

IPRO QIN-QIO Partnership for Community Health

Welcome!

Voices from The Field Series

Session One

Best Practices for Addressing Health-Related Social Needs (HRSN) in Care Coordination

January 24, 2023

This material was prepared by IPRO, a Quality Innovation Network-Quality Improvement Organization under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The content presented does not necessarily reflect CMS policy. Publication #12SOW-IPRO-NJ-TA-AA-23-869.



■ Healthcentric
Advisors
■ Qlarant

QIN-QIO
Quality Innovation Network -
Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES
QUALITY IMPROVEMENT & INNOVATION GROUP

Welcome!

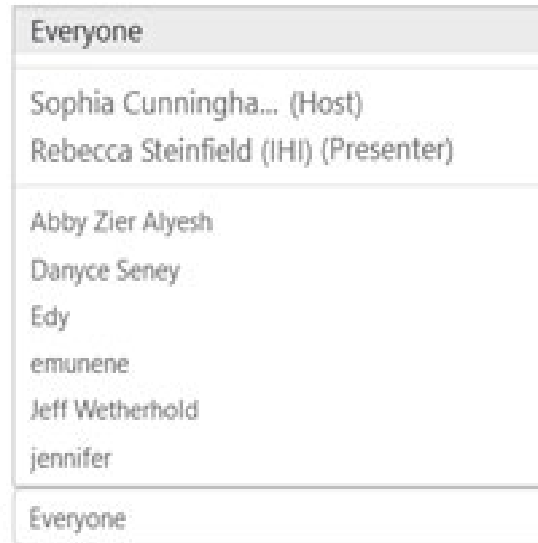
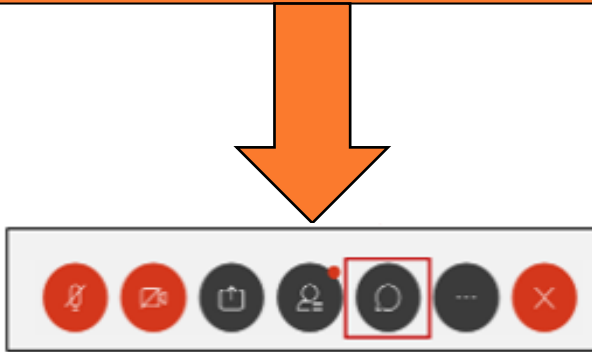
Today's session is being recorded. Access to the recording and presentation slides will be made available on our website.

Although we want active participation, we ask that you please keep yourself on “mute” during the presentation.

Please introduce yourself (name, organization & role, location) using the Chat feature.

How To Use Chat Feature

Chat Feature Highly Encouraged



- In the “Send To” or “To” **drop-down list**, select the recipient of the message
 - *Scroll all the way down*
 - *Select “Everyone”*
 - *Do not select “All Attendees”*
- Enter your **message** in the Chat Text Box, then **press Enter** on your keyboard

Please Enter in Chat:

- Your Name
- Your Role
- Your Hospital
- Your State

Topics for Today

- CMS Strategic Plan & Health Equity Framework
- Why Addressing HRSN is Important
- CMS Health Equity Measures
- The Joint Commission Health Equity Guidelines

Today's program will also feature peer-to-peer sharing. You will hear a firsthand account of the successes, challenges, and opportunities to embed health equity in care coordination.

- Q&A

The IPRO QIN-QIO

The IPRO QIN-QIO

- A federally-funded Medicare Quality Innovation Network – Quality Improvement Organization (QIN-QIO)
- 12 regional CMS QIN-QIOs nationally

IPRO:

New York, New Jersey, and Ohio

Healthcentric Advisors:

Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

Qlarant:

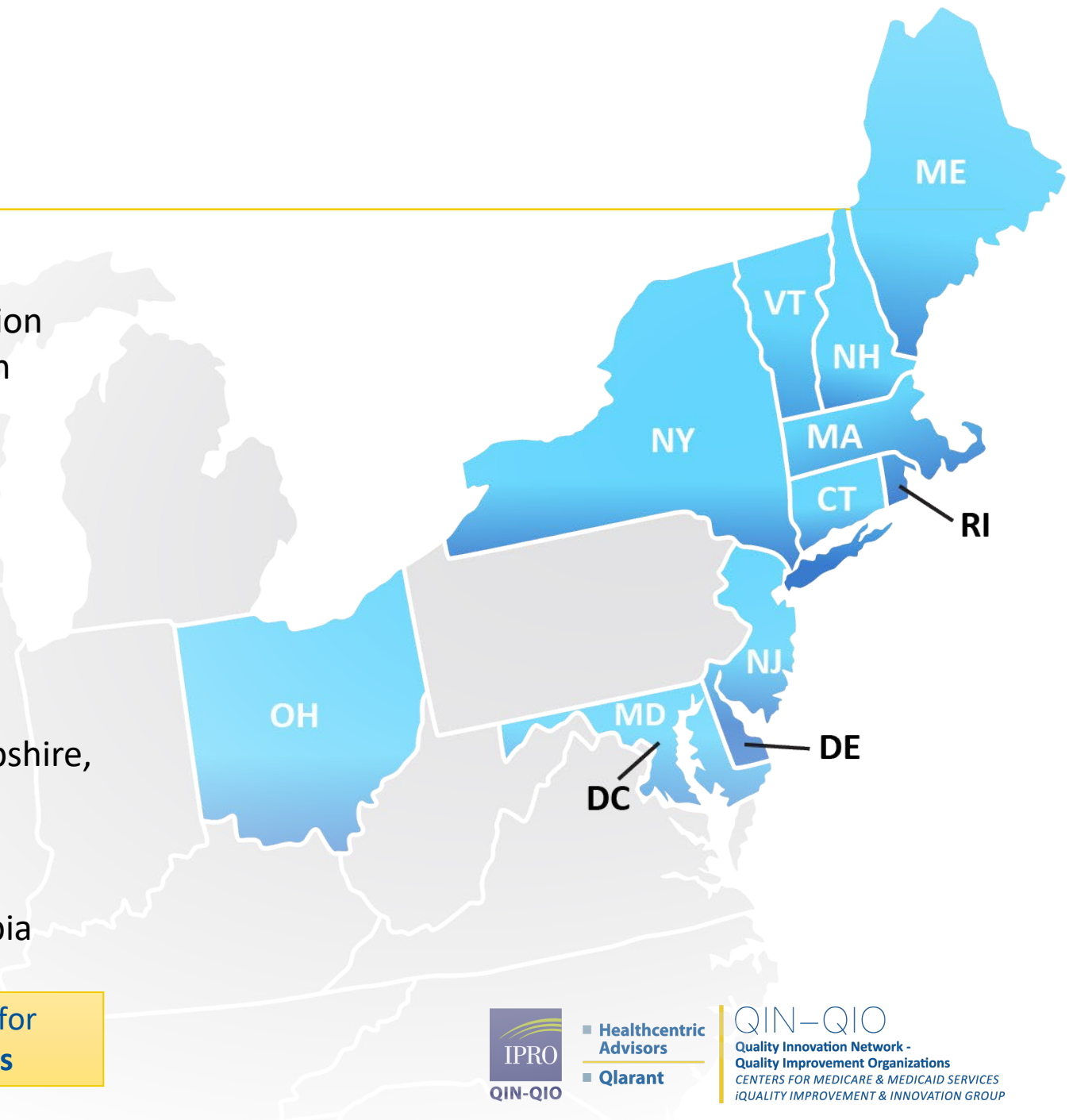
Maryland, Delaware, and the District of Columbia

Working to ensure high-quality, safe healthcare for
20% of the nation's Medicare FFS beneficiaries



■ Healthcentric
Advisors
■ Qlarant

QIN-QIO
Quality Innovation Network -
Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES
EQUALITY IMPROVEMENT & INNOVATION GROUP





Aligning Quality Goals



**Improving Care
Transitions to
Reduce
Unnecessary
Hospitalization**



**Reducing
Opioid-Related
Adverse Events**



**Promoting
Chronic
Disease
Management**



**Supporting
Immunizations**



**Enhancing
Patient Safety**



**Advancing
Infection
Control
Strategies &
Emergency
Preparedness**

Partnership for Community Health

Health Equity – Patient & Family Engagement – Health Information Technology

Laura Benzel, MS, BS, CSSGB

I PRO QIN-QIO Health Equity Subject Matter Expert



■ Healthcentric
Advisors
■ Qlarant

QIN-QIO
Quality Innovation Network -
Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES
EQUALITY IMPROVEMENT & INNOVATION GROUP

CMS Strategic Plan

CMS Strategic Plan

CMS serves the public as a trusted partner and steward, dedicated to advancing health equity, expanding coverage, and improving health outcomes.

CMS Strategic Pillars

ADVANCE EQUITY

Advance health equity by addressing the health disparities that underlie our health system



EXPAND ACCESS

Build on the Affordable Care Act and expand access to quality, affordable health coverage and care



ENGAGE PARTNERS

Engage our partners and the communities we serve throughout the policymaking and implementation process



DRIVE INNOVATION

Drive Innovation to tackle our health system challenges and promote value-based, person-centered care



PROTECT PROGRAMS

Protect our programs' sustainability for future generations by serving as a responsible steward of public funds



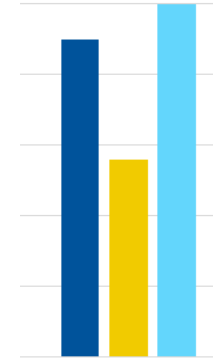
FOSTER EXCELLENCE

Foster a positive and inclusive workplace and workforce, and promote excellence in all aspects of CMS' operations





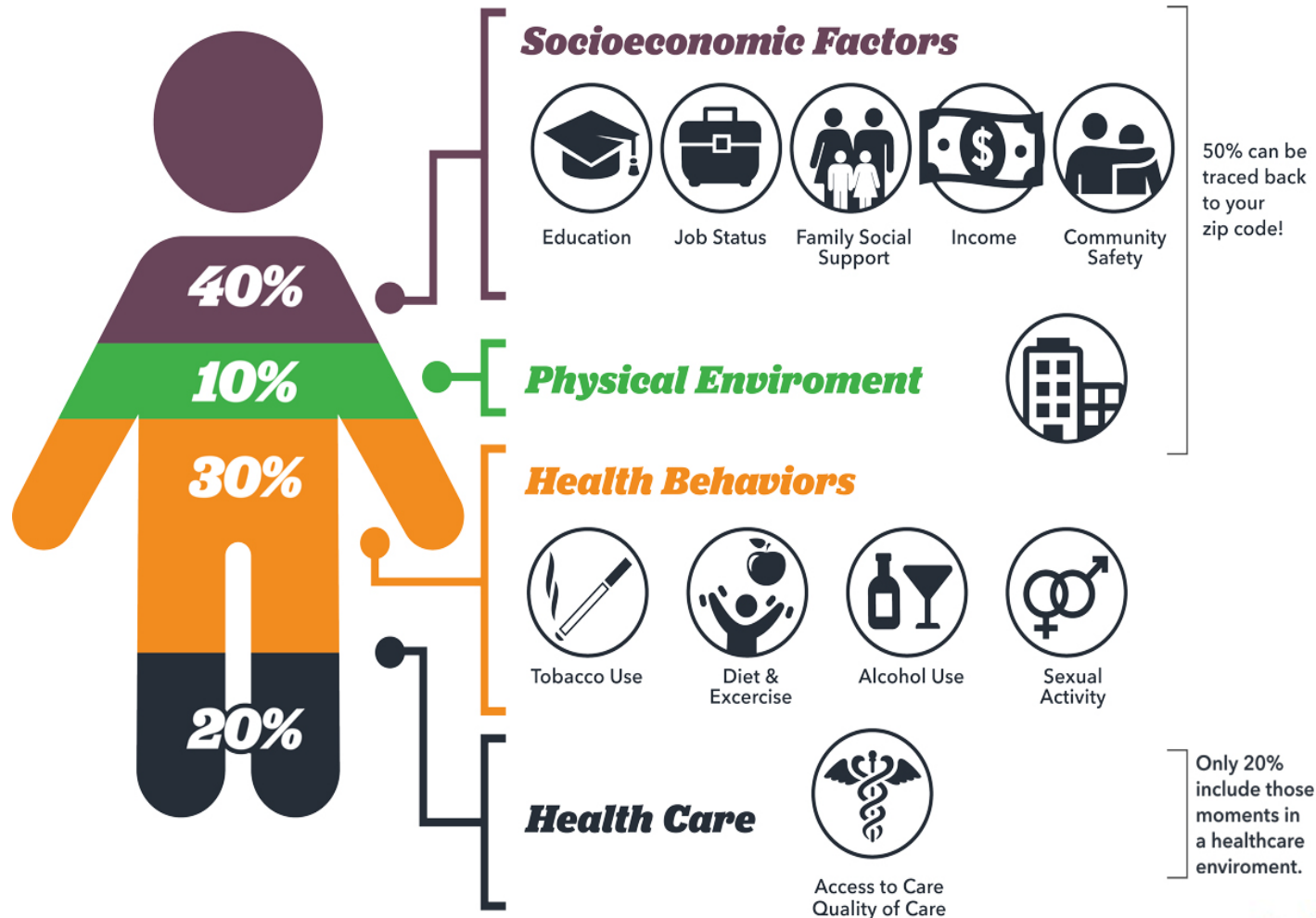
Polling Question



Is your organization using a systematic process to screen for social risk factors?

Please enter your response via the CHAT feature

Why Screening for Health-Related Social Needs (HRSN) Matters



- **20%** of health outcomes attributable to clinical care
- **80%** of health outcomes influenced by **physical environment, social determinants, and behavioral factors**
- **15-year** life expectancy gap between **advantaged** and **disadvantaged** individuals

Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

<https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries>



■ Healthcentric
Advisors
■ Qlarant

QIN-QIO
Quality Innovation Network -
Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES
EQUALITY IMPROVEMENT & INNOVATION GROUP

New CMS Health Equity Measures

CMS Inpatient Quality Reporting Program

- In the FY2023 IPPS/LTCH Final Rule
- 10 new measures, 3 related to health equity:
 - Hospital Commitment to Health Equity
 - Screening for Social Drivers of Health
 - Screen Positive Rate for Social Drivers of Health

New CMS Health Equity Measures

Hospital Commitment to Health Equity

Measure ID: HCHE

- CY 2023 Reporting Period
- CY 2025 Payment Determination
- Structural measure that assesses a hospital's commitment to health equity using five domains of competencies:
 - Equity is a Strategic Priority
 - Data Collection
 - Data Analysis
 - Quality Improvement
 - Leadership Engagement
- Each domain is worth one point, for a total of five possible points.
- Hospitals must attest to all the elements of a domain to receive the point.
- CMS will publicly report the scores for this measure.

New CMS Health Equity Measures

Screening for Social Drivers of Health

Measure ID: HCHE

- CY 2023 Voluntary Reporting
- CY 2024 Mandatory Reporting
- CY 2026 Payment Determination
- Assesses if a hospital screens patients 18 years or older for health-related social needs (HRSNs) at time of admission
- Patients must be screened for five HRSNs:
 - Food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety
- Hospitals can choose the screening tool.
- Numerator: number of patients admitted to an inpatient hospital who are 18 years or older on the date of admission screened for all five HRSNs
- Denominator: number of patients 18 years or older on the date of admission admitted to the hospital

New CMS Health Equity Measures

Screen Positive Rate for Social Drivers of Health Measure ID: SDOH-2

- CY 2023 Voluntary Reporting
- CY 2024 Mandatory Reporting
- CY 2026 Payment Determination
- Structural measure tracks:
 - % of patients admitted for inpatient hospital stay 18 years or older
 - Patients screened for an HRSN and screen positive for one or more of the five HRSNs
- Numerator: number of patients admitted for inpatient hospital stay 18 years or older who were screened for an HRSN, and who *screen positive* for one or more
- Denominator: number of patients admitted for inpatient hospital stay 18 years or older and are screened for an HRSN during their hospital inpatient stay

Summary of Measures

Measure ID	Measure Name	Hospital IQR Program				
		Fiscal Year				
		23	24	25	26	27
SDOH-1*	Screening for Social Drivers of Health			✓	✓	✓
SDOH-2*	Screen Positive Rate for Social Drivers of Health			✓	✓	✓
HCHE*	Hospital Commitment to Health Equity			✓	✓	✓

* Finalized these measures as voluntary beginning FY 2025 and mandatory with FY 2026.
SDOH=social drivers of health

* Finalized this measure with FY 2025.
HCHE=Hospital Commitment to Health Equity



■ Healthcentric
Advisors
■ Qlarant

QIN-QIO
Quality Innovation Network -
Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES
EQUALITY IMPROVEMENT & INNOVATION GROUP

The Joint Commission Health Equity Standards

The Joint Commission

- New and revised standards released January 2023
 - To help reduce health care disparities and remove barriers to safe, high-quality health care
- A new standard in the Leadership (LD) chapter with 6 new elements of performance (EPs)
- The Record of Care, Treatment, and Services (RC) requirement to collect patient race and ethnicity information

<https://www.jointcommission.org/standards/r3-report/r3-report-issue-36-new-requirements-to-reduce-health-care-disparities/#.Y2bA8nbMLIU>



■ Healthcentric
Advisors
■ Qlarant

QIN-QIO
Quality Innovation Network -
Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES
EQUALITY IMPROVEMENT & INNOVATION GROUP

The Joint Commission Health Equity Standards

Leadership (LD) chapter with 6 new elements applies to:

- Critical access hospitals
- Ambulatory health care
- Behavioral health care and human services organizations

Record of Care, Treatment, & Services (RC) requirement applies to:

- All of the above AND
- Hospitals

IPRO Health Equity Resources

Health Equity
Committed to a Culture of Equity in our Communities

IPRO Healthcentric Advisors QIN-QIO

Health Equity
Quality Innovation Network - Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES
QUALITY IMPROVEMENT & INNOVATION GROUP



What is health equity?

There's no one definition, but a 2017 report from Robert Wood Johnson says health equity ensures that "everyone has a fair and just opportunity to be as healthy as possible."

How do we do that? The definition goes on:

"This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and healthcare."

[View Our Resources](#)

What is a health disparity?

What causes health disparities?

Why is achieving health equity important?

Providing equitable care means considering a person's circumstances, culture, and beliefs so services can be delivered to allow people to achieve optimal health.

If all aspects of a person's life are not considered amidst their overall health, they may experience health disparity resulting in worse outcomes and thus a poorer quality life. Health disparities are not just harmful, but expensive.

Disparities in the U.S. account for approximately \$8 billion in excess medical care costs and \$42 billion in lost productivity. Closing the racial equity gap in the U.S. States could mean gains of \$8 trillion in GDP.

IPRO Healthcentric Advisors QIN-QIO

HEALTH EQUITY UPDATES
November 2022

Health Equity
Quality Innovation Network - Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES
QUALITY IMPROVEMENT & INNOVATION GROUP



Racial and Ethnic Differences in Bystander CPR

A study recently published in the New England Journal of Medicine shows that Black and Hispanic individuals who experienced an out-of-hospital cardiac arrest were less likely to receive cardiopulmonary resuscitation (CPR). According to the [American Heart Association](#), CPR can double or triple a person's survival if it is administered correctly.

The researchers examined CPR rates for cardiac arrests at home and in public locations from 2013 to 2019, identifying a cohort of 110,054 witnessed out-of-hospital cardiac arrests for the study. The researchers found that 76.6% of the cardiac arrests occurred at home and 23.4% in public locations. Compared to White individuals, Black and Hispanic individuals were 26% less likely to receive bystander CPR at home and 37% less likely in public locations.

The researchers cite several reasons for these disparities, including less opportunity for individuals from racial and ethnic minority groups to receive CPR training, language barriers, lack of availability of dispatcher-assisted bystander CPR, and implicit and explicit biases. The study suggests that a multifaceted approach is required to address the disparities.

Announcing the IPRO HEOA Affinity Group

Join us for the IPRO Health Equity Organizational Assessment (HEOA) Affinity Group, led by IPRO Health Equity SMEs. This group will work together to advance opportunities for improvement identified from your organization's HEOA report. The affinity group will give participants the opportunity to collaborate, share best practices and lessons learned while implementing the key activities in the HEOA. The first session is 12/8 and registration information is coming soon. Contact Laura Benzel for more information at benzell@qlarant.com.

This Month

National American Indian & Alaska Native Heritage Month

NATIONAL AMERICAN INDIAN & ALASKA NATIVE HERITAGE MONTH

Each November, we recognized the heritage and diverse culture traditions, and histories of Native Americans. The CMS Division Tribal Affairs is holding a [lecture series](#) this month, two of which discuss health equity. Check out AIAN [Outreach and Education](#) webpage for additional resources and information, and learn more about the AIAN population from the [Census Bureau](#).

National Diabetes Month



November is also National Diabetes Month. According to the [NIH](#), 37 million Americans are affected by diabetes. There is a [webpage](#) with information about the disease and a [toolkit](#) to promote the theme: [Diabetes Management: It Takes a Team](#).

Diabetes is more common in racial/ethnic groups and among those with lower socioeconomic status. The CDC [Advancing Health Equity](#) webpage discusses ways to reduce disparities in diabetes care.

IPRO Healthcentric Advisors QIN-QIO

Health Equity
Quality Innovation Network - Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES
QUALITY IMPROVEMENT & INNOVATION GROUP

A Guide to Screening Patients for Food Insecurity

Access to healthy, quality food can help individuals achieve and maintain optimal health. The connection between nutritious food and a healthy, active life are well documented and supported by robust scientific study. But due to food insecurity, many people lack access to adequate food.

According to the U.S. Department of Agriculture (USDA), 1 in 8 people – or 38 million Americans – were food insecure in 2020. The USDA defines food insecurity as a household-level economic and social condition of limited or uncertain access to adequate food. Hunger is an individual-level physiological condition that can result from food insecurity.

Impacts of food insecurity:

- Associated with some of the most costly and preventable diseases in the U.S.
- Exacerbates health disparities, especially for racial/ethnic minorities.
- Increases the risk of malnutrition.
- Increases likelihood of skipping or underuse of prescribed medications.
- Increases the risk for mental health conditions.
- Contributes to higher healthcare costs.

Healthcare providers can play an important role in identifying and addressing food insecurity. Screen all patients and refer those who need help.

The recommendation is that you screen all patients for food insecurity

Use the validated [Hunger Vital Sign](#)™ two-question screening tool to screen your patients for food insecurity:


- "Within the past 12 months, we worried our food would run out before we got money to buy more."
- "Within the past 12 months, the food we bought just didn't last and we didn't have money to get more."

Patients screen positive for food insecurity if they respond "often true" or "sometimes true" to either or both statements.

If a patient screens positive:

- First, ask the patient if they would like help.
- If they say yes, refer them to support services. Please see the Resources section of this flyer.
- Document and code* the results in the patient's electronic medical record:
 - ICD-10-CM Diagnosis Code Z59.41** (Food insecurity)

*Please consult with a coding specialist to ensure proper coding of patient conditions.



Join Us: IPRO CLAS Series



CLAS = Culturally and Linguistically Appropriate Services

Helps make healthcare services

Understandable | Respectful | Effective | Equitable

How Can You Start Implementing CLAS?

Complete the IPRO CLAS Assessment

[IPRO Assessment of Cultural and Linguistic Services](#)

Learn where your organization is implementing CLAS

Educational Series starting February 8th at noon

[REGISTRATION](#)



■ Healthcentric
Advisors
■ Qlarant

QIN-QIO
Quality Innovation Network -
Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES
EQUALITY IMPROVEMENT & INNOVATION GROUP

Today's Guest Speakers

Amy Shideler, MSW, LISW-S

Manager of Primary Care Social Work

Cleveland Clinic | Connected Care

shidela@ccf.org

J. Chase Holmes, M.Ed.

Program Manager

Cleveland Clinic | Community Health

holmesj2@ccf.org



■ Healthcentric
Advisors
■ Qlarant

QIN-QIO
Quality Innovation Network -
Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES
EQUALITY IMPROVEMENT & INNOVATION GROUP

Health Related Social Need Screening

- Annual screening
- Population Health
- Epic 11/2019
- MyChart

139593	Contact date: 11/30/2018
Launch ID Maintenance	
MYC SDH DISCUSS RESOURCE OPTIONS	
Custom List [6]	
Thank you for completing the questionnaire. Can Cleveland Clinic call you to discuss community resource options?	
Response choices are Yes/No	

Health Related Social Need Screening

- Annual screening
- Population Health
- Epic 11/2019
- MyChart

Updated
2022

Ver en Español

Community Care Social Determinants of Health

For an upcoming appointment with **Dr. D Shafer Klink** on 8/25/2022

Cleveland Clinic knows having your basic needs met is essential to your overall health. Your answers indicate you are eligible for connection to community resources. Which of the following is your greatest need?

☐ Food, Financial, Housing, Transportation ☐ Intimate Partner Violence ☐ Not interested at this time

What is the best way for Cleveland Clinic to contact you?

☐ Phone Call ☐ Email ☐ MyChart ☐ Text Message ☐ Not at this time

High Contrast Theme

Only displays if 1 of the first 2 responses are chosen from the previous question

Health System Challenges to Addressing HRSN

- Need volume & caregiver capacity
- Workflow barriers
- Community Benefit Organization (CBO) access & capacity
- Systemic barriers
- Limited access to survey



HEAL, HIRE, INVEST

Create the healthiest communities for everyone

Reduce Barriers to Health

- Community Health Needs Assessment

Improve Community Conditions

- Healthcare Anchor Institution

Engender Trust

- Community voice

Community Collaboration

- Resources on discharge forms
- CMS Accountable Health Communities grant 2016-2022
- Greater Cleveland Food Bank
- United Way of Greater Cleveland



After Visit Summary (AVS) Resources

Thank you for completing this questionnaire

Based on your responses, you may benefit from services provided by our partner United Way 2-1-1 (HelpLink) for things like housing, transportation, and financial resources. The 2-1-1 team will review your options, link you to available community resources, and assist with barriers to service. Dial 2-1-1 from any phone 24 hours per day. If you need additional assistance please contact your Primary Care Team.

United Way of Greater Cleveland will be provided to individuals identified as high risk for Financial, Housing, and Transportation Insecurity on the SDOH screening tool domains.

Thank you for completing this questionnaire

Based on your responses, you may benefit from services provided by our partner The Greater Cleveland Food Bank. The Help Center, located in the Greater Cleveland Food Bank, can help with applications for SNAP as well as other public benefits. They can also direct you to sources for free & nutritious food close to your home. No in-person interview required. Please call: 216-535-2084

Greater Cleveland Food Bank will be provided to individuals identified as high risk for food insecurity on the SDOH screening tool.

Patient Survey



- Did you receive information on your AVS about the United Way of Greater Cleveland and Greater Cleveland Food Bank?
- Did you like receiving this information?

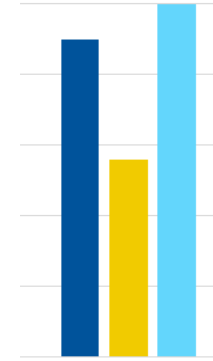


AVS Challenges

- 1% of patients surveyed recalled receiving resources.
- Community partners had limited capacity to identify AVS driven referrals.
- Health system data analytic barriers



Polling Question

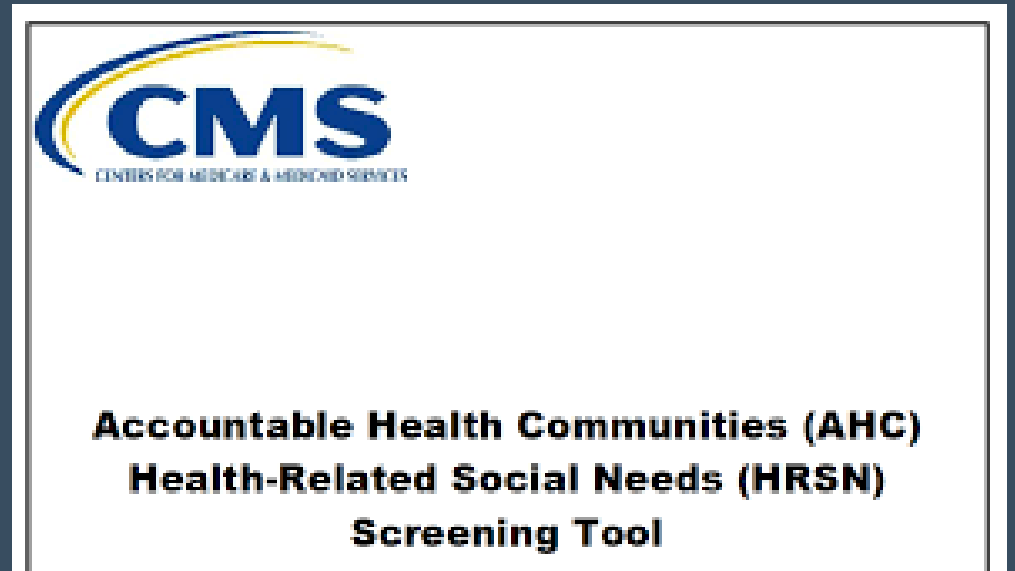


Are you tracking the status outcome of patients identified with social risk factors who have been referred to community-based resources?

Please enter your response via the CHAT feature

Community Collaboration Opportunities

- 1 of 10 cities nationally
- Health care facilities
- Standardized HRSN screening tool
- Navigation support



<https://innovation.cms.gov/innovation-models/ahcm>

Accountable Health Communities

- Model tests whether addressing health-related social needs impacts total health care costs and utilization.
- Eligible Patients: Social Need, Cuyahoga County resident, Medicare/Medicaid, 2 ED visits/year
- United Way 211 navigator in ED



Opt In Volume by Site, Discharge to Home, Acute Care, Critical Access, or Home Health

	Opt Delay	Opt In	Opt In Total	Opt Out	Unable	Missing	Not Started	Total
ED 1	94	188	282	660	80	94	579	1695
ED 2	27	77	104	647	71	281	540	1643
ED 3	45	125	170	936	211	106	60	1483
ED 4	17	367	384	672	165	110		1331

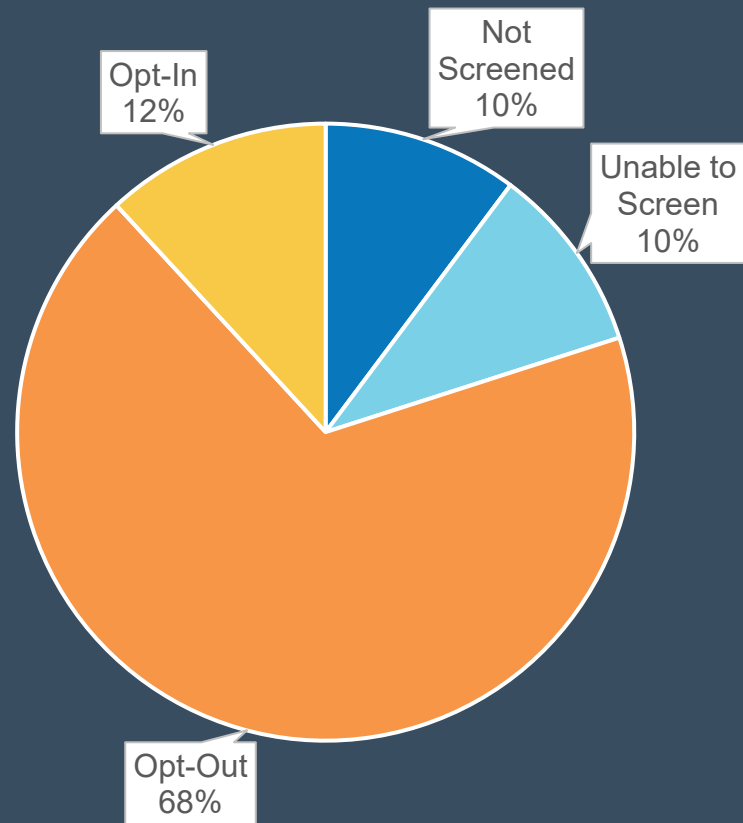
Source: Epic reports on Opt In Status of AHC-eligible patient visits-January 2021



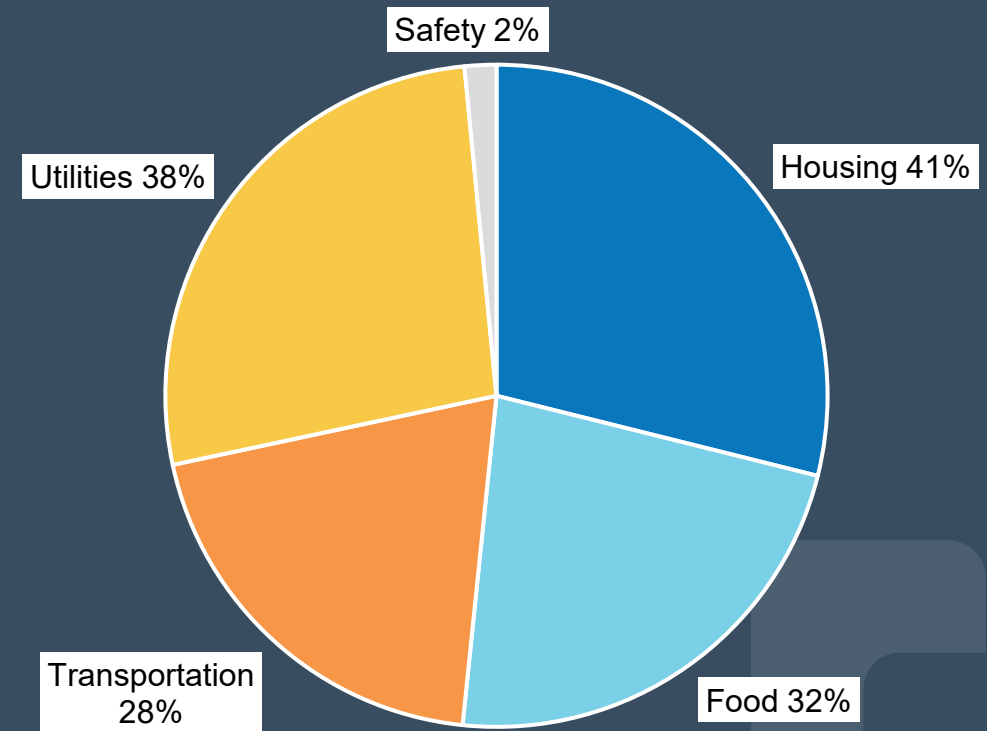
Objectives	Key Results & Measures of Success	Target	Performance	
Addressing vulnerable populations; screening for social needs and gap closure	<ul style="list-style-type: none">• 100% of referrals from PCSW are screened for food, transportation, housing, and finance issues• # and % of those who have reported a need will opt into AHC Program and referred to UW• # and % of those referred were high risk• # and % of those who were high risk will be connected to a resource• # and % gap closure for those who have been connected to a resource	<ul style="list-style-type: none">• 100% Complete• 50%• TBD• 30%• 30%	<div>100%</div> <div>47%</div> <div>15%</div> <div>82%</div> <div>21%</div>	<div></div> <div></div> <div></div> <div></div> <div></div>

Challenges of HRSN Screening

Screen Eligible Patients



National AHC Identified Need



Community Collaboration Challenges

- CBO excluded from HIPAA protections:
 - Legal Contract
 - Business Associate Agreement
 - Memorandum of Understanding
 - Corporate Compliance
 - Consent process



What is Unite Us?

Unite Us connects patients and community residents with identified social needs to Community Based Organizations (CBOs) to deliver integrated whole person care through a shared technology platform



Goals of Unite US

- ✓ Increase patient access to CBO services through electronic referrals
- ✓ Increase collaboration between health systems and CBOs (securely share patient information)
- ✓ Efficiently track referral outcomes to measure health related social needs (gap closure)
- ✓ Unified community approach to address social needs

Unite Us

- CBO Barriers:
 - Infrastructure
 - Staffing
 - Workflow
 - Competing Priorities
 - Community Trust

- Platform Barriers:
 - Data Delivery
 - IT Solutions
 - Operationalizing Workflows for Different Institutes



Connecting People to Care

Screening



John Doe shows up at Cleveland Clinic.



Sue screens John and identifies that he has additional social needs.

Referral



Sue uses Unite Us to first gain digital consent and electronically refers John to multiple community partners. Through the platform, Sue can seamlessly communicate with the other providers in real time and securely share John's information.

Resolution



Feedback



As John receives care, Sue receives real-time updates and tracks John's outcomes through EPIC or a web-based platform.

Community Advisory Council

- A collaboration of hospital systems, community stakeholders, and reps from community-based organizations to come together and provide strategic guidance on ways of improving Unite Us platform.

CAC Focuses On:

1. User experience
2. Network growth
3. Data/evaluation





Every life deserves world class care.

Questions

Please enter your questions for our speakers via the CHAT feature or take yourself off mute



■ Healthcentric
Advisors
■ Qlarant

QIN-QIO
Quality Innovation Network -
Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES
EQUALITY IMPROVEMENT & INNOVATION GROUP

Resources

IPRO QIN-QIO

- Resource Library
https://www.cms.gov/about-cms/agency-information/omh/downloads/omh_readmissions_guide.pdf
- SDoH Getting Started Guide
<https://qi-library.ipro.org/2022/07/07/social-determinants-of-health-sdoh-a-guide-for-getting-started-for-getting-started/>
- A Guide to Screening Patients for Food Insecurity
<https://qi-library.ipro.org/2022/10/25/a-guide-to-screening-patients-for-food-insecurity/>
- A Guide to Screening Patients for Social Isolation/Loneliness
<https://qi-library.ipro.org/2022/11/15/a-guide-to-screening-patients-for-social-isolation-and-loneliness/>
- A Guide to Screening Patients for Transportation Barriers
<https://qi-library.ipro.org/2022/11/15/a-guide-to-screening-for-transportation-barriers/>

CMS Office of Minority Health

- Guide to Reducing Disparities in Readmissions
https://www.cms.gov/about-cms/agency-information/omh/downloads/omh_readmissions_guide.pdf
- Utilization of Z Codes for Social Determinants of Health among Medicare Fee-for-Service Beneficiaries, 2019
<https://www.cms.gov/files/document/z-codes-data-highlight.pdf>

HHS Think Cultural Health

- National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health & Health Care
<https://thinkculturalhealth.hhs.gov/clas>



■ Healthcentric
Advisors
■ Qlarant

QIN-QIO
Quality Innovation Network -
Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES
EQUALITY IMPROVEMENT & INNOVATION GROUP

Added-Value Resources



IPro QIN-QIO Website: <https://qi.ipro.org/>



IPro QIN-QIO Resource Library: <https://qi-library.ipro.org/#>



Data-Driven Quality Improvement: A Guide to IPro QIN-QIO Data Dashboards & Reports:
<https://drive.google.com/file/d/1HH4q8CH7n1-wyxqpaMxKwPiOxHtdaz9L/view?usp=sharing>



Social Determinants of Health—a Guide for Getting Started:
<https://drive.google.com/file/d/1NUEHyVsQ95-noR55ULTEUgPiZzgwKXcM/view?usp=sharing>

We Want Your Feedback...

- Please take a moment to complete the survey following this presentation.
- Today's presentation will be available on our website.

Thank You for Attending!

Connect With Our Team

Cindy Stark, MSN, BS, RN (NY/NJ)
Senior Quality Improvement Specialist
cstark@ipro.org
518-320-3597

Fred Ratto, Jr. (NY/NJ)
Senior Quality Improvement Specialist
fratto2@ipro.org
518-320-3506

Gail Gresko (OH)
Senior Quality Improvement Specialist
ggresko@ipro.org
216-755-3067

Diane Judson, RN, BS, IPC
Assistant Director
djudson@ipro.org
516-402-0311

Sara Butterfield, RN, BSN, CPHQ
Assistant Vice President
sbutterfield@ipro.org
518-320-3504



■ Healthcentric
Advisors
■ Qlarant

QIN-QIO
Quality Innovation Network -
Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES
EQUALITY IMPROVEMENT & INNOVATION GROUP