

Alliant HQIC Quality Leader Summit



Donna Cohen, RN, BSN, CCM

Karen Holtz, MT (ASCP), MS, CPHQ

June 14, 2022

 **ALLIANT**
HEALTH SOLUTIONS

HQIC
Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES
QUALITY IMPROVEMENT & INNOVATION GROUP

Agenda

- Welcome
- HQIC Overview and Goals
- Performance Measures
- Hospital Success Stories
- Hot Topics: Health Equity/Disparities
 - Community Health Needs Assessment
 - Social Care Strategy
- Educational Events and Resources
- Q&A/Wrap Up



Alliant HQIC Moderators



Donna Cohen, RN, BSN, CCM
Director, Quality Projects



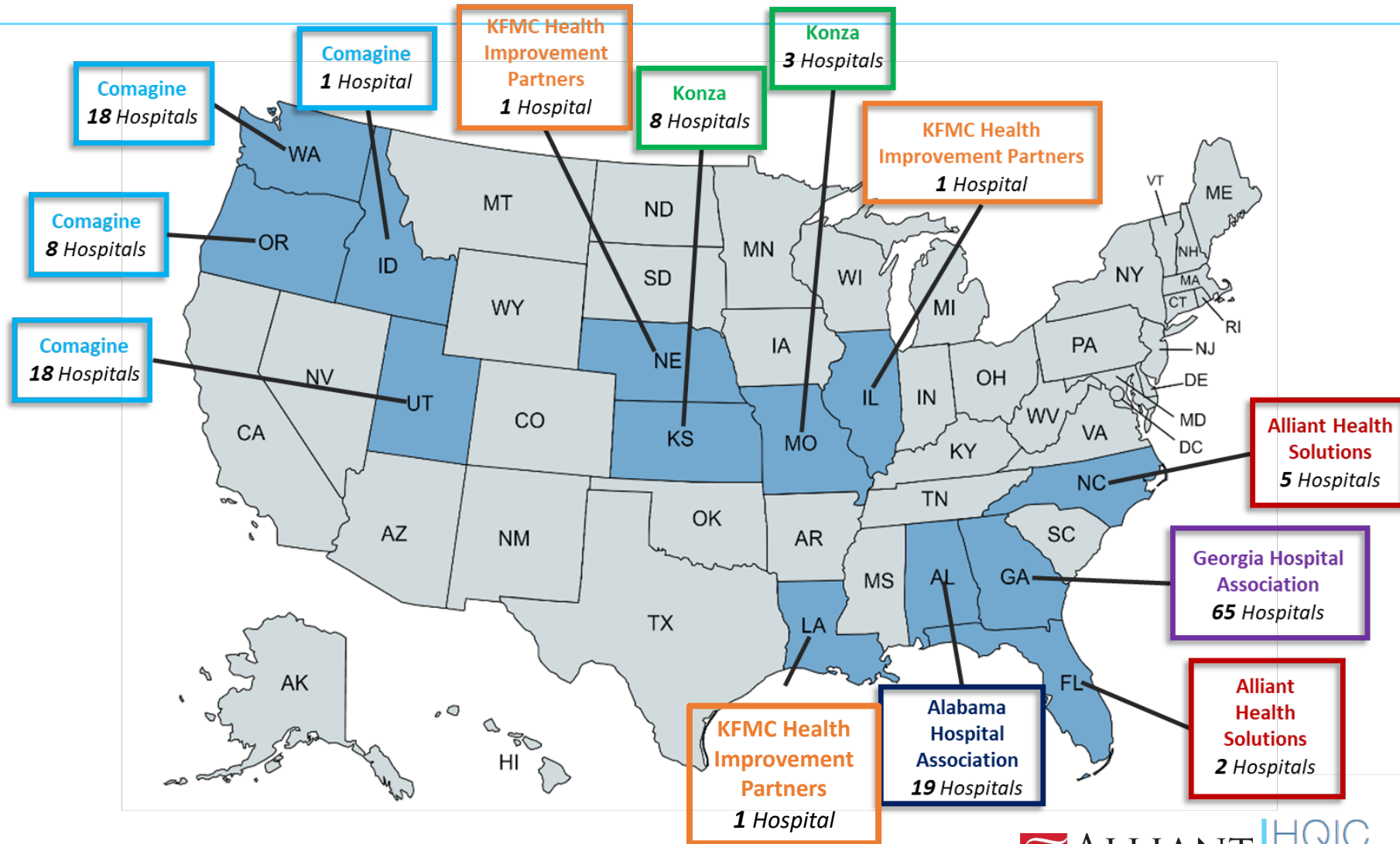
Karen Holtz, MT (ASCP), MS, CPHQ
Education and Training Lead

HQIC Overview

- Four year program active until October 2024
- Supports small, rural and critical access hospitals and facilities that care for vulnerable and underserved patients
- Enrolled hospitals = 150
 - 13 states
 - 48% critical access hospitals (CAHs)

150 Enrolled Hospitals by State and Partner

as of June 1, 2021



Areas of Focus

Patient Safety

- Opioid Stewardship
- Adverse Drug Events (opioids, anti-coag, glycemic)
- CLABSI
- CAUTI
- C diff/MRSA
- Sepsis
- Pressure Injuries
- Readmissions

Other

- COVID-19 and/or public health emergencies
- ★ • Health disparities and health equity
- Patient and family engagement (PFE)
- Leadership engagement

HQIC Evaluation Metrics and Goals By 2024*

Behavioral Health Decreased Opioid Misuse

- Decrease opioid-related ADEs by 7% including deaths
- Decrease opioid prescribing (>90MME) by 12%

Patient Safety Reduction of Harm

- Reduce ADEs by 13%
- Reduce all-cause harm by 9%
- Reduce Clostridioides *difficile* rates

Care Transitions Focus on High Utilizers

- Reduce readmissions by 5%

*For the nine Hospital Quality Improvement Contractors (HQICs)

HQIC Performance Compared to 18 Month (March 2022) Goals

Relative Improvement Rate (RIR) Compared to 2019 Baseline

HQIC	GoalArea	Composite Component	Measure Name	Component RIR	HQIC Composite RIR Score
ALLIANT	All Cause Harm	CAUTI	CDC_CAUTI_ICU_P	-18.81%	-43.73%
		CDIFF	CDIFF_RATE	6.19%	
			CDIFF_SIR		
		CLABSI	CDC_CLABSI_ICU_P	-83.96%	
		MRSA	MRSA_RATE	-32.88%	
			MRSA_SIR		
		PRESSUREINJURIES	PU_STAGE3	-106.6%	
		SEPSIS	SEPSIS_MORT_2	-31.52%	
	SEPSISSHOCK	SEPSIS_SHOCK	-38.49%		
	Anticoagulation and Hypoglycemia ADEs	ANTICOAGULATION	ADE_ANTICOAG	-5.50%	-6.59%
		HYPOGLYCEMIA	ADE_HYPOGLYCEMIA	-7.67%	
	OPIOID ADEs	OPIOIDADES	ADE_OPIOID_RATE	-16.66%	-16.66%
	OPIOID Prescribing	OPIOIDPRESCRIBING	OPIOID_DOSE_DC	5.74%	5.74%
	Readmissions	READMISSIONS	READM_30D_HW	1.32%	1.32%

Source: CMS claims, NHSN

HQIC Performance Compared to 30 Month (March 2023) Goals

Relative Improvement Rate (RIR) Compared to 2019 Baseline

Meeting Target Goal	Within Range Expected to Meet Target Goal	Below Target Goal
C diff rate	Readmissions	CAUTI
C diff SIR	ADE anticoag	CLABSI
	ADE hypoglycemia	MRSA
	ADE opioids	Pressure Injuries 3+
	Opioid dose at discharge	Sepsis Shock/Mortality

Source: CMS claims, NHSN

Hospital Success Stories and Shout Outs

Alliant/Karen Holtz

- Keralty Hospital (125 beds) is a top performer in Catheter Associated Urinary Tract Infections (CAUTI) and Central Line Associated Blood Stream Infections (CLABSI) prevention
- Maintaining zero rates for both CAUTI SIR and CLABSI SIR
- Catheter Utilization Ratio Per Patient Day
 - Improved 41.9% over 2019 baseline
- Central Line Utilization Ratio Per Patient Day
 - Near 2019 baseline (3.35%) and reported lowest ratio to date (0.72%) in March 2022
- Keys to Success
 - Nurse-driven protocols
 - Daily assessment rounds
 - Staff education and competence



Keralty Hospital
Miami, FL

Hospital Success Stories and Shout Outs

Comagine/Rhonda Bowen

Washington Hospital Reduces SSI Rate

📅 March 8, 2022

Washington Hospital Reduces SSI Rate

Between 2012 to 2015, [Newport Hospital and Health Services](#), a 24-bed rural critical access hospital in Newport, Wash., discovered its surgical site infection (SSI) rates had increased from 1.6% to 2.4%. Although the total number of infections over the four years was only 12, the hospital conducted in-depth analyses and structured brainstorming to find the potential root causes for the increase.

It was determined that the relatively higher infection rates in 2012 and 2015 were associated with post-surgery MRSA infections, one each in 2012 and 2015. A root-cause analysis of these infections revealed that MRSA swabbing and test results in advance of the surgery would have identified MRSA and allowed for pre-surgery treatment, offering the patient an improved chance of an infection-free recovery period. Although the hospital has strong infection practices in our surgery department, the MRSA cases exposed a process gap that it sought to countermeasure with grant funds. Newport Hospital and Health Services developed the following processes and initiatives as part of their SSI reduction plan:



<https://quality.allianthealth.org/washington-hospital-reduces-ssi-rate/>

Hospital Success Stories and Shout Outs

ALHA/Carol Snowden

North Baldwin Patient Safety Culture

📅 March 8, 2022

[North Baldwin Infirmary](#), a 78-bed community hospital located in Bay Minette, Ala., is committed to patient safety and a healthy culture. Their high-reliability program consists of:

- Error prevention toolkit – See graphic below
- Hospital huddles
- Unit-based daily huddles
- Patient safety coaches
- Rounding to influence safety behaviors
- Serious safety event committee
- Serious safety event graphs
- Root cause analysis
- Safety LINKS
- Recognition program



Since 2017, North Baldwin Infirmary has had an average of 220 "great catches" a year and currently has 26 Patient Safety Coaches. In addition, the employee recognition program includes 26 Life Guard Awards and 17 Safety Hero Awards.

<https://quality.allianthealth.org/north-baldwin-patient-safety-culture/>

Patient Safety Topic: ADE Anticoagulants and Use of Hospital Portal

📅 April 29, 2022

[Russell Medical Center](#) is an 81-bed hospital located in Alexander City, AL and is 1 of 6 "five star" hospitals in the state of Alabama recognized by CMS. During a recent Quality Leader Summit, Brenda Duncan, RN, Director of Quality Management and Jerry Holley, RPh, Director of Pharmacy shared their success regarding the use of the Hospital Portal to analyze their ADE anticoagulant data.

During a coaching call with the Alabama Hospital Association and an Alliant Pharmacist, an increase in ADE anti-coagulants was reviewed. Opportunities for improvement were the ability to identify ADEs and gain access to resources for best practice interventions. Ongoing goals included recognition of ADEs, identification of cases and identification of the causes of increased ADEs.

Pharmacy-led Interventions included:

- Dosing protocols
- Clinical data support
- Dosage adjustments for renal and liver function



<https://quality.allianthealth.org/patient-safety-topic-ade-anticoagulants-and-use-of-hospital-portal/>

Hospital Success Stories and Shout Outs

ALHA/Carol Snowden



Marshall Medical North
Guntersville, AL

Alabama Hospital Reduces Readmissions

Marshall Medical Centers provides comprehensive inpatient and outpatient healthcare services serving the residents of Marshall County and the surrounding area (population about 125,000) with two hospitals: North, a 90-bed hospital located in Guntersville, AL and South, a 150 bed hospital located in Boaz, AL.

Named by the Joint Commission as a “Top Quality Performer” among America’s hospitals, Marshall Medical Centers has implemented risk reduction strategies to decrease 30-day readmissions, focusing on THA/TKA and COPD patients.



Marshall Medical South
Boaz, AL

<https://quality.allianthealth.org/alabama-hospital-reduces-readmissions/>

Hospital Success Stories and Shout Outs GHA/Lynne Hall

Coffee Regional Medical Center

📅 March 8, 2022

[Coffee Regional Medical Center](https://quality.allianthealth.org/coffee-regional-medical-center/), a 98-bed hospital located in Douglas, GA provides high-quality, patient-centered care and has been named a Top Small Hospital in Georgia. As an acute care facility in a rural community with limited resources and an inefficient discharge process as well as inadequate coordination with clinicians and providers, Coffee Regional Medical Center developed the following processes and initiatives as part of their Readmissions Reduction Plan.

- New Care Management Model: Discharge Planner and Social Worker
- Addition of a Social Worker in the Emergency Department
- Revised Discharge Planning Assessment to include a risk for readmission risk score tool
- Discharge Planning interview conducted on all readmissions
- Multidisciplinary team daily huddle
- New Nurse Navigator/TC2 Care Coordinator
- Discharge post-acute calls within 24 – 48 hours of discharge and weekly calls for 30 days
- Weekly transition of care calls with HHNS and SNFS
- Quarterly post-acute care transitions meetings including post-acute providers, Director of Care Management, Social Workers, Senior Leadership, and Clinical Service Directors. Emphasis on process improvement, new services, education, local/state/national and compliance updates
- Para-medicine EMS pilot study with proven success
- Meds-to-Bed program
- Internal readmissions team lead by CMO
- Review real-time readmission data



Patient Safety Topic: ADE Opioids

📅 April 29, 2022

[Wellstar Sylvan Grove Hospital](https://quality.allianthealth.org/patient-safety-topic-ade-opioids/), a 25 bed critical access hospital located in Jackson, GA shared their journey to improved outcomes with adverse drug events – opioids on a recent Patient Safety Network webinar. Erica Fishell, MSN, RN, Director of Clinical Operations discussed the following interventions which have made a positive impact:

1. Integration of Prescription Drug Monitoring Programs (PDMP) into Epic
 - The physician or nurse can easily click query the PDMP to see a snapshot of where the patient has had a controlled substance like an opioid prescribed, what the opioid is, the quantity filled, and where it was filled
 - Common practice with patients with non-acute and chronic complaints
 - Checked anytime a provider decides to prescribe an opioid



2. EVL notes

<https://quality.allianthealth.org/coffee-regional-medical-center/>

<https://quality.allianthealth.org/patient-safety-topic-ade-opioids/>

Hospital Success Stories and Shout Outs

KFMC Improvement Partners/Nadyne Hagmeier

Hanover Hospital (KS) Uses Patient and Family Engagement to Help Patients Find Community Resources

📅 March 8, 2022

Hanover Hospital (KS) Uses Patient and Family Engagement to Help Patients Find Community Resources

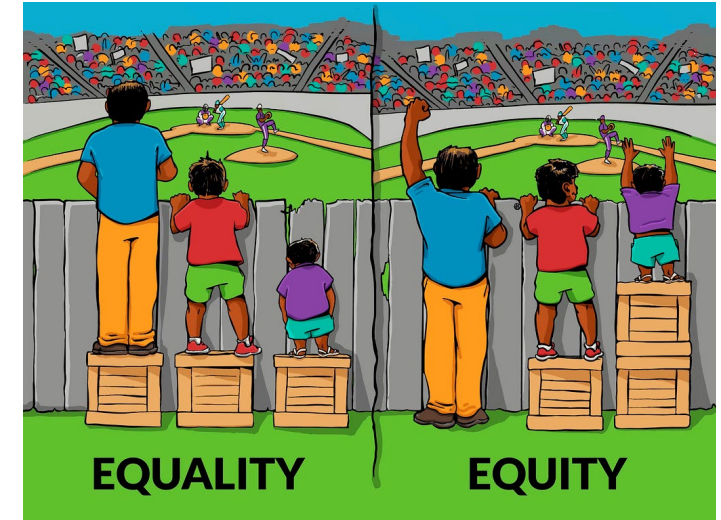
While finishing her master's degree in social work, Cassie Pralle, T-LMSW, learned about the importance of looking at and evaluating which resources are thriving in communities and which were lacking. When she became the social services director at Hanover Hospital in Hanover, Kan., Cassie realized she had a blank slate. As a new person looking in, she was able to see what resources were needed in the community. An interdisciplinary Patient and Family Engagement (PFE) committee was developed that included RNs, DONs, a patient representative, a social worker and an administrator. Working together, the team members could pinpoint which areas in their community needed more resources.

The first area of note was the limited discussion in the clinic about outside resources available for patients. No specific person was responsible for discussing available resources with patients or the steps on how to utilize them. To correct this situation, a clinical referral sheet was developed that the provider could fill out. The clinical referral sheet starts the process of connecting patients with the social services director, who can explain what resources are available to them in the area. The knowledge gained from these meetings provides patients with better access to community resources, thereby decreasing stress related to obtaining assistance.



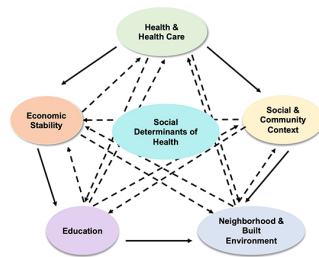
Health Disparities and Health Equity

- Differences in health or medical conditions among populations are called **health disparities**, and they can have a profound impact on the public health of a community
- **Health equity** is getting rid of these health disparities or unfair differences in how people are given health care
- Hospitals Departments:
 - Community Engagement
 - Community Health
 - Diversity and Language Services
 - Health Equity and Inclusion



Health Disparities National Trends - Financial Implications

- Health disparities have amounted to \$93 billion in excess costs annually
- Health outcome contributors:



80% - 90%
social determinants



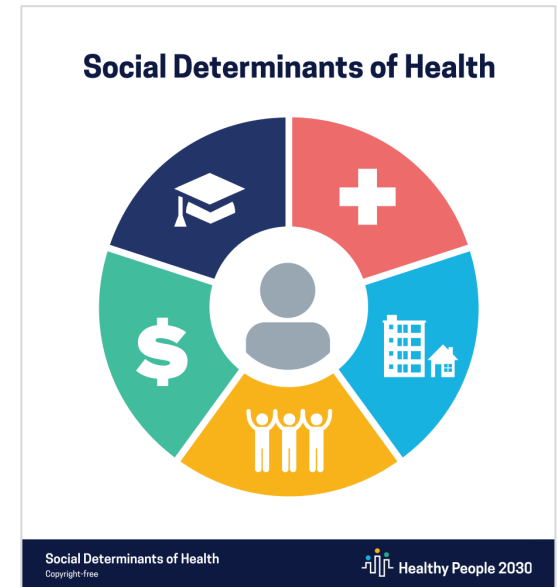
10% - 20%
medical care

- Yet, an estimated 95% of health expenditures are medical costs

1. Healthy People 2030
2. O'Neill, Hayes (2018) Understanding Social Determinants of Health

Health Disparities National Trends – Social Determinants of Health

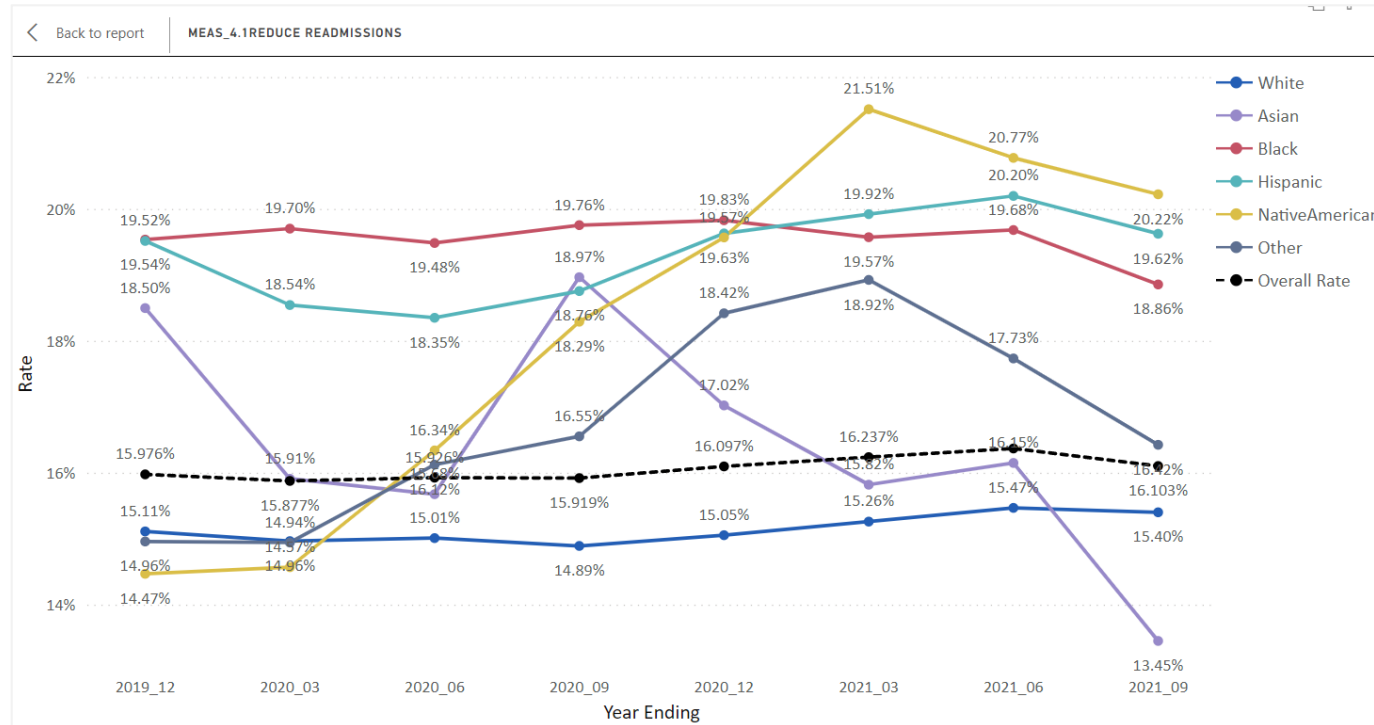
- 1 in 10 Americans live in poverty with the inability to afford health care, healthy food and housing
- Social determinants of health (SDOH) include:
 - Safe housing, transportation, and neighborhoods
 - Income, education level, job opportunities
 - Access to nutritious foods and physical activity
 - Language and literacy skills



1. Healthy People 2030
2. O'Neill, Hayes (2018) Understanding Social Determinants of Health

Alliant HQIC Trends - Quality Implications

SAMPLE



Reduce 30 Day Readmissions

- Increase in Native American
- Followed by Hispanic population

Alliant HQIC: 150 hospitals in 13 states

Source: CMS Medicare Claims

Ideas to Begin Your Team and Plan-Do-Study-Act

- Identify a project leader or champion to manage activities
- Create a team with appropriate members, include community
- Analyze patient Race, Ethnicity, and Language (REaL) data
- Provide Race, Ethnicity, and Language (REaL) data collection training
- ★ • Locate Community Health Needs Assessment (CHNA) results
- ★ • Stratify data using Social Determinants of Health (SDOH)
- Ask CEO to sign #123 for Equity Pledge to Act
<https://ifdhe.aha.org/123forequity>

Featured Speakers



Kimberly Tyler, RN
Director of Nursing



Bria Brown, MHA
Manager Support Services

St. Mary's Good Samaritan

- Located in Greensboro, Georgia
- 25-bed critical access hospital
- Emergency Services 24/7
- Inpatient Services (Acute, Swing-Bed, Specialty Consults)
- Surgical Services (Hip/Knee Replacements)
- Rehabilitative Services (OT,PT, Speech)
- Laboratory Services
- Imaging Services (Nuclear Med, Ultrasound, 640 CT Scanning, Echo)



Community Health Needs Assessment (CHNA)

What/Why

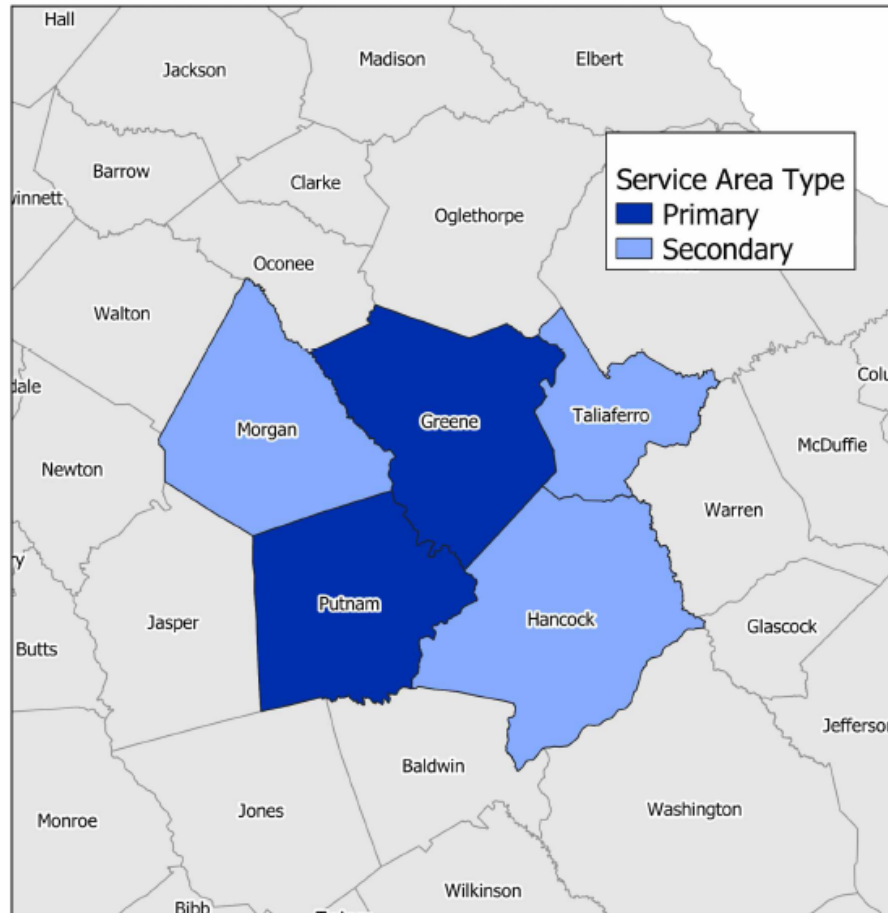
- Thorough analysis of the health needs and assets in our community
- Provides a comprehensive overview of the region we serve, including quantitative and qualitative data regarding socioeconomic factors, health indicators, and health status of the community
- Important tool for our health care system, but also serves as a resource for other organizations and citizens in our community

When

- Every three years St. Mary's conducts a Community Health Needs Assessment (CHNA) in order to most effectively impact our community and to guide our Community Benefit planning
- St. Mary's first formal Community Health Needs Assessment was completed in the summer of 2010
- Report updated for next 3 years June 1, 2022

Good Samaritan Service Area

Good Samaritan Service Area



Determined by counting patient visits by county of residence.

Service Area Demographics

67,612 Service Area Population
Across All 5 Counties

Population estimate as of July 1, 2017 according to the U.S. Census Bureau's Quick Fact Profiles.

1,745.9 Service Area Land Mass, in
Square Miles

Estimate as of July 1, 2017 according to the U.S. Census Bureau's Quick Fact Profiles.

\$42,549 Median Household Income,
2013-2017 Average

Adjusted to 2017 dollars. Median household income data from U.S. Census Bureau's American Community Survey. Median income across all five counties in service area.

Community Health Needs Assessment Partners

Surveys



UNIVERSITY OF
GEORGIA
College of Public Health



Focus Groups



J.W. Fanning Institute
for Leadership Development
UNIVERSITY OF GEORGIA

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CHNA Top 3 Health Needs Identified

Cardiovascular Health

Nutrition, Diabetes & Obesity

Healthcare Access

Implementation strategy: Cardiovascular Health

- **Goal:** Prevent chronic diseases and increase wellness by promoting healthy habits.
- **Objective:** By June 2022, expand community education programs aimed at increasing knowledge of risk factors to manage and prevent chronic diseases by using effective strategies.
- **Strategies:**
 - Walk to Wellness
 - Diabetes Education Classes
 - REACH & Telehealth
- **Impact:**
 - Number of participants that complete Walk to Wellness program by June 2022.
 - Baseline: 15 participants
 - Target: 25 participants
 - Number of participants that complete the Diabetes Education Program by June 2022.
 - Baseline: 70 participants
 - Target: 80 participants
 - Track the number of consults that are evaluated by the Telehealth machine ED/Inpatient.
 - Baseline: 52
 - Target: 96

Implementation strategy: Nutrition, Obesity & Diabetes

- **Goal:** Prevent chronic diseases and increase wellness by promoting healthy habits.
- **Objective:** By June 2022, expand community education programs aimed at increasing knowledge of risk factors to manage and prevent chronic diseases by using effective strategies.
- **Strategies:**
 - Walk to Wellness
 - Diabetes Education Classes
 - Healthy Habits – Pete Nance Boys & Girls Club
- **Impact:**
 - Number of participants that complete Walk to Wellness program by June 2020.
 - Baseline: 15 participants
 - Target: 25 participants
 - Number of participants that complete the Diabetes Education Program by June 2022.
 - Baseline: 70 participants
 - Target: 80 participants
 - Number of children that participate in the program by June 2022.
 - Baseline: 80
 - Target: 140

Implementation strategy: Healthcare Access

- **Goal:** Increase patient access to clinical prevention services.
- **Objective:** By June 2022, improve patient access to care in Greene County.
- **Strategies:**
 - St. Mary's Residency Program
 - Workforce Development Program
 - Charity Care
- **Impact:**
 - Track the number of residents that continue to practice in this area.
 - Baseline: 3 Residents
 - Target: 5 Residents
 - Track the number of students that intern/shadow in the healthcare field.
 - Baseline: 2
 - Target: 5
 - Track the number of uninsured cases.
 - Baseline: 4,114
 - Target: 3,974

Key Takeaways and Where To Start



Don't necessarily need big partners- think about churches, other non-profits in your service area, community centers



Don't know what your community needs are.....run a patient diagnosis report from your Emergency Department



Use students from local colleges to do surveying



Don't re-invent the wheel- find out who is already doing a community needs assessment....for example local schools

Questions?



Contact information:

- **Bria Brown**
- Manager of Support Services
- Bria.brown@stmarysgoodsam.org
- **Kimberly Tyler, RN**
- Director of Nursing
- Kimberly.tyler@stmarysgoodsam.org

Check out St. Mary's Community Health Needs Assessment (CHNA)

<https://www.stmaryshealthcaresystem.org/about-us/community-benefit#ht>

Intermountain Healthcare Social Care Strategy

HQIC Quality Leadership Summit
June 14, 2022

Gene Smith, MHA, MBA
Community Health Director, SDOH



Intermountain Healthcare by the Numbers



7 Primary States¹
(UT, NV, ID, CO, MT, KS, WY)



59,000
Caregivers



\$13.9 billion²
Total Revenue



33 Hospitals
Including **1** Virtual
Hospital



385
Clinics



1,030,000
SelectHealth
Members



4,800
Licensed Beds

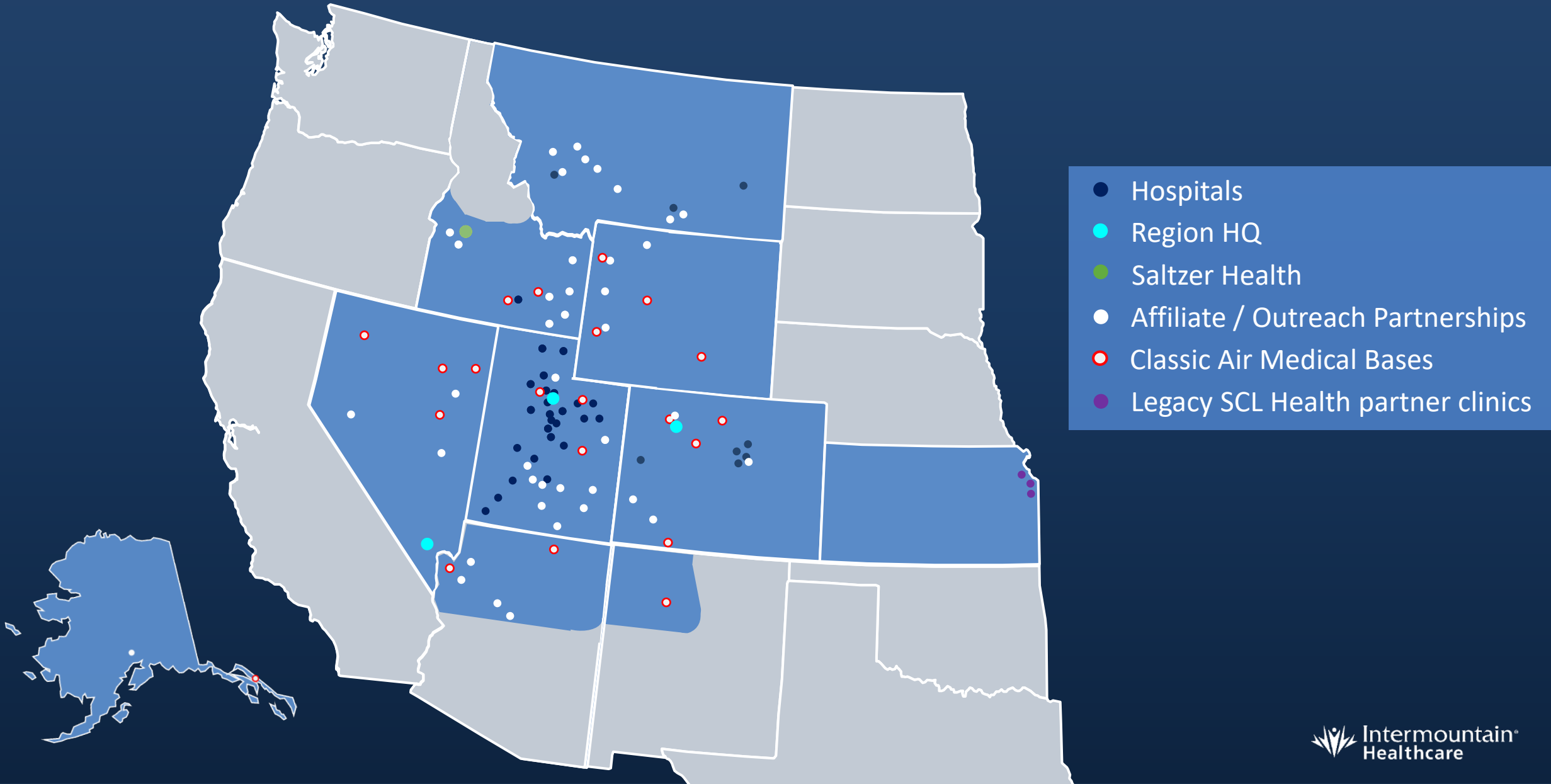


3,800 Employed
Physicians & APPs

¹ Intermountain also provides air medical transport services in other states through Classic Air Medical

² Revenue for the year ended December 31, 2021

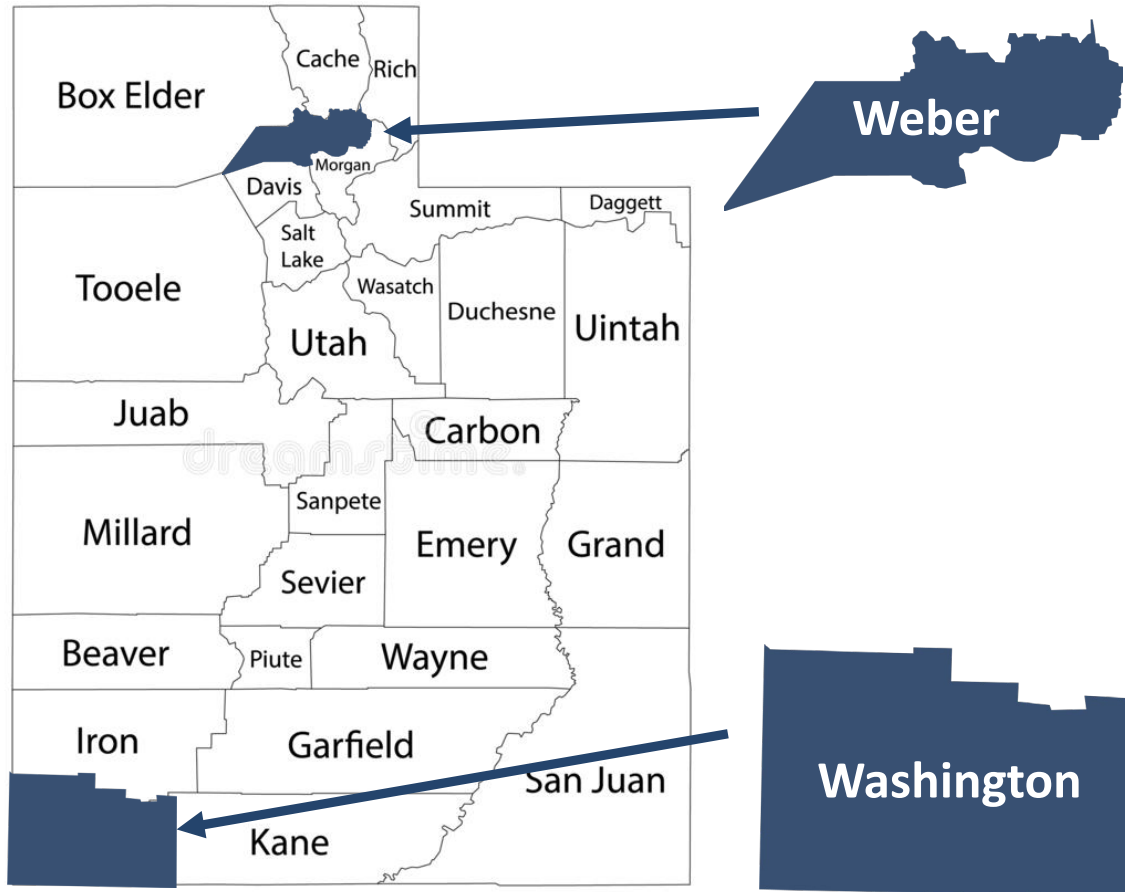
Intermountain Healthcare's Current Footprint



Social Care Strategy



Our Foundation: The Alliance for the Determinants of Health



- 3-year, community-collaborative demonstration project 2018-2021
- Implementation of screening and assistance workflows and tools
- Assess impact of social care on reducing avoidable ED visits
- Two counties
- Medicaid health plan members with 3+ ED visits over 12 months
- \$12M charitable donation

AWARENESS

ASSISTANCE

ALIGNMENT



Point of Care Screenings



Predictive Analytics



Proactive Outreach



Community Social Services Network



Social Need Screening



Digital Referral Platform



Care Manager, Coordinator, or CHW



Individualized Social Care and Treatment Plan

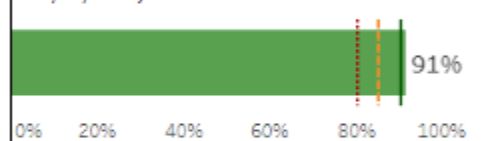


Community Resources

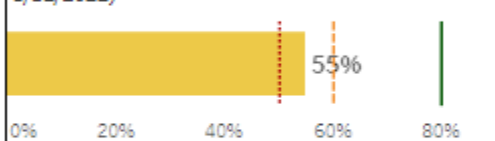
Alliance Screening

MG and ED Screening Rate

RSL MG Screening Rate (Data from 6/1/2021 to 5/31/2022)



RSL ED Screening Rate (Data from 6/1/2021 to 5/31/2022)



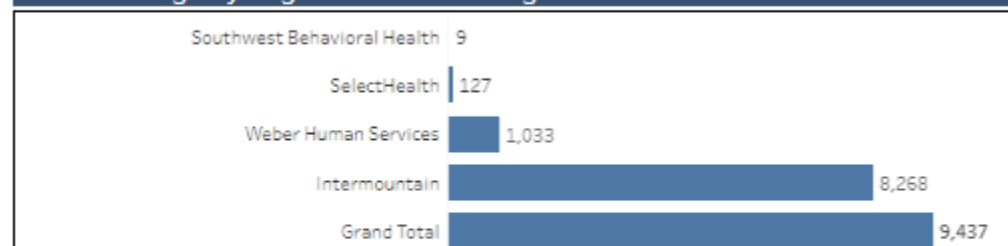
Initial Member Screenings

Previous Month	Rolling 12 Month Total
787	10,239

Initial Screening Trend



All Screenings by Organization - Rolling 12 months



Intermountain includes screenings in the ED and the medical group

SHCC - SelectHealth Community Care, RSL - Risk Stratification List

PRAPARE Screenings

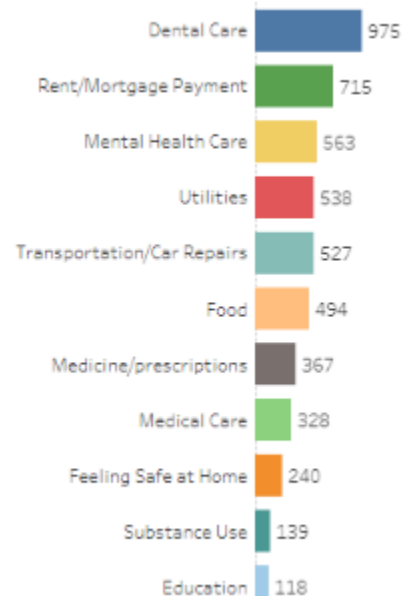
Previous Month	Rolling 12 Month Total
4	108

PRAPARE Screening Trend

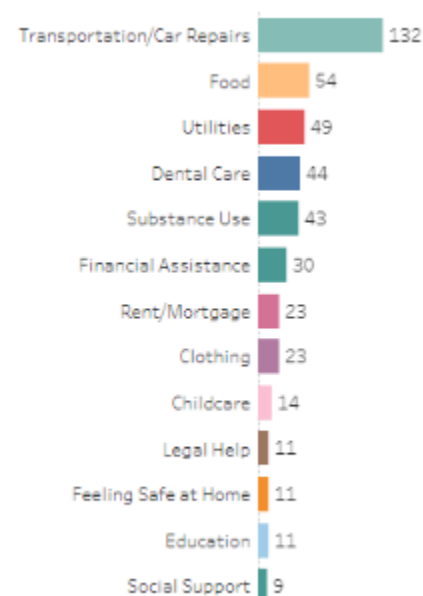


Members With SDOH Needs - Rolling 12 Months

Social check SDOH Needs



Full PRAPARE SDOH Needs

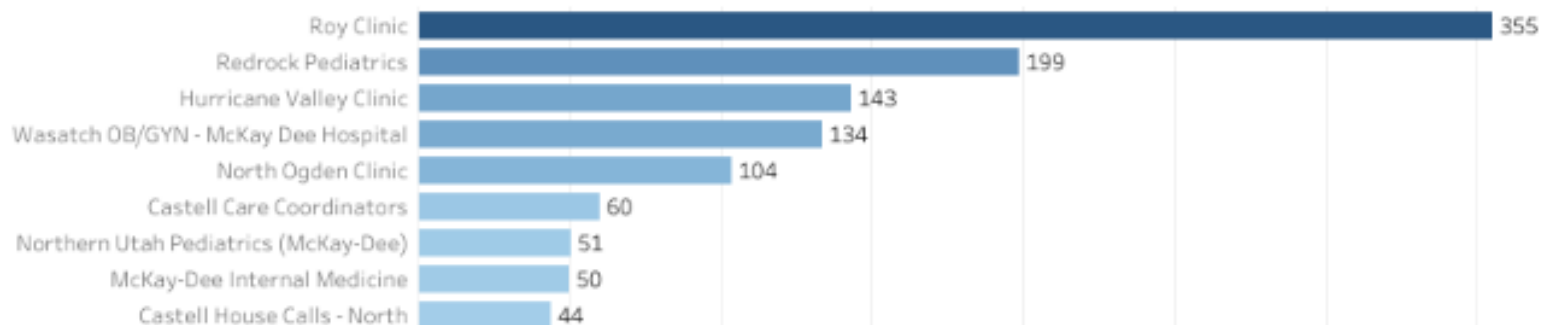


Unite Us Referrals

Case Created (Multiple values) Originating Organization (Multiple values) Started With (Multiple values) SDoH Need (All) Latest Screen Date (All)



Originating Organization



Select Clinic(s) to display patient detail then export

EXPORT DETAIL

Referral Trend



Alliance Network Activity

Monthly Unite Us Cases

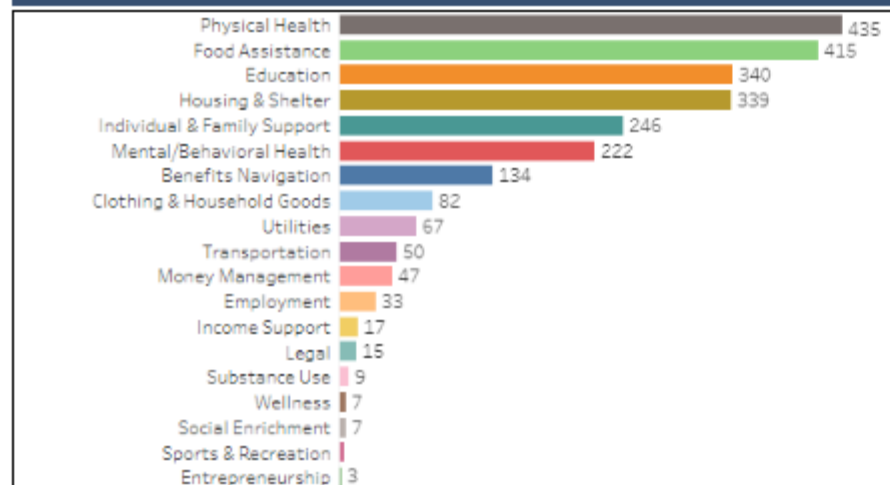
Cases Open	Cases Closed	Resolved Cases	Unresolved Cases	Average # Days from Start of Service to Case Creation (From July 2019)
April 2022	April 2022	April 2022	April 2022	
51	187	40	32	6.11

Total Unite Us Activity (Data from July 2019)

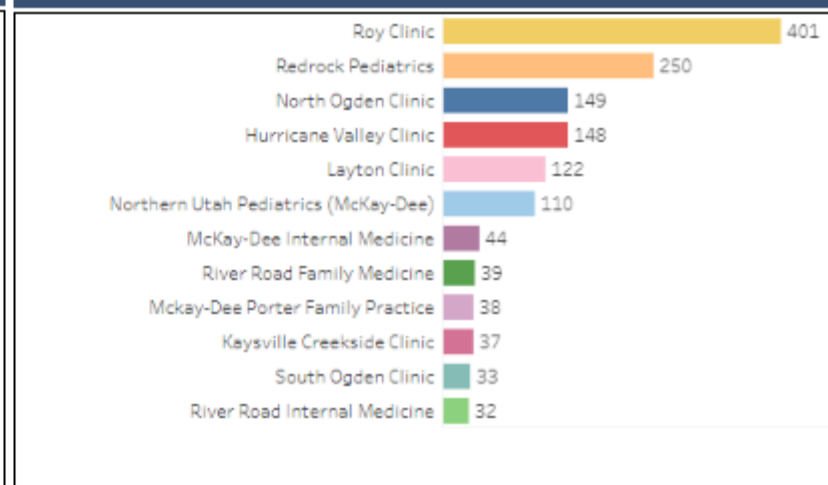
% of Resolved Cases	% Unresolved Cases	% of In Network	% of Out of Network	Total Referrals All Service Type
47.06%	28.98%	77.37%	28.64%	4,347



Referrals by Service Type - Rolling 12 Months



Referrals by Intermountain Organizations



Alliance Screenings and Referrals 2019-2021

- Improving health outcomes and healthcare affordability
- Ongoing evaluation with Children's Hospital of Philadelphia

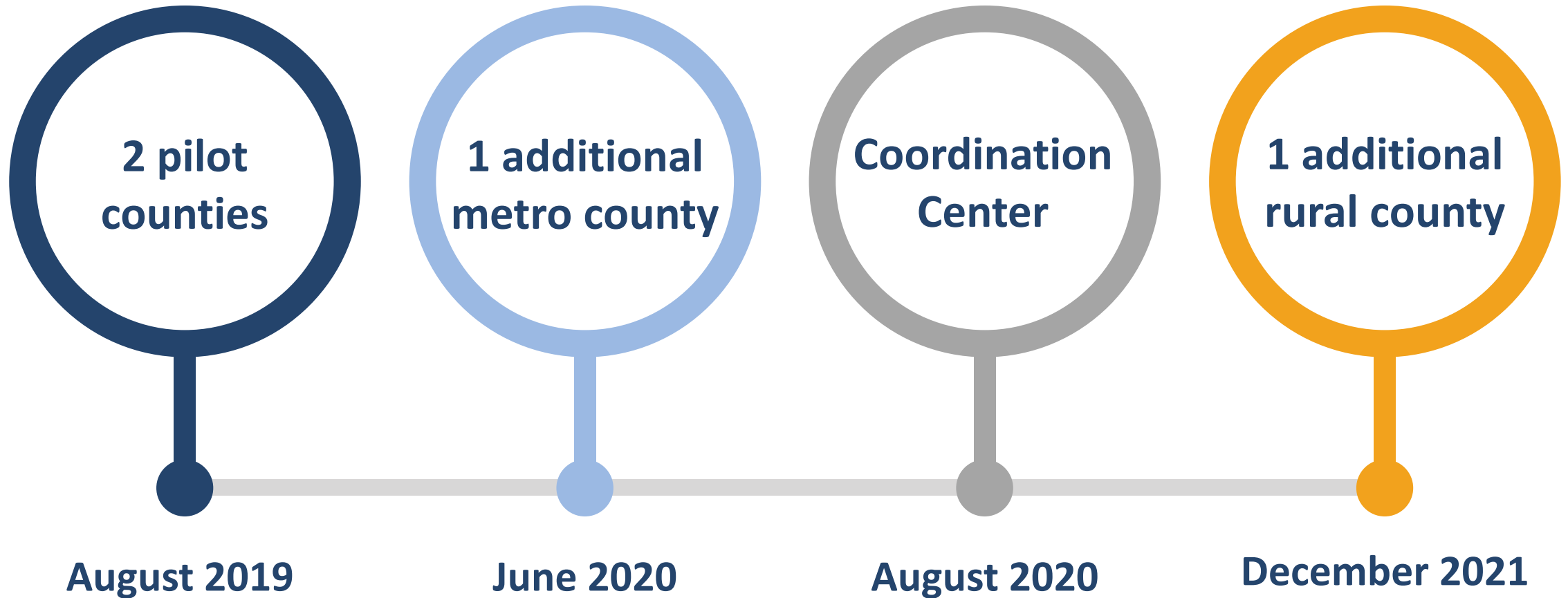


Community Network Infrastructure

Built on a digital referral platform



Connect Us
Building Healthier Communities



Social Care Going Forward

Lessons learned inform next steps

Create a sustainable model for expansion



Develop resources and tools for social care

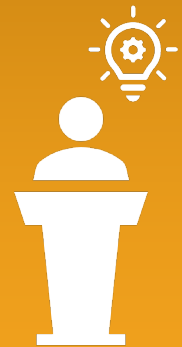


Use the Alliance infrastructure to pilot other initiatives:

- IPV Screening
- Maternal Home Visitation – ACEs
- Nutrition Security



Thought leadership to move social care forward in all sectors



**Type Questions
in Chat**

Thank You



Gene Smith, MHA, MBA
Community Health Director
Gene.Smith@imail.org

Learning and Action Networks (LANs) 2022

- Monthly webinars hosted by Alliant collaboratively with other HQICs
- Featured speakers from enrolled hospitals, subject matter experts and/or patients
- Focus on areas of patient harm, readmissions, patient and family engagement and health equity

Month	Topic
Jan	ADEs and medication reconciliation
Feb	ADE anti-coags
Mar	ADE opioids
Apr	Pressure injuries
May	IP: Words of WISDOM
Jun	CLABSI
Jul	MDRO/MRSA
Aug	CAUTI

Community of Practice (CoP) Calls

- Led by the Centers for Medicare & Medicaid Services to share successes, strategies and best practices
- Calls held on the second Thursday of month from 1:00 – 2:00 p.m. ET.
- Open to all Hospital Quality Improvement Contractors (HQIC) staff and can **extend invitation to their hospitals**
- Presentations and/or recordings posted on [Alliant HQIC Website](#)



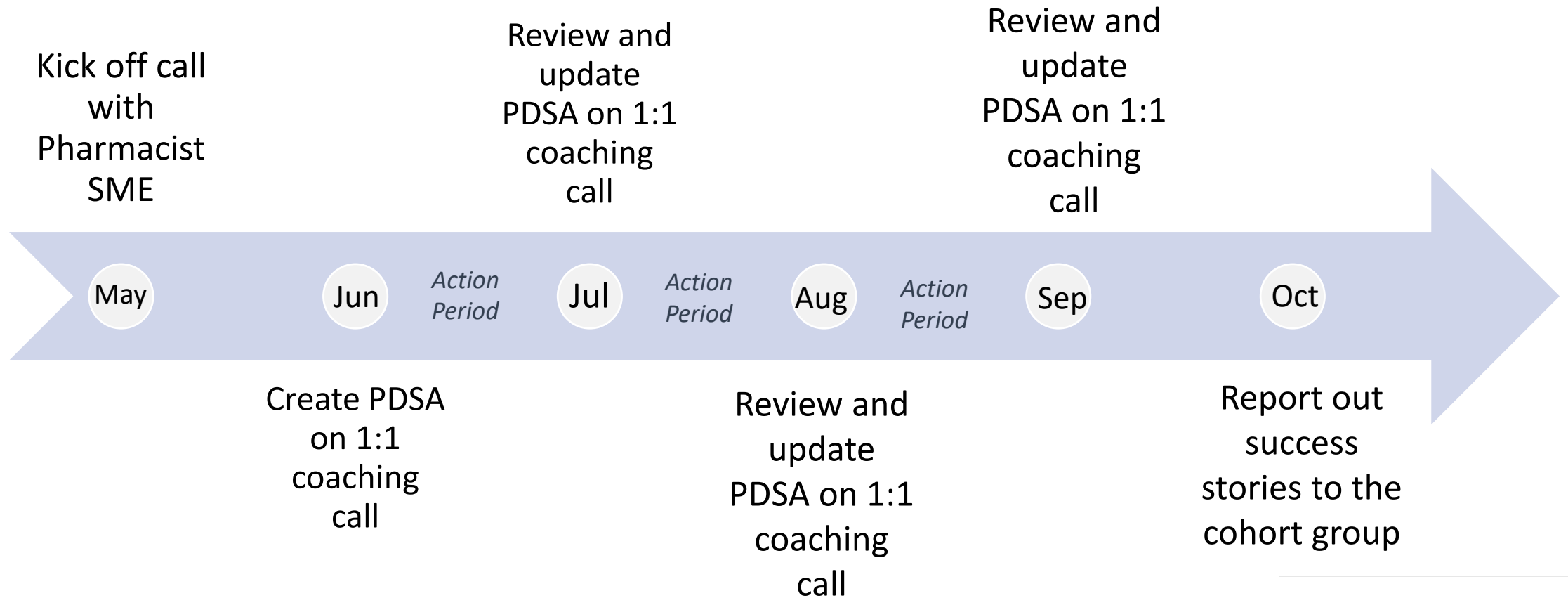
[HQIC COP – Reducing the Health Disparities Gap: A Practical Framework for Promoting Health Equity In Your Hospital | April 14, 2022](#)

[HQIC COP – CLABSI Control and Reduction Efforts During the COVID-19 Pandemic | May 12, 2022](#)

New! Patient Safety Cohorts

- Selected hospitals identified based on performance data
- Kick off calls scheduled in May/Jun
- Six month participation
- Meet monthly with quality improvement coach and SME to create PDSA and 30 day action plan
- Top five interventions for each patient safety topic
- Hospitals implement small tests of change
- Report out success and lessons learned in month 6 (Oct/Nov)
- ★ • NOTE: Readmissions will include health disparities

Cohort Timeline



Subject Matter Experts (SMEs) Provide 1:1 Coaching



Jennifer Massey, PharmD
Pharmacy and ADE Technical Adviser



Amy Ward, RN, BS, MS, CIC
Infection Prevention Specialist



Melody Brown, MSM
Care Transitions/Readmissions

Available for 1:1 coaching calls

Updated! Coaching Packages Located on Alliant HQIC Website

- Total of 13 patient safety topics, readmissions, patient and family engagement (PFE) and health equity
- Category, e.g. data collection
- Best practice/interventions
- Links to resources

<https://quality.allianthealth.org/topic/hospital-quality-improvement/>

HQIC Coaching Packages

[Coaching Package: Sepsis](#)
[Coaching Package: Pressure Injuries](#)
[Coaching Package: Patient & Family Engagement](#)
[Coaching Package: MRSA](#)
[Coaching Package: Health Equity](#)
[Coaching Package: CLABSI](#)
[Coaching Package: CAUTI](#)

[Coaching Package: C diff](#)
[Coaching Package: Antibiotic Stewardship](#)
[Coaching Package: ADE Glycemics](#)
[Coaching Package: ADE Opioids](#)
[Coaching Package: ADE Anticoagulants](#)
[Coaching Package: Readmissions](#)





Making Health Care Better Together

COLLABORATORS:
Alabama Hospital Association
Alliant Health Solutions
Comagine Health
Georgia Hospital Association
KPMC Health Improvement Partners
Korza

HEALTH EQUITY **COACHING PACKAGE**

Purpose: Use the evidence-based best practices and resources to create quality improvement action plans.

Facility/Hospital Name: _____ Date Completed: _____

Category	Best practice/interventions	Links to resources, toolkits, webinars, etc.
Beginning Health Equity Journey	Begin health equity journey with planning and preparation.	Roadmap for Success: Implementing Equitable Care (HSAG HQIC, 2021) Health Equity Snapshot: A Toolkit for Outcomes The Health Equity Roadmap (AHA/IFDHE)
	Conduct an equity of care gap analysis.	Health Equity Organizational Assessment (MHA)
	Review steps and resources from data collection to interventions	Building an Organizational Response to Health Disparities (CMS, 2020)* *contains links to other resources
Data Collection (HEOA #1)	Hospital uses self-reporting methodology to collect race, ethnicity and language (REaL) data for all patients. All race and ethnicity categories collected should, at a minimum, roll up to the OMB categories and should be collected in separate fields.	Inventory of Resources for Standardized Demographic and Language Data Collection (CMS 2021)
		Guide to Demographic Data Collection in Healthcare Settings (Sinai Health System, 2017)
		Reducing Healthcare Disparities: Collection and Use of Real Data (AHA, 2013)
		Improving Health Equity through Data Collection and Use: A Guide for Hospital Leaders (AHA, 2011)
		How Race and Ethnicity Data is Collected and Used (Colorado Trust, 2013) Create the Data Infrastructure to Improve Health Equity (IHI, 2019)


Updated! Infection Prevention (IP) Chats

- Host: Amy Ward, MS, BSN, RN, CIC, Infection Prevention Specialist
- New Title: Office Hours - IP Chats
- Frequency: once a month; 4th Wednesday of the month. **Begin June 22.**
- Time: 30 mins; 2-2:30 p.m. ET
- Registration: Yes
- Flyer will be sent out via email to hospital contacts
- <https://quality.allianthealth.org/topic/hospital-quality-improvement/>

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Making Health Care Better Together

Join Our Monthly Office Hours - Infection Prevention (IP) Chats



*****Please register for each event individually*****

**Every 4th Wednesday of the month
Beginning Wednesday, June 22, 2022
2 - 2:30 p.m. EST**

IP Chats are monthly networking events to build knowledge, share experience, and provide support for hospital infection preventionists.
Register for each of the following sessions:

Wednesday, June 22, 2022 at 2 p.m. EST
Click [HERE](#) to register or visit https://bit.ly/HQICIPChat_June22

Wednesday, July 27, 2022 at 2 p.m. EST
Click [HERE](#) to register or visit https://bit.ly/HQICIPChat_July27

Wednesday, August 24, 2022 at 2 p.m. EST
Click [HERE](#) to register or visit https://bit.ly/HQICIPChat_Aug24

Wednesday, September 28, 2022 at 2 p.m. EST
Click [HERE](#) to register or visit https://bit.ly/HQICIPChat_Sept28

Wednesday, October 26, 2022 at 2 p.m. EST
Click [HERE](#) to register or visit https://bit.ly/HQICIPChat_Oct26

About CMS Hospital Quality Improvement Contractors (HQIC):
The HQIC is a four-year program dedicated to improving behavioral health outcomes with a focus on decreased opioid misuse, patient safety with emphasis on reduction of harm, and care transitions with a focus on high utilizers. HQIC supports rural, critical access hospitals and hospitals that are low performing and serving vulnerable populations.

This material was prepared by Alliant Health Solutions, a Hospital Quality Improvement Contractor (HQIC) under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. Publication No. 1-2020-0000000-0000-0000-0000-0000-0000-0000

ALLIANT HEALTH SOLUTIONS

HQIC
Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES
QUALITY IMPROVEMENT & INNOVATION GROUP

New! NHSN Bite-Sized Learning Videos

- Series of bite-sized learnings for most frequently asked questions regarding CDC's NHSN database
- Topics include annual surveys, monthly reporting plans, adding new users or changing the facility administrator, facility mapping, data entry, and analysis
- Watch the videos
 - https://quality.allianthealth.org/media_library/infection-prevention-hospital-quality-improvement-contractor/

INFECTION PREVENTION
HOSPITAL QUALITY IMPROVEMENT CONTRACTOR

INFECTION PREVENTION (IP) CHATS

Find answers to frequently asked questions in the HQIC IP Chats. A series of short videos regarding how to navigate the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network Database (NHSN).

HQIC IP CHATS

LISTEN [HERE](#) TO FIND OUT HOW THESE VIDEOS CAN HELP YOU.

- **NHSN New User Introduction** | Click [HERE](#) to watch the video. Welcome to Alliant's HQIC IP Chats! Be introduced to the NHSN database and review how to get started as a new user.
- **Adding, Assigning Rights, and Deactivating Users in NHSN** | Click [HERE](#) to watch the video. Watch a short tutorial on how to add new users, assign rights, and deactivate users in the NHSN application.
- **Location Mapping and NHSN Training** | Click [HERE](#) to watch the video. Discover education and training options available from NHSN, as well as watch a short tutorial on how to map locations, edit existing locations and add new locations.
- **NHSN Annual Survey and Monthly Reporting Plans** | Click [HERE](#) to watch the video. Learn best practices for completing the NHSN annual Survey and creating monthly reporting plans.

Additional NHSN Education and Training Resources:

- Click [HERE](#) for the Enrollment and Set-up Training.
- Click [HERE](#) for the Patient Safety Component Roadmap.

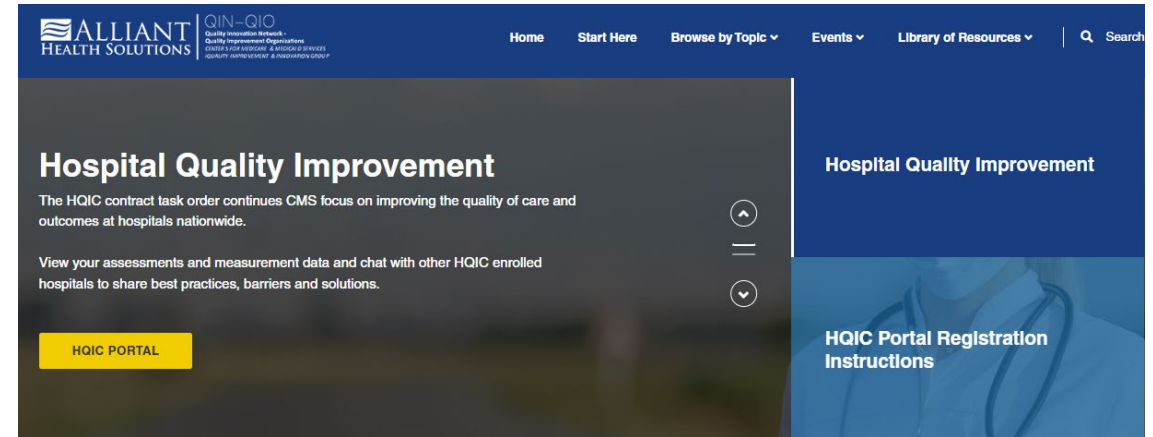
To watch all of the HQIC IP Chats, click [HERE](#), scan the QR code or visit <https://bit.ly/HQICIPChatPlaylist>.

ALLIANT HEALTH SOLUTIONS **Comagine Health** **GHA** **kfmcc** **KONZA**

HQIC Newsletter and Website

- Sent first Thursday of month to contacts
- Check junk mail or unblock email from Donna Cohen, Alliant
- News, educational events, expert insights, resources, success stories
- Past newsletters on [Alliant HQIC Website](https://www.alliantquality.org/)

- <https://www.alliantquality.org/topic/hospital-quality-improvement/>



Updated! Hospital Portal

- [Link to Portal Instructions and Portal Website](#)
- Ensure you log in with the same email address that you shared with your HQIC Quality Advisor
- Contact HQIC Quality Advisor to share your email address to gain access
- Available Information
 1. Assessment Data
 2. Measurement Data*
 3. Discussions
- Same data that Quality Advisor sees in Power BI

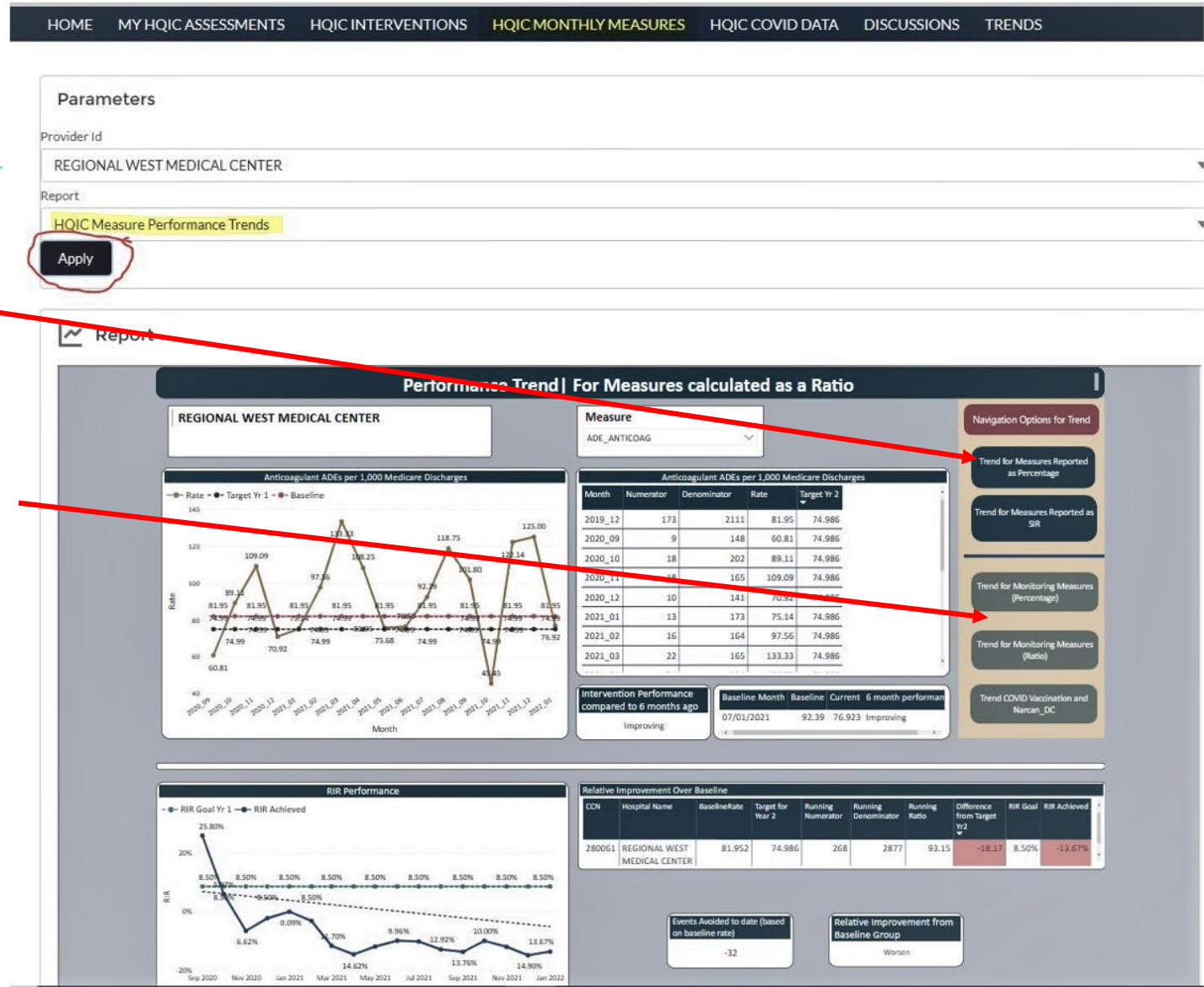
Portal Navigation

Evaluation Measures (Blue Navigation Icons)

- Measures reported as a Percentage
- Measures reported as a SUR

Monthly Monitoring Measures (Green Navigation Icons)

- Trend for Monitoring Measure (Percentage)
- Trend for Monitor Measures (Ratio)
- Trend COVID Vaccination and Narcan at DC



Portal Navigation Additional Information

- Trend
Measurement Data (Default)
- Simple Measure Definitions
- Measurement Definitions
- Notes

Measures Definition		
Measure Name	Description	Rate
ADE_ANTICOAG	ADE_ANTICOAG: Anticoagulant Related Adverse Drug Events	Anticoagulant ADEs per 1,000 Medicare Discharges
ADE_HYPOGLYCEMIA	ADE_HYPOGLYCEMIA: Glycemic Agent Related Adverse Drug Events	Glycemic ADEs per 1,000 Diabetic Discharges
ADE_OPIOID_RATE	ADE_OPIOID_RATE: Opioid Related Adverse Drug Events	Opioid ADEs per 1,000 Medicare Discharges
CDC_CAUTI_ICU_P	CDC_CAUTI_ICU_P: CAUTI SIR for All Units	CAUTI SIR for All Units
CDC_CAUTI_UR	CDC_CAUTI_UR: CAUTI Utilization Ratio	Number of Catheter Days per Patient Day
CDC_CLABSI_ICU_P	CDC_CLABSI_ICU_P: CLABSI SIR for All Units	CLABSI SIR for All Units
CDC_CLABSI_UR	CDC_CLABSI_UR: CLABSI Utilization Ratio	Number of Central Line Days per Patient Day
CDIFF_RATE	CDIFF_RATE: CDI Hospital Onset Infection Rate for All Units	CDIFF Hospital Onset Infection Rate for All Units
CDIFF_SIR	CDIFF_SIR: CDI Hospital Onset SIR for All Units	CDIFF Hospital Onset SIR for All Units
COVID_ED_NON_VENT	COVID_ED_NON_VENT: ED Utilization of Non-Ventilated COVID Patients	ED Utilization of Non-Ventilated Patients per COVID Admission
COVID_ED_VENT	COVID_ED_VENT: ED Utilization of Ventilated COVID Patients	ED Utilization of Ventilated Patients per COVID Admission
COVID_HOSP_ONSET	COVID_HOSP_ONSET: Hospital Onset of COVID 19	Hospital Onset Cases of COVID per Occupied Beds
COVID_VAC_COMP	COVID_VAC_COMP: Health Care Providers Receiving COVID Vaccine	Percent of Health Care Providers Receiving COVID Vaccine
MRSA_RATE	MRSA_RATE: MRSA Infection Rate for All Units	MRSA Infection Rate for All Units
MRSA_SIR	MRSA_SIR: MRSA SIR for All Units	MRSA SIR for All Units
NARCAN_DC	NARCAN_DC: Naloxone to Benes D/C on Opioids	Naloxone Prescriptions per Bene D/C with Opioids
OPIOID_DOSE_DC	OPIOID_DOSE_DC: High-Dose Opioid Prescribing Upon Discharge	Benes with (>=90MME) per Bene D/C with Opioids
PU_STAGE3	PU_STAGE3: Stage 3 or 4 Pressure Ulcers	PU Claims per 1,000 Medical or Surgical Discharges

Notes:
Excluding the baseline period for Claims and NHSN measures, each time period shows data as a discrete month

Trend

Simple Measures Definition

MeasuresDefinitions

Notes

Questions?



Email us at HospitalQuality@allianthealth.org or call us 678-527-3681.

Wrap Up/Adjourn

- Connect every six months for a Quality Leader Summit
- One hour virtual call
- Next Call:
 - Tues, Jan 17, 2023 from 1 - 2:00 p.m. ET
 - Hot Topics:
 - Patient and Family Engagement
 - Patient and Family Advisory Councils (PFACs)
 - Leadership commitment
- Complete post-event survey to submit any agenda items

Thank you for your participation!

CMS Fact Sheet

Hospital Quality Improvement Contractors (HQICs) | Your Quality Improvement Leaders for Acute Care

The Centers for Medicare & Medicaid Services (CMS) Quality Improvement Organization (QIO) Program is one of the largest federal programs dedicated to improving the quality of health care at the community level. **Hospital Quality Improvement Contractors (HQICs)** are strategic partners of the QIO Program that support this mission within hospital settings. Their initiatives are designed to improve health care quality, access, value and equity for people with Medicare.

Health care quality is the overarching goal. The QIO Program and HQICs connect and convene the right people to help solve the nation's most pressing health care challenges, one community at a time.

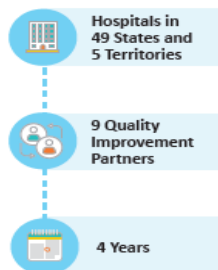
What are HQICs?

Data-driven. It's the data that help hospitals measure progress toward quality improvement (QI) gains. Hundreds of thousands of patients and families benefit from CMS-supported QI projects that make today's hospital stays safer and improve the quality of hospital care.

Dynamic and collaborative. HQICs partner with small, rural and critical access hospitals and facilities that care for vulnerable and underserved patients. Their quality improvement consulting and expertise – offered at no cost to the hospitals – help hospital leaders and clinical teams develop local QI projects designed to:

- Reduce opioid misuse and adverse drug events.
- Increase patient safety with a focus on preventing hospital-acquired infections.
- Refine care coordination processes to reduce unplanned admissions.

HQICs also share their QI resources to assist hospitals with pandemic responses and emergency preparedness.



Local.

- Provide no-cost quality improvement consulting to help leadership teams understand and implement Medicare and other federal health care guidelines.
- Engage with hospital leaders and stakeholders to help tailor national QI priorities to local conditions.
- Support health equity through patient and family engagement.
- Coordinate goal setting, communication, QI resources and crisis response by facilitating partnerships with community, state and local organizations.

Measurable.

- Help gather, analyze and interpret health care data to inform decisions that impact patients, families, partners and communities.
- Visualize data to help hospitals track progress toward local and national quality goals.
- Demonstrate how hospital processes can evolve in response to real-time data.

Sustainable.

- Create and spread learning opportunities for today's evidence-based best practices.
- Develop peer and community networks for learning, collaboration and sharing.
- Teach and coach QI processes and techniques for lasting change.

To Learn More

The four-year HQIC program will remain active through October 2024. Please visit [QIOProgram.org](https://www.cms.gov/qio) to learn more about HQIC partners and QI initiatives.



1250W/Bizell/DVA-456-04/21/20

Alliant HQIC Fact Sheet



MAKING HEALTH CARE BETTER

Alliant Quality - A Network of Quality Improvement and Innovation Contractor (NQIIC) with Demonstrated Success in Recruiting, Engaging and Improving Provider Performance

As the quality improvement services group of Alliant Health Solutions, Alliant Quality is a successful CMS contractor with a national footprint serving public and private customers in 12 states. Alliant Quality successfully manages work and effectively meets clients' quality improvement needs by:

- Operating as a clinically led and data-driven enterprise
- Being an experienced CMS contractor
- Demonstrating value across multiple clinical settings
- Providing customer service orientations
- Having prior positive work with Hospital Improvement and Innovation Networks (HIINs) and hospitals

Alliant Quality Experience

Alliant Quality has demonstrated long-term success providing hospitals with technical assistance for quality reporting and measure improvement. Our partnerships with Hospital Quality Improvement Contractors (HQICs) and hospitals have provided essential value-added experience such as:

- Establishing long-term relationships with providers that impact HQIC measures, such as community partners/long-term care facilities for readmissions
- Proven return on investment relative to time, resources and budget
- Improvement rates relative to the specific aims
- Implemented processes that impact short- and long-term efficiency goals



MEDICATION SAFETY

- Decrease opioid prescribing
- Decrease opioid adverse events



PATIENT SAFETY

- Reduce all cause harm
- Reduce adverse drug events
- Reduce avoidable readmissions
- Reduce incidence of C. Diff

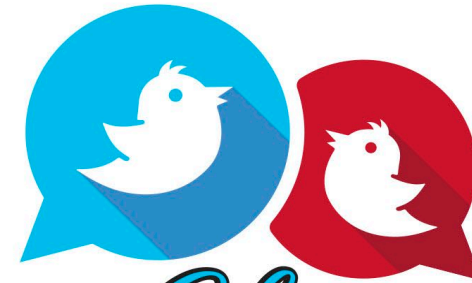


CARE TRANSITIONS

- Reduce hospital admissions
- Reduce hospital readmissions
- Reduce emergency department visits

With decades of experience and access to hundreds of clinical specialists, Alliant Quality's company size allows us to provide personalized customer service and adapt to customer needs—all while putting patients first. We work collaboratively and combine strong data analytics with our clinical specialists to give context to the data while eliminating silos typically found on health care data teams. Alliant Quality helps make health care better by providing services that make health care safer and more effective.

For more information on how Alliant Quality can assist your team, please contact hospitalquality@alliantquality.org.
WWW.ALLIANTQUALITY.ORG



Readmissions Twitter Chat

SAVE THE DATE!

TUESDAY, JUNE 28, 2022 | 11 A.M. - 3 P.M. ET

PARTICIPATE AND FOLLOW THE CHAT USING #ChatWithAlliant ON TWITTER.

Making Health Care Better *Together*

COLLABORATORS:

Alabama Hospital Association
Alliant Health Solutions
Comagine Health
Georgia Hospital Association
KFMC Health Improvement Partners
Konza

Hospital Quality Improvement



@AlliantQIO



@AlliantQIO

Thank you for joining us!
How did we do today?

Alliant Health Solutions



AlliantQIO



This material was prepared by Alliant Health Solutions (AHS), the Hospital Quality Improvement Contractor (HQIC) under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this document do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. Publication No. 12SOW-AHSQIN-QIO TO3 - HQIC--2158-06/10/22

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