Quality Improvement Initiative Sample PDSA Health Equity Interventions
CATEGORY 4 - MEASURES 4.3 AND 4.5

PCH and Champion: _____ **Date:** _____

Target Measure: Promoting HE across one or more selected Category 4 measures

Team Members: Interdisciplinary team of clinical and LINK members partnering together within a PCH; some measures are catered to physician offices as well

Plan/Goal Setting: Describe the Problem to be Solved	
State the problem. ex. who, what when, where, and how long	PCH efforts do not have a foundation to support health equity. An infrastructure needs to be developed to advance health equity standards and best practices in the populations we serve.
Category 4: Care Coordination	Measures 4.3 and 4.5
What exactly will be done? e.g., initial intervention(s), expected outcome for each intervention, goal(s), and expected overall outcome goal rate in a percentage format	**What will be done:** 1. Clinical facilities in the PCH will form a health equity champion and team to review the following document to select at least 1 specific health equity intervention to work on in the below Category 4 measures. 2. Depending on which health equity intervention facilities select, they will either work on promoting health literacy OR developing a partnership with a LINK in their PCH or existing network to address the social determinant of health (i.e., homelessness or transportation) noted in the action step. 3. Implementation topics and updates should be tracked on a on a monthly basis concerning progress on achieving action steps and overall improvement in the key health equity indicators for that PCH measure. **Expected outcome:** The key to this project is to promote a model for community and clinical engagement that supports health equity partnership and addresses the social determinants of health (SDOH) across Category 4 measures. This work exists to ensure that beneficiaries with the greatest need have access to services to align with the CMS, HHS and White House priorities on health disparities reduction.

Measure 4.3: Decrease Medicare beneficiary ED visits (targeting super utilizers) at short-term hospitals, critical access hospitals and inpatient psychiatric facilities (including psychiatric hospital and psychiatric units), by 12%				
DO: Intervention/Improvements:			**STUDY Results**	**Act**
Action Step	**Start Date/ End Date**	**Person Responsible**	**Analysis of Results**	**Outcome and Decisions**
OPTION #1: SDOH INTERVENTION ON HOMELESSNESS Health equity champion and leadership will identify and meet with community leaders who address homelessness for patients 1.) to better understand the needs of the community they serve and 2.) to identify what housing resources are available for patients in need. *Example LINKS/community organizations include local shelters.*		Health equity champion, DON, ADON Administrator, or physician office leader/ staff and homeless LINK/ community organizations	Team will work with the community entities to compile a list of housing options for homeless patients who need it upon discharge. Team connected patients with housing authority, sober living options, utilize local church organizations, VA resources if appropriate, etc. and offered short-term placement options for those able to afford low-cost extended stay motels.	Outcome: Discharge planners have an updated resource/referral list to adequately address homeless challenges for patient's post-discharge. ☑ Adopt ☐ Adapt ☐ Abandon ☐ N/A
OPTION #2: SDOH INTERVENTION ON HEALTH LITERACY Address gaps by providing resources for super utilizer patients. *Below are good resources to share:* *Care Transitions Super Utilizer Patients Bite-Sized Learning* *Impact Super-Utilizer – Patients* *Post-Discharge Text Messaging Works* *Our Family Our Way Free Resources* *Hospital Decision Guide: Go to the Hospital or Stay Home*		Health equity champion and team; DON; clinical case managers; social workers; ED team; psych unit team; front desk staff	Resources shared and discussed in a staff meeting and adapted into patient discharge process. Provided resources in multiple languages where possible (Spanish resources available on AHS site). Use of language interpretation services	Outcome: Resources are adopted and rolled out to all discharge planners for full use. ☐ Adopt ☐ Adapt ☐ Abandon ☐ N/A

OPTION #3: SDOH INTERVENTION ON TRANSPORTATION Health equity champion and leadership will identify and meet with community leaders who offer resources to increase support for transportation to primary care and other referral services *Example LINKS/community organizations include State Area Medicaid Reps, non-emergency medical transport, United Way 211, churches with vans, etc.*		Health equity champion and team and transportation LINKS/ community organizations	Team will work with the community entities to compile a list of low-cost or no cost transportation/ van services for use when a patient has a transportation issue.	Outcome: Discharge planners have an updated resource/referral list to adequately address transportation challenges for patient's post-discharge. ☐ Adopt ☐ Adapt ☐ Abandon ☐ N/A

Measure 4.5: Decrease the total number of hospital readmissions within 30-days for Medicare beneficiaries, by 5%

DO: Intervention/Improvements:			STUDY Results	Act
Action Step	**Start Date/End Date**	**Person Responsible**	**Analysis of Results**	**Outcome and Decisions**
OPTION #1: SDOH INTERVENTION ON HOMELESSNESS Health equity champion and leadership will identify and meet with community leaders who address homelessness for patients 1.) to better understand the needs of the community they serve and 2.) to identify what housing resources are available for patients in need. *Example LINKS/community organizations include local shelters.*		Health equity champion, DON, ADON Administrator, or physician office leader/staff and homeless LINK/ community organizations	Team will work with the community entities to compile a list of housing options for homeless patients who need it upon discharge. Team connected patients with housing authority, sober living options, utilize local church organizations, VA resources if appropriate, etc. and offered short-term placement options for those able to afford low-cost extended stay motels.	Outcome: Discharge planners have an updated resource/referral list to adequately address homeless challenges for patient's post-discharge. ☐ Adopt ☐ Adapt ☐ Abandon ☐ N/A
OPTION #2: SDOH INTERVENTION ON HEALTH LITERACY Address gaps by providing resources on reducing SDOH related readmissions. *Below are good resources to share:* *SNF Rehospitalization Risk Assessment Tool w/ SDOH Questions* *Post-Discharge Text Messaging Works* *Our Family Our Way Free Resources* *Utah CAH Focuses on SDOH Assessment to Reduce Readmissions*		Health equity champion and team; DON; clinical case managers; social workers; ED team; psych unit team; front desk staff		Outcome: Resources are adopted and rolled out to all discharge planners for full use. ☐ Adopt ☐ Adapt ☐ Abandon ☐ N/A

OPTION #3: SDOH INTERVENTION ON TRANSPORTATION Health equity champion and leadership will identify and meet with community leaders who offer resources to increase support for transportation to primary care and other referral services. *Example LINKS/community organizations include State Area Medicaid Reps, non-emergency medical transport, United Way 211, churches with vans, etc.*		Health equity champion and team and transportation LINKS/ community organizations		Outcome: Discharge planners have an updated resource/referral list to adequately address transportation challenges for patient's post-discharge. ☐ Adopt ☐ Adapt ☐ Abandon ☐ N/A

Communication/Notes:

This material was prepared by Alliant Health Solutions, a Quality Innovation Network–Quality Improvement Organization (QIN–QIO) 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. 12SOW-AHS-QIN-QIO-TO1-PCH-4658-10/09/23