programs
- Interventions that promote health equity
- Tailoring approaches to specific communities
  - Cultural contexts
  - Social contexts
  - Economic contexts

Evaluating Impact

Pre- and Post Intervention Surveys | Focus Groups | Health Outcomes Measurement | Behavioral Tracking | Comparative Analysis

- Evaluating the effectiveness of health interventions
- Importance of ongoing assessments and refinement of strategies
- Success stories and measurable outcomes

CHNA as a Tool for Advocacy

- Utilizing CHNA findings to advocate for policy changes
- Role of community forums and stakeholder engagement in advocacy
- Successful advocacy efforts resulting from CHNA data

Healthy Food Access

Mental Health Initiatives

Youth Fitness Programs

Overcoming Challenges

- Common barriers to effective CHNA implementation
- Strategies to address these challenges (e.g., resource allocation, community buy-in)
- Importance of sustainability in addressing health disparities

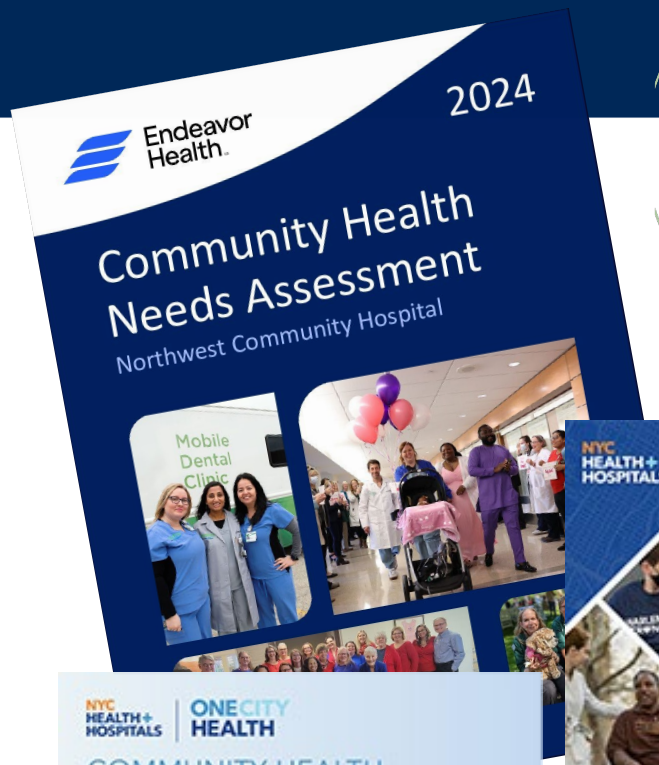
Future Directions for CHNA

- Importance of integrating CHNA in broader health equity frameworks
- Advancements in technology and data collection methods (e.g., GIS mapping)
- Encouraging proactive approaches to identifying emerging health issues

Source: California Health Care Foundation

Conclusion

- Emphasizing the integral role of CHNA in promoting health equity
- Call to action for stakeholders to engage in and support CHNA efforts



Links

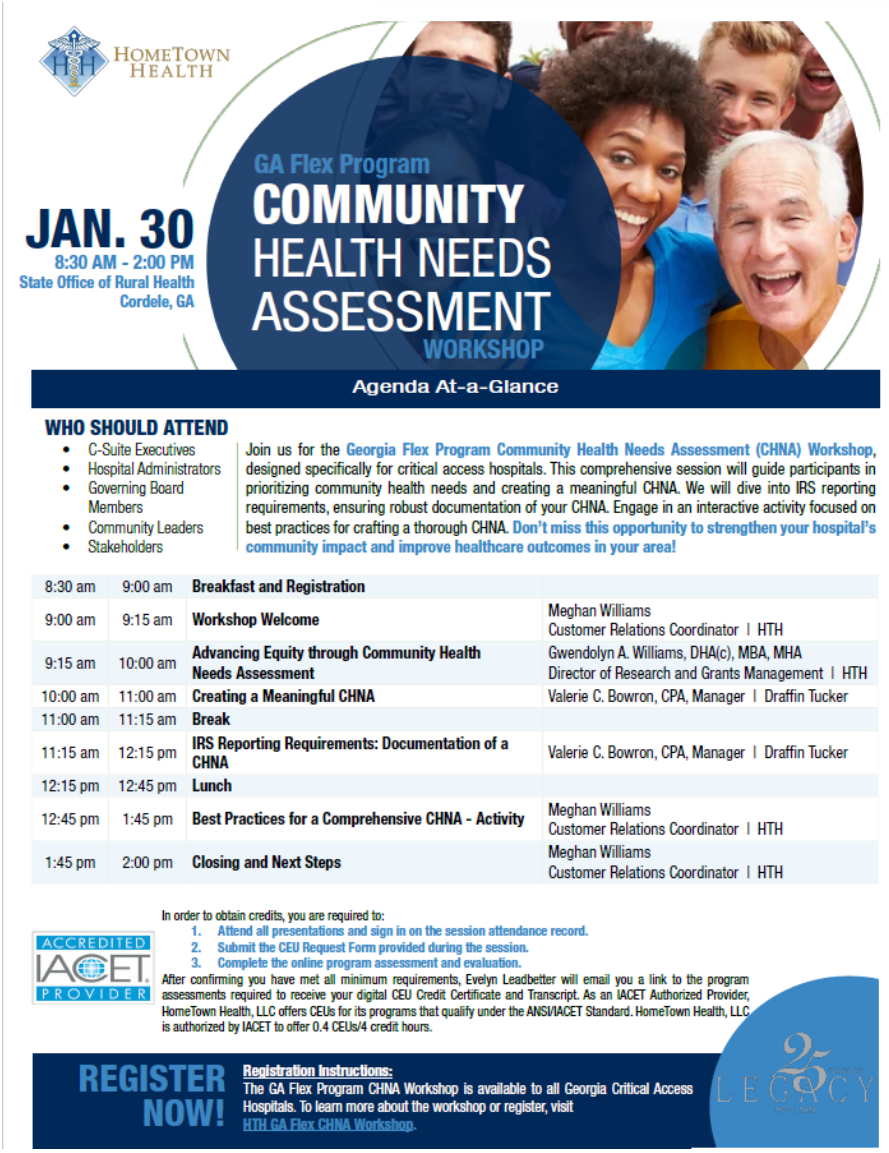
- https://data.census.gov
- https://www.census.gov/programs-surveys/acs/data.html
- https://datausa.io
- https://www.countyhealthrankings.org
- https://www.communitycommons.org/entities/b5e98e53-bd30-442d-ba88-6ea07f8fad38

Questions?

Upcoming Event:

GA Flex Community Health Needs Assessment (CHNA) Workshop
January 30, 2025
Cordele, GA

Info and Registration



Project Timeline

Date	To-Do List
January 28	□ Homework: Begin survey questions to attest to Domain 2 Data Collection □ Find and read your hospital's Community Health Needs Assessment (CHNA) □ CHNA Workshop available on January 30
February 25	□ Workgroup discussion on homework assignment □ Bring your survey responses for report out and networking
March 25	□ Domain 3 Data Analysis □ Complete survey (Domain 2 Data Collection) by March 31

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...

Register Here | 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...

Register Here | Materials

GA FLEX Health Equity Improvement Project Meetings: October 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

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

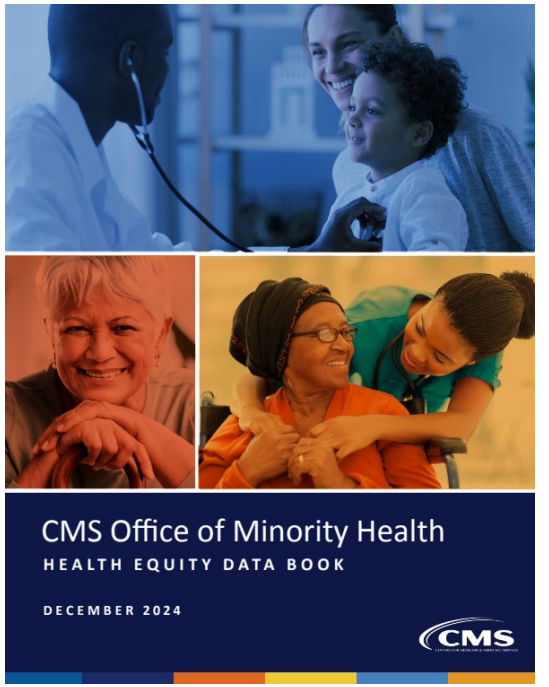
Resources

2. National Assistance to Address Social Drivers of Health https://www.telligen.com/wp-content/uploads/2024/08/National-Assistance-to-Address-SDOH_508.pdf
    - General Assistance (FindHelp.org, Area Agencies on Aging)
    - Food insecurity (food banks and pantries, feedingamerica.org)
    - Housing and Utilities (National Coalition for the Homeless)
    - Transportation (Rides in Sight, GoGo Grandparent)
    - Interpersonal Safety (Domestic Violence Resource Network)

3. Embracing the Shift: The Impact of Health Care Contracting on Community-Based Organizations (December 2024) https://www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2025/01/Embracing-The-Shift-December-2024.pdf

Resources

4. CMS Office of Minority Health: Health Equity Data Book (December 2024)
   https://www.cms.gov/files/document/2025-cms-omh-health-equity-data-book.pdf
   - Demographics
   - Chronic Conditions
   - Behavioral Health
   - Social Determinants of Health on pp. 36 - 47



2025 CMS Health Equity Conference: Building a Healthier America

- The Centers for Medicare & Medicaid Services (CMS) will host the 2025 CMS Health Equity Conference on April 23-24, 2025.
- The free conference will be held at the Hyatt Regency hotel in Bethesda, Maryland, and virtually.
- Registration will open in early 2025.
- https://www.cmshealthequitycon.com.

National Poverty in America Awareness Month Resources

Centers for Medicare & Medicaid Services Office of Minority Health (CMS OMH) recognizes National Poverty in America Awareness Month to raise awareness about the health care challenges faced by people living in poverty.

- Download our Improving the Collection of SDOH Data with ICD-10-CM Z Codes infographic, which explains how Z codes can improve the collection of social determinants of health (SDOH) data and how SDOH data can improve equity in health care delivery and research.
- View the Coverage to Care (C2C) Roadmap to Better Care to help patients better understand their health coverage and how to use it to access primary care and preventive services.
- Explore the Coverage to Care (C2C) Get Preventive Care webpage to learn more about preventive services available to adults, teens, children, and infants.
- Review the CMS Framework for Health Equity 2022–2032 to learn how we're working to advance health equity, expand coverage, and improve health outcomes for those supported by CMS programs, including those affected by persistent poverty.
- Check out the Healthy People 2030 website to learn more about the impact of economic stability on health.


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