June 11th, 2024

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How to Leverage MBQIP Data for Improvement: Health Equity and Social Drivers of Health (SDOH)

Multistate Collaborative

Objectives

- Discuss the relationship of health equity measures and quality improvement
- Review the Medicare Beneficiary Quality Improvement Program (MBQIP) Commitment to Health Equity and Social Drivers of Health (SDOH) measures
- Learn data resources available to you, both nationally and locally
- Identify ways to use SDOH to tell your story!

Role of Rural Quality Improvement Technical Assistance Center (RQITA)

RQITA RESOURCE CENTER

The goal of RQITA is to improve quality and health outcomes in rural communities through technical assistance to beneficiaries of Federal Office of Rural Health Policy (FORHP) quality initiatives, which are focused on quality measure reporting and improvement.

RQITA is intended to add expertise related to quality reporting and quality improvement, not to replace technical assistance support already in place.

Resources and Services

- Monthly Newsletter
- Up-to-date resources, guides and tools
- 1:1 technical assistance
- Learning and action webinar events
- Recorded trainings
- Telligen RQITA website for quality improvement resources
- TASC Rural Center website

The RQITA Team

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All Quality Improvement is Health Equity Work: Designing Improvement to Reduce Disparities

QI has been defined by the Agency for Healthcare Research and Quality as "the framework we use to systematically improve the ways care is delivered to patients," and a wide array of QI approaches have been developed

Applying a QI lens to Health Equity

Step 1: Examine, Identify, and Understand Existing Disparities in the Focus Area of Your QI Work

- Understand Preexisting Disparities
- Consider System Related Factors
- QI Interventions Are Most Effective for the Populations That They Were Designed for, by, and With
- Context Can Cause the Best-Laid Plans in QI to Go Awry

Step 2: Engage the Communities That Experience Those Specific Health and Health Care Disparities in Your QI Project Work

- Establish a Relationship
- Value Community Partner Time
- Ensure Full Engagement

All Quality Improvement Is Health Equity Work: Designing Improvement to Reduce Disparities | Pediatrics | American Academy of Pediatrics (aap.org)

What are the Benefits of the New Health Equity and Social Drivers of Health Measures within MBQIP?

- Collection and Use of Data to Improve – Tell your story!
  - Increase Awareness of Social Drivers of Health
- Community Collaboration for Solutions
  - Community Partners
  - Legislators
  - Board of Directors
  - Grant Funding Opportunities
- Identify key community level needs and improve the health of patients
- Identify a community's vulnerable population(s)
- Support Quality Improvement leadership with data preparation related to strategic planning/discussion

Chat Waterfall Exercise

1. Facilitator will pose a question.
2. Type your state, and response into chat **BUT DO NOT HIT SEND** until prompted.

Watch the waterfall of responses come in!

MBQIP Health Equity & Social Drivers of Health Measures

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Hospital Commitment to Health Equity

Global Measures Domain

Hospital Commitment to Health Equity

Measure Description: This structural measure assesses hospital commitment to health equity.

Hospitals will receive points for responding to questions in five (5) different domains of commitment to advancing health equity.

- Domain 1 – Equity is a Strategic Priority
- Domain 2 – Data Collection
- Domain 3 – Data Analysis
- Domain 4 – Quality Improvement
- Domain 5 – Leadership Engagement

Hospital score can be a total of zero to five points (one point for each domain, must attest “yes” to all sub-questions in each domain, no partial credit).

Hospital Commitment to Health Equity

Measure Rationale: The recognition of health disparities has been heightened in recent years, and it is particularly relevant in rural areas. Rural risk factors for health disparities include geographic isolation, lower socioeconomic status, higher rates of health risk behaviors, limited access to healthcare specialists and subspecialists, and limited job opportunities. Rural residents are also less likely to have employer-provided health insurance coverage, and if they are poor, often are not covered by Medicaid. The intent of this measure is to help ensure hospitals are considering and addressing equity in the care they provide to their community.

Calculation: Hospital score can be a total of zero to five points (one point for each domain, must attest "yes" to all sub-questions in each domain, no partial credit).

Improvement Noted As: Increase in the total score (up to five points).

Hospital Commitment to Health Equity

Encounter Period: Calendar year (January 1 – December 31)

First MBQIP Encounter Period and Reporting Date: The First MBQIP encounter period (measurement period) is January 1, 2025, through December 31, 2025. The first MBQIP submission deadline date is May 15, 2026.

Data Source: Multiple sources.

Data Collection Approach: Attestation.

Measure Submission and Reporting Channel: This is an annual attestation measure submitted through the Hospital Quality Reporting (HQR) secure portal.

Hospital Commitment to Health Equity

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 the following elements (note: attestation of all elements is required 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 quality goals and discrete action steps** to achieve these goals.
C. Our hospital strategic plan **outlines specific resources** which have been dedicated to achieve our equity goals.
D. Our hospital strategic plan **describes our approach for engaging key stakeholders** such as community-based organizations.

Create A Written Plan to Address Healthcare Equity

- **Domain 1 – Equity is a Strategic Priority –**
  Attest that your hospital has a strategic plan for advancing healthcare equity

A. A Strategic Plan is defined as "A Written Plan to Address Healthcare Equity"
B. Three must be an annual review of this written plan by Senior Leadership.
C. Senior Leadership must annually review key performance indicators stratified by demographic and/or social factors.
D. The Written Strategic Plan to Address Healthcare Equity must be shared across the hospital.

Hospital Strategic Plan for Addressing Health Equity

- A strategic plan provides
  - a process to assess current challenges,
  - identifies opportunities for improvement
  - develops thoughtful, data-driven strategies to move the hospital forward toward long-term success.

- Key elements of a Strategic Plan
  - Mission and Vision
  - Data Analysis
  - Setting Goals and Objectives
  - Engaging a wide variety of stakeholders

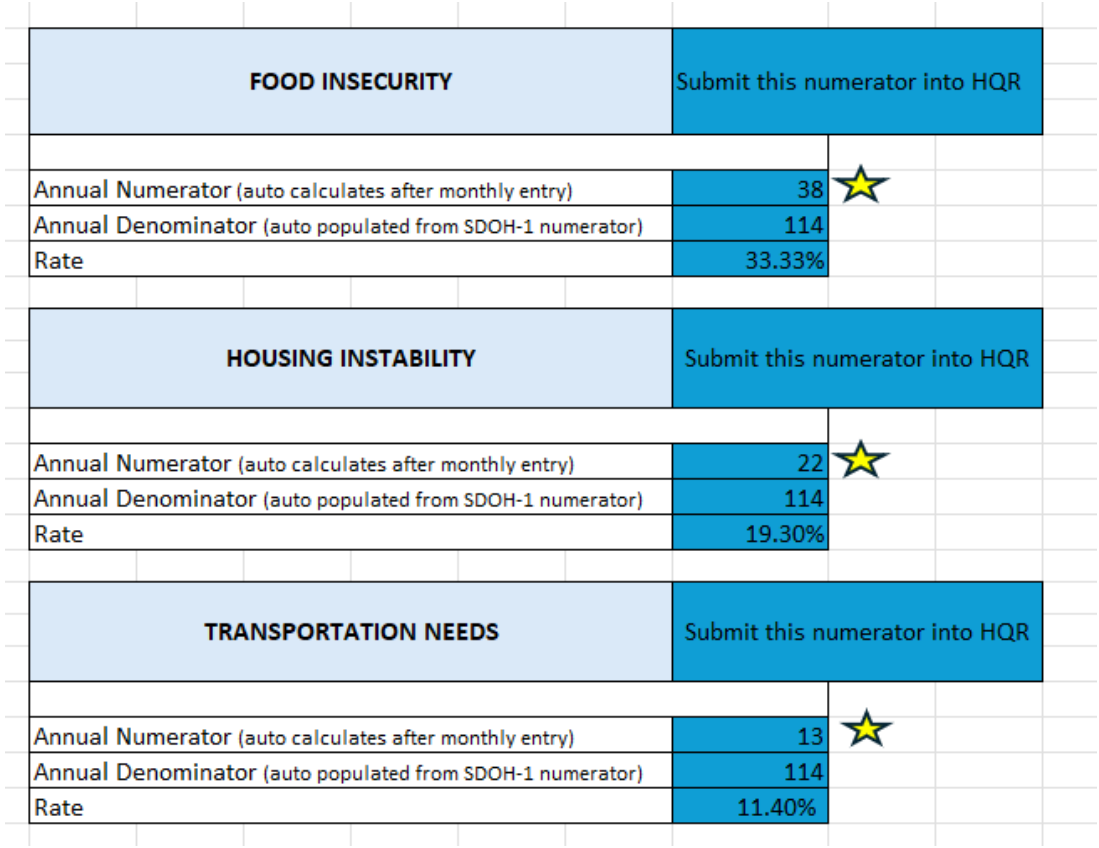
Hospital Commitment to Health Equity

Data Elements:

Domain 2 – Data Collection

Please attest that your hospital engages in the following activities (note: attestation of all elements is required to qualify for the numerator):

A. Our hospital collects demographic information, including self-reported race and ethnicity, and/or social driver 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 drivers of health information.
C. Our hospital inputs demographic and/or social driver of health information collected from patients into structured, interoperable data elements using certified EHR technology.



FOOD INSECURITY	Submit this numerator into HQR
Annual Numerator (auto calculates after monthly entry)	38
Annual Denominator (auto populated from SDOH-1 numerator)	114
Rate	33.33%

HOUSING INSTABILITY	Submit this numerator into HQR
Annual Numerator (auto calculates after monthly entry)	22
Annual Denominator (auto populated from SDOH-1 numerator)	114
Rate	19.30%

TRANSPORTATION NEEDS	Submit this numerator into HQR
Annual Numerator (auto calculates after monthly entry)	13
Annual Denominator (auto populated from SDOH-1 numerator)	114
Rate	11.40%

Hospital Commitment to Health Equity

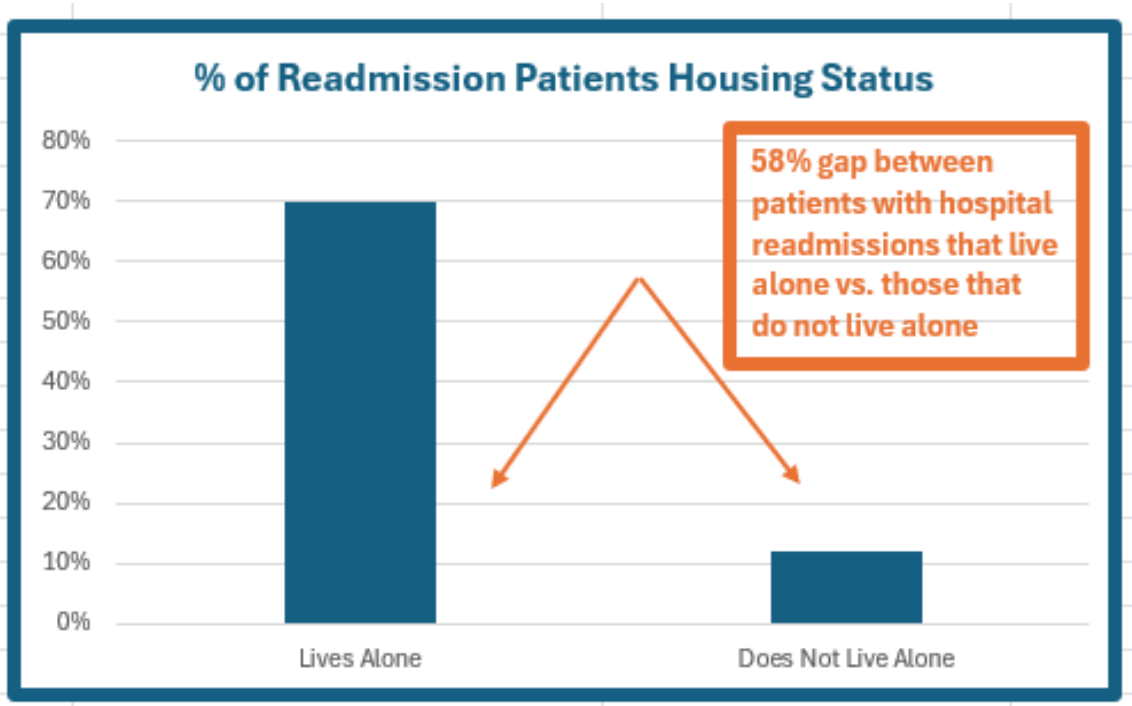
Data Elements:

Domain 3 – Data Analysis

Please attest that your hospital engages in the following activities (note: attestation in all elements is required to qualify for the numerator):

A. 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.

Readmissions Stratified by Housing Status Dashboard



Hospital Commitment to Health Equity

Domain 4 – Quality Improvement

Select all that apply (note: attestation in all elements is required to qualify for the numerator):

A. Our hospital participates in local, regional, or national quality improvement activities focused on reducing health disparities.

Ideas:

- Health Literacy Activities by State
- Rural Health Projects by State – Connect with others working on HE for lessons learned!
  CDC Health Equity Video Training Series
- Stepping Up: Health Equity in Rural Hospital Podcast Series
- Statewide Health fair

Hospital Commitment to Health Equity

Data Elements:

Domain 5 – Leadership Engagement

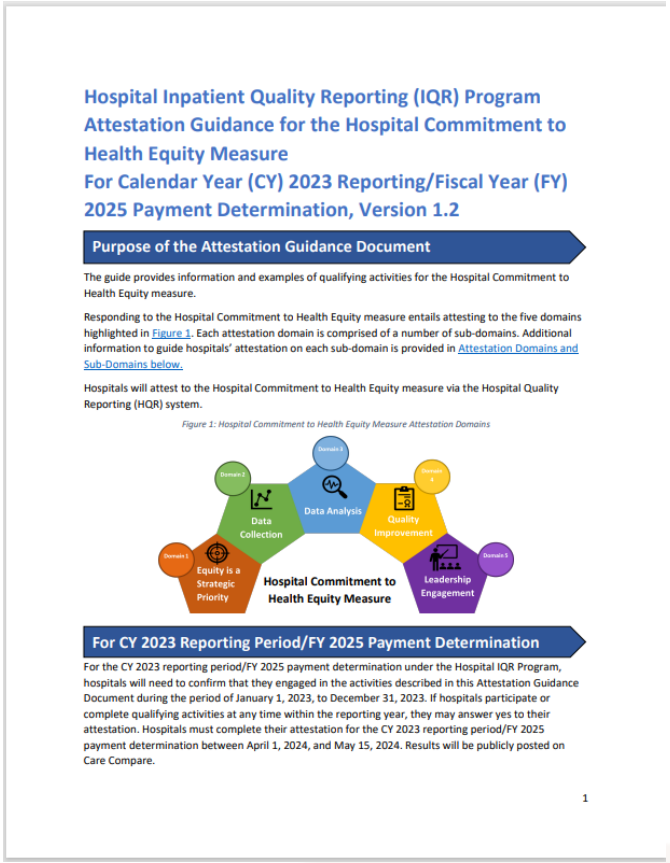
Please attest that your hospital engages in the following activities. Select all that apply (note: attestation in all elements is required to qualify for the numerator).

A. Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews our strategic plan for 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.

Resources to Support You

- Attestation Guidance for Hospital Commitment to Health Equity Measure (scroll down to measure and download 2024 PDF file))
- Rural Health Disparities Overview – Rural Health Information Hub
- Rural Health: Addressing Barriers to Care
- MBQIP 2025 Information Guide
- Future of MBQIP Webinar https://www.telligen.com/rqita/future-of-mbqip-webinar/
- How to submit HCHE and SDOH: https://youtu.be/My9ard_pVcE?si=ak0Opliu8bxGsxw
- Data Submission Guide for Hospital Commitment to Health Equity



Hospital Inpatient Quality Reporting (IQR) Program
Attestation Guidance for the Hospital Commitment to Health Equity Measure
For Calendar Year (CY) 2023 Reporting/Fiscal Year (FY) 2025 Payment Determination, Version 1.2

Purpose of the Attestation Guidance Document

The guide provides information and examples of qualifying activities for the Hospital Commitment to Health Equity measure.

Responding to the Hospital Commitment to Health Equity measure entails attesting to the five domains highlighted in Figure 1. Each attestation domain is comprised of a number of sub-domains. Additional information to guide hospitals' attestation on each sub-domain is provided in Attestation Domains and Sub-Domains below.

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

For CY 2023 Reporting Period/FY 2025 Payment Determination

For the CY 2023 reporting period/FY 2025 payment determination under the Hospital IQR Program, hospitals will need to confirm that they engaged in the activities described in this Attestation Guidance Document during the period of January 1, 2023, to December 31, 2023. If hospitals participate or complete qualifying activities at any time within the reporting year, they may answer yes to their attestation. Hospitals must complete their attestation for the CY 2023 reporting period/FY 2025 payment determination between April 1, 2024, and May 15, 2024. Results will be publicly posted on Care Compare.

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Example Strategic Plan

Peer to Peer Sharing

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Screening for Social Drivers of Health

Care Coordination Domain

Screening for Social Drivers of Health

Measure Description: 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.

To report on this measure, hospitals will provide:

1. The number of patients admitted to the hospital who are 18 years or older at time of admission and who are screened for each of the five health-related social needs (HRSNs): food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety; **and**
2. the total number of patients who are admitted to the hospital who are 18 years or older on the date they are admitted.

A specific screening tool is not required, but all areas of health-related social needs must be included.

Screening for Social Drivers of Health

Measure Rationale: The recognition of health disparities and impact of health-related social needs (HRSN) has been heightened in recent years. Economic and social factors, known as drivers of health, are known to affect health outcomes and costs, and exacerbate health inequities. This measure is derived from the Centers for Medicare & Medicaid Services Innovation Accountable Health Communities (AHC) model and has been tested in large populations across states. The intent of this measure is to help ensure hospitals are considering and addressing social needs in the care they provide to their community.

Improvement Noted As: Increase in rate.

Screening for Social Drivers of Health

Measure Population (determines the cases to abstract/submit): 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: 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. 3.) Patients who expire during their inpatient stay

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 each of the 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.

Screening for Social Drivers of Health

Encounter Period: Calendar year (January 1 – December 31)

First MBQIP Encounter Period and Reporting Date: The first MBQIP encounter period (measurement period) is January 1, 2025, through December 31, 2025. The submission deadline date is May 15, 2026.

Data Source: Chart abstraction.

Calculation: The Screening for Social Drivers of Health measure is calculated by dividing the total number of hospital inpatients who are 18 and older and screened for all five HRSNs by the total number of patients admitted to a hospital inpatient stay who are 18 or older at the time of admission.

Measure Submission and Reporting Channel: Annual numerator and denominator submission through Hospital Quality Reporting (HQR) system.

Example: SDOH Screening Process

Goal: On or before June 15, 2024, an SDOH screening tool will be approved by the medical staff before July 1, 2024, for use with all inpatients. The goal is to have a SDOH screening tool that is designed for self-administration **or** assisted-administration. The tool must contain (but not limited to) the assessment of; Housing, Transportation, Food, Utilities, and Personal Safety.

Process:

1. Upon admission to inpatient care, every patient is assigned to a Case Manager. It is the patient's assigned Case Manager's responsibility to have the SDOH paper assessment tool completed before discharge.
2. Assigned Case Manager's will scan the completed SDOH assessment tool into the patient's medical record. The screening tool is scanned to this location in the EHR _____.
3. It is CAH Memorial's Social Worker's responsibility to take the patient's SDOH assessment results to meetings such as patient care planning meetings and discharge planning meetings AND notify the provider of any social concerns related to patient care.
4. It is the CAH memorial's Social Workers' responsibility to offer 211 resources (and other resources) for positive screening results.
5. Between the 1*st* and 7*th* of each month , the Quality Director will run reports and gather data from the previous month **for each HRSN** .(Housing, Transportation, Food, Utilities, Safety)
    1. Total number of inpatients per month
    2. Total number of inpatients screened per month
    3. Total number of inpatients screened positive per month
6. The Quality Director will gather this data every month of 2025 January through December 2025 in preparation for the submission deadline.
7. Between January 1, 2026, and May 15, 2026 date the Quality Director will report the SDOH-1 and SDOH-2 measures to HQR.

Resources to Support You

- Screening for Social Drivers of Health Measure Specification
- Frequently Asked Questions: SDOH Measures (August 2023)
- Listing of Various Screening Tools
- Guide to Social Needs Screening
- Rural Health Disparities Overview - Rural Health Information Hub
- MBQIP 2025 Information Guide
- Future of MBQIP Webinar https://www.telligen.com/rqita/future-of-mbqip-webinar/
- How to submit HCHE and SDOH: https://youtu.be/My9ard_pVcE?si=ak0Opliu8bxGsxw
- Data Submission Guide For Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health

Screen Positive Rate for Social Drivers of Health

Care Coordination Domain

Screen Positive Rate for Social Drivers of Health (SDOH Screening Positive)

Measure Description: The Screen Positive Rate for Social Drivers of Health Measure 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.

Measure Rationale: The recognition of health disparities and impact of HRSNs has been heightened in recent years. Economic and social factors, known as drivers of health, can affect health outcomes and costs and exacerbate health inequities. This measure is derived from the Centers for Medicare and Medicaid Services Innovation Accountable Health Communities (AHC) model and has been tested in large populations across states. The intent of this measure is to help ensure hospitals are considering and addressing social needs in the care they provide to their community.

Improvement Noted As: This measure is not an indication of performance.

Screen Positive Rate for Social Drivers of Health (SDOH Screening Positive)

Measure Population (determines the cases to abstract/submit): 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 each of the five HSRNs (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. 3.) Patients who expire during their inpatient stay

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 each of the five HSRNs (food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety) during their hospital inpatient stay.

Screen Positive Rate for Social Drivers of Health (SDOH Screening Positive)

Encounter Period: Calendar year (January 1 – December 31)

First MBQIP Encounter Period and Reporting Date: The First MBQIP encounter period (measurement period) is January 1, 2025, through December 31, 2025. The submission deadline date is May 15, 2026.

Data Source: Chart abstraction.

Calculations: The result of this measure would be calculated as **five separate rates.** Each rate is derived from the number of patients admitted for an inpatient hospital stay and who are 18 years or older on the date of admission, screened for an HRSN, and who screen positive for each of the five HRSNs (food insecurity, housing instability, transportation needs, utility difficulties or interpersonal safety) divided by the total number of patients 18 years or older on the date of admission screened for all five HRSNs.

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

Resources to Support You

- Screen Positive Rate for Social Drivers of Health Measure Specification
- Frequently Asked Questions: SDOH Measures (August 2023)
- Listing of Various Screening Tools
- Guide to Social Needs Screening
- Rural Health Disparities Overview - Rural Health Information Hub
- MBQIP 2025 Information Guide
- Future of MBQIP Webinar https://www.telligen.com/rqita/future-of-mbqip-webinar/
- How to submit HCHE and SDOH: https://youtu.be/My9ard_pVcE?si=ak0Opliu8bxGsxw
- Data Submission Guide For Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health

Strategies to Consider

Chat Waterfall Exercise

1. Facilitator will pose a question.
2. Type your state, and response into chat **BUT DO NOT HIT SEND** until prompted.

Watch the waterfall of responses come in!

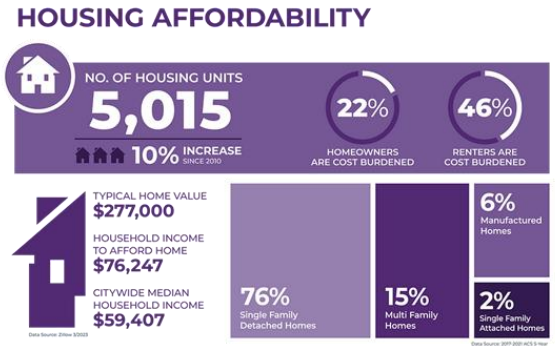
What is the Dream for our Community?

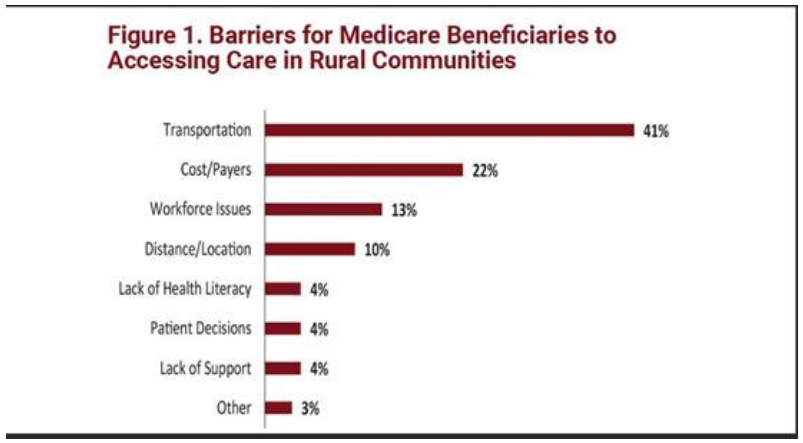
Look around our communities to see what's shaping our health. Collaborate to co-create a shared vision. **Leverage your Community Health Needs Assessment!**

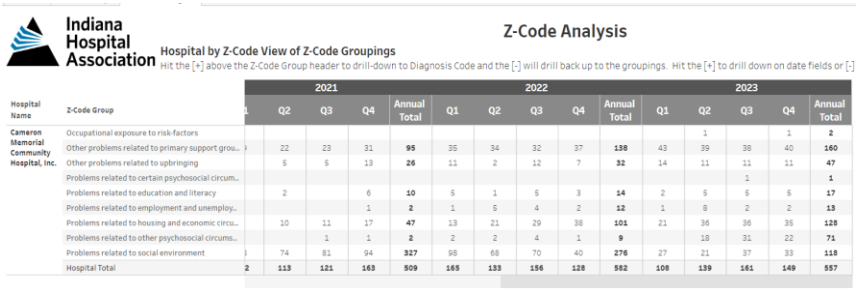
Education
Employment
Housing
Health and Healthcare
Air Quality
Water
Safety

Background As defined by federal regulations of the Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 2010, each not-for-profit hospital facility must complete a Community Health Needs Assessment (CHNA) and accompanying CHNA implementation strategy once every three years. The objective of a CHNA is to identify community health needs with the goal of improving the health status of a population. It is an ongoing process undertaken to:

- identify strengths and needs of a community
- enable the community-wide establishment of health priorities
- facilitate collaborative action planning directed at improving community health status and quality of life







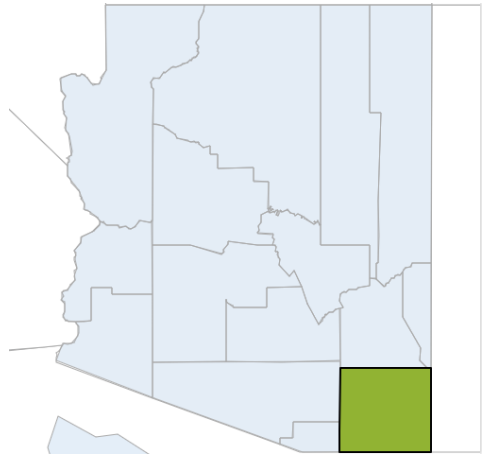
Using Data to Drive Action

- MBQIP SDOH data
- MBQIP SDOH Screen Positive data
- ICD-10 Z codes on factors influencing health status and contact with services
- Medication adherence data from pharmacies
- Clinical data
- Health Literacy data
- Surveys
- Community Stakeholder Interviews
- Strengths, Weaknesses, Opportunities, Threats (SWOT) Analysis
- County Health Rankings Indicators (sneak peek on slide 30)

Community Health Ranking Indicators

Cochise County, AZ

Health Factors				
Health Behaviors		Cochise County	Arizona	United States
Adult Smoking		17%	14%	15%
Adult Obesity		34%	32%	34%
Food Environment Index		6.9	6.9	7.7
Physical Inactivity		25%	22%	23%
Access to Exercise Opportunities		65%	85%	84%
Excessive Drinking		18%	19%	18%
Alcohol-Impaired Driving Deaths		25%	21%	26%
Sexually Transmitted Infections		319.7	570.3	495.5
Teen Births		26	19	17
Additional Health Behaviors (not included in summary)				
Clinical Care		Cochise County	Arizona	United States
Uninsured		12%	13%	10%
Primary Care Physicians		1,730:1	1,500:1	1,330:1
Dentists		1,750:1	1,510:1	1,360:1
Mental Health Providers		730:1	550:1	320:1
Preventable Hospital Stays		1,641	1,962	2,681
Mammography Screening		35%	41%	43%
Flu Vaccinations		29%	43%	46%

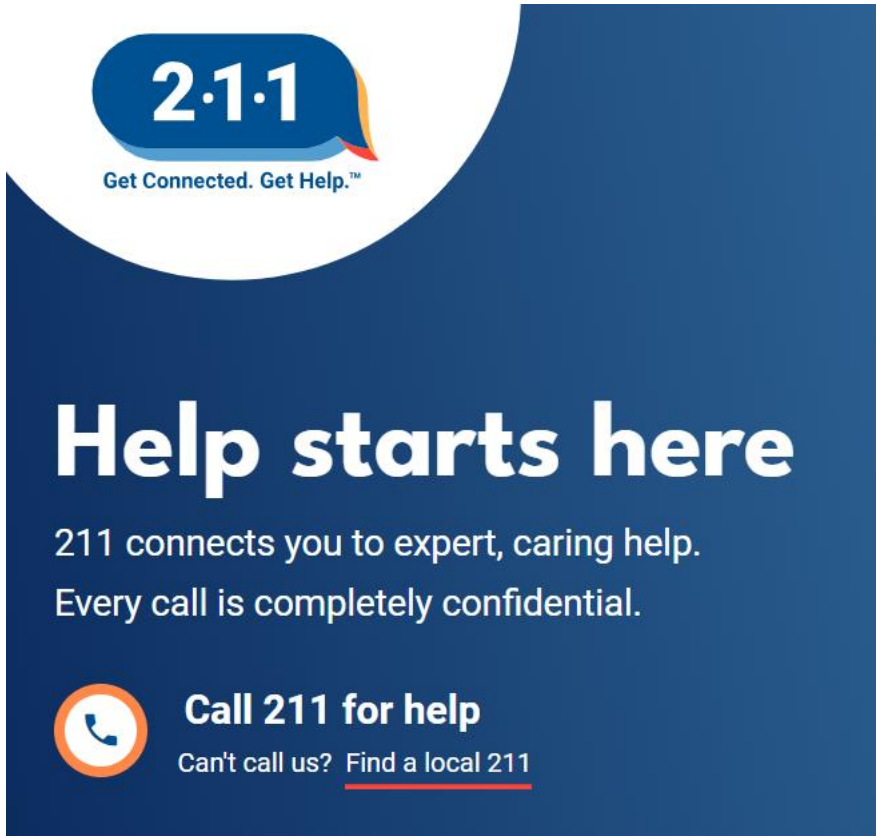


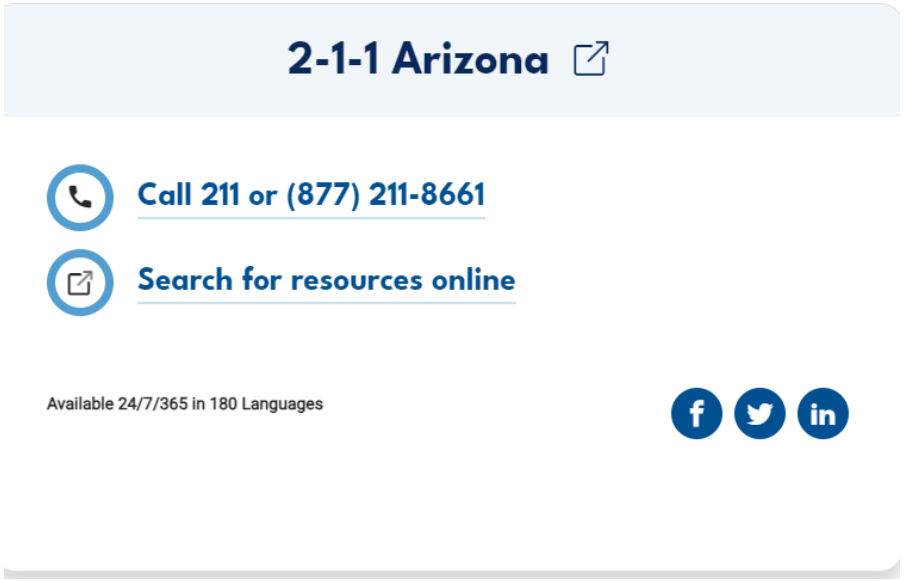
Social & Economic Factors		Cochise County	Arizona	United States
High School Completion		89%	89%	89%
Some College		63%	66%	68%
Unemployment		4.4%	3.8%	3.7%
Children in Poverty		25%	16%	16%
Income Inequality		4.8	4.4	4.9
Children in Single-Parent Households		28%	25%	25%
Social Associations		7.9	5.6	9.1
Injury Deaths		96	96	80

[Community Health Rankings]

View peer counties, nearby counties, similar counties, and more

Do You Know About 211?



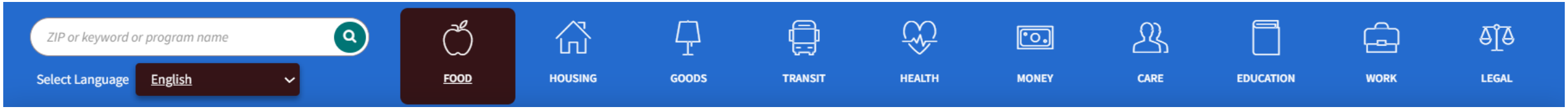


[Find your State/Local 211]

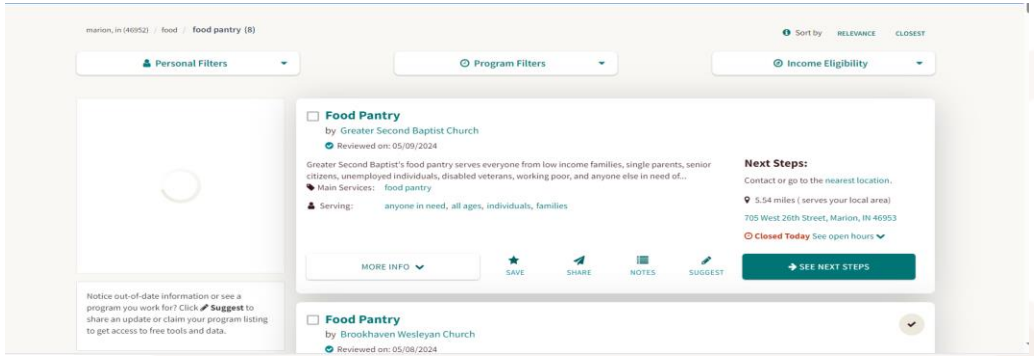
Available Resources

Social Drivers of Health

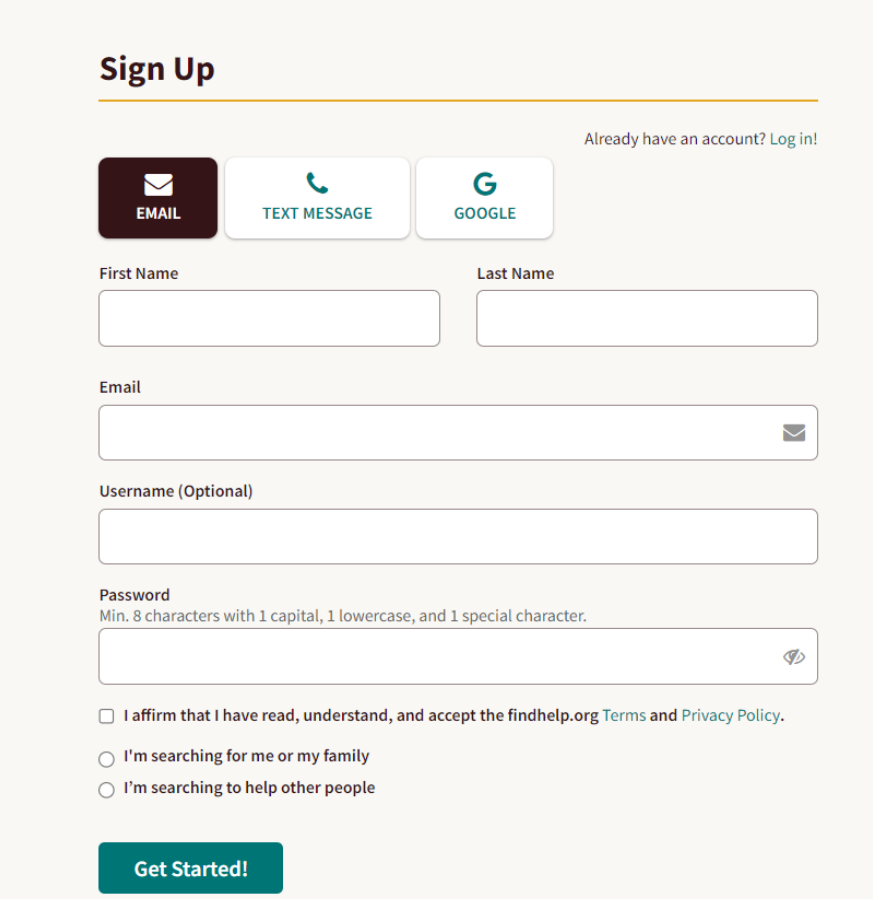
- Food Insecurity
- Housing Instability
- Transportation
- Utility difficulties
- Interpersonal Safety



1. Select Language
2. Select Area of Need
3. Browse available resources



Create an Account



Create an account to:

- Save and share lists of your favorite programs
- Contact or refer programs directly
- Keep notes about programs

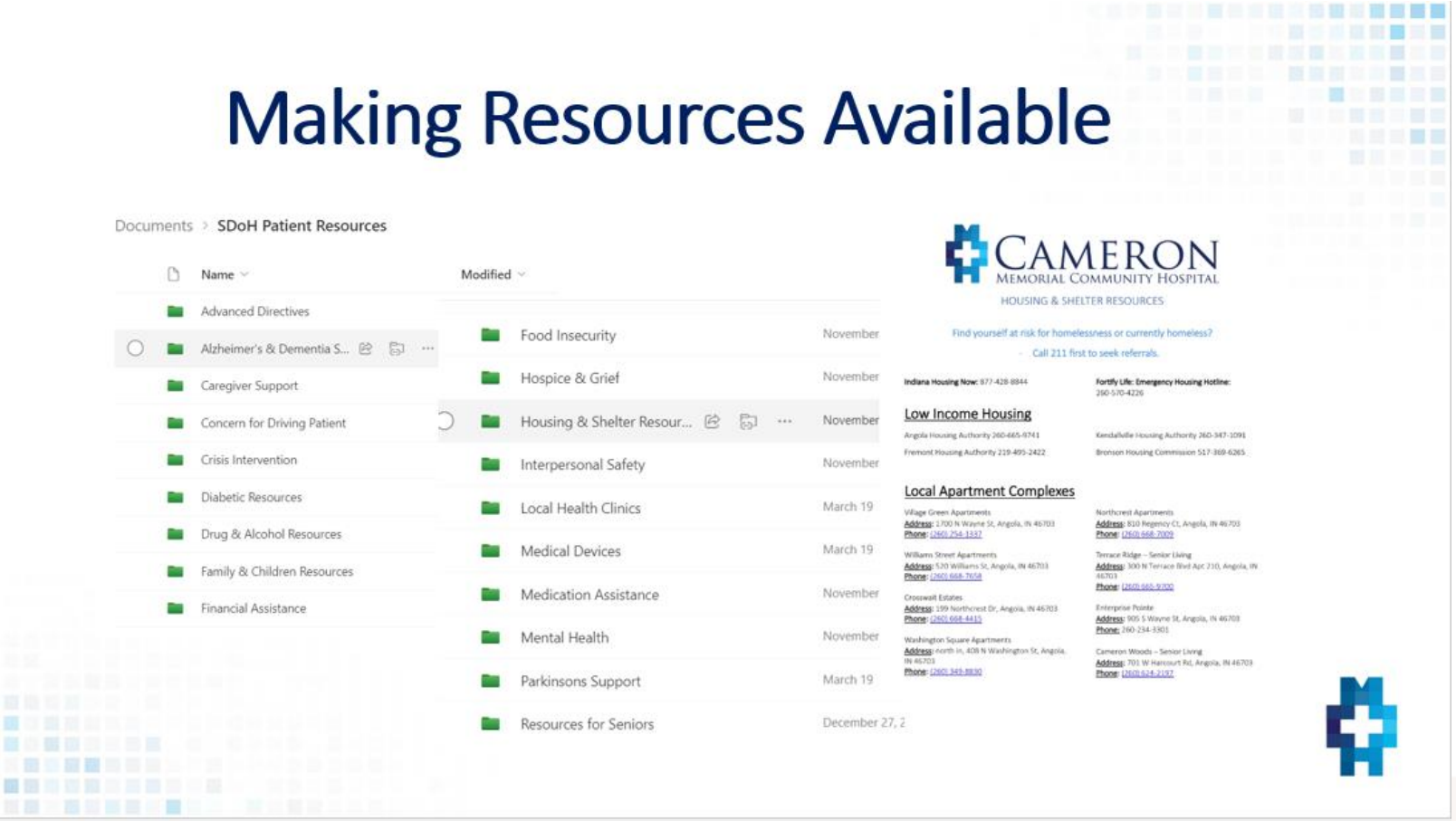
Create A Committee

- Reducing Readmissions Committee
- Health Equity Committee
- Multidiscipline Community Collaborative

Create an Internal Microsite for Easy Access to Resources

RQITA RESOURCE CENTER

Making Resources Available



General Resources to Address Social Drivers of Health Positive Screenings

211 Helpline Center (United Way) - Offers community information and referrals to social services, including transportation options, for everyday needs and in times of crisis

Dial 211 from any phone 24 hours a day, 7 days a week.

www.211.org

FindHelp.org - Provides information on local services, including transportation, by zip code.

https://www.findhelp.org/

Community Action Agencies Across America - State by state network of Community Agencies that serve low-income and poor. Services may include help with emergency assistance, food and nutrition, adult basic education and employment, housing, money management, and transportation.

https://communityactionpartnership.com/?option=com_spreadsheets&view=search&spreadsheet=cap&Itemid=188

Eldercare and Area Agencies on Aging (AAAs) - AAAs help adults with disabilities and older adults and their caregivers find support and local services, including local programs and agencies that provide transportation services.

1-800-677-1116 | Monday – Friday, 9:00 AM to 8:00 PM ET

https://eldercare.acl.gov/Public/Index.aspx

Let’s Hear From You!

Questions?

Other Ideas?

Lessons Learned?

Needs?

Reach Out to Your State Flex Coordinator!

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Thank You!

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