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Hospital Quality Workshop

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St. Charles Medical Center | Bend, OR

Leverage Your Data: A Closer Look into the Community Health Needs Assessment and MBQIP Through the Lens of Health Equity and Social Drivers of Health

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Leverage Your Data: A Closer Look into the Community Health Needs Assessment and MBQIP Through the Lens of Health Equity and Social Drivers of Health

Objectives

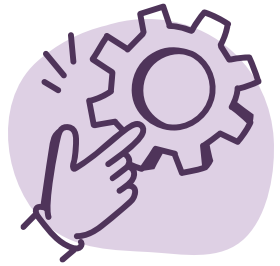
- Review the 2025 Medicare Beneficiary Quality Improvement Program (MBQIP) Core Measure Set
- Identify how the Community Health Needs Assessment (CHNA) and MBQIP equity focus align
- Learn data resources available to you, both nationally and locally

Role of Rural Quality Improvement Technical Assistance Center (RQITA)

RQITA RESOURCE CENTER

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

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



Resources and Services

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

The RQITA Team

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2025 MBQIP Measure Core Set

MBQIP Implementation Timeline for State Flex Programs for the 2025 MBQIP Core Measure Set

- Moving from four domains to five domains
- Align with existing quality reporting programs
- MBQIP 2025 reporting begins September 2025

2025 MBQIP Core Measure Set

- Six new measures (noted in blue)
- 12 total measures (nine submitted annually, three submitted quarterly)

2025 MBQIP Core Measure Set				
Global Measures	**Patient Safety**	**Patient Experience**	**Care Coordination**	**Emergency Department**
• CAH Quality Infrastructure *(annual submission)* • Hospital Commitment to Health Equity *(annual submission)*	• Healthcare Personnel Influenza Immunization *(annual submission)* • Antibiotic Stewardship *(annual submission)* • Safe Use of Opioids (eCQM) *(annual submission)*	• Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS) *(quarterly submission)*	• Hybrid Hospital-Wide Readmissions *(annual submission)* • SDOH Screening *(annual submission)* • SDOH Screening Positive *(annual submission)*	• Emergency Department Transfer Communication (EDTC) *(quarterly submission)* • OP-18 Time from Arrival to Departure *(quarterly submission)* • OP-22 Left Without Being Seen *(annual submission)*

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CAH Quality Infrastructure

Global Measures Domain

CAH Quality Infrastructure

Measure Description: Specifications for CAH Quality Infrastructure Measure will be released in 2024 and are dependent on data collection via the **National CAH Quality Inventory and Assessment.**

Structural measure to assess CAH quality infrastructure based on the nine core elements of CAH quality infrastructure:

1. Leadership Responsibility & Accountability
2. Quality Embedded within the Organization's Strategic Plan
3. Workforce Engagement & Ownership
4. Culture of Continuous Improvement through Behavior
5. Culture of Continuous Improvement through Systems
6. Integrating Equity into Quality Practices
7. Engagement of Patients, Partners and Community
8. Collecting Meaningful and Accurate Data
9. Using Data to Improve Quality

CAH Quality Infrastructure

Measure Rationale: This measure will provide hospital, state, and national comparisons about the quality infrastructure in CAHs. It will help identify areas for improvement for each facility and state. Using the data for this measure, SFPs can plan and prioritize quality activities and identify useful CAH quality-related information to help inform state-level technical assistance. The CAH Quality Infrastructure measure willl also inform national technical assistance and data analytic needs.

Specifications: Will be released in 2024 and are dependent on data collected via the National CAH Quality Inventory and Assessment

Calculations: Hospital score will be a total of zero to nine points (one point for each element, must meet each element's criteria to receive credit).

CAH Quality Infrastructure

Encounter Period: One year

First MBQIP Reporting Date: The first MBQIP submission deadline was December 2023. Future reporting date is annual each Fall.

Data Source: Information about the hospital's capacity, processes, and infrastructure related to quality

Data Collection Approach: Input from a variety of hospital teams and leaders

Measure Submission and Reporting Channel: Annual submission of the National CAH Quality Inventory and Assessment survey submitted via the FMT- administered Qualtrics platform.

Assessment Areas With a Focus on Health Equity

The organization uses standardized methods for improving processes	100.0%	97.9%
Leadership incorporates expectations for QI into job descriptions and department and committee charters	100.0%	94.3%
The organization has processes in place for continuous reporting and monitoring of QI data	100.0%	98.9%
Culture of Continuous Improvement Through Behavior (CQI Behavior)		
The organization monitors adherence to best practices such as evidence-based protocols/order sets in all areas	100.0%	99.4%
The organization intentionally develops strong peer relationships with internal and external partners including those at the local, state, and federal levels	100.0%	99.5%
Employees demonstrate initiative to achieve goals and strive for excellence	92.0%	84.9%
Managers and leaders regularly evaluate behaviors to ensure they align with organizational values	100.0%	99.1%
Integrating Equity into Quality Practices (Equity)		
Managers use collected data and other available resources to identify inequities	80.0%	59.7%
Leaders routinely assess quality interventions and processes to address identified inequities	36.0%	36.0%
Units and departments implement specific health equity projects to improve care and lessen inequities	40.0%	45.7%
Engagement of Patients, Partners, and Community (Pt Engagement)		
The organization collects feedback from patients/families beyond patient experience surveys	100.0%	84.7%
The organization collaborates with other care providers using closed-loop referrals processes to ensure quality of care	100.0%	96.9%
The organization uses a variety of mechanisms to share quality data with patients, families, and the community	88.0%	77.1%
Leaders synthesize and develop action plans in response to patient, family, and community feedback	84.0%	71.1%
Collecting Meaningful and Accurate Data (Collecting Data)		
The organization has a multidisciplinary process for identifying key quality metrics	92.0%	87.2%

CAH Quality Infrastructure Measure – National Results

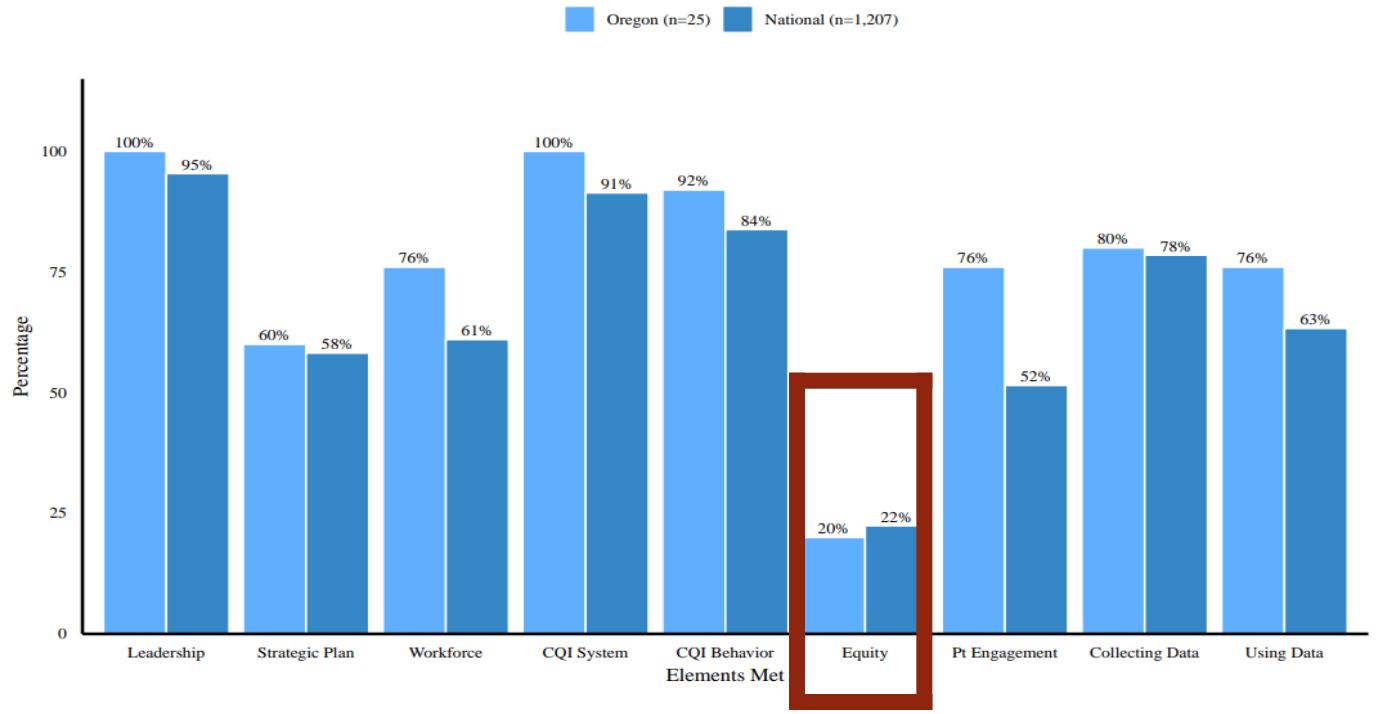

Table 4: Completion of CAH Quality Infrastructure Criteria

Infrastructure Element/Criteria	Oregon CAHs Reporting Completion of Criteria (n=25)	National CAHs Reporting Completion of Criteria (n=1,207)

Resources to Support You

- ****Specifications for CAH Quality Infrastructure Measure will be released in 2024****
- CAH Quality Infrastructure Summit Report
- More information about the Core Elements of Quality Infrastructure and the assessment can be found at:
  - Building Sustainable Capacity for Quality and Organizational Excellence | National Rural Health Resource Center
  - MBQIP 2025 Information Guide

Safe Use of Opioids – Concurrent Prescribing

Patient Safety Domain

Safe Use of Opioids – Concurrent Prescribing

Measure Description: Proportion of inpatient hospitalizations for patients 18 years or older, prescribed or continued on two or more opioids, or an opioid and benzodiazepine concurrently at discharge.

Measure Rationale: Unintentional opioid overdose fatalities have become an epidemic and major public health concern in the United States. Concurrent prescriptions of opioids, or opioids and benzodiazepines, places patients at a greater risk of unintentional overdose due to increased risk of respiratory depression. Patients who have multiple opioid prescriptions have an increased risk for overdose, and rates of fatal overdose are ten times higher in patients who are co-dispensed opioid analgesics and benzodiazepines than opioids alone. A measure that calculates the proportion of patients with two or more opioids or opioids and benzodiazepines concurrently has the potential to reduce preventable mortality and reduce costs associated with adverse events related to opioids.

Improvement Noted As: Decrease in rate.

Safe Use of Opioids – Concurrent Prescribing

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

First MBQIP Encounter Period and Reporting Date: The First MBQIP encounter period (measurement period) is January 1, 2025, through December 31, 2025. The first MBQIP submission deadline date is February 27, 2026.

Data Source: Certified electronic health record technology (CEHRT).

eCQM Identifier: 506v6

Data Collection Approach: Electronic Extraction from EHRs via Quality Reporting Document Architecture (QRDA) Category I File.

Measure Submission and Reporting Channel: Annually, QRDA Category I File via Hospital Quality Reporting (HQR) platform.

Safe Use of Opioids – Concurrent Prescribing

Measure Population (determines the cases to abstract/submit): Inpatient hospitalizations (inpatient stay less than or equal to 120 days) that end during the measurement period, where the patient is 18 years of age and older at the start of the encounter and prescribed one or more new or continuing opioid or benzodiazepine at discharge.

Exclusions: Exclusions include patients with cancer that begin prior to or during the encounter or are receiving palliative or hospice care (including comfort measures, terminal care and dying care) during the encounter, patients discharged to another inpatient care facility and patients who expire during the inpatient stay.

Numerator: Inpatient hospitalizations where the patient is prescribed or continuing to take two or more opioids or an opioid and benzodiazepine at discharge.

Denominator: Inpatient hospitalizations (inpatient stay less than or equal to 120 days) that end during the measurement period, where the patient is 18 years of age and older at the start of the encounter and prescribed one or more new or continuing opioid or benzodiazepine at discharge.

Resources to Support You

- NQF: Quality Positioning System
- Safe Use of Opioids – Concurrent Prescribing | eCQI Resource Center
- eCQM 101
- Getting Started with eCQMs
- Quality Reporting Document Architecture (QRDA)
- Critical Access Hospital eCQM Resource List | National Rural Health Resource Center
- MBQIP 2025 Information Guide

Hybrid Hospital-Wide Readmissions (Hybrid HWR)

Care Coordination Domain

Hybrid Hospital-Wide Readmissions (Hybrid HWR)

Measure Description: Hospital-level, all-cause, risk-standardized readmission measure that focuses on unplanned readmissions 30 days of discharge from an acute hospitalization. The Hybrid HWR was developed to address complex and critical aspects of care that cannot be derived through claims data alone. The Hybrid HWR uses EHR data including clinical variables and linking elements for each patient.

What Does Hybrid Mean? Hybrid measures differ from the claims-only measures in that they **merge electronic health record (EHR) data elements with claims-data** to calculate the risk-standardized readmission rate. CMS will link elements from claims to the electronic medical record data clinical variables.

Hybrid Hospital-Wide Readmissions (Hybrid HWR)

Measure Rationale: Returning to the hospital for unplanned care disrupts patients' lives, increases risk of harmful events like healthcare-associated infections and results in higher costs absorbed by the healthcare system. High readmission rates of patients with clinically manageable conditions in primary care settings, such as diabetes and bronchial asthma, may identify quality of care problems in hospital settings. A measure of readmissions encourages hospitals to improve communication and care coordination to better engage patients and caregivers in discharge plans and, in turn, reduce avoidable readmissions and costs.

Hybrid Hospital-Wide Readmissions (Hybrid HWR)

Initial Population: All Medicare Fee-For-Service and Medicare Advantage encounters for patients 65 and older at the start of inpatient admission, who are discharged during the measurement period (length of stay < 365 days)

***Note:** All Medicare Fee-For-Service and Medicare Advantage meeting the above criteria should be included, regardless of whether Medicare Fee-For-Service/Medicare Advantage is the primary, secondary, or tertiary payer.*

Hybrid Hospital-Wide Readmissions (Hybrid HWR)

- **Numerator:** If a patient has more than one unplanned admission (for any reason) within 30 days after discharge from the index admission, only one is counted as a readmission. The measure looks for a dichotomous yes or no outcome of whether each admitted patient has an unplanned readmission within 30 days. However, if the first readmission after discharge is considered planned, any subsequent unplanned readmission is not counted as an outcome for that index admission because the unplanned readmission could be related to care provided during the intervening planned readmission rather than during the index admission
- **Denominator:** 1.Enrolled in Medicare FFS for the 12 months prior to the date of admission and during the index admission; 2. Aged 65 or over; 3. Discharged alive from a non-federal short-term acute care hospital; 4. Not transferred to another acute care facility
- **Exclusions:** The measure excludes index admissions for patients: 1. Admitted to Prospective Payment System (PPS)-exempt cancer hospitals; 2. Without at least 30 days post-discharge enrollment in Medicare FFS; 3. Discharged against medical advice (AMA); 4. Admitted for primary psychiatric diagnoses; 5. Admitted for rehabilitation; or 6. Admitted for medical treatment of cancer

Hybrid Hospital-Wide Readmissions (Hybrid HWR)

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Core Clinical Data Elements

- Heart Rate
- Systolic Blood Pressure
- Respiratory Rate
- Temperature
- Oxygen Saturation
- Weight
- Hematocrit
- White Blood Cell Count
- Potassium
- Sodium
- Bicarbonate
- Creatinine
- Glucose

(This will come from electronic medical record)

For each encounter, please also submit the following Linking Variable:

- CMS Certification Number
- Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI)
- Date of Birth
- Sex
- Inpatient Admission Date
- Discharge Date

(This will come from claims data)

Hybrid Hospital-Wide Readmissions (Hybrid HWR)

Encounter Period: First MBQIP encounter period is July 1, 2024, through June 30, 2025. The submission deadline is September 30, 2025.

Data Source: Chart extraction and administrative claims

Data Collection Approach: Hybrid – chart extraction of electronic clinical data and administrative claims data

Measure Submission and Reporting Channel: Annual Hospital Quality Reporting (HQR) via patient-level file in QRDA I format. CMS will calculate your score after submission

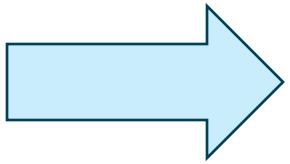
****Currently available for submission****

Steps to Successful Submission

1.) Collect/Extract the data

2.) Populate the core clinical data elements into a QRDA Category I file

3.) Submit the QRDA Category I file through the HQR system



4.) The data you submitted will be linked with administrative claims linking variables data to risk adjust the hybrid HWR outcome measure. This is done by CMS.

Resources to Support You

- Hybrid Hospital-Wide Readmission Measure Specification | eCQI Resource Center
- CMS Implementation Guide for QRDA 1 Implementation Guide for 2024 **(see chapter 6 for submission steps)**
- QualityNet Hybrid Methodology
- Hybrid Measure Overview
- MBQIP 2025 Information Guide

Any Questions So Far?

We've reviewed the following measures:

- CAH Quality Infrastructure
- Safe Use of Opioids – Concurrent Prescribing
- Hybrid Hospital Wide Readmissions Measure

Hospital Commitment to Health Equity

Global Measures Domain

Hospital Commitment to Health Equity

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

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

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

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

Hospital Commitment to Health Equity

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

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

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

Hospital Commitment to Health Equity

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

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

Data Source: Multiple sources.

Data Collection Approach: Attestation.

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

Let’s Take a Closer Look at the HCHE Domains

Hospital Commitment to Health Equity

Data Elements:

Domain 1 – Equity is a Strategic Priority –
Please attest that your hospital has a strategic plan for advancing healthcare equity and that it includes all the following elements (note: attestation of all elements is required to qualify for the numerator):

A. Our hospital strategic plan **identifies priority populations** who currently experience health disparities.
B. Our hospital strategic plan **identifies healthcare quality goals and discrete action steps** to achieve these goals.
C. Our hospital strategic plan **outlines specific resources** which have been dedicated to achieve our equity goals.
D. Our hospital strategic plan **describes our approach for engaging key stakeholders** such as community-based organizations.

Create A Written Plan to Address Healthcare Equity

Domain 1 – Equity is a Strategic Priority

Attest that your hospital has a strategic plan for advancing healthcare equity

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

Hospital Strategic Plan for Addressing Health Equity

A strategic plan provides

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

Key elements of a Strategic Plan

- Mission and Vision
- Data Analysis
- Setting Goals and Objectives
- Engaging a wide variety of stakeholders

Hospital Commitment to Health Equity

Data Elements:

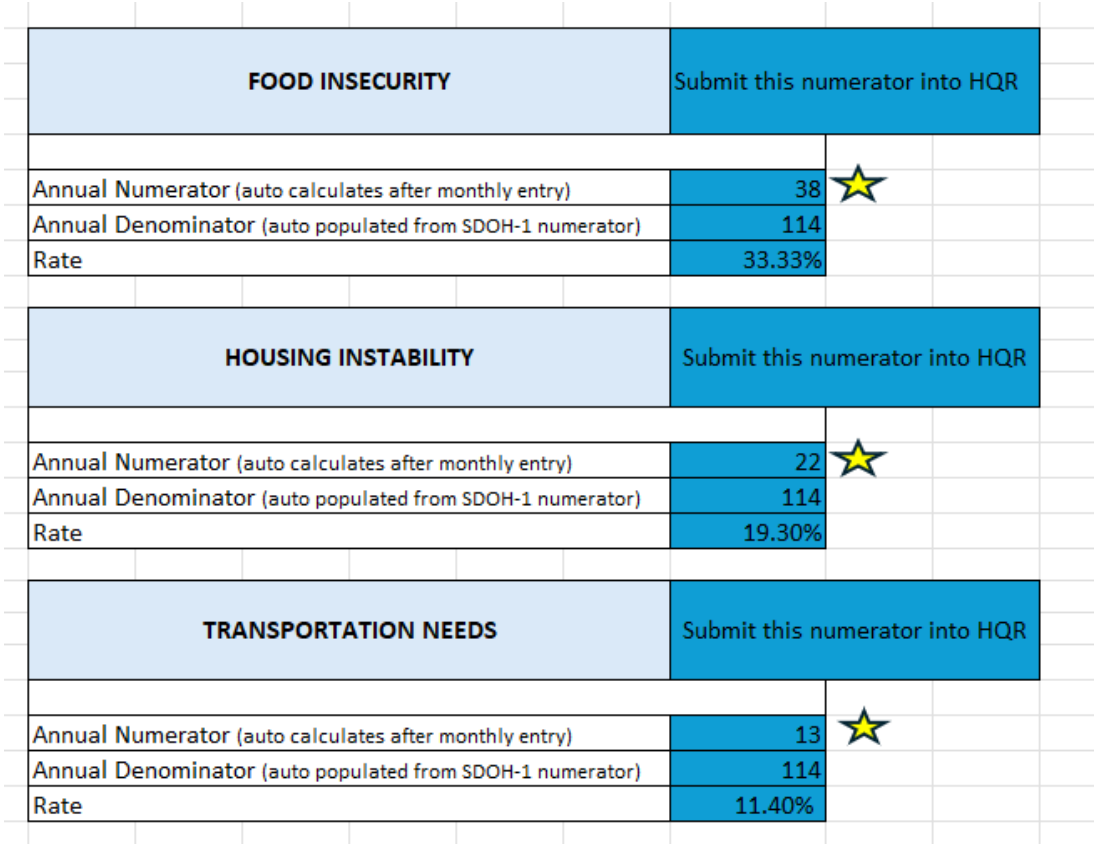
Domain 2 – Data Collection

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

A. Our hospital collects demographic information, including self-reported race and ethnicity, and/or social driver of health information on the majority of our patients.

B. Our hospital has training for staff in culturally sensitive collection of demographic and/or social drivers of health information.

C. Our hospital inputs demographic and/or social driver of health information collected from patients into structured, interoperable data elements using certified EHR technology.



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

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

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

Hospital Commitment to Health Equity

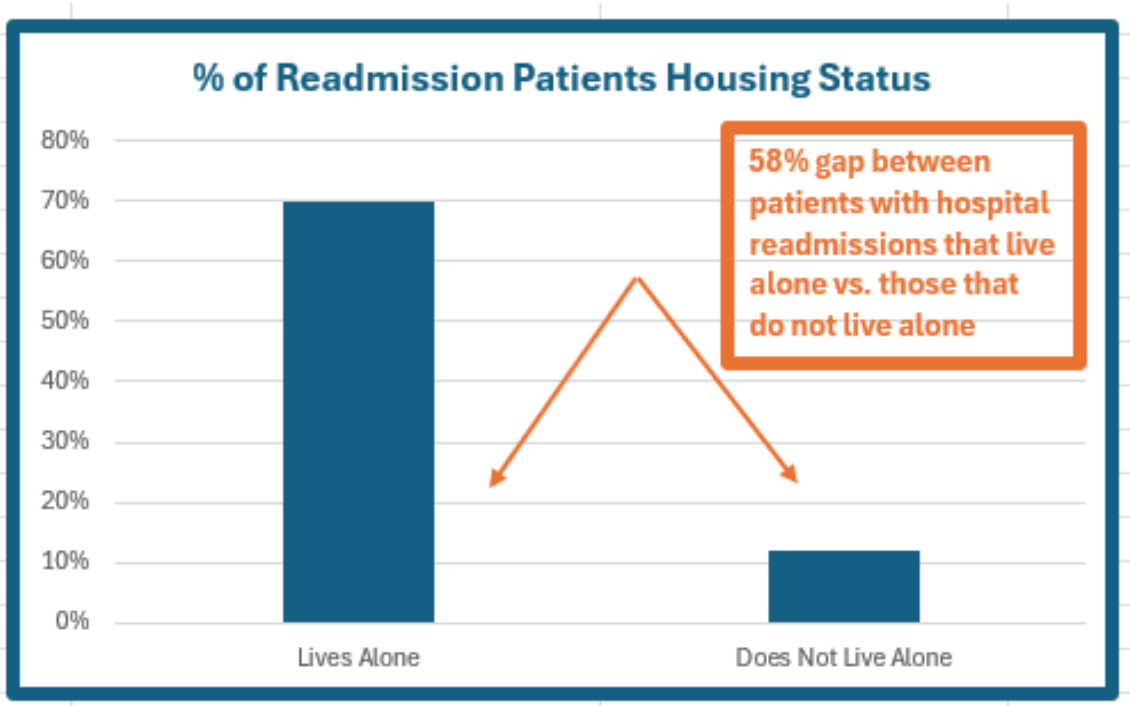
Data Elements:

Domain 3 – Data Analysis

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

A. Our hospital stratifies key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and includes this information on hospital performance dashboards.

Readmissions Stratified by Housing Status Dashboard



Hospital Commitment to Health Equity

Domain 4 – Quality Improvement

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

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

Ideas:

- Patient and Family Engagement Cohort
- Internal quality measures and activities
- Participation in Collaboratives or Coalitions focused on decreasing health disparities
- The Health Equity Collaborative
- The Alliance for Innovation on Maternal Health
- Million Hearts

Hospital Commitment to Health Equity

Data Elements:

Domain 5 – Leadership Engagement

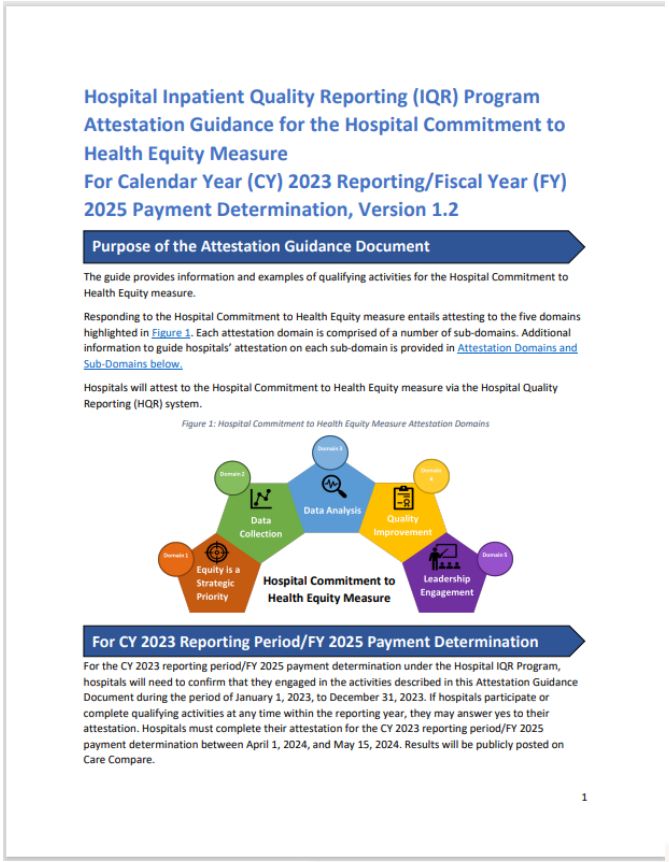
Please attest that your hospital engages in the following activities. Select all that apply (note: attestation in all elements is required to qualify for the numerator).

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

B. Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews key performance indicators stratified by demographic and/or social factors.

Resources to Support You

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



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

Purpose of the Attestation Guidance Document

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

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

Hospitals will attest to the Hospital Commitment to Health Equity measure via the Hospital Quality Reporting (HQR) system.

Figure 1: Hospital Commitment to Health Equity Measure Attestation Domains

For CY 2023 Reporting Period/FY 2025 Payment Determination

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

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Screening for Social Drivers of Health

Care Coordination Domain

Screening for Social Drivers of Health

Measure Description: The Screening for Social Drivers of Health Measure assesses whether a hospital implements screening for all patients that are 18 years or older at time of admission for food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety.

To report on this measure, hospitals will provide:

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

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

Screening for Social Drivers of Health

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

Improvement Noted As: Increase in rate.

Screening for Social Drivers of Health

Measure Population (determines the cases to abstract/submit): The number of patients who are admitted to a hospital inpatient stay and who are 18 years or older on the date of admission.

Exclusions: The following patients would be excluded from the denominator: 1) Patients who opt out of screening; and 2) patients who are themselves unable to complete the screening during their inpatient stay and have no caregiver able to do so on the patient's behalf during their inpatient stay. 3.) Patients who expire during their inpatient stay

Numerator: The number of patients admitted to an inpatient hospital stay who are 18 years or older on the date of admission and are screened for each of the five HRSNs: food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety during their hospital inpatient stay.

Denominator: The number of patients who are admitted to a hospital inpatient stay and who are 18 years or older on the date of admission.

Screening for Social Drivers of Health

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

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

Data Source: Chart abstraction.

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

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

Example: SDOH Screening Process

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

Process:

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

Resources to Support You

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

Screen Positive Rate for Social Drivers of Health

Care Coordination Domain

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

Measure Description: The Screen Positive Rate for Social Drivers of Health Measure provides information on the percent of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, were screened for an HSRN and who screen positive for one or more of the following five health-related social needs (HSRNs): food insecurity, housing instability, transportation problems, utility difficulties or interpersonal safety.

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

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

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

Measure Population (determines the cases to abstract/submit): The number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission and are screened for each of the five HSRNs (food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety) during their hospital inpatient stay.

Exclusions: The following patients would be excluded from the denominator: 1) Patients who opt out of screening; and 2) patients who are themselves unable to complete the screening during their inpatient stay and have no caregiver able to do so on the patient's behalf during their inpatient stay. 3.) Patients who expire during their inpatient stay

Numerator: The number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, who were screened for all five HSRN, and who screen positive for having a need in one or more of the following five HRSNs (calculated separately): food insecurity, housing instability, transportation needs, utility difficulties or interpersonal safety.

Denominator: The number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission and are screened for each of the five HSRNs (food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety) during their hospital inpatient stay.

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

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

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

Data Source: Chart abstraction.

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

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

Resources to Support You

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

In Summary

- Measures in blue are the 2025 MBQIP measures
- A star (★) indicates the measure is currently available for reporting

2025 MBQIP Core Measure Set				
Global Measures	**Patient Safety**	**Patient Experience**	**Care Coordination**	**Emergency Department**
• CAH Quality Infrastructure *(annual submission)* • Hospital Commitment to Health Equity *(annual submission)*	• Healthcare Personnel Influenza Immunization ★ *(annual submission)* • Antibiotic Stewardship Implementation ★ *(annual submission)* • Safe Use of Opioids (eCQM) ★ *(annual submission)*	• Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS) ★ *(quarterly submission)*	• Hybrid Hospital-Wide Readmissions *(annual submission)* ★ • SDOH Screening *(annual submission)* • SDOH Screening Positive *(annual submission)*	• Emergency Department Transfer Communication (EDTC) ★ *(quarterly submission)* • OP-18 Time from Arrival to Departure ★ *(quarterly submission)* • OP-22 Left without Being Seen ★ *(annual submission)*

Reporting Channels for 2025 MBQIP Measures

RQITA RESOURCE CENTER

Hospital Quality Reporting (HQR)

★ Hospital Commitment to Health Equity
★ Hybrid Hospital Wide Readmissions
★ Safe Use of Opioids-Concurrent Prescribing
★ Screening for Social Drivers of Health
★ SDOH Screening Positive
- HCAHPS Survey (vendor or self-administered)
- CMS Outpatient Measures (submitted via HARP) OP-22
- CMS Outpatient Measures (submitted via CART or vendor tool) OP-18

FMT Qualtrics Platform

★ CAH Quality Infrastructure

NHSN

- Antibiotic Stewardship
- Influenza Vaccination Coverage Among Healthcare Personnel (HCP)

State Flex Coordinator

- Emergency Department Transfer Communication

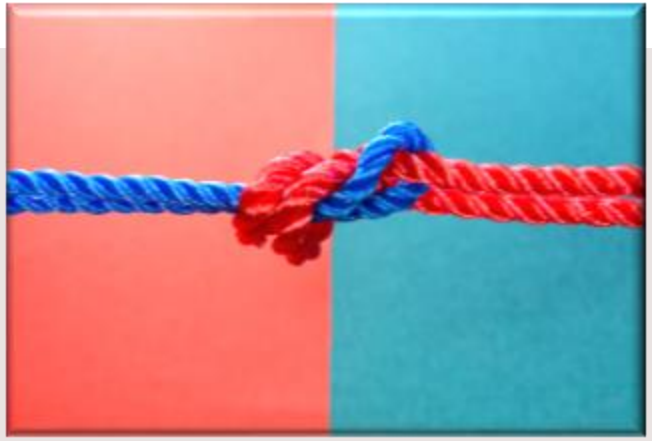
Still with me?

We've reviewed the following 2025 MBQIP measures:

- CAH Quality Infrastructure
- Safe Use of Opioids – Concurrent Prescribing
- Hybrid Hospital Wide Readmissions Measure
- Health Commitment to Health Equity
- Screen for SDOH
- Screen Positive for SDOH

Leveraging Your Community Health Needs Assessment (CHNA) and MBQIP Focus on Equity

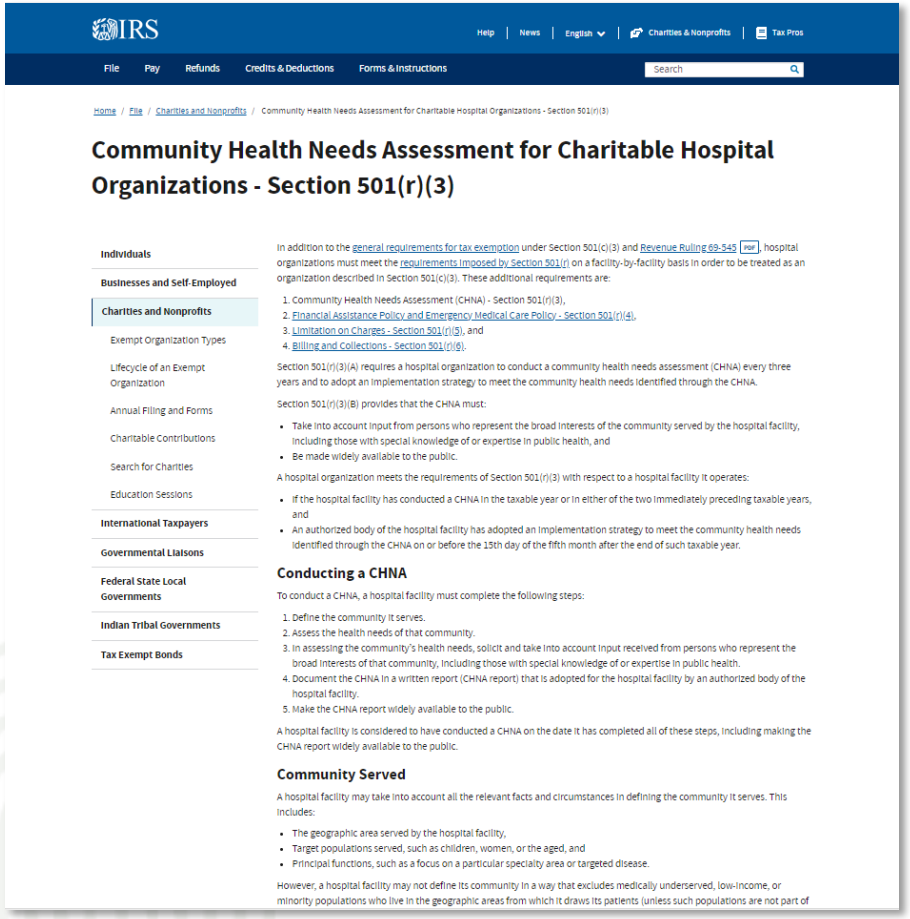
- Community Health Needs Assessment

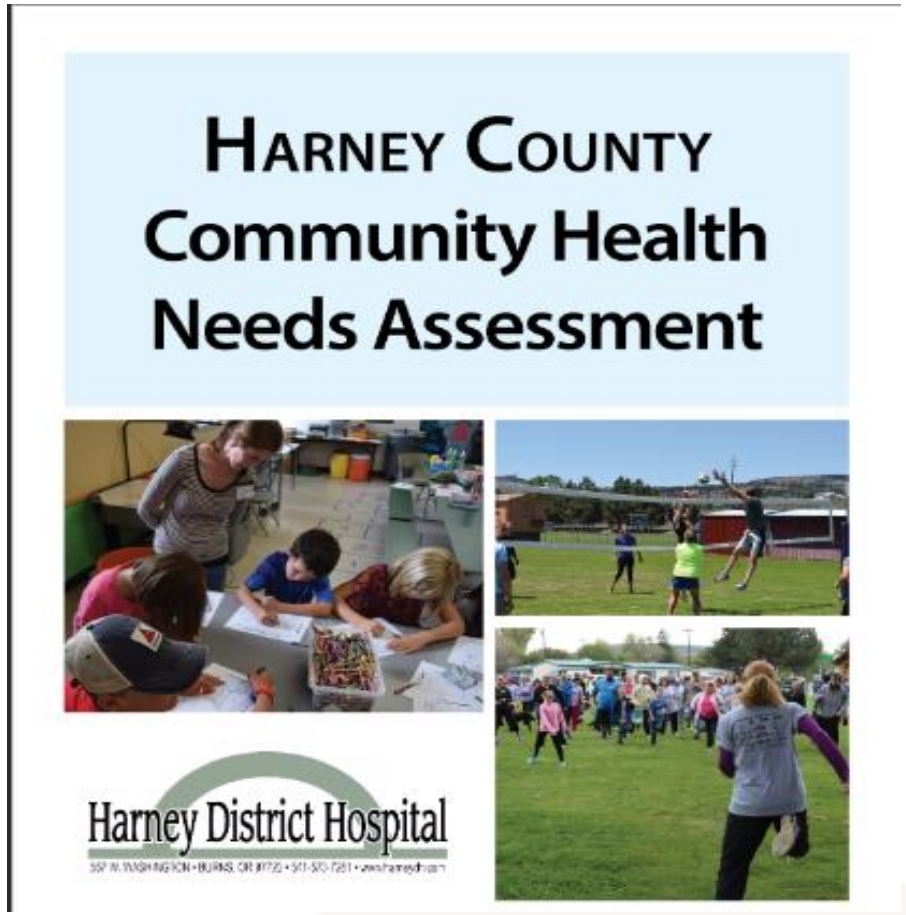


- CAH Quality Infrastructure Assessment
  - Integrating Equity into quality practices
- Hospital Commitment to Health Equity
- Screening for Social Drivers of Health
- Screen Positive for Social Drivers of Health

Who is Involved with the Community Health Needs Assessment Responsibilities at your hospital?

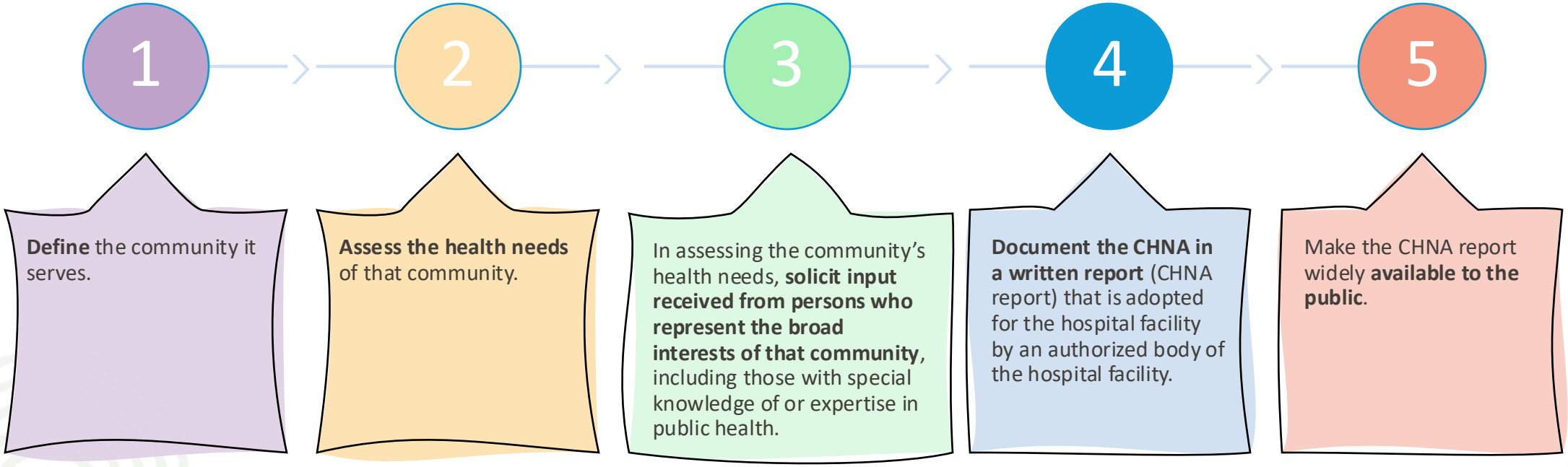
Community Health Needs Assessment





[Community Health Needs Assessment for Charitable Hospital Organizations - Section 501(r)(3) | Internal Revenue Service (irs.gov)]

Hospitals Must Complete the Following Steps to Conduct a CHNA



Community Health Needs Assessment for Charitable Hospital Organizations - Section 501(r)(3) | Internal Revenue Service (irs.gov)

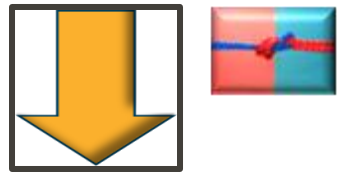
Assessing Community Health Needs

The health needs of a community include requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community, such as particular neighborhoods or populations experiencing health disparities.

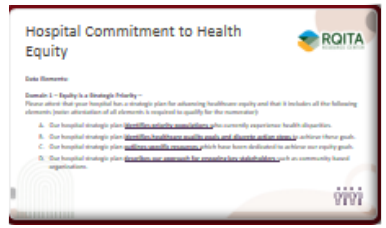
Needs may include, for example, the need to:

- Address financial and other barriers to accessing care,
- Prevent illness,
- Ensure adequate nutrition, or
- Address social, behavioral, and environmental factors that influence health in the community.

Direct Alignment



HCHE (slide 36)



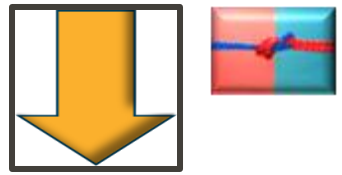
SDOH (slide45)

Input Representing the Broad Interests of the Community

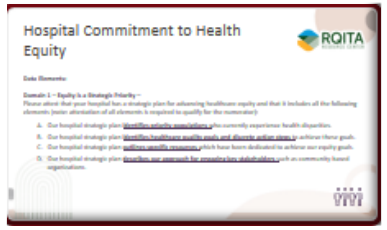
A hospital must both solicit and take into account input received from all of the following sources in identifying and prioritizing significant health needs and in identifying resources potentially available to address those health needs.

1. At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency), or a State Office of Rural Health described in Section 338J of the Public Health Services Act, with knowledge, information, or expertise relevant to the health needs of the community.
2. Members of medically underserved, low-income, and minority populations in the community served by the hospital facility, or individuals or organizations serving or representing the interests of these populations.
3. Written comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy

Direct Alignment



HCHE (slide 36)



CAH Quality Infrastructure (slide 13)

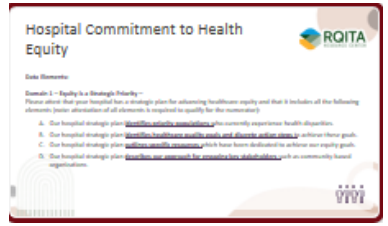
CHNA Implementation Strategy

A hospital facility's implementation strategy must be a written plan that, for each significant health need identified, either:

- Describes how the hospital facility plans to address the health need, or
- Identifies the health need as one the hospital facility does not intend to address and explains why it does not intend to address the health need.
- Although an implementation strategy must consider all of the significant health needs identified through a hospital facility's CHNA, the implementation strategy is not limited to considering only those health needs and may describe activities to address health needs that the hospital facility identifies in other ways

Direct Alignment

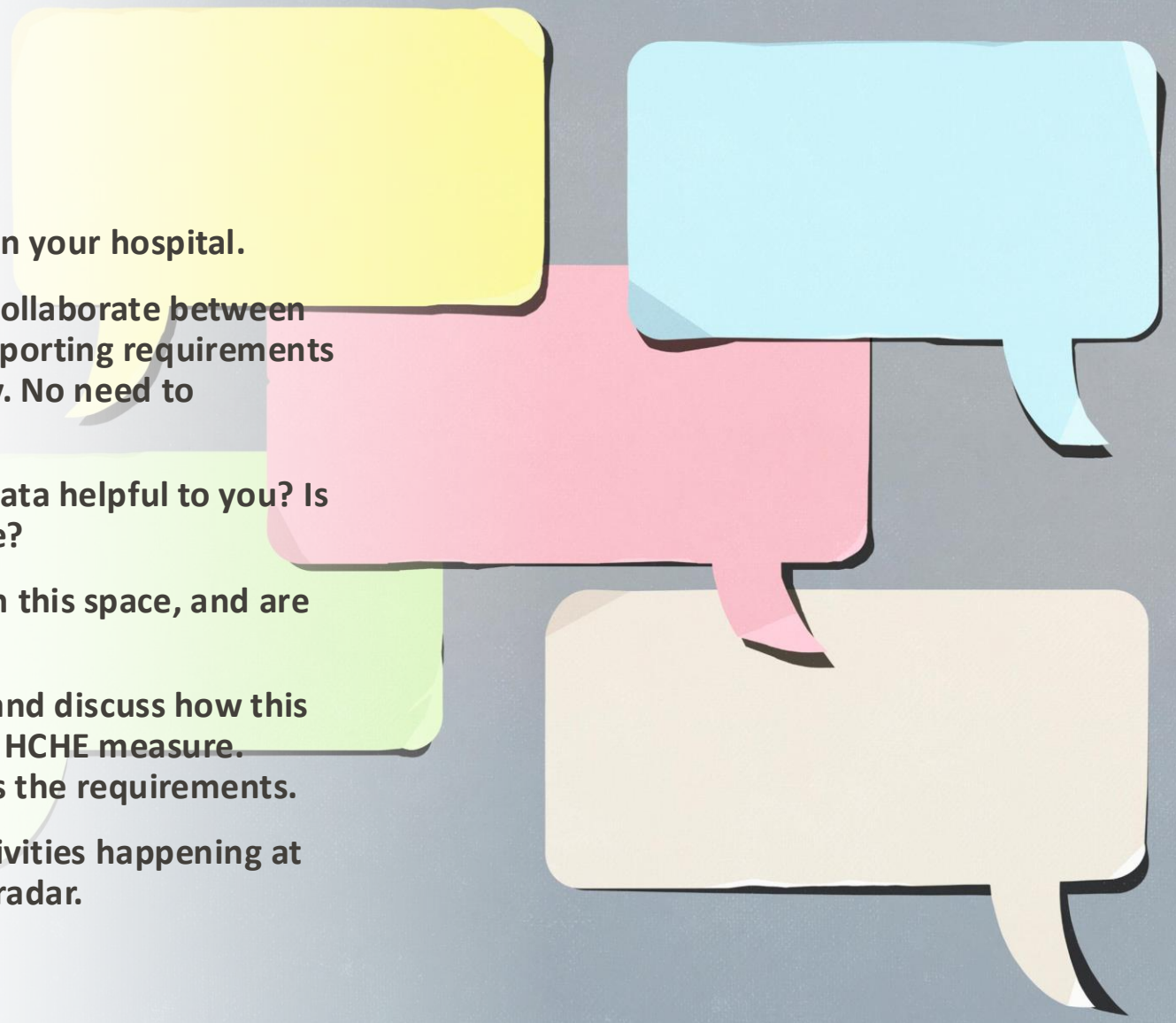
HCHE (slide 36)



CAH Quality Infrastructure (slide 13)

Ideas to Bring Back With You!

- **Find out who is responsible for the CHNA in your hospital.**
- **Coordinate a meeting to identify ways to collaborate between the CHNA requirements and the MBQIP reporting requirements for the measures focused on Health Equity. No need to duplicate work!**
- **Review your CHNA. Is there information/data helpful to you? Is there information/data you can contribute?**
- **Who are the key partners you work with in this space, and are they part of the CHNA? Should they be?**
- **Bring your CHNA to your quality meeting and discuss how this aligns/meets the requirements for MBQIP HCHE measure. Determine which elements of CHNA meets the requirements.**
- **Identify how you will get trainings and activities happening at the local, state and national level on your radar.**



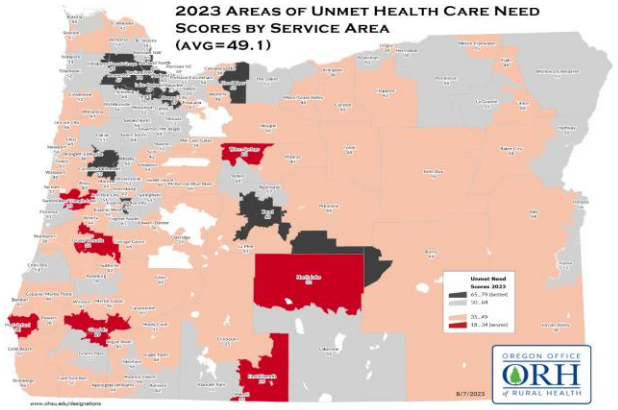
Applying a QI lens to Health Equity

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

- Understand Preexisting Disparities
- Consider System Related Factors
- QI Interventions Are Most Effective for the Populations That They Were Designed for, by, and With

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

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



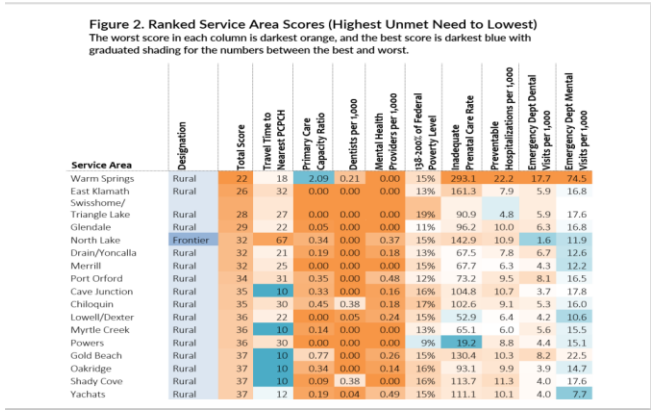
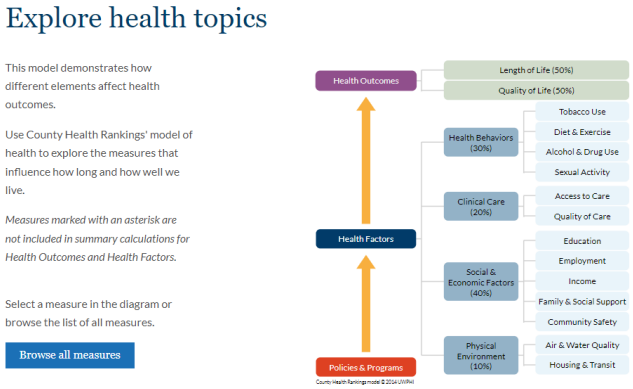
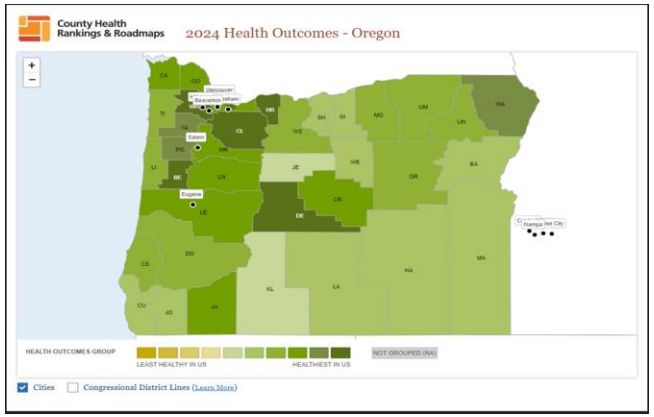


Figure 2. Ranked Service Area Scores (Highest Unmet Need to Lowest)
The worst score in each column is darkest orange, and the best score is darkest blue with graduated shading for the numbers between the best and worst.

Service Area	Designation	Total Score	Travel Time to Nearest PCP/CH	Primary Care Capacity Ratio	Dentists per 1,000	Mental Health Providers per 1,000	138-200% of Federal Poverty Level	Inadequate Prenatal Care Rate	Preventable Hospitalizations per 1,000	Emergency Dept Dental Visits per 1,000	Emergency Dept Mental Visits per 1,000
Warm Springs	Rural	22	18	2.09	0.21	0.00	15%	293.1	22.2	17.7	74.5
East Klamath	Rural	26	32	0.00	0.00	0.00	13%	161.3	7.9	5.9	16.8
Swisshome/											
Triangle Lake	Rural	28	27	0.00	0.00	0.00	19%	90.9	4.8	5.9	17.6
Glendale	Rural	29	22	0.05	0.00	0.00	11%	96.2	10.0	6.3	16.8
North Lake	Frontier	32	67	0.34	0.00	0.37	15%	142.9	10.9	1.6	11.9
Drain/Yoncalla	Rural	32	21	0.19	0.00	0.18	13%	67.5	7.8	6.7	12.6
Merrill	Rural	32	25	0.00	0.00	0.00	15%	67.7	6.3	4.3	12.2
Port Orford	Rural	34	31	0.35	0.00	0.48	12%	73.2	9.5	8.1	16.5
Cave Junction	Rural	35	10	0.33	0.00	0.16	16%	104.8	10.7	3.7	17.8
Chiloquin	Rural	35	30	0.45	0.38	0.18	17%	102.6	9.1	5.3	16.0
Lowell/Dexter	Rural	36	22	0.00	0.05	0.24	15%	52.9	6.4	4.2	10.6
Myrtle Creek	Rural	36	10	0.14	0.00	0.00	13%	65.1	6.0	5.6	15.5
Powers	Rural	36	30	0.00	0.00	0.00	9%	19.2	8.8	4.4	15.1
Gold Beach	Rural	37	10	0.77	0.00	0.26	15%	130.4	10.3	8.2	22.5
Oakridge	Rural	37	10	0.34	0.00	0.14	16%	93.1	9.9	3.9	14.7
Shady Cove	Rural	37	10	0.09	0.38	0.00	16%	113.7	11.3	4.0	17.6
Yachats	Rural	37	12	0.19	0.04	0.49	15%	111.1	10.1	4.0	7.7

[Oregon Office of Rural Health Data]





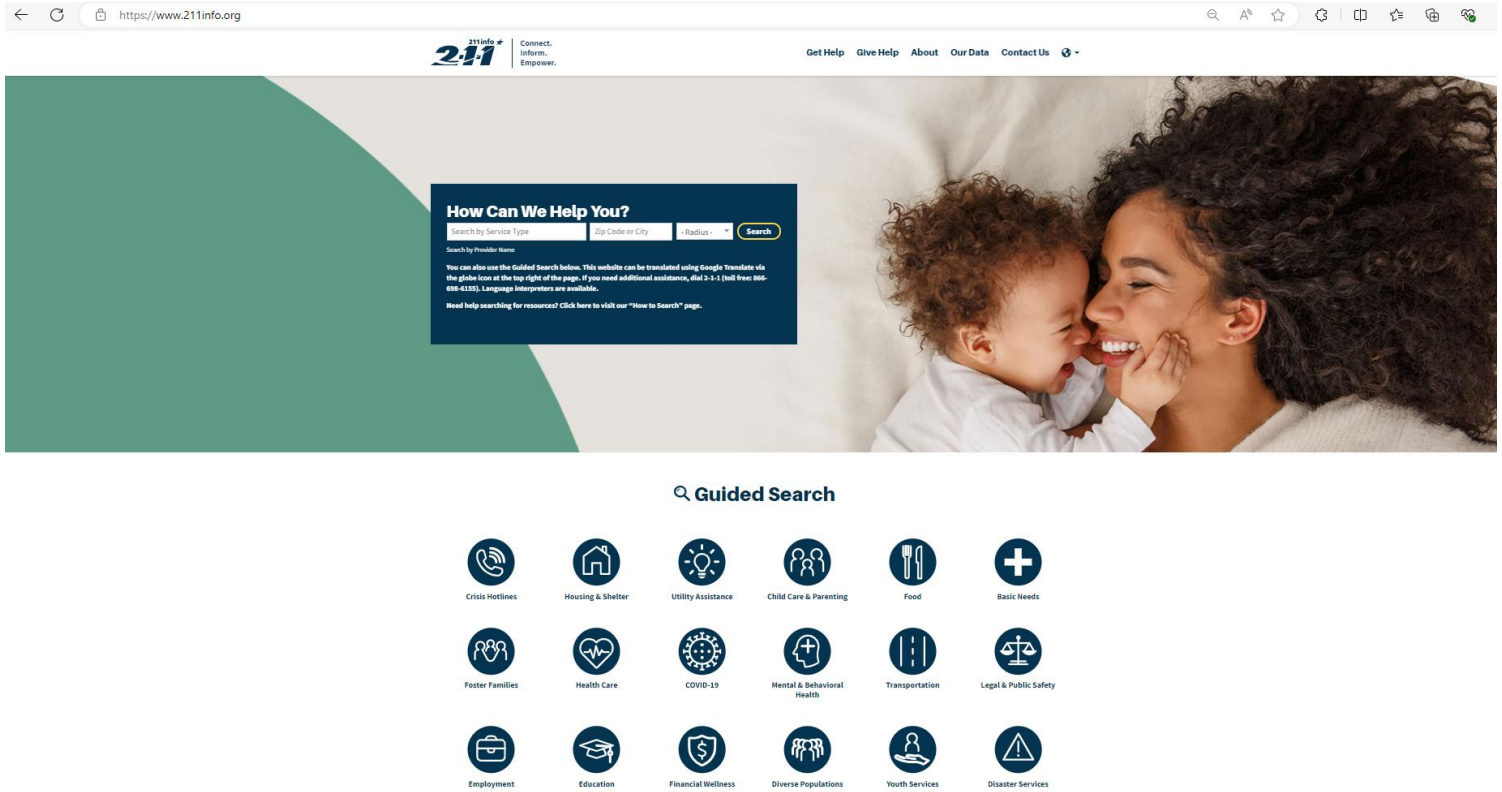
[Community Health Rankings]
View peer counties, nearby counties, similar counties, and more

Using Data to Drive Action

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

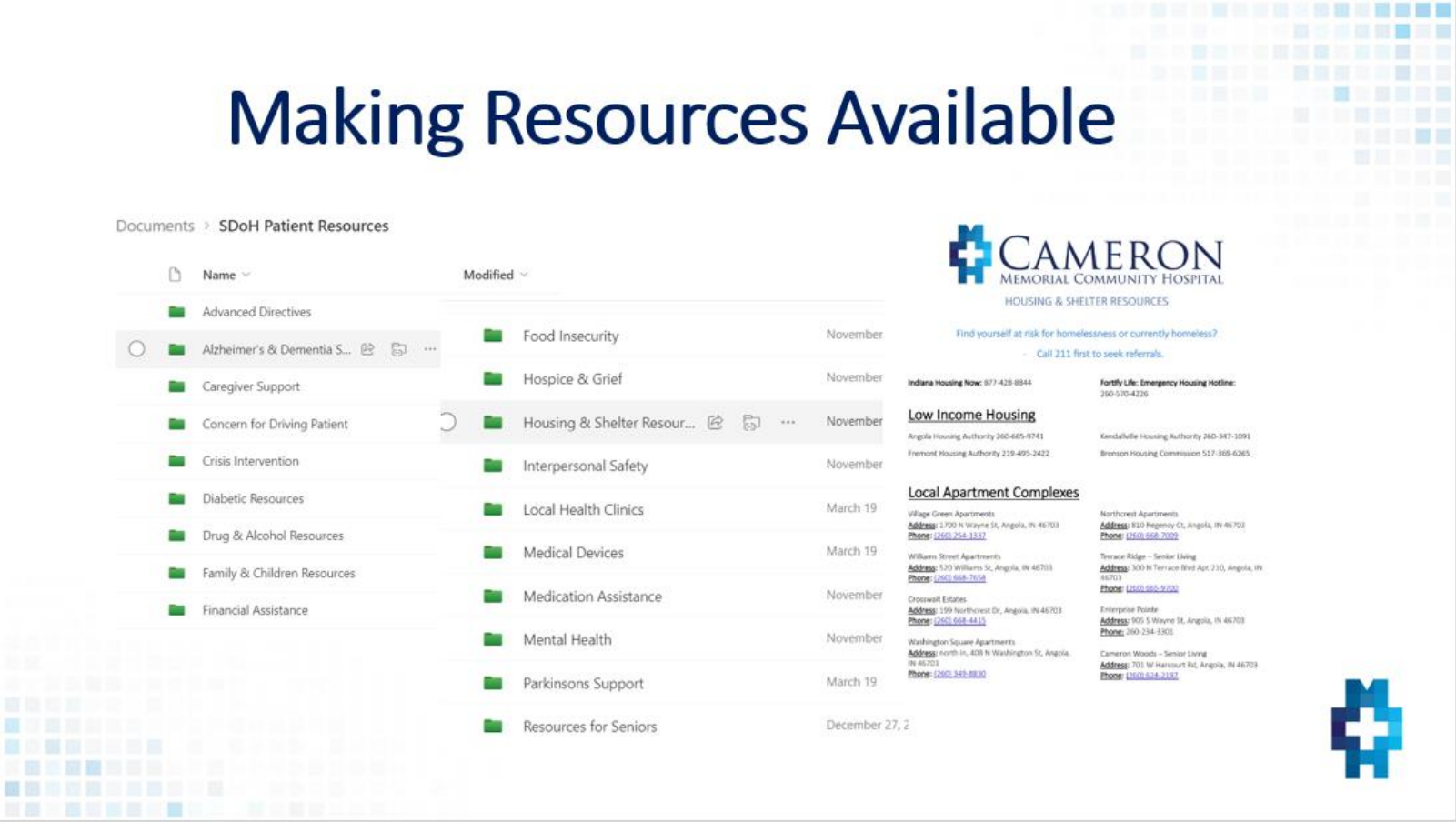
Do You Know About 211?

[Find your State/Local 211]



Create an Internal Microsite for Easy Access to Resources

RQITA RESOURCE CENTER



Create A Committee/Coalition

- Reducing Readmissions Committee
- Health Equity Committee
- Multidiscipline Community Collaborative.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Thank You!

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Thank you!

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