Quality Leader Summit

Welcome!

- All lines are muted, please ask your questions in Chat and send to everyone
- Please actively participate in polling questions that pop up on the lower right-hand side of your screen
- Please be aware that this event will be recorded

Alliant HQIC Quality Leader Summit

Donna Cohen, RN, BSN, CCM
Karen Holtz, MT(ASCP), MS, CPHQ

June 6, 2023

ALLIANT HEALTH SOLUTIONS | HQIC Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES iQUALITY IMPROVEMENT & INNOVATION GROUP

Alliant HQIC Moderators

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

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

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

Welcome from all of us!

ALABAMA HOSPITAL ASSOCIATION

ALLIANT HEALTH SOLUTIONS

Comagine Health

GHA Georgia Hospital Association

kfmc HEALTH IMPROVEMENT PARTNERS

KONZA

Agenda

- Welcome
- HQIC Updates
- Performance Data
- Hot Topics: Sepsis, Health Equity
- Educational Events and Networking
- Updated Resources
- Wrap Up/Adjourn

HQIC Updates: Additional areas of focus in the coming months

1. Patient Engagement – patient/family voice in learning events
2. Staff Onboarding and Retention – bundles of workforce training and resources
3. High Reliability Culture – collaboration with aviation or nuclear industry
4. Rural Emergency Hospitals (REHs)- convert to emergency services and observation care
5. Violence Prevention – environmental scan; improve security policies
6. Hospital Governance Engagement – engage with hospital boards
7. Regional Hospital Networks – network development to avoid duplication of effort

Summary HQIC Level Performance: 30 Month

Measure	30 Month RIR Performance	RIR Goal
Anticoagulation and Hypoglycemia ADEs	43.45%	8.5%
OPIOID ADEs	90.39%	5.0%
OPIOID Prescribing	-0.22%	8.0%
Readmissions	4.95%	3.0%
All Cause Harm	-23.01	6.0%
CDC_CAUTI_ICU_P		
CDIFF_Combination		
CDIFF_RATE		
CDC_CLABSI_ICU_P		
MRSA_Combination		
PU_STAGE3		
SEPSIS_MORT_2		
SEPSIS_SHOCK		

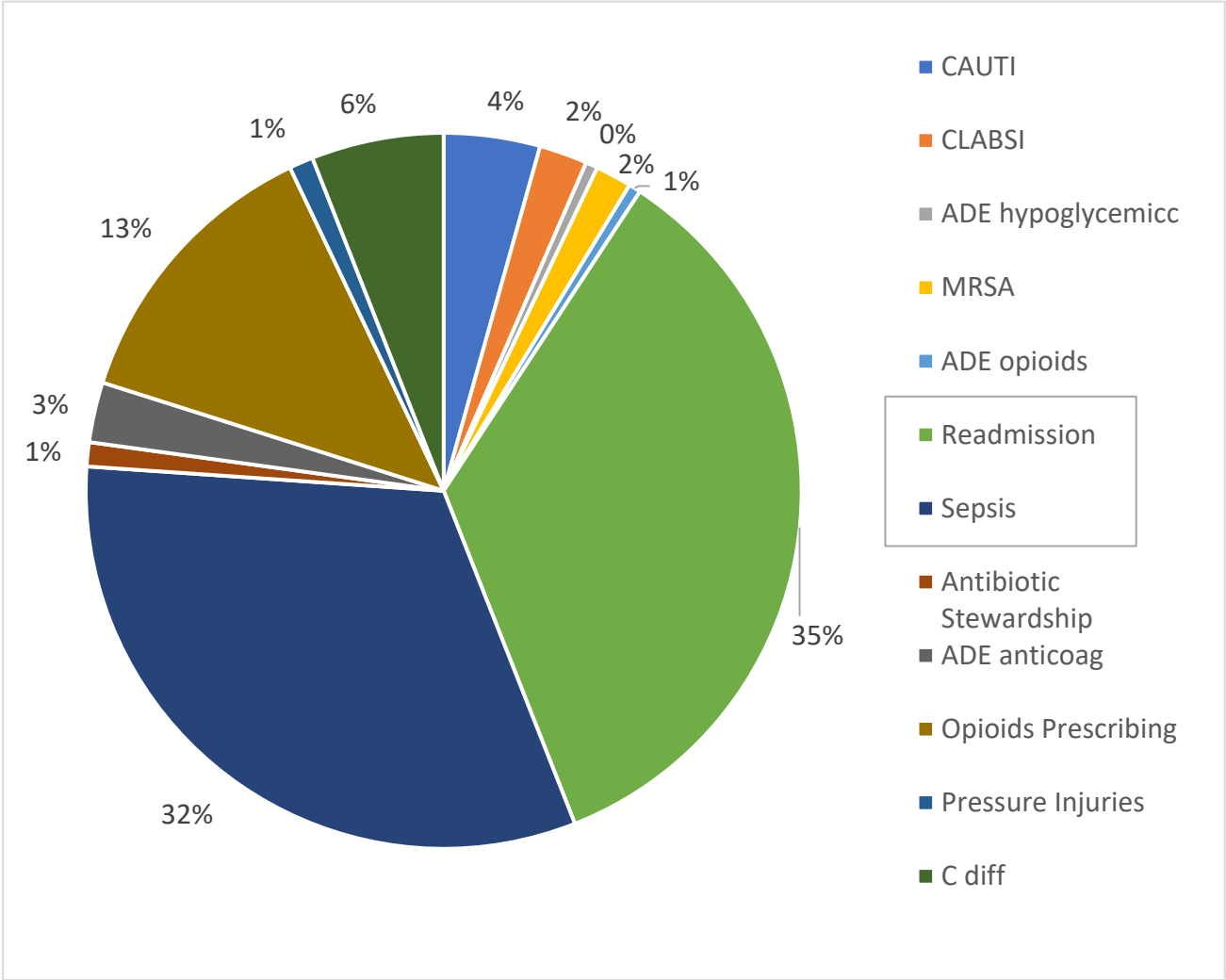
RIR Goal Month 30 = Relative Improvement Rate Goal for March 2023

RIR Achieved = Relative Improvement Rate compared to baseline (2019 data for all measures except CAUTI, CLABSI and MRSA which is 2020 data)

Source:
CMS claims and NHSN data as of September 2021-September 2022

Focused Measures Cohorts in Action

- Hospitals focus on 1-2 areas and implement interventions from coaching packages
- Top patient safety topics include readmissions (35%) and sepsis (32%) followed by opioid prescribing at discharge (13%)
- Health equity interventions included in all patient safety topics
- Monitoring by domains:
  - Reach
  - Adoption
  - Implementation



Meet the Speakers from Colquitt Regional Medical Center

Melinda (Lindy) Sanderson, MSN, RN, CMSRN
Assistant Director of Quality Assurance

After graduating from the University of Georgia with a Bachelor of Science in biology, Lindy decided to go back to nursing school. In the six years since she obtained her BSN, she has worked as a medical-surgical RN and graduated with a Master's in nursing leadership and development.

Ashley McDaniel, MSN, RN, CIC
Infection Preventionist

Ashley McDaniel has been a nurse for 18 years where she spent most of her bedside career working in the ICU. She earned her Master's of Science in nursing in 2018 and became certified in infection prevention and control in 2019.

Making Sepsis As Easy To Recognize As A Heart Attack

- 99-bed acute care facility located in rural southwest Georgia

Sepsis goals:

- Improve bundle compliance from baseline 35% in 2019
- Improve rate of recognition and diagnosis of Severe Sepsis and Septic Shock
- Decrease Sepsis mortality rate of 13% in 2019

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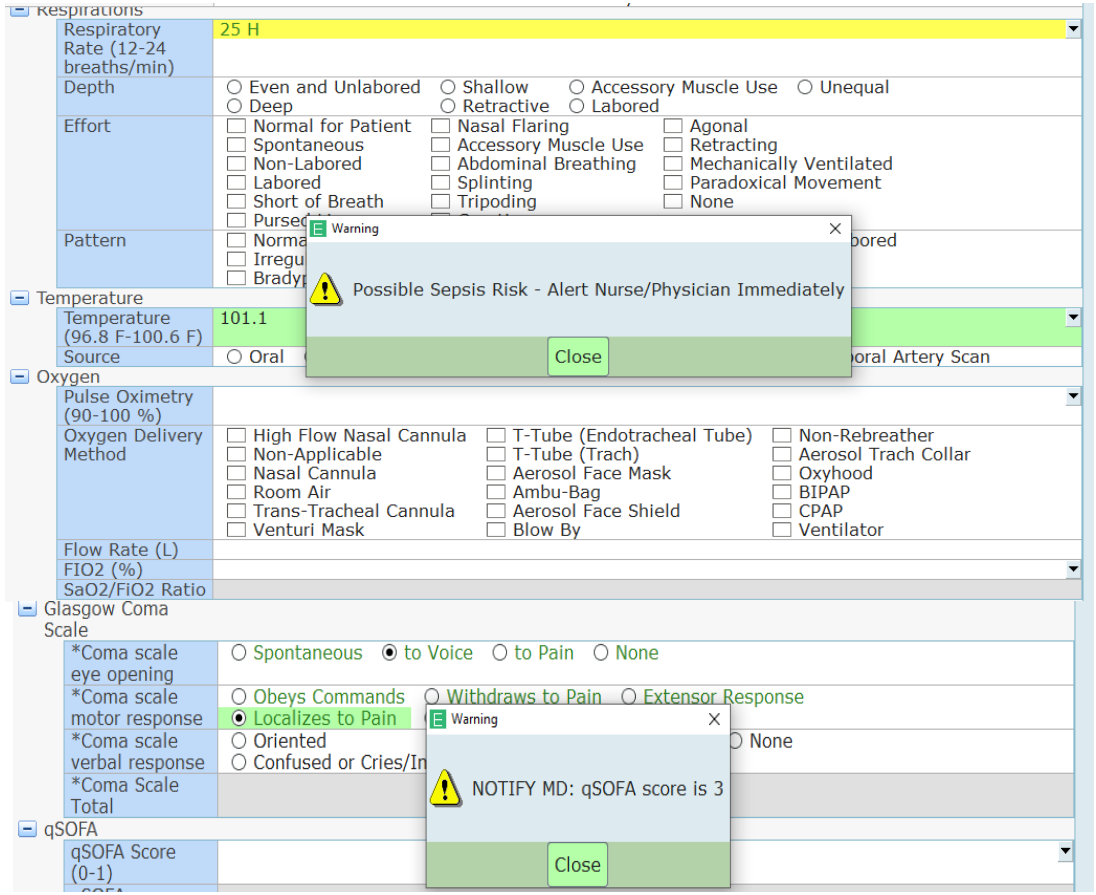
Sepsis Taskforce

- Multidisciplinary group meets monthly
- Reviews each sepsis chart to look for opportunities for improvement
  - Antibiotic administration time
  - Lab work; blood cultures and lactic acid collection timing
  - Failures in reporting critical lab values
- Implements best practice processes
- Provides feedback to frontline staff
- Develops process changes including enhancements to the EMR

EMR Enhancements



- Triage assessment including Systemic Inflammatory Response Syndrome (SIRS) criteria
- Quick Sepsis-related Organ Failure Assessment (qSOFA) score calculated based on the Glasgow Coma Scale (GCS)
- Code Sepsis Protocol
- National Early Warning Score (NEWS)

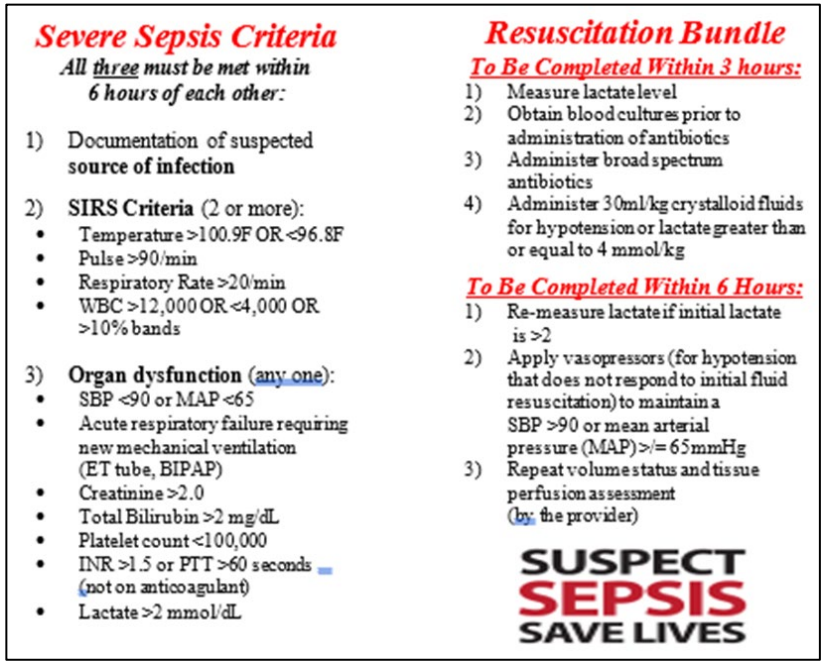
Staff Buy-In and Education

Staff Engagement

- Clinical ladder
- Annual incentive bonus
- Recognition of staff weekly

Staff Education

- Weekly emails
- Annual skills fair
- HealthStream
- Quality rounding
- Badge buddies*
- Sepsis workflow form
- ED Code Sepsis checklist



Severe Sepsis Criteria

All three must be met within 6 hours of each other:

1) Documentation of suspected **source of infection**

2) **SIRS Criteria** (2 or more):
   - Temperature >100.9F OR <96.8F
   - Pulse >90/min
   - Respiratory Rate >20/min
   - WBC >12,000 OR <4,000 OR >10% bands

3) **Organ dysfunction** (any one):
   - SBP <90 or MAP <65
   - Acute respiratory failure requiring new mechanical ventilation (ET tube, BIPAP)
   - Creatinine >2.0
   - Total Bilirubin >2 mg/dL
   - Platelet count <100,000
   - INR >1.5 or PTT >60 seconds (not on anticoagulant)
   - Lactate >2 mmol/dL

Resuscitation Bundle

To Be Completed Within 3 hours:

1) Measure lactate level
2) Obtain blood cultures prior to administration of antibiotics
3) Administer broad spectrum antibiotics
4) Administer 30ml/kg crystalloid fluids for hypotension or lactate greater than or equal to 4 mmol/kg

To Be Completed Within 6 Hours:

1) Re-measure lactate if initial lactate is >2
2) Apply vasopressors (for hypotension that does not respond to initial fluid resuscitation) to maintain a SBP >90 or mean arterial pressure (MAP) >/= 65mmHg
3) Repeat volume status and tissue perfusion assessment (by the provider)

SUSPECT SEPSIS SAVE LIVES

*Badge Buddy

Educational Tools

Severe Sepsis/Septic Shock Workflow

Transfer Unit: ER 2nd 3rd 4th 5th ICU OB OR

Sepsis Criteria Met: *Source of Infection *2 or more SIRS *Organ Dysfunction Date/Time:_____

Septic Shock: Persistent hypotension one hour following administration of target volume crystalloid fluids (30ml/kg). SBP <90 or MAP <65 or decrease in SBP >40mmHg.

Within 3 hours of presentation:		Within 6 hours of presentation:	
0-1 hour	0-3 hours	3-4 hours	0-6 hours
Obtain Serum Lactate Time Drawn_____ LA Result_____	**Administer initial bolus of 30ml/kg of crystalloid fluids for initial hypotension or serum lactate >=4.** Pt wt_____kg x 30 = _____ml	**Repeat Lactate if initial level >2** Time Drawn_____ LA Result_____	**Place on Vasopressors if hypotension persists after fluid administration** Time started_____ Name of Vasopressor_____ **AND**
Obtain Blood cultures prior to antibiotic administration Time Drawn_____			
Administer broad spectrum antibiotic Time Given_____	**Bolus Initiated:** _____ **Bolus Completed:**_____		**Re-assess volume status and tissue perfusion**- provider documentation of perfusion assessment, sepsis focused exam or systems review.
Name of first antibiotic or already on IV antibiotic(s) appropriate for infection _____	**Total Volume infused:** _____ml		

ED CODE SEPSIS Checklist

Sepsis Recognition

Concern for Sepsis
- ☐ Symptoms of Infection: cough, red skin, chills, rigors, dysuria, flank pain, diarrhea
- ☐ 2 SIRS Criteria:
  - o Temperature >38.3(>100.9) or <36.0(<96.8)
  - o RR >20/min
  - o HR >90/min

Concern for Severe Sepsis & **Time Zero for CODE SEPSIS.** **Time of Code Sepsis:**_____
- ☐ Symptoms of Infection + 2 SIRS Criteria +
- ☐ 1 "Sepsis Game-Changer"
  - o Altered Mental Status (or change from baseline)
  - o SBP <90 or MAP <65
  - o Immunocompromised
  - o Lactic Acid >2.0

Within 20 minutes of ED Arrival + Concern for CODE SEPSIS
- ☐ Obtain patient weight **Weight in kg:**_____
- ☐ Undress patient and remove bandages if present
- ☐ Insert 2 large-bore PIVs
- ☐ I-stat VBG, Lactic Acid, & Chem 8 drawn *and resulted*. **Time of VBG Result:** _____
- ☐ 2 blood cultures from 2 different sites
- ☐ CBC, Hepatic Panel, Procalcitonin

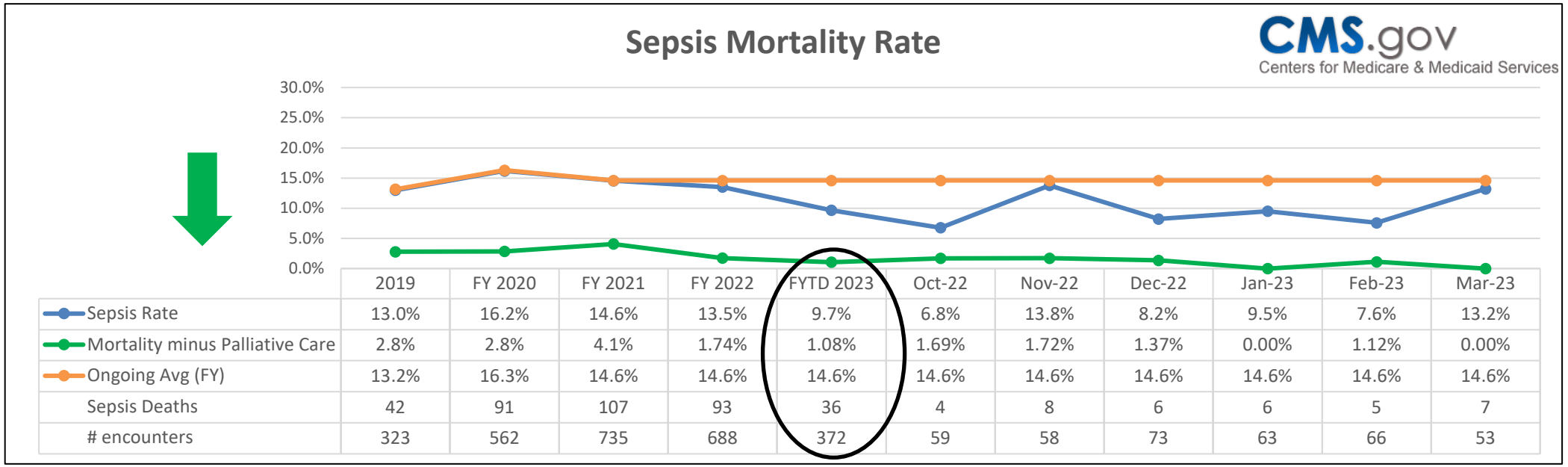
Within 10 minutes of CODE SEPSIS
- ☐ MD evaluates patient. **Time of MD eval:** _____
  - o Confirms suspicion of infection/Code Sepsis & rules out Surgical Abdomen
  - o OR Code Sepsis cancelled. (Reason_____
- ☐ Obtain order for crystalloid fluids (30ml/kg for initial hypotension or lactate >4)

Within 60 minutes of CODE SEPSIS
- ☐ Urinalysis and Urine Culture (Straight cath if needed)
- ☐ 30ml/kg NS/LR infused (as appropriate for patient with reassessment after each liter).
- ☐ Indicated Imaging (CXR, CT abd, etc)

Within 120 minutes of CODE SEPSIS
- ☐ Antibiotics ordered & initiated. (see attached guidelines) **Time of Abx order:** _____
- ☐ OR Antibiotics not ordered. (Reason)_____ **Time of Abx initiation:** _____
- ☐ Repeat Lactic Acid if initial result >2.0.

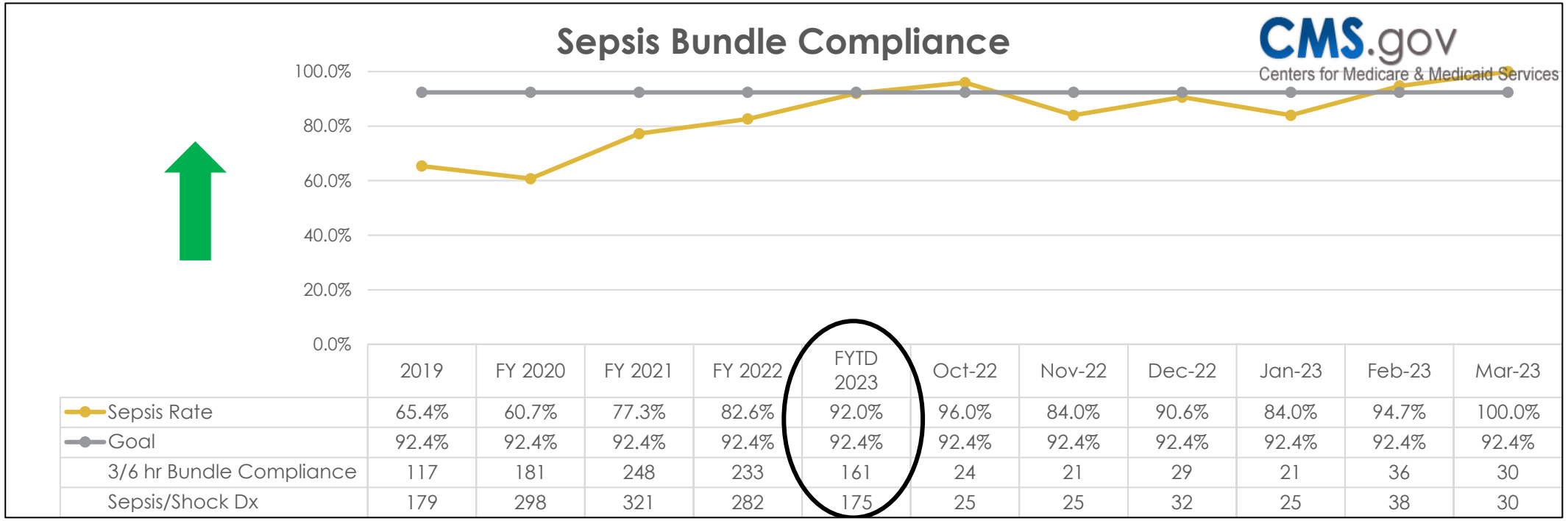
Ongoing CODE SEPSIS Care
- ☐ IF Repeat Lactic Acid <4 or SBP >90, MD to initiate Floor Admission.
- ☐ IF Repeat Lactic Acid >4 or SBP <90, MD to consider ICU Admission and Vasopressors.
- ☐ Call Report & transfer patient **Time Report Called:** _____ **Time of Transfer:** _____

FYTD 2023 Results: Sepsis Mortality Rate



	2019	FY 2020	FY 2021	FY 2022	FYTD 2023	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Sepsis Rate	13.0%	16.2%	14.6%	13.5%	9.7%	6.8%	13.8%	8.2%	9.5%	7.6%	13.2%
Mortality minus Palliative Care	2.8%	2.8%	4.1%	1.74%	1.08%	1.69%	1.72%	1.37%	0.00%	1.12%	0.00%
Ongoing Avg (FY)	13.2%	16.3%	14.6%	14.6%	14.6%	14.6%	14.6%	14.6%	14.6%	14.6%	14.6%
Sepsis Deaths	42	91	107	93	36	4	8	6	6	5	7
# encounters	323	562	735	688	372	59	58	73	63	66	53

FYTD 2023 Results: Sepsis Bundle Compliance



	2019	FY 2020	FY 2021	FY 2022	FYTD 2023	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Sepsis Rate	65.4%	60.7%	77.3%	82.6%	92.0%	96.0%	84.0%	90.6%	84.0%	94.7%	100.0%
Goal	92.4%	92.4%	92.4%	92.4%	92.4%	92.4%	92.4%	92.4%	92.4%	92.4%	92.4%
3/6 hr Bundle Compliance	117	181	248	233	161	24	21	29	21	36	30
Sepsis/Shock Dx	179	298	321	282	175	25	25	32	25	38	30

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Sustainability Plan

- Sepsis Taskforce continues to meet monthly to review sepsis charts, recommendation changes, definition updates, and new regulatory requirements
- Seeks out and provides ongoing educational opportunities to the frontline staff, leadership team, and Sepsis Coordinator
- Participation in state and national collaboratives, conferences, and virtual learning opportunities provide networking and best practice updates
- Monitoring and reporting of Sepsis data occurs monthly to the leadership team
- "We ARE going to make Sepsis as easy to recognize as a heart attack!"

Health Equity Speaker

Rosa Abraha, MPH
Health Equity Lead
Alliant Health Solutions
rosa.abraha@allianthealth.org

Rosa joined Alliant in December 2021 to lead the company's first health equity strategic portfolio and embed health equity in the core of Alliant's work. Rosa has 10 years of experience in public health advisory for premier agencies, including the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), and the Food and Drug Administration (FDA). She holds a Master of Public Health in Health Policy and Management from Emory University.

Hospital Leadership Engagement in Health Equity

CMS HCHE *Mandatory CY23*	**MUC 2021-106 | Domain 5A** Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews our strategic plan for achieving health equity.
TJC *Mandatory 1/1/24*	**Standard LD.04.03.08** Reducing healthcare disparities for the [organization's] [patients] is a quality and safety priority. **EP 1** The [organization] designates an individual(s) to lead activities to reduce healthcare disparities for the [organization's] [patients].

HOW TO: Engage Hospital Leadership in Health Equity

Health Equity Gap Analysis

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

The following checklist assesses a hospital's incorporation of health equity best practices as part of its overall operations.

Hospital name: _____

Date: _____

ELEMENT	BEST PRACTICE RECOMMENDATION	IMPLEMENTATION STATUS			ACTION PLAN/ NEXT STEPS List specific activities your team will seek to accomplish to fully implement each practice recommendation
		FULLY	PARTIALLY	NONE	
ORGANIZATIONAL LEADERSHIP					
Health equity is a key strategic priority with established structures and processes in place to eliminate disparities and ensure equitable healthcare is prioritized and delivered to all patient populations.	Health equity is articulated as a key organization-wide priority (e.g., goals and objectives, strategic plan, policy, protocol, pledges, mission/vision/values, data transparency, leadership buy-in, community partnerships, diverse workforce) supported by a clear business case and plan for operationalizing health equity strategies and interventions that address multiple determinants of health, decrease institutional racism and strengthen community partnerships to improve health and equity.	○	○	○	
Hospital has designated a leader(s) or functional area (i.e., health equity committee) responsible for advancing health equity and who actively engages in strategic and action planning activities to reduce disparities.	Health equity leaders are designated and held accountable for disparities reduction with established roles and responsibilities to champion equity and improve quality of care. Designated leaders actively engage hospital staff, patients and families and create linkages with community stakeholders to support health equity improvement activities.	○	○	○	

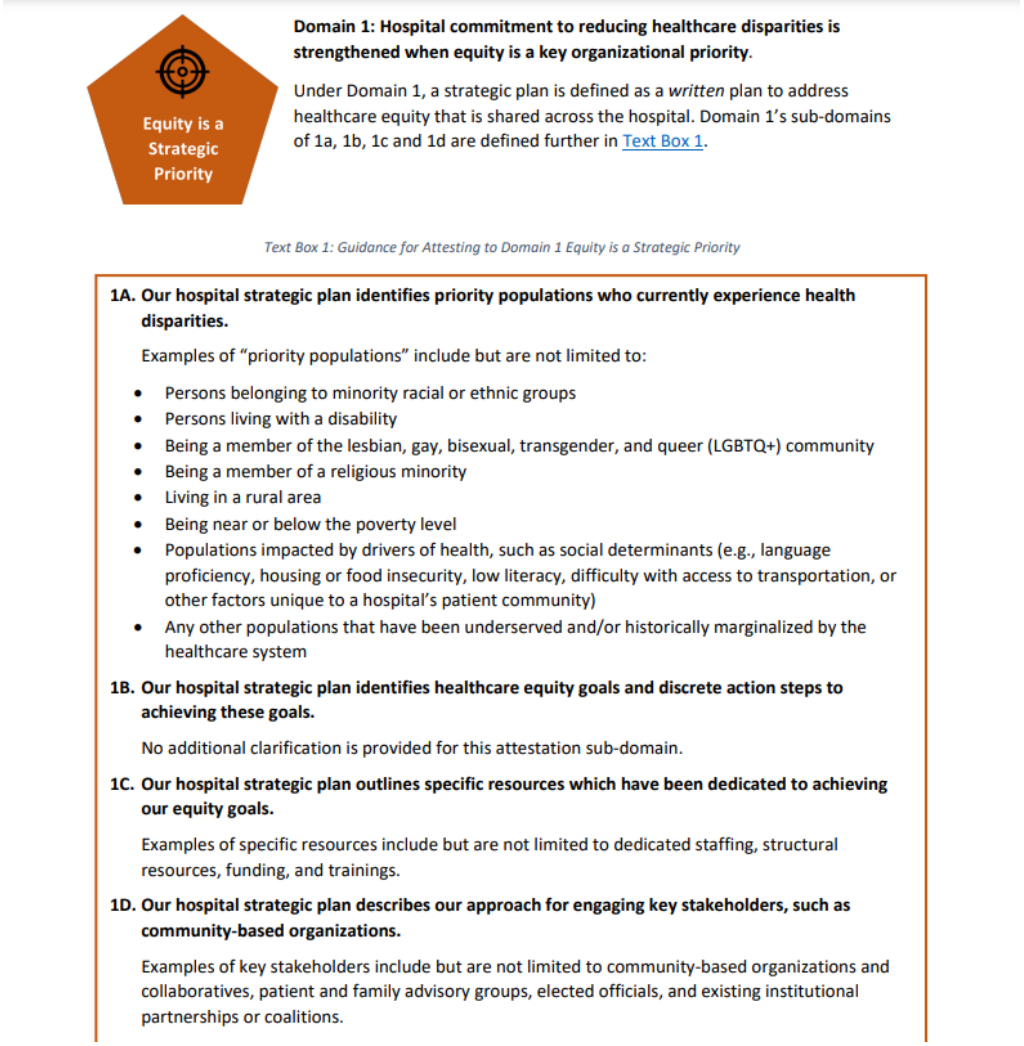
- This **template** aims to help organizations assess the extent to which they have incorporated health equity best practices as part of its overall operations.
- There are *7 major categories* for evaluation in this analysis: organizational leadership, workforce training, data collection, data validation, data stratification, health literacy/cultural competence, community partnerships.

(Source: Eastern US Quality Improvement Collaborative)

Health Equity Action Plan

CMS HCHE *Mandatory CY23*	**MUC 2021-106** **Domain 1A** Our hospital strategic plan identifies priority populations who currently experience health disparities. **Domain 1B** Our hospital strategic plan identifies healthcare equity goals and discrete action steps to achieving these goals. **Domain 1C** Our hospital strategic plan outlines specific resources which have been dedicated to achieving our equity goals.
TJC *Mandatory 1/1/24*	**Standard LD.04.03.08** Reducing healthcare disparities for the [organization's] [patients] is a quality and safety priority. **EP 4** The [organization] develops a written action plan that describes how it will address at least one of the healthcare disparities identified in its [patient] population. **EP 5** The [organization] acts when it does not achieve or sustain the goal(s) in its action plan to reduce healthcare disparities.

HOW TO: CMS Requirements for a Hospital Health Equity Action Plan



Equity is a Strategic Priority

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

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

Text Box 1: Guidance for Attesting to Domain 1 Equity is a Strategic Priority

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

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

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

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

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

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

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

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

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

CMS has released a full attestation document which includes a breakdown on each of the domains required to fulfill the hospital commitment to health equity. This screenshot includes details on what to include in your hospital action plan. (Source: CMS)

HOW TO: Create a Hospital Health Equity Action Plan

This **fillable worksheet** guides the development of a 5-step action plan to identify health disparities and priority populations, define goals, establish a health equity strategy, determine what your organization needs to implement its strategy. (Source: CMS)

Data Collection: REaL and SDOH Patient Demographic Data

CMS HCHE *Mandatory CY23*	**MUC 2021-106** **Domain 2A** Our hospital collects demographic information, including self-reported race and ethnicity and/or social determinant of health information on the majority of our patients. **Domain 2B** Our hospital has training for staff in culturally sensitive collection of demographic and/or social determinant of health information. **Domain 2C** Our hospital inputs demographic and/or social determinant of health information collected from patients into structured, interoperable data elements using a certified EHR technology.
TJC *Mandatory 1/1/24*	**Standard RC.02.01.01** The [medical] record contains information that reflects the [patient's] care, treatment, and services. **EP 28** The medical record contains the patient's race and ethnicity.

HOW TO: CMS Requirements for Collecting REAL and SDOH Data

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.

The Centers for Medicare and Medicaid Services (CMS) has not yet finalized standards for data collection so hospitals should attest if they are collecting these data in any way. Hospitals are also encouraged to collect social determinant and other 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.

Text Box 2: Guidance for Attesting to Domain 2 Data Collection

2A. Our hospital collects demographic information, including self-reported race and ethnicity, 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 the LGBTQ+ community
- 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.

CMS has released a full attestation document which includes a breakdown on each of the domains required to fulfill the hospital commitment to health equity. This screenshot includes details on what to include in your REAL and SDOH collection. (Source: CMS)

HOW TO: Scripting on REaL Data Collection for Hospital Staff

REAL Data Collection Script and Definition

This document can be provided to staff during orientation or training on the collection of REAL data to ensure consistent screening and documentation are being collected across all points of registration. These are recommended script and suggested responses when screening patients.

Recommended Script for Patient's Ethnicity, Race, and Language Screening

"I would like you to tell me your race and ethnic background. We use this information to review the treatment patients received and make sure everyone gets the highest quality of care."

- *First, do you consider yourself Hispanic or Latino? (See ethnicity definition at end of document)*

  - ☐ Yes
  - ☐ No
  - ☐ Declined
  - ☐ Unknown/ Unavailable

- *Which category or categories best describe your race? (See race definitions at end of document)*

  - ☐ American Indian or Alaska Native
  - ☐ Asian
  - ☐ Black or African American
  - ☐ Native Hawaiian or Other Pacific Islander
  - ☐ White
  - ☐ Declined
  - ☐ Unknown
  - ☐ Other Race

- *What language do you feel most comfortable speaking with your doctor or nurse (patient's primary language)?*

  - ☐ Provide a list of options. Consider the community you serve, for example if your community is mostly Asian, provide a list of Asian languages (i.e., Mandarin, Hindi, Japanese, etc.) along with your commonly spoken language such as English and Spanish.

Data Collection: 5 CMS Domains of SDOH Screening

1. **Food Insecurity**
   Food insecurity is defined as limited or uncertain access to adequate quality and quantity of food at the household level.

2. **Housing Instability**
   Housing instability encompasses multiple conditions ranging from the inability to pay rent or mortgage, frequent changes in residence including temporary stays with friends and relatives, living in crowded conditions, and actual lack of sheltered housing in which an individual does not have a personal residence.

3. **Transportation Needs**
   Unmet transportation needs include limitations that impede transportation to destinations required for all aspects of daily living.

4. **Utility Difficulties**
   Inconsistent availability of electricity, water, oil, and gas services is directly associated with housing instability and food insecurity.

5. **Interpersonal Safety**
   Assessment for this domain includes screening for exposure to intimate partner violence, child abuse, and elder abuse.

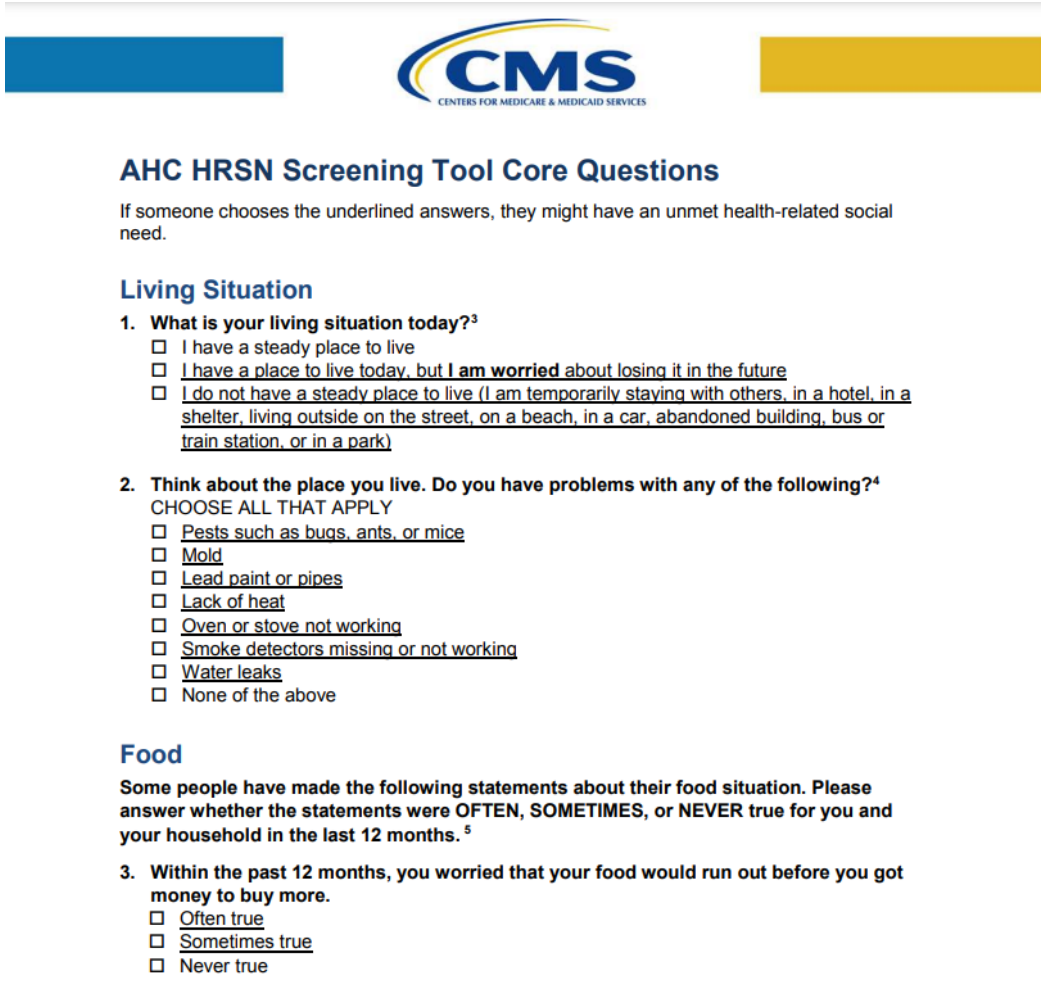
Data Collection: Screening Patients for SDOH

● CMS SDH *Mandatory CY24*	**Screening for Social Drivers of Health MUC2021–136** Numerator: Number of beneficiaries 18 and older screened for food insecurity, housing instability, transportation needs, utility assistance, and interpersonal violence. Denominator: Number of beneficiaries 18 and older in practice (or population). **Screen Positive Rate for Social Drivers of Health MUC2021–134** Numerator: Number of beneficiaries 18 and older that screen positive for food insecurity, housing instability, transportation needs, utility assistance or interpersonal violence. Denominator: Total number of beneficiaries 18 and older screened for food insecurity, housing instability, transportation needs, utility assistance or interpersonal violence.

NOTES:

- *These are both structural measures and the data can come from multiple sources (administrative claims data, electronic clinical data, standardized patient assessments, or patient-reported data and surveys).*
- *Exclusion criteria exists for patients who opt-out of screening and/or patients who are unable to complete the screening during their stay and have no legal guardian or caregiver who can do so on their behalf.*
- *The screen positive rate will result in 5 unique rates for each of the 5 categories of social drivers of health.*

HOW TO: CMS AHC HRSN SDOH Screening Tool



AHC HRSN Screening Tool Core Questions

If someone chooses the underlined answers, they might have an unmet health-related social need.

Living Situation

1. **What is your living situation today?**[3]
   - ☐ I have a steady place to live
   - ☐ I have a place to live today, but **I am worried** about losing it in the future
   - ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. **Think about the place you live. Do you have problems with any of the following?**[4]
   CHOOSE ALL THAT APPLY
   - ☐ Pests such as bugs, ants, or mice
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Lack of heat
   - ☐ Oven or stove not working
   - ☐ Smoke detectors missing or not working
   - ☐ Water leaks
   - ☐ None of the above

Food

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months. [5]

3. **Within the past 12 months, you worried that your food would run out before you got money to buy more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

- CMS and CMMI developed the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool.
- It is recommended to use this form and integrate the questions into your EHR as it contains 2 questions in each of the 5 core domains that CMS will be evaluating for both structural measures (SDOH-1 and SDOH-2) .

Additional SDOH Screening Tools

HealthBegins

Upstream Risks Screening Tool & Guide

"Everyone deserves the opportunity to have a safe, healthy place to live, work, eat, sleep, learn and play. Problems or stress in these areas can affect health. We ask our patients about these issues because we may be able to help."

Domain*	Minimum Frequency**	Question	Response	Suggested Scoring	Referral Plan Complete?
Education	First visit	1a. What is the highest level of school you have completed? Check one.	Elementary School High School College Graduate / Professional School	+1 for "Elementary School "	
		1b. What is the highest degree you earned? Check one.	High school diploma GED Vocational certificate (post high school or GED) Associate's degree (junior college) Bachelor's degree Master's degree Doctorate	+1 for "High School Diploma, GED, or Vocational Certificate)	
Education	First visit & annually	1c. Are you concerned about your child's learning, performance, or behavior in school?	YES NO Not applicable	+1 for YES	
Employment	First visit & biannually	2. Choose one of the following. Which best describes your current occupation?	Homemaker, not working outside the home Employed (or self-employed) full time Employed (or self-employed) part time Employed, but on leave	+1 for: "Employed, but on leave for health reasons"; "Unemployed"; OR	

PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Paper Version of PRAPARE® for Implementation as of September 2, 2016

Personal Characteristics

1. Are you Hispanic or Latino?

☐ Yes	☐ No	☐ I choose not to answer this question

2. Which race(s) are you? Check all that apply

☐ Asian	☐ Native Hawaiian
☐ Pacific Islander	☐ Black/African American
☐ White	☐ American Indian/Alaskan Native
☐ Other (please write):	
☐ I choose not to answer this question	

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

☐ Yes	☐ No	☐ I choose not to answer this question

4. Have you been discharged from the armed forces of the United States?

☐ Yes	☐ No	☐ I choose not to answer this question

5. What language are you most comfortable speaking?

8. Are you worried about losing your housing?

☐ Yes	☐ No	☐ I choose not to answer this question

9. What address do you live at?
Street: _____
City, State, Zip code: _____

Money & Resources

10. What is the highest level of school that you have finished?

☐ Less than high school degree	☐ High school diploma or GED
☐ More than high school	☐ I choose not to answer this question

11. What is your current work situation?

☐ Unemployed	☐ Part-time or temporary work	☐ Full-time work
☐ Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:		
☐ I choose not to answer this question		

12. What is your main insurance?

AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

Social Needs Screening Tool

HOUSING

1. Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household?[1]
   - ☐ Yes
   - ☐ No

2. Think about the place you live. Do you have problems with any of the following? (check all that apply)[2]
   - ☐ Bug infestation
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Inadequate heat
   - ☐ Oven or stove not working
   - ☐ No or not working smoke detectors
   - ☐ Water leaks
   - ☐ None of the above

FOOD

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.[3]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

CHILD CARE

7. Do problems getting child care make it difficult for you to work or study?[5]
   - ☐ Yes
   - ☐ No

EMPLOYMENT

8. Do you have a job?[6]
   - ☐ Yes
   - ☐ No

EDUCATION

9. Do you have a high school degree?[6]
   - ☐ Yes
   - ☐ No

FINANCES

10. How often does this describe you? I don't have enough money to pay my bills:[7]
    - ☐ Never
    - ☐ Rarely
    - ☐ Sometimes
    - ☐ Often
    - ☐ Always

NOTE: Hospitals may use any self-reported screening tool but it's recommended not required to use as many questions as possible from the CMS AHC Health-Related Social Needs Screening Tool.

Reporting on Health Equity Data Collection

- You must **report these measures once annually using the web-based data collection tool within the HQR (Hospital Quality Reporting) system** online (Ex. similar to submission as the Maternal Morbidity structural measure).

- CMS has not officially released the submission deadline but in the final rule they said it would follow the same submission schedule as the other structural measures. In the case of the Maternal Morbidity structural measure, you collect the data during the calendar year and submit it by May 15 of the following year. It is likely to work like this.

- **Potential Reporting Period:**
  - *Voluntary reporting*
    - Collection period: January 1, 2023 – December 31, 2023
    - Submission deadline: May 15, 2024
  - *Mandatory reporting*
    - Collection period: January 1, 2024 – December 31, 2024
    - Submission deadline: May 15, 2025

Source: Link

Z-Code Billing for 5 CMS SDOH Categories

American Hospital Association™
Advancing Health in America

Table 1
ICD-10-CM Code Categories

ICD-10-CM Code Category	Problems/Risk Factors Included in Category
Z55 – Problems related to education and literacy	Illiteracy, schooling unavailable, underachievement in a school, less than a high school diploma, no general equivalence degree (GED), educational maladjustment, and discord with teachers and classmates.
Z58 – Problems related to physical environment	Inadequate drinking-water supply, and lack of safe drinking water.
Z59 – Problems related to housing and economic circumstances	Sheltered homelessness, unsheltered homelessness, residing in street, inadequate housing, housing instability, discord with neighbors, lodgers and landlord, problems related to living in residential institutions, inadequate food, lack of adequate food, food insecurity, extreme poverty, low income, and insufficient social insurance and welfare support.

Source: Link

Data Analysis and Stratification by Hospital Quality Measures

CMS HCHE *Mandatory CY23*	**MUC 2021-106** **Domain 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. **Domain 1B** 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.
TJC *Mandatory 1/1/24*	**Standard LD.04.03.08** Reducing healthcare disparities for the [organization's] [patients] is a quality and safety priority. **EP 3** The [organization] identifies healthcare disparities in its [patient] population by stratifying quality and safety data using the sociodemographic characteristics of the [organization's] [patients].

HOW TO: CMS Requirements for Data Stratification by Quality Measure

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. CMS has not yet finalized standards for data collection so hospitals should attest if they are collecting these data in any way.

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.

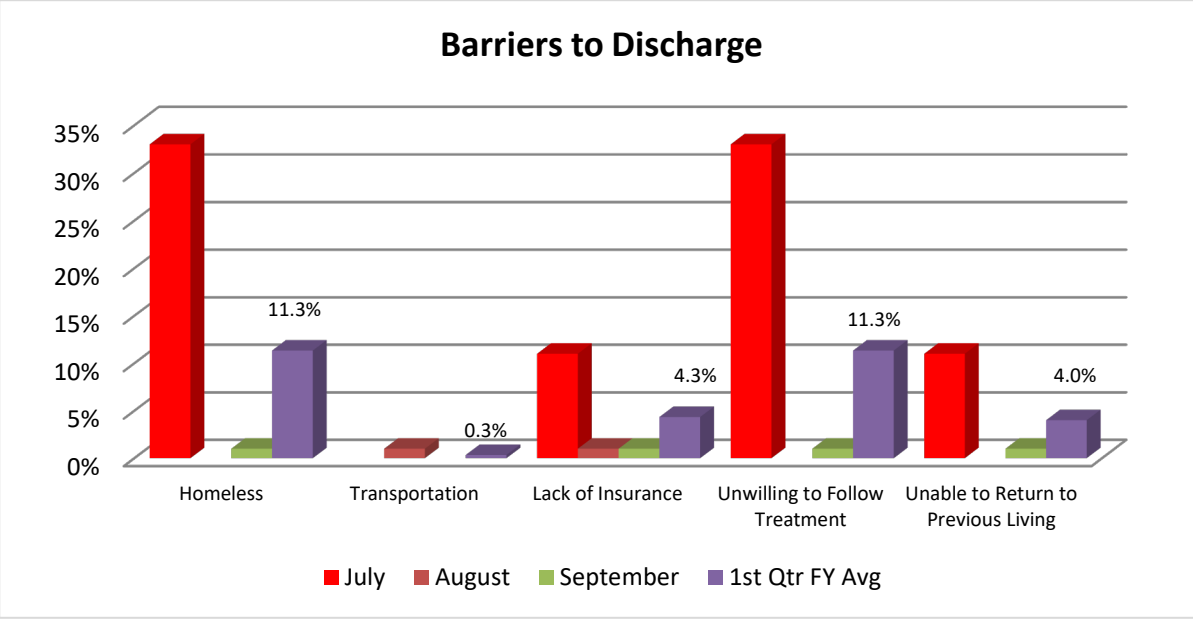
The purpose of measure stratification is to understand if certain patient groups are receiving better care. Stratification in this case refers to examining quality measure results by subgroups of patients to identify important gaps in quality between patient groups.

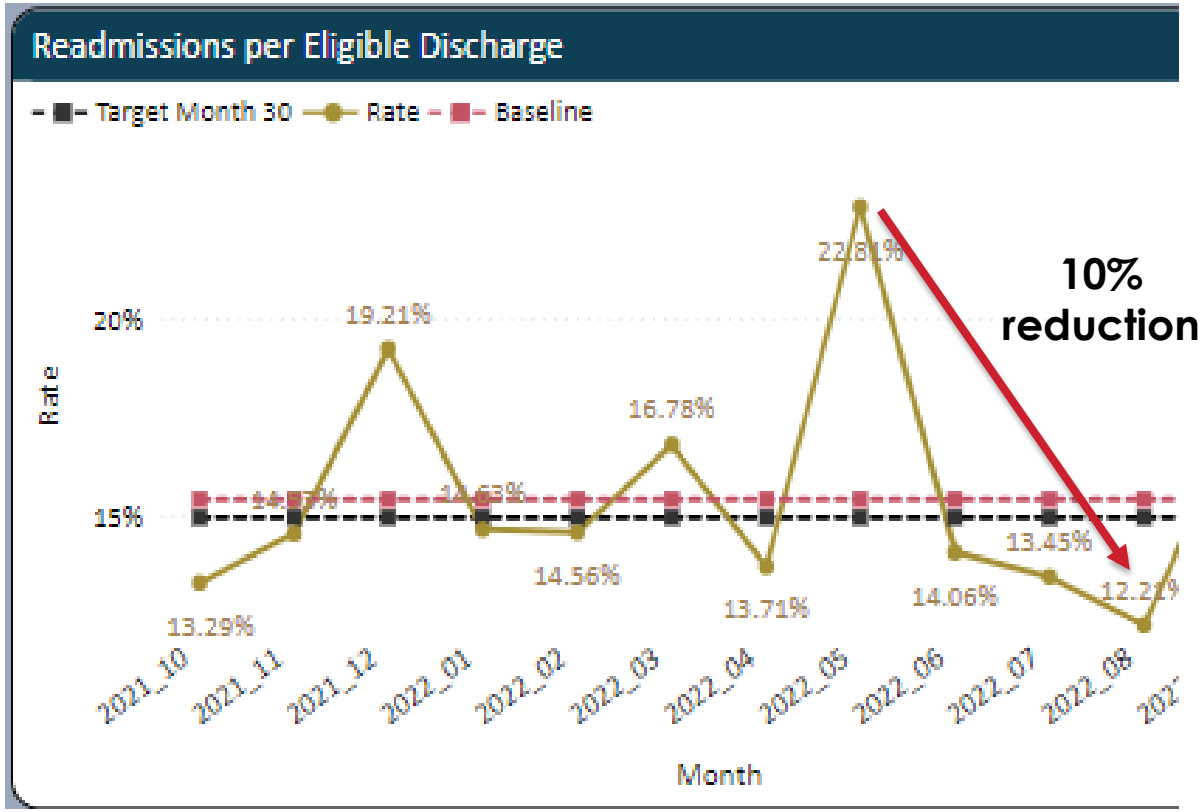
Hospitals may develop stratification metrics for priority populations (as defined by your organization e.g., by race and ethnicity, economic burden, etc.) and monitor results on these metrics using existing internal quality dashboards.

CMS expects hospitals to identify equity gaps by displaying 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.

CMS has released a full attestation document which includes a breakdown on each of the domains required to fulfill the hospital commitment to health equity. This screenshot includes details on how to stratify REaL and SDOH data by quality measure. (Source: CMS)

HOW TO: Baptist Medical Center South Case Study - Tracking SDOH in 30-Day Readmissions





BMCS participated in our Fall '22 HQIC readmission cohort and they were early adopters of embedding SDOH questions into their admissions/readmissions process. Over a 90-day window, they identified their top SDOH barrier for 30-day readmission patients was homelessness and they developed community partnerships to reduce that rate by 10%.

HOW TO: Baptist Medical Center South Case Study - Interventions for Addressing Homelessness in 30-Day Readmissions

Primary Interventions ***(in the hospital setting)***	1. Initiate Charity Care applications where available. 2. Develop follow up plan for medical care (primary and specialty). 3. Look to shelters/group homes for basic needs (housing, food, etc.). 4. Offer a short-term placement option for those able to afford low-cost extended stay motels. 5. Connect patient with housing authority, sober living options, utilize local church organizations, VA resources if appropriate, etc. 6. Schedule possible psych consult. Reissue meds if needed.
Secondary Interventions ***(in the community setting)***	1. Review social support network and current involvement. 2. Ensure DC meds are filled before discharge (up to 90 days). 3. If no form of contact for patient is provided, locate the CCM office number to schedule weekly calls and/or as needed. 4. Conduct reminder calls before follow-up appointments. 5. Offer transportation assistance to follow-up appts if needed. 6. Enroll in Medicaid/Insurance specific CCM program for after 30-day period.

Interventions for Patients with SDOH Needs and Health Disparities

CMS HCHE	**MUC 2021-106** **Domain 4A** Our hospital participates in local, regional, or national quality improvement activities focused on reducing health disparities.
CMS HCHE	**MUC 2021-106 Domain 1D** Our hospital strategic plan describes our approach for engaging key stakeholders, such as community-based organizations.
TJC	**Standard LD.04.03.08** Reducing healthcare disparities for the [organization's] [patients] is a quality and safety priority. **EP 2** The [organization] assesses the [patient's] health-related social needs and provides information about community resources and support services.

HOW TO: CMS Requirements for Quality Improvement Activities

Domain 4: Health disparities are evidence that high quality care has not been delivered equally[1] to all patients. Engagement in quality improvement activities can improve quality of care for all patients.

Domain 4 has only one sub-domain (4a) which is defined further in Text Box 4.

Text Box 4: Guidance for Attesting to Domain 4 Quality Improvement

4A. Our hospital participates in local, regional, or national quality improvement activities focused on reducing health disparities.

Quality improvement (QI) activities may include participation in collaboratives, partnerships and coalitions focused on decreasing health disparities, including among specific patient populations or for specific medical conditions – e.g., working with Medicare Quality Improvement Networks, or joining collaboratives such as The Health Equity Collaborative; Eastern U.S. Quality Improvement Collaborative; The Alliance for Innovation on Maternal Health (AIM) or Perinatal Quality Collaboratives (PQCs); American Hospital Association Center for Health Innovations' Hospital Community Collaborative; Million Hearts; or other local, regional, and national initiatives as long as the effort has a specific focus on improving quality and reducing disparities.

CMS has released a full attestation document which includes a breakdown on each of the domains required to fulfill the hospital commitment to health equity. This screenshot includes details on how to engage in quality improvement activities to reduce health disparities. (Source: CMS)

A Culture of Health Equity: Key Clinical-Community Partnerships

Example Clinical Partners

- Facilities (i.e., hospitals, nursing homes)
- Critical Service Areas (i.e., ED)
- Individual Clinicians and Critical Service Areas (i.e., ED, Case Management Team)
- Dialysis Centers
- Behavioral Health Clinics
- Social Services
- Pharmacies
- EMS

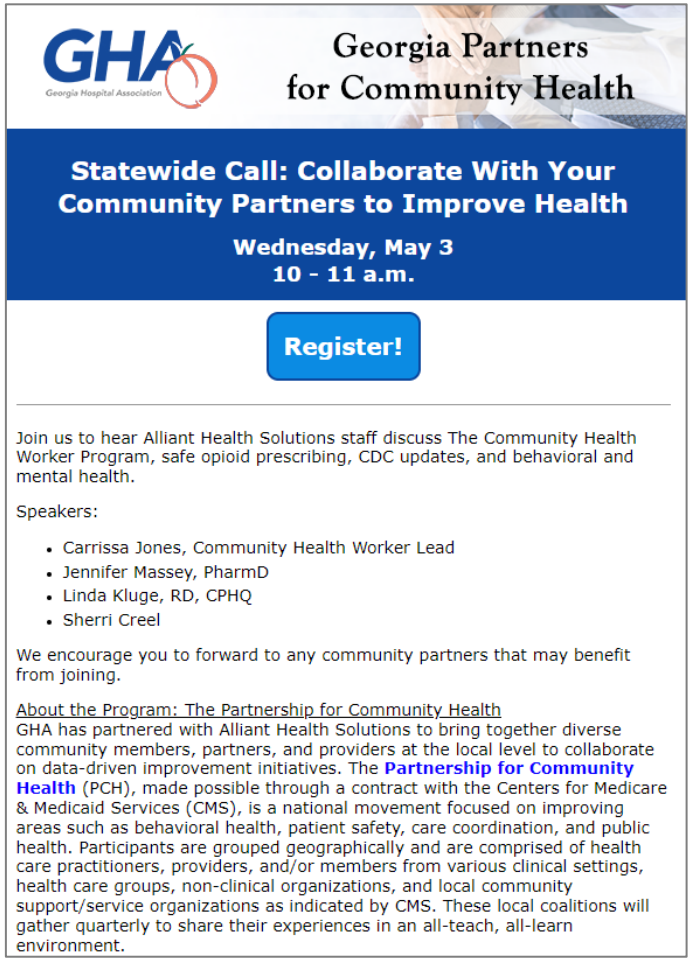
Example Community Partners

- United Way
- Area Agency On Aging
- Area Medicaid Reps
- Faith-Based Organizations
- Local Business (i.e., Barbershops, Grocery Stores)
- Local Employee Retiree Organizations
- Local Senior Centers
- Local Political Organizations
- Local Power Company
- Community Health Workers
- Local Transportation Agencies
- Housing Agencies
- Food Pantries/Shelters
- Literacy Volunteers
- Police and Fire Depts.
- Veterans Association
- Universities/Research Centers

Ways to Engage with Community Coalitions/PCHs

- Attend PCH meeting to learn what community outreach is going on in your region or state
- Engage with affinity or work groups – share best practices
- Use coaching calls to get questions answered
- Attend regional and statewide community coalition meetings
- State contacts:

LA: Carla Schuler	Carla.schuler@allianthealth.org
TN: Julie Clark	julie.clark@allianthealth.org
GA: Mel Brown	melody.brown@allianthealth.org
NC: Marilee Johnson	Marilee.johnson@allianthealth.org
FL: Renee DelMonico	renee.delmonico@allianthealth.org
KY: Leighann Sauls	Leighann.sauls@allianthealth.org
AL: Beth Greene	beth.greene@allianthealth.org



GHA Georgia Hospital Association

Georgia Partners for Community Health

Statewide Call: Collaborate With Your Community Partners to Improve Health

Wednesday, May 3
10 - 11 a.m.

Register!

Join us to hear Alliant Health Solutions staff discuss The Community Health Worker Program, safe opioid prescribing, CDC updates, and behavioral and mental health.

Speakers:

- Carrissa Jones, Community Health Worker Lead
- Jennifer Massey, PharmD
- Linda Kluge, RD, CPHQ
- Sherri Creel

We encourage you to forward to any community partners that may benefit from joining.

About the Program: The Partnership for Community Health
GHA has partnered with Alliant Health Solutions to bring together diverse community members, partners, and providers at the local level to collaborate on data-driven improvement initiatives. The **Partnership for Community Health** (PCH), made possible through a contract with the Centers for Medicare & Medicaid Services (CMS), is a national movement focused on improving areas such as behavioral health, patient safety, care coordination, and public health. Participants are grouped geographically and are comprised of health care practitioners, providers, and/or members from various clinical settings, health care groups, non-clinical organizations, and local community support/service organizations as indicated by CMS. These local coalitions will gather quarterly to share their experiences in an all-teach, all-learn environment.

HOW TO: SDOH Action Plan Template for Care Team Members

AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

Social Needs Patient Action Plan

Name: _____ Date of Birth: _____ Date: _____

Social Needs Resources and Actions

☐ Housing | Resource and/or action:

☐ Food | Resource and/or action:

☐ Transportation | Resource and/or action:

☐ Utilities | Resource and/or action:

This resource is a patient-level fillable template on resources and actions being taken to address a patient's SDOH needs. (Source: AAFP)

Culturally and Linguistically Appropriate Services (CLAS) Standards

TJC

PC.02.01.21

The hospital effectively communicates with patients when providing care, treatment, and services.

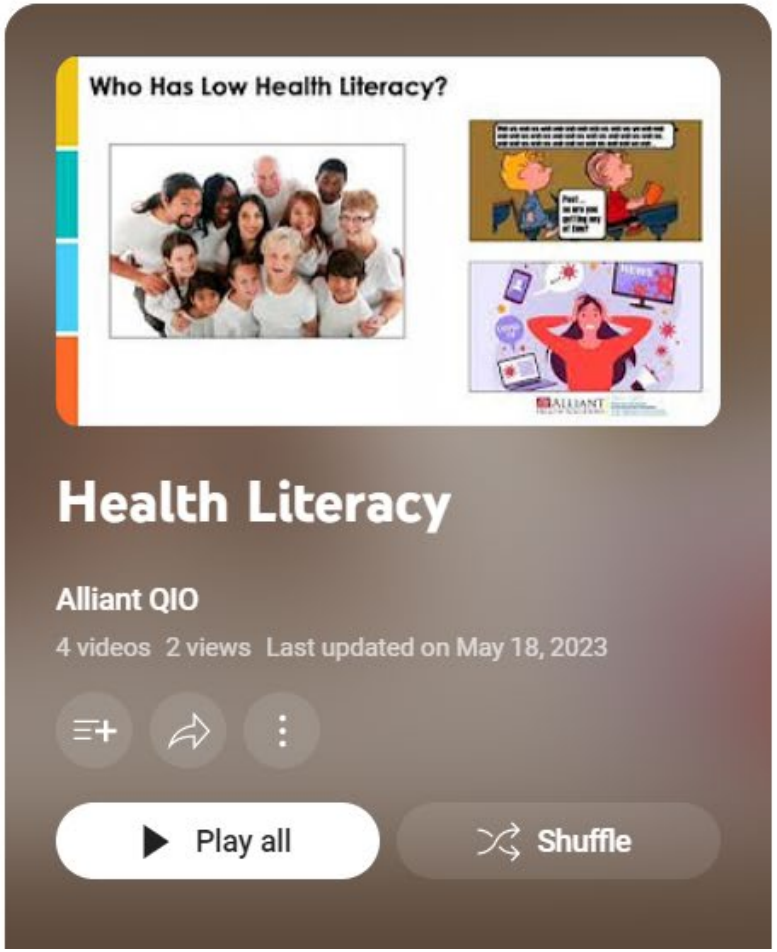
EP 1

The hospital identifies the patient's oral and written communication needs, including the patient's preferred language for discussing healthcare.

EP 2

The hospital communicates with the patient during the provision of care, treatment, and services in a manner that meets the patient's oral and written communication needs.

HOW TO: Train Staff on CLAS Standards (*Alliant CLAS Videos*)



1 

Health Literacy with Dr. Iris Feinberg, PhD, CHES

Alliant QIO • 116 views • 3 months ago

2 

Bite-Sized Learning: Using Teach-Back

Alliant QIO • 26 views • 8 days ago

3 

Bite-Sized Learning: CLAS 101

Alliant QIO • 37 views • 1 month ago

4 

Bite-Sized Learning: CLAS Implementation

Alliant QIO • 38 views • 1 month ago

Source: Link

Resource Links to Download for Full CMS Guidance on Health Equity

File Name	File Type	File Size	
Attestation Guidance for the Hospital Commitment to Health Equity Measure (12/2022)	PDF	481 KB	Download
Hospital Commitment to Health Equity Structural Measure Specifications (12/2022)	PDF	251 KB	Download
Screening for Social Drivers of Health Measure and the Screen Positive Rate for Social Drivers of Health Measure (December 2022)	PDF	122 KB	Download
Frequently Asked Questions: Social Drivers of Health (SDOH) Measures	PDF	281 KB	Download

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

Alliant Health Solutions Health Equity Coaching Package

HEALTH EQUITY COACHING PACKAGE

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

Category	Best Practices/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)
	Become familiar with federal and private sector definitions, standards and requirements for hospital health equity	CMS New SDOH Standards - Remington Report
		NPSG.16.01.01 Improving health care equity for the hospital's patients is a quality and safety priority
		CMS Health Equity Fact Sheet
		CMS Health Equity Programs
		CMS Framework for Health Equity 2022 - 2032
		The Joint Commission Health Equity R3 Report
	Conduct an equity of care gap analysis	Health Equity Organizational Assessment (MHA)
	Review resources on best practices for effective hospital health equity implementation	A Practical Guide for Implementing Hospital Health Equity - AHS HQIC LAN
		AHS Health Equity Presentation to Alabama Hospital Association
		Change Path of Health Equity Resources (Feb 28, 2023)
		Building an Organizational Response to Health Disparities (CMS, 2020)* *Contains links to other resources

https://quality.allianthealth.org/wp-content/uploads/2023/04/2023-Coaching-Package-Health-Equity_508.pdf

Educational Events

- **Learning and Action (LAN) Events**
- Moving to Zoom platform
- Jun 27 Reengineering Fall and Fall Injury Programs
- Jul 25 Reenergizing Patient and Family Advisory Councils (PFACs)
- Aug through Oct Antibiotic Stewardship Series

Community of Practice (CoP) Calls

- Monthly webinars hosted by Centers for Medicare & Medicaid Services (CMS) to share successes, strategies and best practices across the learning community
- Calls held on the second Thursday of every month from 1-2 p.m. ET
- Please direct any questions to dvacsupport@bizzellus.com

All events available on the Alliant HQIC website
https://quality.allianthealth.org/topic/hospital-quality-improvement/

Infection Prevention

Office Hours – IP Chats

- IP Chats are quarterly networking events to build knowledge, share experience and provide support for hospital infection preventionists
- Hosted by Amy Ward, MS, BSN, RN, CIC, FAPIC
- July 26 from 2-2:30 p.m. ET
- October 25 from 2-2:30 p.m. ET
- Registration link:
  - **https://bit.ly/HQIC_IPChats**

- Check out the Apr 26 slides for COVID 19 hospital data reporting updates

https://quality.allianthealth.org/wp-content/uploads/2022/12/HQIC-Office-Hours-IP-Chats-April-2023_FINAL_508.pdf

- COVID-19 Hospital Data Guidance Update – Office Hours Session
Thursday, June 15, 2023, from 2-3 pm ET
Register: https://cdc.zoomgov.com/webinar/register/WN_2CnKZ7bnTE-wTAeRmOpm_g

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

Rosa Abraha, MPH
Health Equity Lead

Melody Brown, MSM
Care Transitions/Readmissions

Updated coaching packages posted on Alliant website

Updated Resources on Alliant HQIC Website

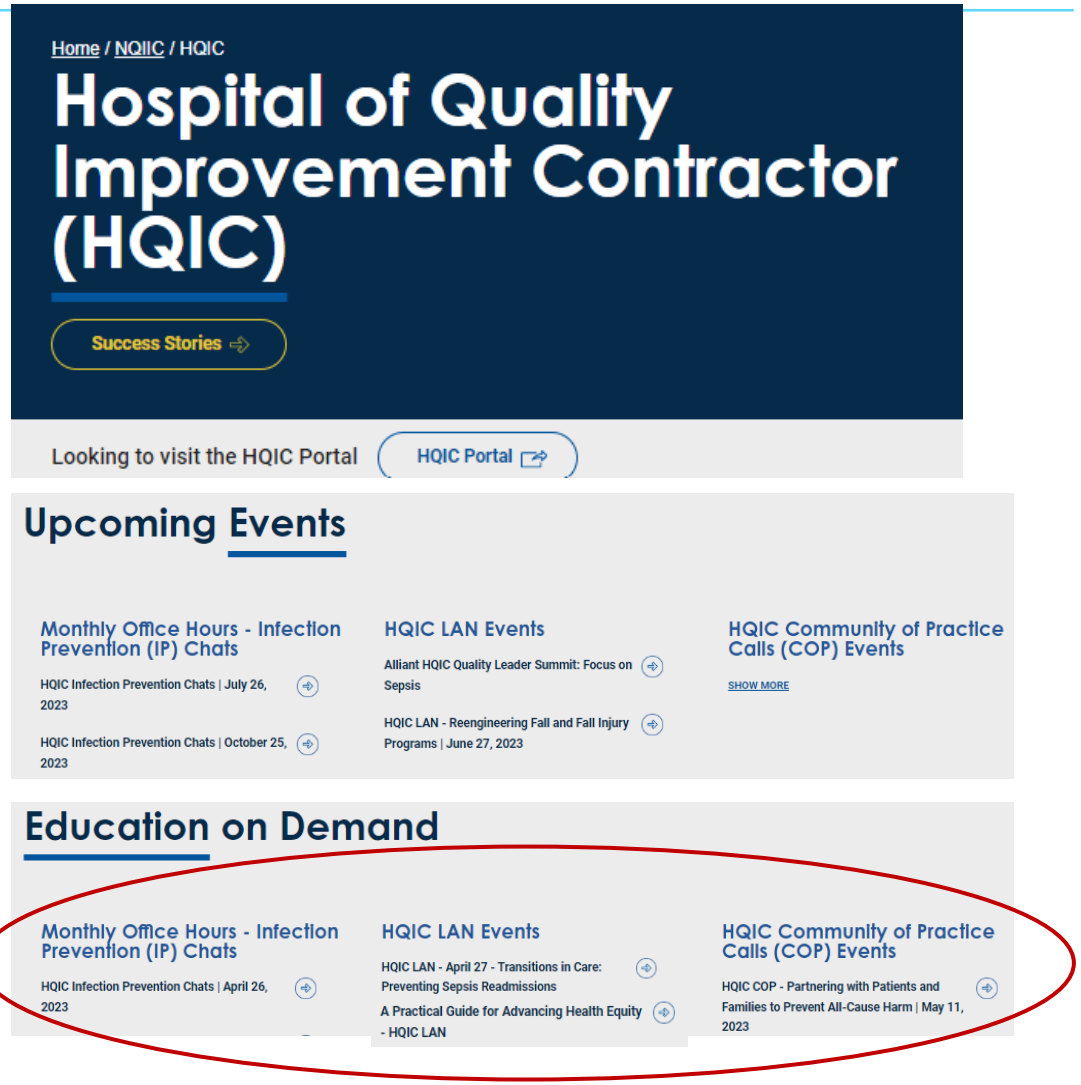
- Coaching Packages – A total of 13 patient safety topics, readmissions, patient and family engagement (PFE) and health equity
- Added health equity interventions to all coaching packages where relevant

Health Equity NPSG #16	Assess health-related social needs and provide community resource information	NPSG.16.01.01 Improving health care equity for the hospital's patients is a quality and safety priority
Health Equity NPSG #16	Identify disparities by stratifying data using sociodemographic characteristics	NPSG.16.01.01 Improving health care equity for the hospital's patients is a quality and safety priority
Health Equity Alliant Data	Review Alliant health disparities data by race and ethnicity.	Check Power BI data
Health Equity Alliant Data	Review Alliant health disparities data by dual eligibility.	Planning for June; Check Power BI data

1. ADE Anticoagulants
2. ADE Hypoglycemics
3. ADE Opioids
4. Antibiotic Stewardship
5. CAUTI
6. CLABSI
7. C diff
8. MRSA
9. Pressure Injuries
10. Readmissions
11. Sepsis
12. Patient and Family Engagement
13. Health Equity

Updated Resources on Alliant HQIC Website

- HQIC LAN Events
  - –Upcoming
  - –On-Demand
    - Choose a topic under On-Demand Education for slides, recordings, and change path
- Archived newsletters - News, educational events, expert insights, resources
  - ✓To receive monthly newsletter, give name, title and email address to your assigned QI Adviser
- Success stories from enrolled hospitals



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 the HQIC quality advisor to share your email address to gain access
- Available Information
    1. Assessment Data
    2. Measurement Data*
    3. Summary Performance Data*
    4. Discussions

    *Same data that quality advisor sees in Power BI

Questions?

- Type questions in Chat and send to everyone
- Email us at hospitalquality@allianthealth.org
- Call us at 678-527-3681

Wrap Up/Adjourn

- Complete the post-event poll
- Connect in spring 2024 for a Quality Leader Summit
- One-hour virtual call
- Add hot topics to post-event evaluation
- Today's slides are posted in Chat

Thank you for your participation!

Upcoming Events

June 27, 2023, 2 - 3 p.m. ET

Enhancing Capacity - Reengineering Fall and Fall Injury Programs: Infrastructure, Capacity and Sustainability

Patricia A. Quigley, PhD, APRN, CRRN, FAAN, FAANP, FARN

Event registration and information:

https://quality.allianthealth.org/conference/hqic-lan-reengineering-fall-and-fall-injury-programs-june-27-2023/

July 25, 2023, 1 p.m. ET

Reenergizing Patient and Family Advisory Councils (PFACs)

Wills Memorial Hospital (GA)

Event registration forthcoming:

https://quality.allianthealth.org/nqiic/hqic/

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

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Thank you for joining us!

Alliant Health Solutions

AlliantQIO

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