



TAHOE FOREST
HOSPITAL DISTRICT

2025-11-06 Board Quality Committee

Thursday, November 06, 2025 at 12:00 p.m.

Tahoe Forest Hospital - Aspen Conference Room

10800 Donner Pass Rd, Suite 200, Truckee CA 96161

Meeting Book - 2025-11-06 Board Quality Committee

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QUALITY COMMITTEE AGENDA

Thursday November 6, 2025, at 12:00 p.m.
Aspen Conference Room – Tahoe Forest Hospital
10800 Donner Pass Rd, Suite 200, Truckee, CA 96161

1. CALL TO ORDER

2. ROLL CALL

Alyce Wong, Chair; Rob Darzynkiewicz, MD, Board Member

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA

4. INPUT – AUDIENCE

This is an opportunity for members of the public to address the Committee on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Board Clerk 24 hours prior to the meeting to allow for distribution. Under Government Code Section 54954.2 – Brown Act, the Committee cannot take action on any item not on the agenda. The Committee may choose to acknowledge the comment or, where appropriate, briefly answer a question, refer the matter to staff, or set the item for discussion at a future meeting.

5. APPROVAL OF MINUTES OF: 08/21/2025 ATTACHMENT

6. CLOSED SESSION

6.1. Hearing (Health & Safety Code § 32155)

Subject Matter: Case Review

Number of items: One (1)

6.1. Approval of Closed Session Minutes

6.1.1. 05/07/2025 Closed Session Board Quality Committee

6.1.2. 08/21/2025 Closed Session Board Quality Committee

7. OPEN SESSION

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

9. INFORMATIONAL REPORTS

9.1. Patient & Family Centered Care

9.1.1. Patient & Family Advisory Council (PFAC) Update ATTACHMENT

Quality Committee will receive an update related to the activities of the Patient and Family Advisory Council (PFAC).

9.2. Patient Safety

9.2.1. BETA HEART Program Progress Report ATTACHMENT

Quality Committee will receive a progress report regarding the BETA Healthcare Group Culture of Safety program.

10. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

10.1. Safety First ATTACHMENT

Review and discuss the Interpreter services available at Tahoe Forest Health System.

10.2. Board Quality Committee Charter and Goals ATTACHMENT

The Committee will review and provide input on the Board Quality Committee Charter and goals.

10.3. Health Equity Report ATTACHMENT

The Committee will review the health equity summary report required by AB1204 and posted on the tfhd.com website.

10.4. Quality / Patient Safety / Risk Roundtable

The Committee will hold discussion on insights, identification of emerging challenges, and strategic opportunities to enhance care delivery and organizational safety culture.

10.5. Board Quality Education ATTACHMENT

The Committee will review the educational article listed below and discuss topics for future board quality education.

Kennedy, M., et. al. *Reach and Adoption of a Geriatric Emergency Department Accreditation Program in the United States*. Ann Emerg Med. 2022 April; 79(4): 367–373.

11. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

12. NEXT MEETING DATE

The next committee date and time will be confirmed for February TBD, 2026 at 1200 p.m.

13. ADJOURN

*Denotes material (or a portion thereof) may be distributed later.

Note: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of services, hiring, training and employment practices on the basis of color, national origin, sex, religion, age or disability including AIDS and related conditions. Equal Opportunity Employer. The telephonic meeting location is accessible to people with disabilities. Every reasonable effort will be made to accommodate participation of the disabled in all of the District’s public meetings. If particular accommodations for the disabled are needed or a reasonable modification of the teleconference procedures are necessary (i.e., disability-related aids or other services), please contact the Executive Assistant at 582-3583 at least 24 hours in advance of the meeting.

QUALITY COMMITTEE

DRAFT MINUTES

Thursday, August 21, 2025 at 12:00 p.m.
Aspen Conference Room – Tahoe Forest Hospital
10800 Donner Pass Rd, Suite 200, Truckee, CA 96161

1. CALL TO ORDER

Meeting was called to order at 12:00 p.m.

2. ROLL CALL

Board Alyce Wong, Chair; Robert Darzynkiewicz, Board Member

Staff in attendance: Dr. Brian Evans, Chief Medical Officer; Louis Ward, Chief Operating Officer; Janet Van Gelder, Director of Quality & Regulations; Jan Iida, Chief Nursing Officer; Alex Bezaire, Patient Experience Specialist; Christine O'Farrell, Risk Manager; Kim McCarl, Administrative Services Officer; Sarah Jackson, Executive Assistant / Clerk of the Board

Other: Sharon (patient); Mr. Kevin Ward, PFAC representative;

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA

No changes were made to the agenda.

4. INPUT – AUDIENCE

None

5. APPROVAL OF MINUTES OF: 05/07/2025

Director Darzynkiewicz moved to approve the Open Session Board Quality Committee Minutes of May 07, 2025, seconded by Director Wong.

6. Patient Experience Presentation (timed item 12:05 p.m.)

Patient shared her recent healthcare experience at Tahoe Forest Hospital District.

Risk Management reviewed informed consent education resulting from this case and procedure improvements resulting from this patient's pain.

Open Session recessed at 12:36 p.m.

7. CLOSED SESSION

7.1. Hearing (Health & Safety Code § 32155)

Subject Matter: Case Review

Number of items: One (1)

Discussion was held on a privileged item.

7.2. Hearing (Health & Safety Code § 32155)

Subject Matter: Standard of Work Bundle Review

Discussion was held on a privileged item

Open Session reconvened at 12:54 p.m.

8. INFORMATIONAL REPORTS

8.1. Patient & Family Centered Care

8.1.1. Patient & Family Advisory Council (PFAC) Update

Mr. Kevin Ward, PFAC representative re-joined the meeting at 1:00 p.m.

Quality Committee review the attached update related to the activities of the Patient and Family Advisory Council (PFAC).

8.2. Patient Safety

8.2.1. BETA HEART Program Progress Report

Janet Van Gelder, Director of Quality & Regulations Quality Committee provided a progress report regarding the BETA Healthcare Group Culture of Safety program.

9. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

9.1. Safety First

Janet Van Gelder, Director of Quality & Regulations present the Safety First topic of C-U-S

“I am Concerned, I am Uncomfortable, This is a Safety Issue.”

9.2. Board Quality Committee Charter & Goals

The Quality Committee reviewed the recommendations for the Charter and Goals.

Revisions will be sent via email to the Committee.

9.3. Patient Safety Structural Measure

As part of the FY 2025 final rule, CMS is requiring hospitals participating in the Hospital Inpatient Quality Reporting Program (IQR) program to attest to the Patient Safety Structure Measures (PSSM).

Director of Quality & Regulations reviewed the PSSM standards. We don't have to follow these standards as a CAH, but we follow most of these standards already.

9.4. Quality Star Rating Overview

Provided for informational review.

9.5. Process Improvement Projects

An update was reviewed Process Improvement – Projects and Initiatives. These are the projects and initiatives that are fielded out of the Process Improvement and Project Management Offices. This is separate from the Quality Improvement projects and data.

9.6. Board Quality Education

Director Wong would like to review two articles at the next meeting: Better Care and Greater Value, starting on page 19, and Trends Snaps.

American Hospital Association. *Environmental Scan*. 2025

10. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

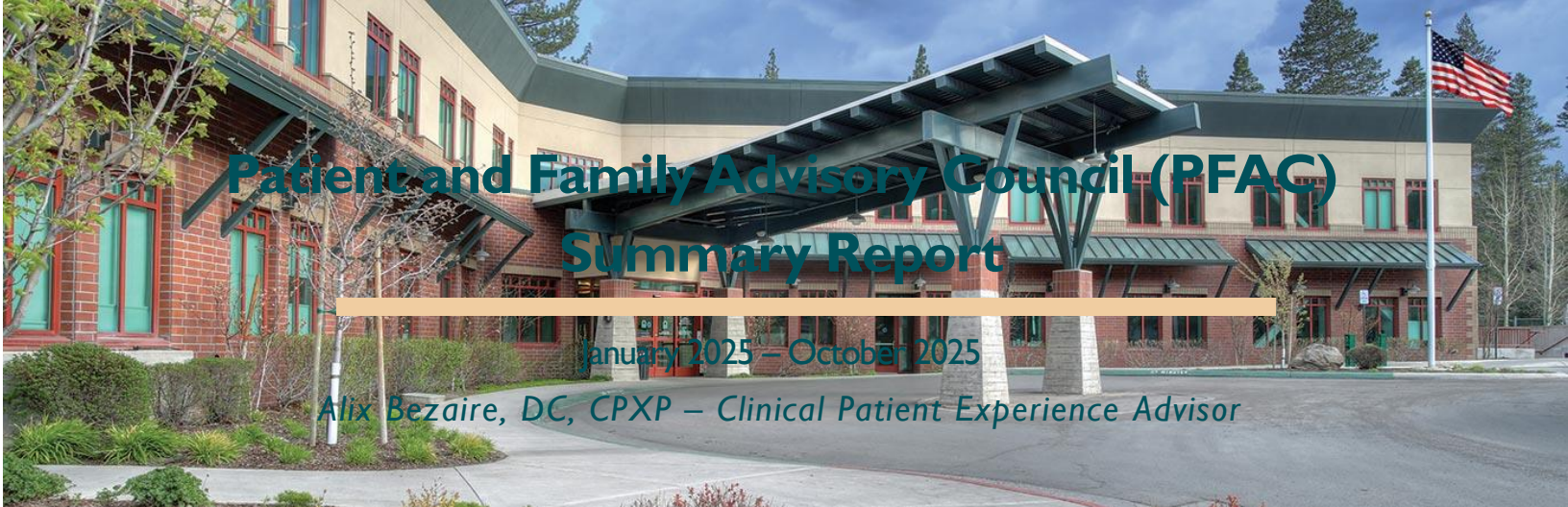
11. NEXT MEETING DATE

The next committee date and time will be confirmed for November 6th, 2025 at 12:00 p.m..

12. ADJOURN

Meeting adjourned at 1:35 p.m.

DRAFT



Patient and Family Advisory Council (PFAC) Summary Report

January 2025 – October 2025

Alix Bezaire, DC, CPXP – Clinical Patient Experience Advisor

Summary of Monthly Topics

January – Christine O’Farrell, Risk Manager/Patient Safety Associate, presented a case review/analysis in which a medical error occurred. The case involved an ICU nurse who inadvertently administered IV insulin to a patient instead of a different medication. The error was immediately identified and intervention began promptly, resulting in no harm or symptoms to the patient. There was discussion about the event analysis process, including the disclosure to patient and family members, identifying contributing factors, and the action plan to prevent similar situations from happening again.

February – Chris Malone, Director of Urgent Care, and Dr. David Lemak, Urgent Care Medical Director, presented on the Urgent Care Clinics and goal to improve efficiency and care. Overall, total visit time has been decreased from 138+ minutes (December 2022) to 67 minutes (September 2024). RN triage system allows independent evaluation/order testing prior to patient being seen by provider to streamline visit. UC has also implemented “On My Way” feature to help spread patients out throughout the day versus loaded mornings. Ryan Solberg, Director of Therapy Services, also came to request feedback/input on consistently high cancellation/no-show rates. PFAC input was that appointment reminder system ineffective for preventing no-shows, and suggested new system requiring patient “confirmation” of appointment, or risk losing appointment. Also suggested a “cancellation/no-show” fee, as other outside services generally utilize.

March – Alan Kern was named as PFAC Co-Chair and we held workshop to improve meeting structure, focus and council utilization. Generated a presentation template for all presenters to utilize that explicitly identifies their top challenges within their service line/department, and prompts pointed questions from the PFAC for input. Received input on proposed meeting format and template from the group, and asked for specific topics/areas of interest for future meetings from the group. Due to Med Staff meetings conflicting with PFAC meetings, it was agreed to move meetings to the 4th Tuesday of the month, effective in May.

April – Dr. Brian Evans, Chief Medical Officer, provided update on previous Access to Care project that has been ongoing for the past year. Overall goal has been to improve quality of care through improved efficiency and consistency (i.e., ‘standard work’). Patient access to timely appointments remains priority, and tracking “3rd Next Available” appointment is the industry standard for measuring. We have attained goal for some clinics, but are not yet there for others. Dr. Evans and CEO Anna Roth expressed an interest in better leveraging the PFAC for future improvement initiatives, and providing more opportunities for the PFAC to be utilized.

May – Our new CEO, Anna Roth, met with the group to discuss her experience and vision with PFAC at her previous facility. The group emphasized the desire for strengthened leadership accountability, curiosity, and desire

PATIENT AND FAMILY ADVISORY COUNCIL (PFAC) SUMMARY REPORT

January 2025 – October 2025

to incorporate patient perspective/input into process improvements. Anna will facilitate in matching council members with committees of interest throughout the health system, and potential to visit sites or staff huddle meetings.

June – Brian Parrish, Director of Behavioral Health Services, presented on the growth and overall development of Behavioral Health over the last 2 years. Services are Outpatient-focused only (no Inpatient psychiatric care) primarily for adults, with limited services for those under 18. Currently limited to referrals directly from primary care or pediatrics, with a goal of converting 50% of referrals into patient appointments. BH expands across 5 locations in the health system, so has challenges maintaining a consistent workflow. BH would like to improve and expand assistance for patients and families with external resources, when they need services outside of TFH offerings.

July – Debi Stanley, Director of Access Center, and 3 of the Access Center Managers presented on the scheduling, referrals and authorizations process, as well as the challenges that the Department faces. On top of insurance restrictions and inconsistent provider scheduling preferences, demand for appointments has increased significantly with the community growth, and has outpaced our ability to see patients in a timely manner. Currently contracting with Vizient (Access to Care) to improve patient access across the health system. Improvements have been made but we have not yet reached our goals for timeline to schedule new or established patients for primary care. Members provided input on current concerns about high no-show and cancellation rates, and suggested an incentivized system requiring patients to confirm appointments and/or use discretionary fees. Other suggestions were an interactive text confirmation system that released appointments if not confirmed within 24 hours.

September – Ryan Solberg, Director of Therapy Services, presented on their primary challenges surrounding late cancellations/no shows as well as general appointment scheduling for patients. He presented data regarding a downward trend of perceived patient access, according to Press Ganey patient satisfaction data. Staff shortages/call-outs and continued high no show/late cancellation rates have been major factors driving decreased access. Recently re-implemented a 'Broken Appointment' policy that places scheduling restrictions on patients that have 2 or more late cancellations or no-shows, and will review data in 3-6 months to evaluate data. PFAC members shared experiences with Therapy Services and reiterated previously provided input for more robust appointment confirmation system.

October – Lizzy Henasey, Population Health Analyst, presented on highlights from the most current 2025 Community Health Needs Assessment (CHA) and desire to recruit a community member for the CHIP Plan task force. She reviewed how to access materials online and elicited feedback on how to make the "Community" page more visible to the general public. Dr. Alison Semrad, Endocrinologist and Chair of the current HbA1c Workgroup, came to present on the inception and objective of this workgroup in response to the CHA and Healthy People 2030 goal. Dr. Semrad provided clarification on number of diabetic patients TFH serves versus patients under care of Endocrinology clinic, and presented proposed barriers to care (e.g., cost of lab tests, cost of prescription drugs for management, time constraints, etc.).

PATIENT AND FAMILY ADVISORY COUNCIL (PFAC) SUMMARY REPORT

January 2025 – October 2025

Key Items of Feedback/Elicited Input from PFAC:

February - Therapy Services:

- PFAC noted the appointment reminder system was ineffective.
- Suggested requiring patient confirmation to retain appointments.
- Proposed implementing a cancellation/no-show fee, similar to external services.

March - Meeting Structure:

- PFAC provided input on a new presentation template to improve meeting focus.
- Offered suggestions for future meeting topics.
- Agreed to change meeting schedule to the 4th Tuesday of each month.

April – Access to Care

- PFAC was invited to be more involved in improvement initiatives.
- Expressed interest in contributing to standardization and efficiency efforts.

May – Leadership Engagement

- PFAC emphasized the need for stronger leadership accountability and curiosity.
- Supported CEO's plan to match members with committees and site visits.

July – Access/Scheduling Center

PFAC suggested:

- Incentivized appointment confirmation system.
- Interactive text confirmations that release unconfirmed appointments after 24 hours.

September – Therapy Services (Follow Up)

- PFAC reiterated previous feedback on appointment confirmation systems.
- Shared personal experiences with scheduling challenges.

October – Community Health Needs Assessment/HbA1c Workgroup

- Provided feedback on improving visibility of the “Community” webpage.
- Engaged in discussion on barriers to diabetes care (e.g., cost, time constraints).

PATIENT AND FAMILY ADVISORY COUNCIL (PFAC) SUMMARY REPORT

January 2025 – October 2025

Current Overview

- Ongoing goal is to have PFAC more actively involved and leveraged in hospital-wide process improvement initiatives.
- Topics of interest for future meetings include Scheduling/Authorizations/Referrals, patient advocacy/support groups for oncology patients, primary care medical director and operational director, retail pharmacy and impact of closed local pharmacies, financial/operational impacts of healthcare cuts, etc.
- PFAC met 10 months in the year, on the 4th Tuesday of the month. This year we added a meeting in July, continued with no meetings scheduled for August or December. Will look to add August meeting for 2026.
- Next PFAC meeting is November 18, 2025.

Current Members and Start Date

Kevin Ward	9/20/2018	Cris Valerio	12/1/2022
Sandy Horn	9/5/2019	Jane Rudolph-Bloom	1/1/2024
Violet Nakayama	10/31/2019	Amber Mello	5/1/2024
Alan Kern	2/20/2020	Sharon Strojny	6/1/2024
Carina Toledo	11/17/2022	Bob Barnett	2/1/2024

Beta HEART Progress Report for Year 2025

(October 2025)

- Beta HEART Validation Survey completed May 22, 2024: validated in all 5 domains, cost savings of \$159,866.
- Beta HEART Validation Survey completed May 28, 2025: validated in all 5 domains, cost savings of \$174,554

Domain	History of Incentive Credits (2% annually)	Readiness for next Validation	Goal	Comments
Culture of Safety: A process for measuring safety culture and staff engagement (Lead: Ashley Davis, Patient Safety Officer)	Validated 2024: \$31,973.20 2025: \$34,910.80	100%	Greater than 75% completion rate for SCOR Culture of Safety Survey Achieve Tier 2 in Zero Harm (OB & ED)	- SCOR culture of safety survey was administered February-March 2025 with a 74% response rate. Director/Managers will debrief with their staff and develop an action plan of the top 2 areas for improvement. - TFHD Women & Family Center and TFH/IVCH Emergency Departments will be participating in Zero Harm programs again in 2025. 3 physicians & 5 leaders attended February workshop
Rapid Event Response and Analysis: A formalized process for early identification and rapid response to adverse events that includes an investigatory process that integrates human factors and systems analysis while applying Just Culture principles (Lead: Christine O'Farrell, Risk Manager)	Validated 2024: \$31,973.20 2025: \$34,910.80	100%	75% or greater response time for event analyses within 45 days of event reported 75% or greater response time for closure of action items within 90 days of event reported	- TFHD incorporates the transparent and timely reporting of safety events to ensure rapid change in providing safer patient care. All investigations utilize collaborative just culture and high reliability principles and encourage accountability. A member of the Reliability Management Team reviews all action plans to address strength of action items. - Tahoe Forest Hospital District Serious Safety Event Checklist was developed to guide the response after a serious safety event. 3 physicians & 5 leaders attended February workshop
Communication and transparency: A commitment to honest and transparent communication with patients and family members after an adverse event (Lead: Christine O'Farrell, Risk Manager)	Validated 2024: \$31,973.20 2025: \$34,910.80	100%	75% or greater response time for closure of event within 60 days	- Disclosure checklist updated and refined as we update process and leaders trained to respond to events. - Risk Management provided a case presentation to PFAC in January 2025 to promote transparency and request feedback on action items. 3 physicians & 4 leaders attended April workshop
Care for the Caregiver: An organizational program that ensures support for caregivers involved in an adverse event (Lead: Ashley Davis, Patient Safety Officer)	Validated 2024: \$31,973.20 2025: \$34,910.80	100%	75% or greater response time for peer supporter deployment made in 0-12 hours	- Ongoing training and quarterly peer support and steering committee meetings. Currently have 40 peer supporters available to all staff. 2024 average time from peer support request to deployment was 45 minutes. - Peer Support team member trained as a Mental Health First Aid trainer and will provide in-house training to staff and Medical Staff in 2025. - Interested Medical Staff have been asked to complete an application and participate in formal training – Interviews in June 2025 - Peer support module in RL Datix will be implemented in June 2025 3 physicians & 4 leaders attended April workshop
Early Resolution: A process for early resolution when harm is deemed the result of inappropriate care or medical error (Lead: Christine O'Farrell, Risk Manager)	Validated 2024: \$31,973.20 2025: \$34,910.80	100%	75% or greater response time for closure of event within 60 days	- QAPI polices reviewed and updated as needed to reflect process improvement 2 physicians & 4 leaders attended the September workshop. Focus was providing fundamental concepts and strategies to develop an early resolution process and conduct resolution conversations.

Safety First

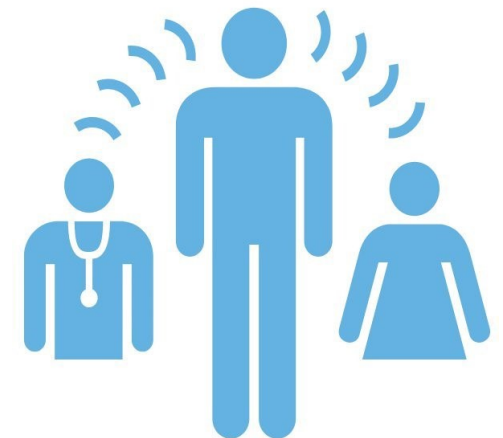


tip of the week

Interpreter Services

Interpretive services are available 24 hours a day, seven days a week, within the Tahoe Forest Health System to provide appropriate and safe patient care (and to comply with federal ADA requirements). Interpreter services provide limited English proficient, sensory, or speech impairment patients and their representatives with timely and accurate interpretation in order to assure access to and understanding of necessary healthcare services.

- ♦ Currently, certified or qualified medical interpreters often undergo annual evaluations to maintain their proficiency, which is a crucial quality assurance measure. Relying on untrained bilingual staff or family members simply because it is convenient bypasses this safeguard and potentially endangers both patients and staff.
- ♦ Medical interpretation should only be conducted by those who are trained and qualified to do so, and healthcare systems should prioritize this as a matter of ethical, legal, and clinical responsibility.
- ♦ All use of interpreter services should be clearly documented in the patient's medical record. **Please document the interpreter name and ID number for reference (if there are any concerns/questions/feedback about the interaction, this is necessary to follow up.)**
- ♦ Should the patient, after being informed of the availability of the interpreter service, choose to use a family member or friend who volunteers to interpret, staff will encourage the use of interpreter services. At the point of care, when considering the complexity of the condition/treatment and whether the patient and or representative appears to understand the proposed treatment/plan of care, staff may choose to utilize interpreter services. All efforts to arrange for interpretive services will be documented by the appropriate point of care.



Refer to Policy Interpreter & Translator Services, DPTREG-2001 for more information

DRAFT Charter
Quality Committee
Tahoe Forest Hospital District
Board of Directors

PURPOSE:

The purpose is to define the duties, responsibilities, and scope of authority of the Quality Committee.

RESPONSIBILITIES:

The Quality Committee serves as the standing committee of the Board of Directors, providing oversight of Quality Assessment and Performance Improvement (QAPI), assuring the delivery of high-quality care, promotes patient safety, and enhances the overall patient experience across the Health System.

DUTIES:

1. Recommend to the governing Board, action items and recommendations regarding any policies and procedures governing quality, patient safety, environmental safety, and performance improvement throughout the organization.
2. Assure the provision of organization-wide quality of care, treatment, and service provided and prioritization of performance improvement throughout the organization.
3. Steward the improvement of care, treatment, and services to ensure that it is safe, beneficial, patient-centered, customer-focused, timely, efficient, and equitable and it reflects the community.
4. Monitor the organization's performance in national quality measurement efforts, accreditation programs, and subsequent quality improvement activities adheres to the mission, vision, and values.
5. Whenever quality goals/benchmarks are not met, recommend corrective actions to the governing Board to address deficiencies, mitigate risks, and improve performance.
6. Ensure the development and implementation of ongoing board education, focusing on service excellence, performance improvement, risk reduction/safety enhancement, and healthcare outcomes.

COMPOSITION:

The Committee is comprised of at least two (2) board members as appointed by the Board Chair, the Medical Director of Quality, and Vice Chief of Staff or designee.

MEETING FREQUENCY:

The Committee shall meet quarterly.

November 6, 2025

Hospital Equity Measures Report

General Information

Report Type:	Hospital Equity Measures Report
Year:	2024
Hospital Name:	TAHOE FOREST HOSPITAL
Facility Type:	General Acute Care Hospital
Hospital HCAI ID:	106291053
Report Period:	1/1/2024 - 12/31/2024
Status:	Submitted
Due Date:	09/30/2025
Last Updated:	08/22/2025
Hospital Location with Clean Water and Air:	Y
Hospital Web Address for Equity Report:	www.tfhd.com

Overview

Assembly Bill No. 1204 requires the Department of Health Care Access and Information (HCAI) to develop and administer a Hospital Equity Measures Reporting Program to collect and post summaries of key hospital performance and patient outcome data regarding sociodemographic information, including but not limited to age, sex, race/ethnicity, payor type, language, disability status, and sexual orientation and gender identity.

Hospitals (general acute, children's, and acute psychiatric) and hospital systems are required to annually submit their reports to HCAI. These reports contain summaries of each measure, the top 10 disparities, and the equity plans to address the identified disparities. HCAI is required to maintain a link on the HCAI website that provides access to the content of hospital equity measures reports and equity plans to the public. All submitted hospitals are required to post their reports on their websites, as well.

Laws and Regulations

For more information on Assembly Bill No. 1204, please visit the following link by copying and pasting the URL into your web browser:

https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB1204

Hospital Equity Measures

Joint Commission Accreditation

General acute care hospitals are required to report three structural measures based on the Commission Accreditation's Health Care Disparities Reduction and Patient-Centered Communication Accreditation Standards. For more information on these measures, please visit the following link by copying and pasting the URL into your web browser:

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

The first two structural measures are scored as "yes" or "no"; the third structural measure comprises the percentages of patients by five categories of preferred languages spoken, in addition to one other/unknown language category.

Designate an individual to lead hospital health equity activities (Y = Yes, N = No).

Y

Provide documentation of policy prohibiting discrimination (Y = Yes, N = No).

Y

Number of patients that were asked their preferred language, five defined categories and one other/unknown languages category.

21264

Table 1. Summary of preferred languages reported by patients.

Languages	Number of patients who report preferring language	Total number of patients	Percentage of total patients who report preferring language (%)
English Language	18948	21264	89.1
Spanish Language	2233	21264	10.5
Asian Pacific Islander Languages	18	21264	0.1
Middle Eastern Languages	suppressed	21264	suppressed
American Sign Language	suppressed	21264	suppressed
Other Languages	43	21264	0.2

Centers for Medicare & Medicaid Services (CMS) Hospital Commitment to Health Equity Structural (HCHE) Measure

There are five domains that make up the CMS Hospital Commitment to HCHE measures. Each domain is scored as "yes" or "no." In order to score "yes," a general acute care hospital is required to confirm all the domain's attestations. Lack of one or more of the attestations results in a score of "no." For more information on the CMS Hospital Commitment to HCHE measures, please visit the following link by copying and pasting the URL into your web browser:
<https://data.cms.gov/provider-data/topics/hospitals/health-equity>

Centers for Medicare & Medicaid Services (CMS) Hospital Commitment to Health Equity Structural (HCHE) Measure Domain 1: Strategic Planning (Yes/No)

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

Y

CMS HCHE Measure Domain 2: Data Collection (Yes/No)

- Our hospital strategic plan identifies healthcare equity goals and discrete action steps to achieve these goals.
- Our hospital has training for staff in culturally sensitive collection of demographics and/or social determinant of health information.

- Our hospital inputs demographic and/or social determinant of health information collected from patients into structured, interoperable data elements using a certified electronic health record (EHR) technology.

Y

CMS HCHE Measure Domain 3: Data Analysis (Yes/No)

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

Y

CMS HCHE Measure Domain 4: Quality Improvement (Yes/No)

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

Y

CMS HCHE Measure Domain 5: Leadership Engagement (Yes/No)

- Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews our strategic plan for achieving health equity.
- Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually review key performance indicators stratified by demographic and/or social factors.

Y

Centers for Medicare & Medicaid Services (CMS) Social Drivers of Health (SDOH)

General acute care hospitals are required to report on rates of screenings and intervention rates among patients above 18 years old for five health related social needs (HRSN), which are food insecurity, housing instability, transportation problems, utility difficulties, and interpersonal safety. These rates are reported separately as being screened as positive for any of the five HRSNs, positive for each individual HRSN, and the intervention rate for each positively screened HRSN. For more information on the CMS SDOH, please visit the following link by copying and pasting the URL into your web browser:
<https://www.cms.gov/priorities/innovation/key-concepts/social-drivers-health-and-health-related-social-needs>

Number of patients admitted to an inpatient hospital stay who are 18 years or older on the date of admission and are screened for all of the five HRSN
838

Total number of patients who are admitted to a hospital inpatient stay and who are 18 years or older on the date of admission
1205

Rate of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, were screened for an HRSN, and who screened positive for one or more of the HRSNs
1.2

Table 2. Positive screening rates and intervention rates for the five Health Related Social Needs of the Centers of Medicare & Medicaid Services (CMS) Social Drivers of Health (SDOH).

Social Driver of Health	Number of positive screenings	Rate of positive screenings (%)	Number of positive screenings who received intervention	Rate of positive screenings who received intervention (%)
Food Insecurity	3	0.4		
Housing Instability	4	0.5		
Transportation Problems	2	0.2		
Utility Difficulties	0	0		
Interpersonal Safety	1	0.1		

Core Quality Measures for General Acute Care Hospitals

There are two quality measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. For more information on the HCAHPS survey, please visit the following link by copying and pasting the URL into your web browser:
<https://hcahpsonline.org/en/survey-instruments/>

Patient Recommends Hospital

The first HCAHPS quality measure is the percentage of patients who would recommend the hospital to friends and family. For this measure, general acute care hospitals provide the percentage of patient respondents who responded "probably yes" or "definitely yes" to whether they would recommend the hospital, the percentage of the people who responded to the survey (i.e., the response rate), and the inputs for the percentages. The percentages and inputs are stratified by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity. The corresponding HCAHPS question number is 19.

Number of respondents who replied "probably yes" or "definitely yes" to HCAHPS Question 19, "Would you recommend this hospital to your friends and family?"

6152

Total number of respondents to HCAHPS Question 19

6912

Percentage of total respondents who responded "probably yes" or "definitely yes" to HCAHPS Question 19

89

Total number of people surveyed on HCAHPS Question 19

288

Response rate, or the percentage of people who responded to HCAHPS Question 19

24

Table 3. Patient recommends hospital by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of "probably yes" or "definitely yes" responses	Total number of responses	Percent of "probably yes" or "definitely yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
American Indian or Alaska Native					
Asian					
Black or African American					
Hispanic or Latino					
Middle Eastern or North African					
Multiracial and/or Multiethnic (two or more races)					
Native Hawaiian or Pacific Islander					
White					
Age	Number of "probably yes" or "definitely yes" responses	Total number of responses	Percent of "probably yes" or "definitely yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Age < 18					
Age 18 to 34					
Age 35 to 49					
Age 50 to 64					
Age 65 Years and Older					
Sex assigned at birth	Number of "probably yes" or "definitely yes" responses	Total number of responses	Percent of "probably yes" or "definitely yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Female					
Male					
Unknown					
Payer Type	Number of "probably yes" or "definitely yes" responses	Total number of responses	Percent of "probably yes" or "definitely yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Medicare					
Medicaid					
Private					
Self-Pay					
Other					
Preferred Language	Number of "probably yes" or "definitely yes" responses	Total number of responses	Percent of "probably yes" or "definitely yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
English Language					
Spanish Language					
Asian Pacific Islander Languages					
Middle Eastern Languages					
American Sign Language					
Other/Unknown Languages					

Disability Status	Number of "probably yes" or "definitely yes" responses	Total number of responses	Percent of "probably yes" or "definitely yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Does not have a disability					
Has a mobility disability					
Has a cognition disability					
Has a hearing disability					
Has a vision disability					
Has a self-care disability					
Has an independent living disability					

Sexual Orientation	Number of "probably yes" or "definitely yes" responses	Total number of responses	Percent of "probably yes" or "definitely yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Lesbian, gay or homosexual					
Straight or heterosexual					
Bisexual					
Something else					
Don't know					
Not disclosed					

Gender Identity	Number of "probably yes" or "definitely yes" responses	Total number of responses	Percent of "probably yes" or "definitely yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Female					
Female-to-male (FTM)/ transgender male/trans man					
Male					
Male-to-female (MTF)/ transgender female/trans					
Non-conforming gender					
Additional gender category or other					
Not disclosed					

Patient Received Information in Writing

The second HCAHPS quality measure is the percentage of patients who reported receiving information in writing on symptoms and health problems to look out for after leaving the hospital. General acute care hospitals are required to provide the percentage of patient respondents who responded "yes" to being provided written information, the percentage of the people who responded to the survey (i.e., the response rate), and the inputs for these percentages. These percentages and inputs are stratified by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity. The corresponding HCAHPS question number is 17.

Number of respondents who replied "yes" to HCAHPS Question 17, "During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the

hospital?"

6359
Total number of respondents to HCAHPS Question 17
6912

Percentage of respondents who responded "yes" to HCAHPS Question 17
92

Total number of people surveyed on HCAHPS Question 17
288

Response rate, or the percentage of people who responded to HCAHPS Question 17
24

Table 4. Patient reports receiving information in writing about symptoms or health problems by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of "yes" responses	Total number of responses	Percentage of "yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
American Indian or Alaska Native					
Asian					
Black or African American					
Hispanic or Latino					
Middle Eastern or North African					
Multiracial and/or Multiethnic (two or more races)					
Native Hawaiian or Pacific Islander					
White					

Age	Number of "yes" responses	Total number of responses	Percentage of "yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Age < 18					
Age 18 to 34					
Age 35 to 49					
Age 50 to 64					
Age 65 Years and Older					

Sex assigned at birth	Number of "yes" responses	Total number of responses	Percentage of "yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Female					
Male					
Unknown					

Payer Type	Number of "yes" responses	Total number of responses	Percentage of "yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Medicare					
Medicaid					
Private					
Self-Pay					
Other					

Preferred Language	Number of "yes" responses	Total number of responses	Percentage of "yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
English Language					
Spanish Language					
Asian Pacific Islander Languages					
Middle Eastern Languages					
American Sign					
Other/Unknown Languages					

Disability Status	Number of "yes" responses	Total number of responses	Percentage of "yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Does not have a disability					
Has a mobility disability					
Has a cognition					
Has a hearing disability					
Has a vision disability					
Has a self-care					
Has an independent living disability					

Sexual Orientation	Number of "yes" responses	Total number of responses	Percentage of "yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Lesbian, gay or homosexual					
Straight or heterosexual					
Bisexual					
Something else					
Don't know					
Not disclosed					

Gender Identity	Number of "yes" responses	Total number of responses	Percentage of "yes" responses (%)	Total number of patients surveyed	Response rate of patients surveyed (%)
Female					
Female-to-male (FTM)/ transgender male/trans man					
Male					
Male-to-female (MTF)/ transgender female/trans woman					
Non-conforming gender					
Additional gender category or other					
Not disclosed					

Agency for Healthcare Research and Quality (AHRQ) Indicators

General acute care hospitals are required to report on two indicators from the Agency for Healthcare Research and Quality (AHRQ). For general information about AHRQ indicators, please visit the following link by copying and pasting the URL into your web browser:
<https://qualityindicators.ahrq.gov/>

Pneumonia Mortality Rate

The Pneumonia Mortality Rate is defined as the rate of in-hospital deaths per 1,000 hospital discharges with a principal diagnosis of pneumonia or a principal diagnosis of sepsis with a secondary diagnosis of pneumonia present on admission for patients ages 18 years and older. General acute care hospitals report the Pneumonia Mortality Rate by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity. The corresponding AHRQ Inpatient Quality Indicator is 20. For more information about this indicator, please visit the following link by copying and pasting the URL into your web browser:
https://qualityindicators.ahrq.gov/Downloads/Modules/IQI/V2023/TechSpecs/IQI_20_Pneumonia_Mortality_Rate.pdf

Number of in-hospital deaths with a principal diagnosis of pneumonia or a principal diagnosis of sepsis with a secondary diagnosis of pneumonia present on admission

0

Total number of hospital discharges with a principal diagnosis of pneumonia or a principal diagnosis of sepsis with a secondary diagnosis of pneumonia present on admission

55

Rate of in-hospital deaths per 1,000 hospital discharges with a principal diagnosis of pneumonia or a principal diagnosis of sepsis with a secondary diagnosis of pneumonia present on admission

0

Table 5. Pneumonia Mortality Rate by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of hospital discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
American Indian or Alaska Native			
Asian			
Black or African American	suppressed	suppressed	suppressed
Hispanic or Latino	suppressed	suppressed	suppressed
Middle Eastern or North African			
Multiracial and/or Multiethnic (two or more)			
Native Hawaiian or Pacific Islander			
White	0	43	0

Age	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of hospital discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
Age < 18			
Age 18 to 34	suppressed	suppressed	suppressed
Age 35 to 49	suppressed	suppressed	suppressed
Age 50 to 64	suppressed	suppressed	suppressed
Age 65 Years and Older	0	38	0

Sex assigned at birth	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of hospital discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
Female	0	26	0
Male	0	29	0
Unknown			

Payer Type	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of hospital discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
Medicare	0	31	0
Medicaid	0	14	0
Private	suppressed	suppressed	suppressed
Self-Pay	suppressed	suppressed	suppressed
Other			

Preferred Language	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of hospital discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
English Language	suppressed	suppressed	suppressed
Spanish Language	suppressed	suppressed	suppressed
Asian Pacific Islander Languages			
Middle Eastern Languages			
American Sign Language			
Other/Unknown Languages			

Disability Status	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of hospital discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
Does not have a disability			
Has a mobility disability			
Has a cognition disability			
Has a hearing disability			
Has a vision disability			
Has a self-care disability			
Has an independent living disability			

Sexual Orientation	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of hospital discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
Lesbian, gay or homosexual			
Straight or heterosexual			
Bisexual			
Something else			
Don't know			
Not disclosed			

Gender Identity	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of hospital discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
Female			
Female-to-male (FTM)/ transgender male/trans man			
Male			
Male-to-female (MTF)/ transgender female/trans woman			
Non-conforming gender			
Additional gender category or other			
Not disclosed			

Death Rate among Surgical Inpatients with Serious Treatable Complications

The Death Rate among Surgical Inpatients with Serious Treatable Complications is defined as the rate of in-hospital deaths per 1,000 surgical discharges among patients ages 18-89 years old or obstetric patients with serious treatable complications. General acute care hospitals report this measure by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity. The corresponding AHRQ Patient Safety Indicator is 04. For more information about this indicator, please visit the following link by copying and pasting the URL into your web browser:

https://qualityindicators.ahrq.gov/Downloads/Modules/PSI/V2023/TechSpecs/PSI_04_Death_Rate_among_Surgical_Inpatients_with_Serious_Treatable_Complications.pdf

Number of in-hospital deaths among patients aged 18-89 years old or obstetric patients with serious treatable complications

suppressed

Total number of surgical discharges among patients aged 18-89 years old or obstetric patients

suppressed

Rate of in-hospital deaths per 1,000 surgical discharges, among patients aged 18-89 years old or obstetric patients with serious treatable complications

suppressed

Table 6. Death Rate among Surgical Inpatients with Serious Treatable Complications by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of surgical discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
American Indian or Alaska Native			
Asian			
Black or African American			
Hispanic or Latino	suppressed	suppressed	suppressed
Middle Eastern or North African			
Multiracial and/or Multiethnic (two or more)			
Native Hawaiian or Pacific Islander			
White	suppressed	suppressed	suppressed

Age	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of surgical discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
Age < 18			
Age 18 to 34			
Age 35 to 49	suppressed	suppressed	suppressed
Age 50 to 64	suppressed	suppressed	suppressed
Age 65 Years and Older	suppressed	suppressed	suppressed

Sex assigned at birth	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of surgical discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
Female	suppressed	suppressed	suppressed
Male	suppressed	suppressed	suppressed
Unknown			

Payer Type	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of surgical discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
Medicare	suppressed	suppressed	suppressed
Medicaid	suppressed	suppressed	suppressed
Private	suppressed	suppressed	suppressed
Self-Pay			
Other			

Preferred Language	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of surgical discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
English Language	suppressed	suppressed	suppressed
Spanish Language	suppressed	suppressed	suppressed
Asian Pacific Islander Languages			
Middle Eastern Languages			
American Sign Language			
Other/Unknown Languages			

Disability Status	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of surgical discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
Does not have a disability			
Has a mobility disability			
Has a cognition disability			
Has a hearing disability			
Has a vision disability			
Has a self-care disability			
Has an independent living disability			

Sexual Orientation	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of surgical discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
Lesbian, gay or homosexual			
Straight or heterosexual			
Bisexual			
Something else			
Don't know			
Not disclosed			

Gender Identity	Number of in-hospital deaths that meet the inclusion/exclusion criteria	Number of surgical discharges that meet the inclusion/exclusion criteria	Rate of in-hospital deaths per 1,000 hospital discharges that meet the inclusion/exclusion criteria (%)
Female			
Female-to-male (FTM)/ transgender male/trans man			
Male			
Male-to-female (MTF)/ transgender female/trans woman			
Non-conforming gender			
Additional gender category or other			
Not disclosed			

California Maternal Quality Care Collaborative (CMQCC) Core Quality Measures

There are three core quality maternal measures adopted from the California Maternal Quality Care Collaborative (CMQCC).

CMQCC Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate

The CMQCC Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate is defined as nulliparous women with a term (at least 37 weeks gestation), singleton baby in a vertex position delivered by cesarian birth. General acute care hospitals report the NTSV Cesarean Birth Rate by race and/or ethnicity, maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity. For more information, please visit the following link by copying and pasting the URL into your web browser:
<https://www.cmqcc.org/quality-improvement-toolkits/supporting-vaginal-birth/ntsv-cesarean-birth-measure-specifications>

Number of NTSV patients with Cesarean deliveries

20

Total number of nulliparous NTSV patients

137

Rate of NTSV patients with Cesarean deliveries

0.146

Table 7. Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate by race and/or ethnicity, maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of NTSV patients with cesarean deliveries	Total number of NTSV patients	Rate of NTSV patients with Cesarean deliveries (%)
American Indian or Alaska Native	0		
Asian	suppressed	suppressed	suppressed
Black or African American	0		
Hispanic or Latino	suppressed	suppressed	suppressed
Middle Eastern or North African			
Multiracial and/or Multiethnic (two or more races)	suppressed	suppressed	suppressed
Native Hawaiian or Pacific Islander	0		
White	suppressed	suppressed	suppressed

Age	Number of NTSV patients with cesarean deliveries	Total number of NTSV patients	Rate of NTSV patients with Cesarean deliveries (%)
Age < 18	suppressed	suppressed	suppressed
Age 18 to 29	suppressed	suppressed	suppressed
Age 30 to 39	suppressed	suppressed	suppressed
Age 40 Years and Older	suppressed	suppressed	suppressed

Sex assigned at birth	Number of NTSV patients with cesarean deliveries	Total number of NTSV patients	Rate of NTSV patients with Cesarean deliveries (%)
Female			
Male			
Unknown			

Payer Type	Number of NTSV patients with cesarean deliveries	Total number of NTSV patients	Rate of NTSV patients with Cesarean deliveries (%)
Medicare	0		
Medicaid	suppressed	suppressed	suppressed
Private	suppressed	suppressed	suppressed
Self-Pay	0		
Other	suppressed	suppressed	suppressed

Preferred Language	Number of NTSV patients with cesarean deliveries	Total number of NTSV patients	Rate of NTSV patients with Cesarean deliveries (%)
English Language	suppressed	suppressed	suppressed
Spanish Language	suppressed	suppressed	suppressed
Asian Pacific Islander Languages	0		
Middle Eastern Languages	0		
American Sign Language	0		
Other/Unknown Languages	0		

Disability Status	Number of NTSV patients with cesarean deliveries	Total number of NTSV patients	Rate of NTSV patients with Cesarean deliveries (%)
Does not have a disability			
Has a mobility disability			
Has a cognition disability			
Has a hearing disability			
Has a vision disability			
Has a self-care disability			
Has an independent living disability			

Sexual Orientation	Number of NTSV patients with cesarean deliveries	Total number of NTSV patients	Rate of NTSV patients with Cesarean deliveries (%)
Lesbian, gay or homosexual			
Straight or heterosexual			
Bisexual			
Something else			
Don't know			
Not disclosed			

Gender Identity	Number of NTSV patients with cesarean deliveries	Total number of NTSV patients	Rate of NTSV patients with Cesarean deliveries (%)
Female			
Female-to-male (FTM)/transgender male/trans man			
Male			
Male-to-female (MTF)/transgender female/trans woman			
Non-conforming gender			
Additional gender category or other			
Not disclosed			

CMQCC Vaginal Birth After Cesarean (VBAC) Rate

The CMQCC Vaginal Birth After Cesarean (VBAC) Rate is defined as vaginal births per 1,000 deliveries by patients with previous Cesarean deliveries. General acute care hospitals report the VBAC Rate by race and/or ethnicity, maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity. The VBAC Rate uses the specifications of AHRQ Inpatient Quality Indicator 22. For more information, please visit the following link by copying and pasting the URL into your web browser:

[https://qualityindicators.ahrq.gov/Downloads/Modules/IQI/V2023/TechSpecs/IQI_22_Vaginal_Birth_After_Cesarean_\(VBAC\)_Delivery_Rate_Uncomplicated.pdf](https://qualityindicators.ahrq.gov/Downloads/Modules/IQI/V2023/TechSpecs/IQI_22_Vaginal_Birth_After_Cesarean_(VBAC)_Delivery_Rate_Uncomplicated.pdf)

Number of vaginal delivery among cases with previous Cesarean delivery that meet the inclusion and exclusion criteria

suppressed

Total number of birth discharges with previous Cesarean delivery that meet the inclusion and exclusion criteria

suppressed

Rate of vaginal delivery per 1,000 deliveries by patients with previous Cesarean deliveries

suppressed

Table 8. Vaginal Birth After Cesarean (VBAC) Rate by race and/or ethnicity, maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of vaginal deliveries with previous Cesarean delivery	Total number of birth discharges with previous Cesarean delivery	Rate of vaginal delivery per 1,000 deliveries by patients with previous Cesarean deliveries (%)
American Indian or Alaska Native	0		
Asian	0		
Black or African American	0		
Hispanic or Latino	suppressed	suppressed	suppressed
Middle Eastern or North African			
Multiracial and/or Multiethnic (two or more races)	suppressed	suppressed	suppressed
Native Hawaiian or Pacific	0		
White	0	19	0

Age	Number of vaginal deliveries with previous Cesarean delivery	Total number of birth discharges with previous Cesarean delivery	Rate of vaginal delivery per 1,000 deliveries by patients with previous Cesarean deliveries (%)
Age < 18	suppressed	suppressed	suppressed
Age 18 to 29	suppressed	suppressed	suppressed
Age 30 to 39	0	24	0
Age 40 Years and Older	suppressed	suppressed	suppressed

Sex assigned at birth	Number of vaginal deliveries with previous Cesarean delivery	Total number of birth discharges with previous Cesarean delivery	Rate of vaginal delivery per 1,000 deliveries by patients with previous Cesarean deliveries (%)
Female			
Male			
Unknown			

Payer Type	Number of vaginal deliveries with previous Cesarean delivery	Total number of birth discharges with previous Cesarean delivery	Rate of vaginal delivery per 1,000 deliveries by patients with previous Cesarean deliveries (%)
Medicare	0		
Medicaid	suppressed	suppressed	suppressed
Private	0	14	0
Self-Pay	0		
Other	suppressed	suppressed	suppressed

Preferred Language	Number of vaginal deliveries with previous Cesarean delivery	Total number of birth discharges with previous Cesarean delivery	Rate of vaginal delivery per 1,000 deliveries by patients with previous Cesarean deliveries (%)
English Language	suppressed	suppressed	suppressed
Spanish Language	suppressed	suppressed	suppressed
Asian Pacific Islander Languages	0		
Middle Eastern Languages	0		
American Sign Language	0		
Other/Unknown Languages	0		

Disability Status	Number of vaginal deliveries with previous Cesarean delivery	Total number of birth discharges with previous Cesarean delivery	Rate of vaginal delivery per 1,000 deliveries by patients with previous Cesarean deliveries (%)
Does not have a disability			
Has a mobility disability			
Has a cognition disability			
Has a hearing disability			
Has a vision disability			
Has a self-care disability			
Has an independent living			

Sexual Orientation	Number of vaginal deliveries with previous Cesarean delivery	Total number of birth discharges with previous Cesarean delivery	Rate of vaginal delivery per 1,000 deliveries by patients with previous Cesarean deliveries (%)
Lesbian, gay or homosexual			
Straight or heterosexual			
Bisexual			
Something else			
Don't know			
Not disclosed			

Gender Identity	Number of vaginal deliveries with previous Cesarean delivery	Total number of birth discharges with previous Cesarean delivery	Rate of vaginal delivery per 1,000 deliveries by patients with previous Cesarean deliveries (%)
Female			
Female-to-male (FTM)/transgender male/trans man			
Male			
Male-to-female (MTF)/transgender female/trans woman			
Non-conforming gender			
Additional gender category or			
Not disclosed			

CMQCC Exclusive Breast Milk Feeding Rate

The CMQCC Exclusive Breast Milk Feeding Rate is defined as the newborns per 100 who reached at least 37 weeks of gestation (or 3000g if gestational age is missing) who received breast milk

exclusively during their stay at the hospital. Other criteria are that the newborns did not go to the neonatal intensive care unit (NICU), transfer, or die, did not reflect multiple gestation, and did not have codes for parenteral nutrition or galactosemia. General acute care hospitals report the Exclusive Breast Milk Feeding Rate by race and/or ethnicity, maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity. The CMQCC Exclusive Breast Milk Feeding Rate uses the Joint Commission National Quality Measure PC-05. For more information, please visit the following link by copying and pasting the URL into your web browser: <https://manual.jointcommission.org/releases/TJC2024B/MIF0170.html>

Number of newborn cases that were exclusively fed breast milk during their hospital stay and meet the inclusion and exclusion criteria

307

Total number of newborn cases born in the hospital that meet the inclusion and exclusion criteria

339

Rate of newborn cases per 100 that were exclusively fed breast milk during their hospital stay and meet the inclusion and exclusion criteria

90.6

Table 9. Exclusive Breast Milk Feeding Rate by race and/or ethnicity, maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of newborn cases that were exclusively breastfed and meet inclusion/exclusion criteria	Total number of newborn cases born in the hospital that meet inclusion/exclusion criteria	Rate of newborn cases per 100 that were exclusively breastfed and met inclusion/exclusion criteria (%)
American Indian or Alaska Native	suppressed	suppressed	suppressed
Asian	suppressed	suppressed	suppressed
Black or African American	0		
Hispanic or Latino	suppressed	suppressed	suppressed
Middle Eastern or North African			
Multiracial and/or Multiethnic (two or more races)	suppressed	suppressed	suppressed
Native Hawaiian or Pacific	0		
White	182	202	90.1

Age	Number of newborn cases that were exclusively breastfed and meet inclusion/exclusion criteria	Total number of newborn cases born in the hospital that meet inclusion/exclusion criteria	Rate of newborn cases per 100 that were exclusively breastfed and met inclusion/exclusion criteria (%)
Age < 18	suppressed	suppressed	suppressed
Age 18 to 29	suppressed	suppressed	suppressed
Age 30 to 39	182	195	93.3
Age 40 Years and Older	suppressed	suppressed	suppressed

Sex assigned at birth	Number of newborn cases that were exclusively breastfed and meet inclusion/exclusion criteria	Total number of newborn cases born in the hospital that meet inclusion/exclusion criteria	Rate of newborn cases per 100 that were exclusively breastfed and met inclusion/exclusion criteria (%)
Female			
Male			
Unknown			

Payer Type	Number of newborn cases that were exclusively breastfed and meet inclusion/exclusion criteria	Total number of newborn cases born in the hospital that meet inclusion/exclusion criteria	Rate of newborn cases per 100 that were exclusively breastfed and met inclusion/exclusion criteria (%)
Medicare	0		
Medicaid	118	135	87.4
Private	182	197	92.4
Self-Pay	suppressed	suppressed	suppressed
Other	suppressed	suppressed	suppressed

Preferred Language	Number of newborn cases that were exclusively breastfed and meet inclusion/exclusion criteria	Total number of newborn cases born in the hospital that meet inclusion/exclusion criteria	Rate of newborn cases per 100 that were exclusively breastfed and met inclusion/exclusion criteria (%)
English Language	suppressed	suppressed	suppressed
Spanish Language	suppressed	suppressed	suppressed
Asian Pacific Islander Languages	0		
Middle Eastern Languages	0		
American Sign Language	0		
Other/Unknown Languages	suppressed	suppressed	suppressed

Disability Status	Number of newborn cases that were exclusively breastfed and meet inclusion/exclusion criteria	Total number of newborn cases born in the hospital that meet inclusion/exclusion criteria	Rate of newborn cases per 100 that were exclusively breastfed and met inclusion/exclusion criteria (%)
Does not have a disability			
Has a mobility disability			
Has a cognition disability			
Has a hearing disability			
Has a vision disability			
Has a self-care disability			
Has an independent living			

Sexual Orientation	Number of newborn cases that were exclusively breastfed and meet inclusion/exclusion criteria	Total number of newborn cases born in the hospital that meet inclusion/exclusion criteria	Rate of newborn cases per 100 that were exclusively breastfed and met inclusion/exclusion criteria (%)
Lesbian, gay or homosexual			
Straight or heterosexual			
Bisexual			
Something else			
Don't know			
Not disclosed			

Gender Identity	Number of newborn cases that were exclusively breastfed and meet inclusion/exclusion criteria	Total number of newborn cases born in the hospital that meet inclusion/exclusion criteria	Rate of newborn cases per 100 that were exclusively breastfed and met inclusion/exclusion criteria (%)
Female			
Female-to-male (FTM)/transgender male/trans man			
Male			
Male-to-female (MTF)/transgender female/trans woman			
Non-conforming gender			
Additional gender category or			
Not disclosed			

HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate

General acute care hospitals are required to report several HCAI All-Cause Unplanned 30-Day Hospital Readmission Rates, which are broadly defined as the percentage of hospital-level, unplanned, all-cause readmissions after admission for eligible conditions within 30 days of hospital discharge for patients aged 18 years and older. These rates are first stratified based on any eligible condition, mental health disorders, substance use disorders, co-occurring disorders, and no behavioral health diagnosis. Then, each condition-stratified hospital readmission rate is further stratified by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity. For more information on the HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate, please visit the following link by copying and pasting the URL into your web browser:
https://hcai.ca.gov/wp-content/uploads/2024/10/HCAI-All-Cause-Readmission-Rate-Exclusions_ADA.pdf

HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate – Any Eligible Condition

Number of inpatient hospital admissions which occurs within 30 days of the discharge date of an eligible index admission and were 18 years or older at time of admission
91
Total number of patients who were admitted to the general acute care hospital and were 18 years or older at time of admission
1217

Rate of hospital-level, unplanned, all-cause readmissions after admission for any eligible condition within 30 days of hospital discharge for patients aged 18 and older

7.5

Table 10. HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate for any eligible condition by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
American Indian or Alaska Native	suppressed	suppressed	suppressed
Asian	suppressed	suppressed	suppressed
Black or African American	suppressed	suppressed	suppressed
Hispanic or Latino	suppressed	suppressed	suppressed
Middle Eastern or North African	suppressed	suppressed	suppressed
Multiracial and/or Multiethnic (two or more races)	suppressed	suppressed	suppressed
Native Hawaiian or Pacific Islander			
White	82	1051	7.8

Age	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Age 18 to 34	suppressed	suppressed	suppressed
Age 35 to 49	suppressed	suppressed	suppressed
Age 50 to 64	16	193	8.3
Age 65 Years and Older	59	548	10.8

Sex assigned at birth	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female	46	728	6.3
Male	45	489	9.2
Unknown			

Payer Type	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Medicare	53	531	10
Medicaid	13	218	6
Private	25	442	5.7
Self-Pay	0	12	0
Other	0	14	0

Preferred Language	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
English Language	suppressed	suppressed	suppressed
Spanish Language	suppressed	suppressed	suppressed
Asian Pacific Islander Languages	suppressed	suppressed	suppressed
Middle Eastern Languages			
American Sign Language			
Other/Unknown Languages	suppressed	suppressed	suppressed

Disability Status	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Does not have a disability			
Has a mobility disability			
Has a cognition disability			
Has a hearing disability			
Has a vision disability			
Has a self-care disability			
Has an independent living disability			

Sexual Orientation	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Lesbian, gay or homosexual			
Straight or heterosexual			
Bisexual			
Something else			
Don't know			
Not disclosed			

Gender Identity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female			
Female-to-male (FTM)/transgender male/trans man			
Male			
Male-to-female (MTF)/transgender female/trans woman			
Non-conforming gender			
Additional gender category or other			
Not disclosed			

HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate - Mental Health Disorders

Number of inpatient hospital admissions which occurs within 30 days of the discharge date for mental health disorders and were 18 years or older at time of admission

12

Total number of patients who were admitted to the general acute care hospital and were 18 years or older at time of admission

161

Rate of hospital-level, unplanned, all-cause readmissions after admission for mental health disorders within 30 days of hospital discharge for patients aged 18 and older

7.5

Table 11. HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate for mental health disorders by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
American Indian or Alaska Native			
Asian	suppressed	suppressed	suppressed
Black or African American	suppressed	suppressed	suppressed
Hispanic or Latino	suppressed	suppressed	suppressed
Middle Eastern or North African			
Multiracial and/or Multiethnic (two or more races)			
Native Hawaiian or Pacific Islander			
White	suppressed	suppressed	suppressed

Age	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Age 18 to 34	0	41	0
Age 35 to 49	suppressed	suppressed	suppressed
Age 50 to 64	suppressed	suppressed	suppressed
Age 65 Years and Older	suppressed	suppressed	suppressed

Sex assigned at birth	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female	suppressed	suppressed	suppressed
Male	suppressed	suppressed	suppressed
Unknown			

Payer Type	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Medicare	suppressed	suppressed	suppressed
Medicaid	suppressed	suppressed	suppressed
Private	suppressed	suppressed	suppressed
Self-Pay	suppressed	suppressed	suppressed
Other	suppressed	suppressed	suppressed

Preferred Language	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
English Language	suppressed	suppressed	suppressed
Spanish Language	suppressed	suppressed	suppressed
Asian Pacific Islander Languages			
Middle Eastern Languages			
American Sign Language			
Other/Unknown Languages			

Disability Status	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Does not have a disability			
Has a mobility disability			
Has a cognition disability			
Has a hearing disability			
Has a vision disability			
Has a self-care disability			
Has an independent living disability			

Sexual Orientation	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Lesbian, gay or homosexual			
Straight or heterosexual			
Bisexual			
Something else			
Don't know			
Not disclosed			

Gender Identity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female			
Female-to-male (FTM)/transgender male/trans man			
Male			
Male-to-female (MTF)/transgender female/trans woman			
Non-conforming gender			
Additional gender category or other			
Not disclosed			

HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate - Substance Use Disorders

Number of inpatient hospital admissions which occurs within 30 days of the discharge date for substance use disorders and were 18 years or older at time of admission

suppressed

Total number of patients who were admitted to the general acute care hospital and were 18 years or older at time of admission

suppressed

Rate of hospital-level, unplanned, all-cause readmissions after admission for substance use disorders within 30 days of hospital discharge for patients aged 18 and older

suppressed

Table 12. HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate for substance use disorders by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
American Indian or Alaska Native			
Asian	suppressed	suppressed	suppressed
Black or African American	suppressed	suppressed	suppressed
Hispanic or Latino	suppressed	suppressed	suppressed
Middle Eastern or North African			
Multiracial and/or Multiethnic (two or more races)			
Native Hawaiian or Pacific Islander			
White	suppressed	suppressed	suppressed
Age	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Age 18 to 34	suppressed	suppressed	suppressed
Age 35 to 49	0	31	0
Age 50 to 64	suppressed	suppressed	suppressed
Age 65 Years and Older	suppressed	suppressed	suppressed
Sex assigned at birth	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female	suppressed	suppressed	suppressed
Male	suppressed	suppressed	suppressed
Unknown			
Payer Type	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Medicare	suppressed	suppressed	suppressed
Medicaid	suppressed	suppressed	suppressed
Private	suppressed	suppressed	suppressed
Self-Pay	suppressed	suppressed	suppressed
Other	suppressed	suppressed	suppressed
Preferred Language	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
English Language	suppressed	suppressed	suppressed
Spanish Language	suppressed	suppressed	suppressed
Asian Pacific Islander Languages			
Middle Eastern Languages			
American Sign Language			
Other/Unknown Languages			

Disability Status	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Does not have a disability			
Has a mobility disability			
Has a cognition disability			
Has a hearing disability			
Has a vision disability			
Has a self-care disability			
Has an independent living disability			

Sexual Orientation	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Lesbian, gay or homosexual			
Straight or heterosexual			
Bisexual			
Something else			
Don't know			
Not disclosed			

Gender Identity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female			
Female-to-male (FTM)/transgender male/trans man			
Male			
Male-to-female (MTF)/transgender female/trans woman			
Non-conforming gender			
Additional gender category or other			
Not disclosed			

HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate - Co-occurring disorders

Number of inpatient hospital admissions which occurs within 30 days of the discharge date for co-occurring disorders and were 18 years or older at time of admission

16

Total number of patients who were admitted to the general acute care hospital and were 18 years or older at time of admission

107

Rate of hospital-level, unplanned, all-cause readmissions after admission for co-occurring disorders within 30 days of hospital discharge for patients aged 18 and older

15

Table 13. HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate for co-occurring disorders by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
American Indian or Alaska Native			
Asian			
Black or African American			
Hispanic or Latino	suppressed	suppressed	suppressed
Middle Eastern or North African			
Multiracial and/or Multiethnic (two or more races)			
Native Hawaiian or Pacific Islander			
White	suppressed	suppressed	suppressed
Age	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Age 18 to 34	0	11	0
Age 35 to 49	suppressed	suppressed	suppressed
Age 50 to 64	suppressed	suppressed	suppressed
Age 65 Years and Older	suppressed	suppressed	suppressed
Sex assigned at birth	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female	suppressed	suppressed	suppressed
Male	suppressed	suppressed	suppressed
Unknown			
Payer Type	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Medicare	suppressed	suppressed	suppressed
Medicaid	suppressed	suppressed	suppressed
Private	suppressed	suppressed	suppressed
Self-Pay	suppressed	suppressed	suppressed
Other	suppressed	suppressed	suppressed
Preferred Language	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
English Language	suppressed	suppressed	suppressed
Spanish Language			
Asian Pacific Islander Languages			
Middle Eastern Languages			
American Sign Language			
Other/Unknown Languages			

Disability Status	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Does not have a disability			
Has a mobility disability			
Has a cognition disability			
Has a hearing disability			
Has a vision disability			
Has a self-care disability			
Has an independent living disability			

Sexual Orientation	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Lesbian, gay or homosexual			
Straight or heterosexual			
Bisexual			
Something else			
Don't know			
Not disclosed			

Gender Identity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female			
Female-to-male (FTM)/transgender male/trans man			
Male			
Male-to-female (MTF)/transgender female/trans woman			
Non-conforming gender			
Additional gender category or other			
Not disclosed			

HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate - No Behavioral Health Diagnosis

Number of inpatient hospital admissions which occurs within 30 days of the discharge date with no behavioral diagnosis and were 18 years or older at time of admission

55

Total number of patients who were admitted to the general acute care hospital and were 18 years or older at time of admission

812

Rate of hospital-level, unplanned, all-cause readmissions after admission with no behavioral diagnosis within 30 days of hospital discharge for patients aged 18 and older

6.8

Table 14. HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate with No Behavioral Diagnosis by race and/or ethnicity, non-maternal age categories, sex, payer type, preferred language, disability status, sexual orientation, and gender identity.

Race and/or Ethnicity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
American Indian or Alaska Native	suppressed	suppressed	suppressed
Asian	suppressed	suppressed	suppressed
Black or African American	suppressed	suppressed	suppressed
Hispanic or Latino	suppressed	suppressed	suppressed
Middle Eastern or North African	suppressed	suppressed	suppressed
Multiracial and/or Multiethnic (two or more races)	suppressed	suppressed	suppressed
Native Hawaiian or Pacific Islander			
White	suppressed	suppressed	suppressed

Age	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Age 18 to 34	suppressed	suppressed	suppressed
Age 35 to 49	suppressed	suppressed	suppressed
Age 50 to 64	suppressed	suppressed	suppressed
Age 65 Years and Older	suppressed	suppressed	suppressed

Sex assigned at birth	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female	suppressed	suppressed	suppressed
Male	suppressed	suppressed	suppressed
Unknown			

Payer Type	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Medicare	suppressed	suppressed	suppressed
Medicaid	suppressed	suppressed	suppressed
Private	suppressed	suppressed	suppressed
Self-Pay	suppressed	suppressed	suppressed
Other	suppressed	suppressed	suppressed

Preferred Language	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
English Language	suppressed	suppressed	suppressed
Spanish Language	suppressed	suppressed	suppressed
Asian Pacific Islander Languages	suppressed	suppressed	suppressed
Middle Eastern Languages			
American Sign Language			
Other/Unknown Languages	suppressed	suppressed	suppressed

Disability Status	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Does not have a disability			
Has a mobility disability			
Has a cognition disability			
Has a hearing disability			
Has a vision disability			
Has a self-care disability			
Has an independent living disability			

Sexual Orientation	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Lesbian, gay or homosexual			
Straight or heterosexual			
Bisexual			
Something else			
Don't know			
Not disclosed			

Gender Identity	Number of inpatient readmissions	Total number of admitted patients	Readmission rate (%)
Female			
Female-to-male (FTM)/transgender male/trans man			
Male			
Male-to-female (MTF)/transgender female/trans woman			
Non-conforming gender			
Additional gender category or other			
Not disclosed			

Health Equity Plan

All general acute care hospitals report a health equity plan that identifies the top 10 disparities and a written plan to address them.

Top 10 Disparities

Disparities for each hospital equity measure are identified by comparing the rate ratios by stratification groups. Rate ratios are calculated differently for measures with preferred low rates and those with preferred high rates. Rate ratios are calculated after applying the California Health and Human Services Agency's "Data De-Identification Guidelines (DDG)," dated September 23, 2016.

Table 15. Top 10 disparities and their rate ratio values.

Measures	Stratifications	Stratification Group	Stratification Rate	Reference Group	Reference Rate	Rate Ratio
HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Expected Payor			Private	5.7	3.5
HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Expected Payor			Private	5.7	2.1
HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Sex Assigned at Birth			Female	6.3	1.5
HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Age (excluding maternal measures)			50 to 64	8.3	1.3
CMQCC Exclusive Breast Milk Feeding	Expected Payor			Private	92.4	1.1

Plan to address disparities identified in the data

Based on our risk stratification data, Tahoe Forest Hospital has only five key disparities, instead of ten, for targeted interventions.

Disparity 1: Exclusive Breastfeeding (EBF)-Medicaid, Goal: Increase EBF rates at discharge among Medicaid-insured patients by 5% in the first year, achieving parity across payer groups. **Strategies:** Equity-focused perinatal education: Increase Medicaid patient participation in Baby Friendly 101 virtual class. Early outreach: Prioritize prenatal Lactation and Perinatal Care Coordination for Medicaid patients. **Population Impact:** Supports infant immunity, maternal health, and reduced healthcare utilization.

Disparity 2: Hospital Readmissions-Medicaid, Goal: Reduce 30-day all-cause readmissions for Medicaid patients by 10% in the first year. **Strategies:** Risk stratification for all admissions/ discharges. Dedicated Transitional Care Team: discharge planning, teach-back, medication reconciliation, Social Determinants of Health (SDOH) support. Early outpatient access within 7 days for high-risk patients. Post-discharge calls within 72 hours to confirm medications, symptoms, and social needs. SDOH screening and rapid referral via community health advocates. Warm handoffs with closed-loop referral verification. Daily review of readmissions for root cause analysis and equity-focused interventions. **Population Impact:** Enhances continuity of care, reduces disparities, strengthens community partnerships, and lowers preventable readmissions.

Disparity 3: Hospital Readmissions-Medicare, Goal: Reduce 30-day all-cause readmissions for Medicare patients by 10% in the first year. **Strategies:** Risk stratification for all Medicare admissions. Transitional Care Team support including medication reconciliation, teach-back, and SDOH interventions. Early outpatient access within 14 days for high-risk patients. 72 hour post-discharge contact; home visits for highest-risk. Closed-loop referrals to ensure appointment attendance. Daily readmission review and trending. **Population Impact:** Improves patient safety, reduces hospital utilization, enhances satisfaction, and supports value-based care goals.

Disparity 4: Hospital Readmissions-Male Patients, Goal: Reduce 30-day all-cause readmissions for male patients by 10% in the first year. **Strategies:** Gender-specific discharge plans addressing

cardiovascular, mental health, and substance use needs. Care Transitions Program for proper discharge and follow-up. Chronic Disease Management for conditions such as diabetes, heart disease, and hypertension. Behavioral health integration with hospital and post-discharge referrals. Daily readmission review for root cause analysis. Population Impact: Improves chronic disease management, mental health support, adherence to therapy, and reduces disparities in post-discharge outcomes.

Disparity 5: Hospital Readmissions-Patients 65 Years, Goal: Reduce 30-day all-cause readmissions for patients aged 65+ by 10% in the first year. Strategies: Age-Friendly Hospital measures across five domains: healthcare goals, medication management, frailty interventions, social vulnerability, and leadership. Transitional Care Management with follow-up and home support (Meals on Wheels, Friendly Visitor programs). Chronic Disease Management tailored to older adults.

Daily review of readmissions for timely interventions.

Population Impact: Reduces avoidable readmissions, improves quality of life, supports vulnerable older adults, and achieves cost savings.

Summary:

Our hospitals five-disparity equity plan focuses on Medicaid and Medicare populations, male patients, and older adults, using evidence-based, equity-focused strategies. Interventions include early outreach, transitional care, chronic disease management, SDOH support, and ongoing data-driven review. This plan aims to improve health outcomes, reduce disparities, and enhance patient satisfaction and community trust.

Performance in the priority area

General acute care hospitals are required to provide hospital equity plans that address the top 10 disparities by identifying population impact and providing measurable objectives and specific timeframes. For each disparity, hospital equity plans will address performance across priority areas: person-centered care, patient safety, addressing patient social drivers of health, effective treatment, care coordination, and access to care.

Person-Centered Care

The Tahoe Forest Health District (TFHD) values the perspectives of the patients and families we serve, and is committed to providing patient-centered care that is guided by the voices of our patients and community members.

The Patient and Family Advisory Council (PFAC) represents the collective voice of patients and families in our community by sharing health system-related experiences and engaging in the process of quality improvement. In collaboration with TFHD, the PFAC acts as a resource and provides valuable input to improve and enhance the health care experience from the perspective of the patient. Departments across the system are encouraged to submit items to the PFAC for review, including communication materials, patient education tools, technology rollouts and standard processes/protocols. A specific request for questions and feedback is intended to elicit transparent and experience-based input that may enhance the relevance and usability of services.

PFAC members also serve as active participants on several key governance and clinical committees, to include the Board Quality Assurance Committee, Medical Staff Quality Assurance Committee, IT Clinical Governance Committee, and Cancer Committee. The cross-functional representation helps to strengthen our ability to embed patient-centered perspectives into multiple areas across the health system. TFHD continues to evolve its approach with strategic priorities to

include expanding PFAC membership and immersion within other hospital quality and safety committees.

In addition, the Patient Experience Committee is a multidisciplinary group of TFHD employees which focuses on improving patient care experiences through the lens of the frontline employee. Through discussion of patient feedback and employee-identified concerns, this committee serves to identify system-wide trends and opportunities for improvement. This committee serves as a vital link between patient feedback and frontline improvement efforts.

Our organization has a deep commitment to service excellence, and seeks to provide a positive experience for every patient and visitor. TFHD has implemented a mandatory, system-wide training on the Perfect Care Experience, which aims to train employees on delivering exemplary customer service through respectful communication, listening and empathy. Both clinical and non-clinical staff are expected to uphold our high standards for service excellence, regardless of their role or extent of their direct patient contact.

Patient Safety

The Tahoe Forest Hospital District (TFHD) Board of Directors makes a commitment to provide for the safe and professional care of all patients, and also to provide for the safety of visitors, employees and health care practitioners. The commitment is made through the provision of a Patient Safety Plan that will identify, evaluate, and take appropriate action to prevent unintended patient care outcomes (adverse events), as well as protect the TFHD's financial resources, tangible assets, personnel and brand. Leadership structures and systems are established to ensure that there is organization-wide awareness of patient safety performance, direct accountability of leaders for that performance and adequate investment in performance improvement abilities, and that actions are taken to ensure safe care of every patient served.

TFHD endorses the National Patient Safety Goals for the Critical Access Hospital Program. Further, the District ascribes to the tenets and practices of the High Reliability Organization (HRO), Collaborative Just Culture and the BETA HEART programs in the investigation of near-misses, adverse events and unexpected/unintended outcomes. TFHD has a goal of zero preventable harm.

- Utilizing the Beta HEART (healing, empathy, accountability, resolution, trust) principles fostering a culture of safety and transparency including the following:
 - ✧ Administration of the SCOR Culture of Safety survey and sharing of the results utilizing a debrief methodology.
 - ✧ Utilizing a formalized process for early identification and rapid response to adverse events integrating human factor/ergonomic analysis and high reliability organization principles.
 - ✧ A commitment to honest and transparent communication with patient and families after an adverse event.
 - ✧ Staff referral to the Peer Support/Care for the Caregiver program, which is available 24/7.
 - ✧ A process for early resolution when harm is deemed a result of inappropriate care or medical error.
- Benefits of HRO Principles:
 - ✧ Reduced errors and adverse events, Improved patient safety, enhanced quality and efficiency, Increased resilience in the face of unexpected events, and greater employee satisfaction and reduced burnout.

Addressing Patient Social Drivers of Health

Over the past reporting period, Tahoe Forest Hospital District (TFHD) has made meaningful progress in addressing the social determinants of health (SDOH) that impact patient outcomes in

the Truckee-North Tahoe region and outlying communities. We take a proactive, systems-oriented approach to identifying and mitigating barriers to health by integrating SDOH screening during hospital admissions and routine care, connecting patients with appropriate resources through the referral processes in patient care workflows, and tracking follow-up to ensure needs are met.

Collaboration remains central to our work. We partner with local community-based organizations, social service agencies, and public health departments to address priority needs such as housing instability, food insecurity, transportation barriers, behavioral health support, and access to preventive care. These partnerships allow us to coordinate services efficiently, reduce duplication of effort, and improve patient navigation through the continuum of care.

We also engage with local government agencies to shape policies and community programs that advance health equity. Joint initiatives such as regional food access programs, community wellness events, and emergency housing resources are designed not only to address immediate patient needs but also to promote long-term systemic changes that benefit the broader population.

Through these coordinated efforts, we are advancing our mission to enhance the health of our communities through excellence and compassion in all we do. Our commitment is rooted in quality, understanding, excellence, stewardship and teamwork with the belief that improving social conditions is essential to improving health outcomes.

Performance in the priority area continued

Performance across all of the following priority areas.

Effective Treatment

Tahoe Forest Health System remains committed to delivering safe, evidence-based, and timely care for all patients, with a focus on eliminating preventable harm and ensuring equitable outcomes. Below are a few examples of TFHD programs that reflect our commitment to Effective Treatment.

In the Emergency Departments, we advanced our Zero Harm initiative with the BETA Healthcare Group, reinforcing standardized handoffs and diagnostic safety. These efforts have strengthened patient safety and reliability of care, ensuring that every patient receives consistent, high-quality treatment across all populations. This work is supported by our **Level III Trauma Center designation**, ensuring 24/7 availability of trauma-trained clinicians, advanced diagnostic capabilities, and rapid stabilization for critically injured patients.

Within Obstetrics, the BETA Healthcare Group's Zero Harm program has prioritized early recognition of maternal and fetal risk factors including maternal sepsis. The team has also participated in BETA's Perinatal Safety Collaborative, a multidisciplinary initiative focused on improving maternal and newborn outcomes through evidence-based best practices, data sharing, and continuous quality improvement. This involvement has allowed us to collaborate with other hospitals and experts, implement standardized protocols, and address disparities in perinatal care to ensure safe, equitable experiences for all birthing patients. These strategies support equitable, safe birthing experiences and have resulted in improved maternal and newborn safety metrics.

Additionally, TFHD has been recognized with the American Heart Association's Get with the Guidelines Stroke Rural Recognition GOLD Award. This designation reflects our ability to rapidly identify and treat stroke symptoms, reducing time to intervention and improving patient outcomes.

Stroke protocols are applied consistently, ensuring that all patients - regardless of language, socioeconomic status, or background - receive the same high standard of emergent care.

Care Coordination

Care Coordination is a comprehensive, patient-centered process designed to enhance patient engagement, support self-management of chronic conditions, improve health outcomes and satisfaction, and increase efficiency and satisfaction among healthcare providers. At Tahoe Forest Health District (TFHD), Care Coordination offers a range of specialized programs, including:

- ✧ Chronic Care Management (CCM)
- ✧ Transitional Care Management (TCM)
- ✧ Behavioral Health Care Coordination
- ✧ Neuro Trauma Care Coordination
- ✧ Perinatal Care Coordination
- ✧ Lactation Care Coordination
- ✧ Pediatric Care Coordination
- ✧ Youth Behavioral Health Care Coordination

While each program targets a distinct patient population, all services are delivered by either a registered nurse or a social worker. Additionally, the Care Coordination team includes one medical assistant.

Care Coordinators assess individual patient needs and provide services such as:

- ✧ Person-centered care plans
- ✧ Medication reconciliation and education
- ✧ Health education
- ✧ In-person visits (including home, and field visits)

These efforts aim to identify and address barriers to care, ultimately improving patient health and outcomes.

Care Coordinators also facilitate a variety of classes through TFHD, including (but not limited to):

- ✧ Wise Minds
- ✧ Chronic Disease Self-Management (in collaboration with Health and Resource Advocates)
- ✧ Caregiver Support Groups
- ✧ Infant Feeding Support Groups
- ✧ Baby-Friendly Classes
- ✧ Bilingual New Mother Support Groups

Health and Resource Advocates:

Health and Resource Advocates support patients by helping them access community resources, enhance health literacy, and promote self-sufficiency. They collaborate with local organizations to provide culturally appropriate, patient-centered services. The current team is bilingual in English and Spanish. Additionally, Health and Resource Advocates provide patients in person advocacy at medical appointments within Tahoe Forest Health System.

Like Care Coordinators, Health and Resource Advocates also teach classes in both English and Spanish, including but not limited to:

- ✧ Chronic Disease Self-Management (in conjunction with Care Coordinators)
- ✧ Diabetes Self-Management
- ✧ Prevent T2 (Pre-diabetic education)
- ✧ Childbirth education in Spanish

They participate in community outreach events, offering health education and conducting blood pressure and blood glucose screenings, while also providing follow up outreach to the patient after these events.

Care Coordinators and Health and Resource Advocates frequently work together to support shared patients.

- ✧ Care Coordinators primarily address clinical needs while considering social drivers of health.
- ✧ Health and Resource Advocates focus on addressing social drivers of health and connecting patients to relevant community resources.

Together, they form a collaborative, multidisciplinary team dedicated to improving the well-being of the community through integrated, compassionate care.

Access to Care

Tahoe Forest Hospital District (TFHD) is committed to ensuring timely, equitable, and comprehensive access to care for all individuals in the Truckee-North Tahoe region and outlying communities. We monitor access indicators closely, including appointment availability, emergency department wait times, after-hours service use, and patient-reported barriers such as transportation, cost, or limited provider availability.

Over the past year, we have expanded primary and specialty care capacity through targeted provider recruitment, telehealth services, and performance improvement projects focused on clinic efficiencies and staffing/scheduling models. This resulted in the addition of another Cardiologist and Obstetrics/Gynecology provider.

To further increase capacity and reduce wait times, we have expanded our **advanced care provider (APP) workforce**, including nurse practitioners and physician assistants, who now deliver a significant portion of primary and follow-up care. This team-based model integrating physicians, APPs, nurses, and care coordinators has enabled extended service hours, increased appointment availability, and improved care continuity.

We remain committed to eliminating barriers to care by offering **financial assistance programs**, simplifying eligibility for charity care, and expanding language access with bilingual staff and medical interpreters.

We have strengthened our care coordination infrastructure, linking patients to appropriate services both within our facility and through community-based partners. This includes access to behavioral health consultations, enhanced referral pathways to specialty care, and integration with regional urgent care and public health services.

Through these efforts, we continue to close gaps in care access, improve patient satisfaction, and ensure that all residents regardless of geography, socioeconomic status, or background can receive the care they need when they need it.

Methodology Guidelines

Did the hospital follow the methodology in the Measures Submission Guide?
(Y/N)

Y



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Reach and Adoption of a Geriatric Emergency Department Accreditation Program in the United States

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Abstract

Study Objectives: The objectives of this study were to describe the reach and adoption of Geriatric Emergency Department accreditation (GEDA) program and care processes instituted at accredited geriatric emergency departments (GEDs).

Methods: We analyzed a cross-section of a cohort of United States (US) emergency departments that received GEDA from 5/2018–3/2021. We obtained data from the American College of Emergency Physicians and publicly available sources, including GEDA level, geographic location,

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Maura Kennedy, Nicole Tidwell, Kevin Biese and Ula Hwang currently serve on the board of governors of ACEP's Geriatric ED accreditation (GEDA) program. Chris Carpenter previously served on the GEDA board of governors and currently serves on the GEDA advisory board. Shan Liu and Lauren Southerland are reviewers for the GEDA program.

Conflict of Interest: None

urban/rural designation, and care processes instituted. Frequency and proportions, and median and interquartile ranges were used to summarize categorical and continuous data, respectively.

Results: Over the study period, 225 US GED accreditations were issued and included in our analysis: 14 Level 1, 21 Level 2, and 190 Level 3 GEDs; five GEDs re-applied and received higher level accreditation after initial accreditation at a lower level. Only 9 GEDs were in rural regions. There was significant heterogeneity in protocols enacted at GEDs; minimizing urinary catheter use and fall prevention were the most common.

Conclusions: There has been rapid growth in GEDs, driven by Level 3 accreditation. Most GEDs are in urban areas, indicating the potential need for expansion beyond these areas. Future research is needed evaluating the impact of GEDA on health care utilization and patient-oriented outcomes.

Keywords

Geriatrics; Aged; Emergency Medicine; Emergency Service; Hospital; Accreditation

Introduction

Background:

As the United States (US) population ages, the healthcare system is increasingly challenged to provide high quality care to older adults. Older adults increasingly require care in emergency departments (EDs) and typically have more extensive evaluations and are more likely to be admitted.¹ However, hospitalization also carries risk for older adults, including functional and cognitive decline.^{2,3}

Geriatric EDs (GEDs) were first established in the US over a decade ago in response to the growing geriatric population and their unique emergency care needs.⁴ However, there was significant variation in staffing, equipment and care processes among these self-designated GEDs.⁵ In 2014, the Geriatric Emergency Department Guidelines were published to standardize and improve emergency care delivery in GEDs.⁶ In 2018, ACEP launched the Geriatric ED Accreditation (GEDA) program⁷ to accredit GEDs based on adherence to the guidelines. GEDA classifies accredited GEDs as Level 1 (gold), 2 (silver) or 3 (bronze) according to degrees of adherence to best practices. Higher level GEDs must meet greater requirements with respect to staffing, geriatric-specific protocols, outcome monitoring, equipment and environmental changes; costs of application are also greater for higher level GEDs (Supplement Figure S1).

Importance:

Since the establishment of the GEDA process over two years ago, there has been no systematic study describing accredited GEDs in the US.

Goals of this investigation:

The objectives of this study were to describe the reach and adoption of ACEP's GEDA program in the US and geriatric improvement processes implemented across accredited GEDs.

Methods

Study design and setting:

We performed a cross-sectional analysis of a cohort of EDs that received GED accreditation by ACEP on or before March 1, 2021. This was a secondary analysis of previously collected data from the GEDA database; data were not collected specifically to meet the objectives of the study. This study adhered to the strengthening of reporting of observational study designs in epidemiology (STROBE).

Selection of Participants:

We included GEDs that applied for and received accreditation between May 7, 2018 and March 1, 2021. GEDs in countries other than the US were excluded since US classification systems were used to group EDs geographically. In addition, GEDs were excluded from some aspects of the study if data use agreement restrictions prevented review of the GEDA application for research purposes.

Measurements:

We obtained aggregate data on GED applications and approvals from the GEDA database. We reviewed individual applications to abstract data on ED visit volume, proportion of ED volume by individuals ≥ 5 years of age, primary reason for applying for GEDA, and geriatric-specific policies and protocols. Applications were reviewed after GED accreditation was issued. Zip code was used to classify the facility geographically based on US census region and as metropolitan or non-metropolitan based on 2013 Urban Influence Codes (UICs).⁸ GEDs with a UIC of 1 or 2 were classified as metropolitan and GEDs with UIC codes of 3 or greater were classified as non-metropolitan (rural). GEDs were also classified by affiliation with an emergency medicine residency program.

The GEDA application guide⁹ describes 27 potential policies or protocols to improve the emergency care of older ED patients. In the GEDA application, Level 1 and 2 applicants must classify their geriatric care initiatives into these categories; for Level 3 GEDs, a trained research assistant (RA) reviewed the quality initiative(s) described in the application and classified them using the same categories. This research did not involve human subjects, and utilized data from aggregate and anonymous sources, as well as publicly reported data; accordingly, IRB review was not required. Release of data was approved for comparison purposes via a data use agreement with all sites, except for one Level 1 GED which declined and was not included in the analysis and reporting.

Outcomes:

We identified accredited GEDs and GEDA level from the GEDA database.

Analysis:

Frequency and proportions were used to summarize categorical data and median and interquartile ranges (IQR) were used to summarize non-parametric continuous variables.

Results

Characteristics of accredited GEDs:

Since the GEDA program began through March 1, 2021, ACEP issued a total of 230 geriatric ED accreditations for a total of 225 EDs across 36 US states, as well as in Canada, Brazil and Spain. The vast majority of approved GEDs were Level 3 (Figure 1; Supplement Figure 1). Over the course of the study, five accredited GEDs applied for and were approved as higher level GEDs: three level 3 GEDs were subsequently accredited as level 2 GEDs, and one level 2 and one level 3 GED were subsequently accredited as level 1 GEDs. Five GEDs were excluded from further analysis: two Level 3 and one Level 2 non-US GEDs and one Level 1 US GED due to data-use-agreement restrictions (Figure 1).

Characteristics for the 225 US GED accreditations included in our study are presented in Supplement Table 1. The most common reason cited for applying for GEDA was to improve care delivery to older adults. Across all GEDs, the median annual ED visit volume was 37,044 (interquartile range [IQR] 22,545 to 59,233) and visits by individuals 65 years of age or older comprised 25% (IQR 19 to 32%) of overall visit volume. The geographic distribution of accredited GEDs, superimposed on a heatmap reflecting the percent of the population that is aged 65 and older, is shown in Figure 2. Only 9 GEDs (4%) were in non-metropolitan regions, 8 of which were Level 3 (Supplement Table 1). Twenty-nine GEDs (13%) were affiliated with an emergency medicine residency program (Supplement Table 1).

Geriatric Care Processes

Geriatric care processes implemented at the included GEDs are listed in Table 1. The most common care processes implemented related to addressing geriatric falls (90/225, 40%), minimizing urinary catheter use (87/225, 39%), identifying elder abuse (53/225, 24%), addressing delirium (49/225, 22%) and identifying assessment of function and functional decline (47/225, 21%). Though Level 3 GEDs were only required to have one quality initiative for GEDA, one-quarter reported more than one care process in their application (48/190, 25%).

Limitations:

This study has several limitations. Most data were extracted from the GEDA applications; errors in data entry by sites could have impacted our results. Additionally, the data only allow for a cross-sectional analysis of GEDs based on information provided at the time of accreditation, as opposed to tracking site characteristics and trends over time. Geriatric care processes at level 3 GEDs were classified by a single trained RA; though classifications were reviewed by at least one researcher, an assessment of inter-rater reliability was not performed. We were also unable to independently verify the accuracy or completeness of the data included in the application or validate the quality of geriatric emergency care delivered at these GEDs. However, the process for Level 1 GED accreditation includes a site visit to ensure the GED meets accreditation standards and Level 2 GEDs undergo a telephone site review. Additionally, some of the care processes may have already been enacted prior

to deciding to apply for GED; however, as part of accreditation all GEDs must provide evidence that their GEDs actively monitor process and outcomes metrics related to these care processes. Lastly, we limited our analysis to US accredited GEDs; future studies may wish to study GED implementation outside of the US.

Discussion

Over the first two years of ACEP's GEDA program, 230 GED accreditations were issued. The steady growth in accreditations and its reach to over 36 US states and internationally is one measure of success of this program. While there has been a rapid growth in accredited GEDs, this still accounts for only 4% of the 5,533 EDs in the US¹⁰ and, as demonstrated in the heat map, there remain swaths of the country without a GED.

One important consideration is whether GED growth geographically matches the growing population of older adults. The distribution of the GEDs in urban versus rural regions is particularly notable. Only 9 GEDs (4%) were in rural regions, 8 of which were Level 3 GEDs; however, in the US nearly one-fifth of all ED visits occur in the rural setting.¹¹ Potential barriers to GEDA for rural EDs include costs of the application as well as expenses associated with staffing, managing, and equipment for GEDs. While the staffing requirements for higher level GEDs may be a particular challenge for rural EDs, which may have limited resources, financial constraints due to increasing numbers of Medicaid or uninsured patients, and difficulty recruiting and retaining staff,¹¹ if achieved the benefits are universally appealing and can be shared and received by ED patients of all ages. For example, creating processes to facilitate care coordination with primary care physicians or referrals to community programs for older patients discharged home can also be extended to non-geriatric patients. Innovative solutions like leveraging telehealth to extend geriatric-focused interdisciplinary resources such as pharmacy, case management, social work, PT and occupational therapy can assist resource-constrained hospitals for patients of all ages. Such an endeavor is currently underway as a collaboration between the West Health Institute and Dartmouth-Hitchcock Connected Care and Center for Telehealth.¹²

It is also notable that the two most common quality initiatives enacted at level 3 GEDs align with national safety and reporting measures. Appropriate urinary catheter use is included in ACEP's Clinical Emergency Data Registry and CMS Merit-based Incentive Payment System (MIPS). Fall risk assessment is another MIPS and National Quality Forum measure. GEDA aligns with such programs by recognizing hospitals who provide appropriate care by giving them status and raising the bar for care in all patients. This reinforces the idea that every ED in the US that cares for adults, including resource-constrained EDs, should be able to apply for level 3 GEDA. While this could also be viewed as a relatively low standard to achieve, GEDA requires specific outcome monitoring for these care processes, staff education in geriatric principles, and physician and nurse champions. As Level 3 GEDs reach the end of the 3-year approval period, they will also be required to demonstrate quality improvement to qualify for reaccreditation. Another measure of success for the GEDA program will be the proportion of accredited GEDs that reapply for GEDA, as well as the number that apply for a higher level of geriatric ED accreditation. Though this program has not reached the end

of the first three-year approval period, to date 5 GEDs have applied for and received higher level of GEDA.

To ensure continued investment by hospital leaders, the GEDA program will need to be able to demonstrate a return on investment. There is growing evidence demonstrating the positive impact and benefits of Level 1 GEDs: having ED-based transitional care nurses or social workers perform structured assessments for older ED patients is associated with a reduced risk of hospital admission, 30-day readmission, and 30 and 60 days aggregate costs of care.¹³ Research evaluating the impact of level 2 and 3 GEDs on health care utilization, however, is limited. This is part because lower level GEDs are less likely to be academic institutions and data on impact is more likely to be collected for internal purposes than for publication. Future research will need to evaluate the impact of level 2 and level 3 GEDs. Evaluation of the impact of GEDA on patient-oriented outcomes, such as physical functioning, cognition, and quality of life, will also be an important avenue of research.¹⁴ Given the heterogeneity of care processes at accredited GEDs, demonstrating the value and impact of the GEDA program will be complicated by multiple confounders. This underscores the importance of leveraging existing geriatric ED-based research networks such as the Geriatric Emergency Care Applied Research network¹⁵ to evaluate the impact of GEDA and GEDs.

In summary, there has been a rapid growth in accredited GEDs in the US and internationally, driven by a desire to improve emergency care for older adults. Continued adoption of GEDA and extension of the program geographically will be important measures of programmatic success, as well whether GEDs apply for re-accreditation or for higher level accreditation. Research is needed on the impact of GEDA on health care utilization and patient-oriented outcomes.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Disclosures:

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Abbreviations:

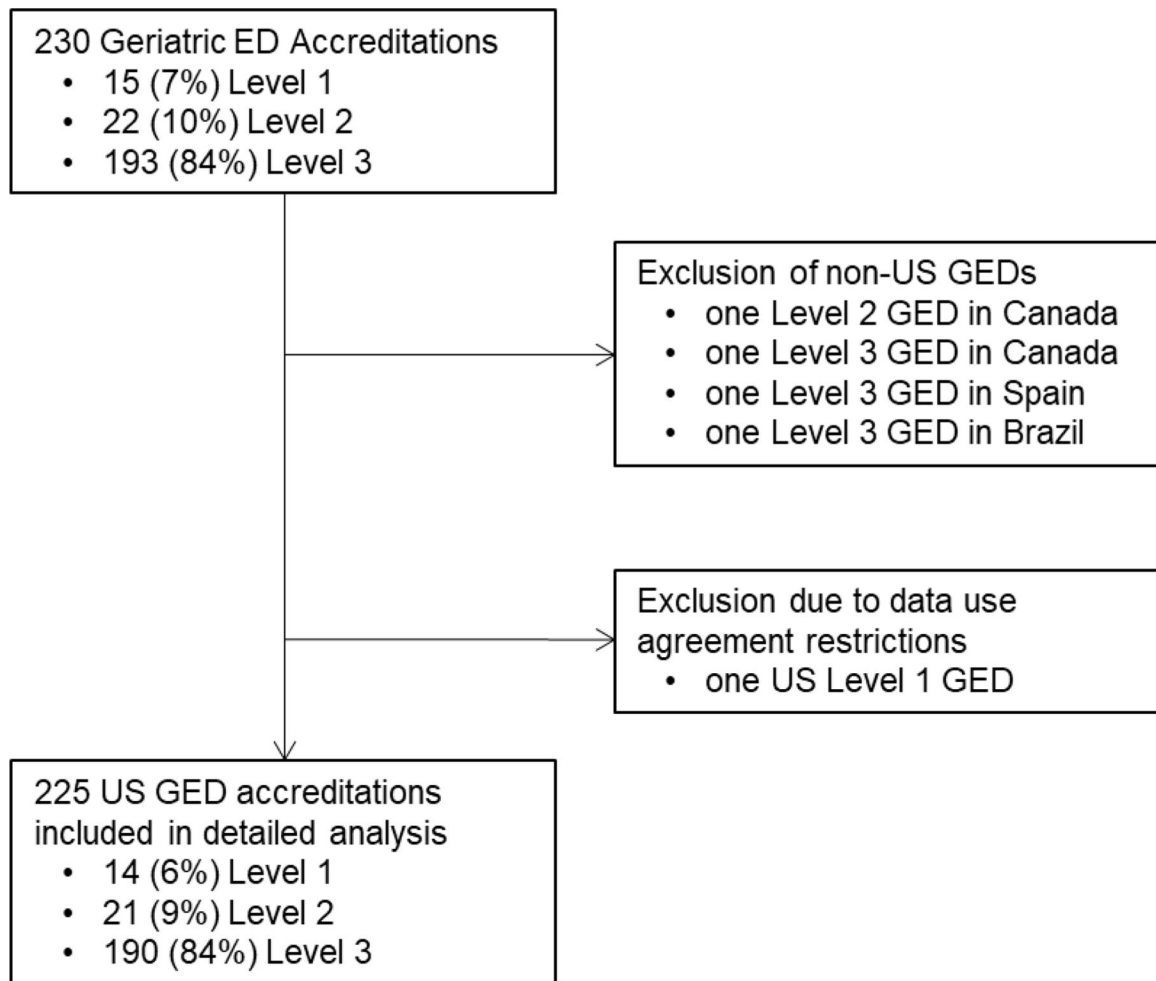
ED	Emergency Department
GED	Geriatric Emergency Department
GEDA	Geriatric Emergency Department Accreditation
ACEP	American College of Emergency Physicians
PCP	Primary Care Physician

US	United States
CMS	Centers for Medicare & Medicaid Services
APP	Advanced Practice Provider
PIMs	Potentially Inappropriate Medications
CAM	Confusion Assessment Method
bCAM	brief Confusion Assessment Method

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**Figure 1:**

Flow diagram of geriatric ED accreditations included in detailed analysis. Analysis included 225 GED accreditations from 220 EDs; five GEDs re-applied and were approved for a higher level of accreditation during study period. GED=Geriatric Emergency Department; ED=Emergency Department

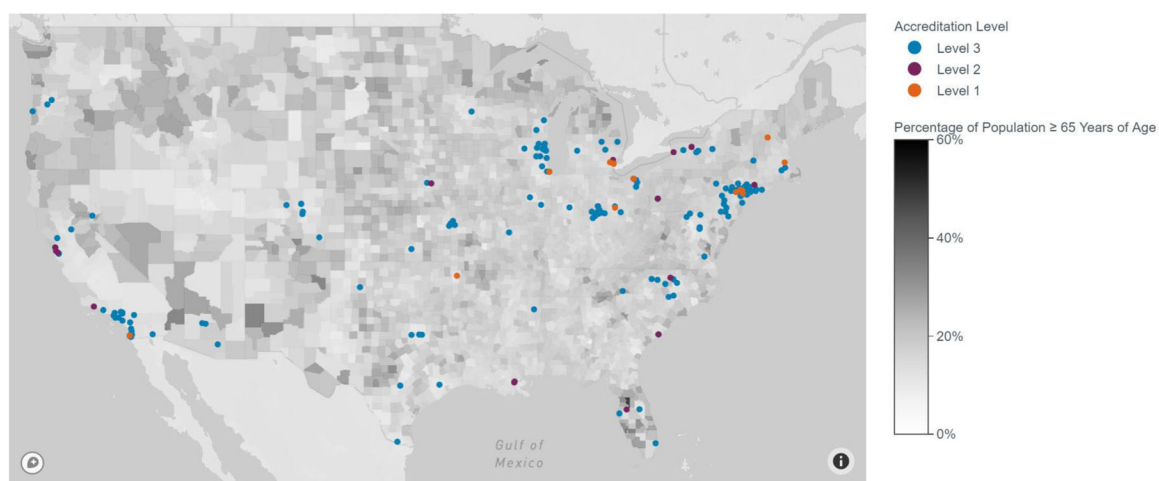


Figure 2:
Geographic distribution of accredited geriatric emergency departments in the United States, by accreditation level, and superimposed on a heatmap that reflects the percent of the population that is aged 65 and older, by county.

Table 1:

Geriatric specific protocols, policies, guidelines, or initiatives enacted at US GEDs.

Protocol/ Policy, n (%)	Level 1 (n = 14)	Level 2 (n = 21)	Level 3 (n=190)
Program to minimization use of urinary catheters	14 (100)	20 (95)	53 (28)
Process for identification of elder abuse	14 (100)	14 (67)	25 (13)
Program to minimize use of physical restraints	14 (100)	14 (67)	11 (6)
Access to palliative care consultation	14 (100)	11 (52)	10 (5)
Geriatric pain control guidelines	14 (100)	11 (52)	4 (2)
Program on geriatric fall assessment	13 (93)	18 (86)	59 (31)
Process for PCP notification	13 (93)	14 (67)	2 (1)
Access to transportation services for return to home	13 (93)	12 (57)	0 (0)
Program to minimize use of potentially inappropriate medications	13 (93)	11 (52)	9 (5)
Delirium screening process	13 (93)	9 (43)	27 (14)
Process for care transitions to residential care facilities	13 (93)	8 (38)	0 (0)
Guideline to define access to GED from ED triage*	13 (93)	6 (29)	N/A *
Process for medication reconciliation with a pharmacist	12 (86)	9 (43)	16 (8)
Standardized assessment of function and functional decline	12 (86)	8 (38)	27 (14)
Dementia screening process	12 (86)	5 (24)	5 (3)
Guidelines to minimize NPO designation	11 (79)	7 (33)	2 (1)
Program for access to short and long-term rehabilitation	11 (79)	5 (24)	1 (0.5)
Program for volunteer engagement	10 (71)	5 (24)	0 (0)
Guideline to promote mobility	11 (79)	3 (14)	1 (0.5)
Process for post-discharge follow up	11 (79)	2 (10)	3 (2)
Access to geriatric psychiatry consultation	10 (71)	5 (24)	5 (3)
Program for home assessment of function and safety	9 (64)	6 (29)	0 (0)
Access to geriatric specific outpatient clinics for follow up	9 (64)	5 (24)	3 (2)
Order sets for 3 common geriatric presentations	8 (57)	9 (43)	4 (2)
Program for community paramedicine follow up	3 (21)	2 (10)	0 (0)
Outreach program to residential care homes	1 (7)	4 (19)	0 (0)

N=225 - one Level 1 GED was not included due to restrictions in the data use agreement. Level 1 GEDs are required to have at least 20 items and Level 2 GEDs are required to have at least 10 items from the GEDA model of care. Level 3 GEDs are required to have at least one quality initiative, which were reclassified into the GEDA model of care structure. Sites may have exceeded the number of required items. Five GEDs applied for and were accredited at a higher GEDA level; data from original and updated applications were both included under the respective accreditation level.

* Not applicable to Level 3 GEDs. GED=Geriatric Emergency Department. ED=Emergency Department. PCP=Primary Care Physician. NPO= "Nil per os"/nothing by mouth.

Why should my institution seek GED accreditation?

20 million seniors visit our nation’s EDs.

With the number of older adults growing rapidly, there is a critical need for more geriatric-focused care.

Preparing for accreditation allows the hospital and ED to focus on the needs of this complex and growing population and to ensure that the resources available to the ED meet the needs of the patients they serve.

Early data from existing models of geriatric emergency care – models that promote best clinical practices and create a more positive and sensitive physical environment – show they have the potential to improve health outcomes, coordinate care more effectively, and reduce costs.

“Accreditation is just one step in the process of providing geriatric attuned healthcare in the Emergency Department. We continue to try out new clinical pathways or equipment to make our care better.”

– Lauren T. Southerland, MD, FACEP
The Ohio State University Wexner Medical Center, OH

For More Information, Contact:

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Criteria by accreditation level:



CRITERIA	LEVEL 3	LEVEL 2	LEVEL 1
a) Staffing			
1 emergency medicine MD/DO lead with evidence of focused geriatric EM education	🔴		
1 RN with evidence of focused geriatric EM education	🔴	🔵	🟡
Physician champion/Medical Director with evidence of focused geriatric EM education		🔵	🟡
Nurse case manager/transitional care nurse present > 56 hrs/week		🔵	🟡
Interdisciplinary geriatric assessment team includes > 2 roles		🔵	
Interdisciplinary geriatric assessment team includes > 4 roles			🟡
> 1 executive/administrative sponsor supervising GED program		🔵	🟡
Patient advisor/patient council			🟡
b) Education			
MD/DO geriatric lead/ Physician champion/Medical Director geriatric EM education (in hours)	4	6	8
Staff physician education related to 8 domains of GEM	🔴	🔵	🟡
Nursing education in geriatric EM (NICHE / GENE preferred)	🔴	🔵	🟡
c) Policies/protocols guidelines & procedures			
Evidence of four geriatric emergency care initiatives and adherence plan	🔴		
> 10 items as part of the ED model of care for patients >65ysr		🔵	
> 20 items as part of the ED model of care for of patients >65ysr			🟡
d) Quality improvement			
10 of 27 policies/protocols, guidelines & procedures		🔵	
20 of 27 policies/protocols, guidelines & procedures			🟡
e) Outcome measures			
Track > 3 process and outcome metrics for eligible patients		🔵	
Track > 5 process and outcome metrics for eligible patients			🟡
f) Equipment and supplies			
Access to and proof of mobility aids (canes and walkers)	🔴	🔵	🟡
Access to > 5 supplies (including mobility aids)		🔵	
Access to > 10 supplies (including mobility aids)			🟡
g) Physical environment			
Easy access to free food/drink, 24/7	🔴	🔵	🟡
2 chairs per patient bed		🔵	🟡
Large analog clock		🔵	🟡
Enhanced lighting			🟡
Efforts at noise reduction			🟡
Non-slip floors			🟡
Adequate hand rails			🟡
High quality signage and way-finding			🟡
Wheel-chair accessible toilets			🟡
Availability of raised toilet seats			🟡

MC421_1020

Developed by leaders in emergency medicine to ensure that our older patients receive well-coordinated, quality care at the appropriate level of every emergency department encounter.



Improve the Care Provided to Older Patients
by Becoming an Accredited Geriatric Emergency Department



One size ED care does not fit all.
ACEP.org/GEDA

Become an Accredited Geriatric Emergency Department Today



Become accredited and show the public that your institution is focused on the highest standards of care for your community's older citizens.



The following criteria outline the minimum standards for accreditation of a geriatric ED in three levels. Levels 1 and 2 are designed to reflect an increasing commitment to senior-specific care in the ED. Each level has an accreditation term of three years.



Level 1

An ED with policies, guidelines, procedures, and staff (both within the ED and throughout the institution) providing a coherent system of care targeting and measuring specific outcomes that form an overall elevation in ED operations and transitions of care both to and from the ED, all coordinated for the improved care of older adults.

Accreditation Fee:
\$15,000



Level 2

An ED that has integrated and sustained senior care initiatives into daily operations and demonstrates interdisciplinary cooperation for delivery of senior services. This level has an established supervisor coordinating the staff tasked with the daily performance of senior services.

Accreditation Fee:
\$7,500



Level 3

An ED with one or more specific initiatives that are expected to elevate the level of senior care. Personnel to implement these efforts are identified and trained. Metrics for the initiatives are followed.

Accreditation Fee:
\$2,500

Geriatric EDs promote best clinical practices for older adults and have the potential to improve health outcomes, coordinate care more effectively, and reduce cost of care.

Apply for ACEP's geriatric ED accreditation program and validate your hospital's commitment to:

- Providing a more positive and sensitive physical environment
- Adopting standardized approaches to geriatric care
- Ensuring optimal transitions of care from the ED to other settings such as inpatient, home, community-based care, rehabilitation or long-term care
- Supporting geriatric-focused quality improvement



Learn more about accreditation at
ACEP.org/GEDA

Developed with support from:



ACEP EMERGENCY MEDICINE PODCAST

ACEP | Frontline

with Ryan Stanton, MD, FACEP

○ Why Geriatrics and Emergency Medicine?

Kevin Biese, MD, MAT, FACEP

Covers the broader needs of seniors in the ED and what is being done today.

○ Why GEDA?

Mark Rosenberg, DO, MBA, FACEP, FAAHPM | Sandy Schneider, MD, FACEP

Describes the GEDA program, the journey, the patient benefit and stakeholder value, and the levels of participation.

○ How does your institution become a GED?

Michael L. Malone, MD | Kevin Biese, MD, MAT, FACEP | Ula Hwang, MD, FACEP

Presents available resources on how your ED can become more geriatric-focused, and available resources for providers and EDs.

“Becoming an accredited Geriatric ED provided a focus for our ED and hospital to expand on, and improve the care we provide our elderly patients. It led to our hospital increasing needed resources like physical therapy and pharmacy into the ED specifically to improve safety and reduce harm for this special patient population.”

— Brian B. Patel, MD, FACEP
Sturdy Memorial Hospital, MA



Quick Start Guide:

Age-Friendly Hospital Measure

As part of the FY2025 rule, CMS is requiring hospitals participating in the Hospital Inpatient Quality Reporting (IQR) program to report on the Age-Friendly Hospital Measure annually.

Why? Structural measures provide a way for hospitals to address a topic for which no outcome measure exists. CMS expects that by attesting to these measures, hospitals will develop evidence-based programs and processes to support improvements in high impact areas.

As the U.S. population ages and lives longer, we continue to see increasing morbidity and healthcare costs. Patients are more complex and often live with multiple chronic conditions. To assist in addressing delivery of care to the aging population, CMS reports that “multiple organizations, including American College of Surgeons (ACS), the Institute for Healthcare Improvement (IHI), and the American College of Emergency Physicians, collaborated to identify and establish age-friendly initiatives based on evidence-based best practice that provide goal centered, clinical effective care for older patients.”

What? Hospitals must attest to activities within five domains deemed essential to providing clinical care to over 65 years old: eliciting patient healthcare goals, responsible medication management, frailty screening and intervention, social vulnerability, and age-friendly care leadership. Hospitals and health systems will evaluate and determine whether they engage in activities that meet the elements of the attestation statement(s). Each domain is worth one point, for a total of five (5) points. The hospital must meet each element within a domain to receive a point. CMS will not give partial credit within the domain.

How? Additional details and specifications for this measure are not available from CMS yet. This Quick Start Guide outlines the five domains and provides resources to assist hospitals as they evaluate activities and processes against each domain.

Domain 1: Eliciting Patient Healthcare Goals

Patient’s health-related goals and treatment preferences should be obtained and utilized to inform shared decision-making and goal concordant care.

Attestation Statement

- A. Established protocols are in place to ensure patient goals related to healthcare (health goals, treatment goals, living wills, identification of healthcare proxies, advance care planning) are obtained/reviewed and documented in the medical record. These goals are updated before major procedures and upon significant changes in clinical status.

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Domain 2: Responsible Medication Management

Medication management can be optimized through the monitoring of the pharmacologic record for drugs that may be considered inappropriate in older adults due to increased risk of harm.

Attestation Statement

- A. Medications are reviewed for the purpose of identifying potentially inappropriate medications (PIMs) for older adults as defined by standard evidence-based guidelines, criteria, or protocols. Review should be undertaken upon admission, before major procedures, and/or upon significant changes in clinical status. Once identified, PIMS should be considered for discontinuation, and/or dose adjustment as indicated.

Domain 3: Frailty Screening and Intervention

Screening patients for geriatric issues related to frailty (including cognitive impairment/delirium, physical function/mobility, and malnutrition) allows for early detection and early and appropriate intervention.

Attestation Statements

- A. Patients are screened for risks regarding mentation, mobility, and malnutrition using validated instruments (ideally upon admission, before major procedures, and/or upon significant changes in clinical status).
- B. Positive screens result in management plans including but not limited to minimizing delirium risks, encouraging early mobility, and implementing nutrition plans where appropriate. The plans should be included in discharge instructions and communicated to post-discharge facilities.
- C. Data are collected on the rate of falls, decubitus ulcers, and 30-day readmissions for patients >65. These data are stratified by demographic and/or social factors.
- D. Protocols exist to reduce the risk of emergency department delirium by reducing length of emergency department stay with a goal of transferring a targeted percentage of older patients out of the emergency department within 8 hours of arrival and/or within 3 hours of the decision to admit.

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Domain 4: Social Vulnerability

Social vulnerability screening is a key way to identify social issues, which can then drive systems in place to address these as part of the patient's care plan.

Attestation Statements

- A. Older adults are screened for geriatric specific social vulnerability including social isolation, economic insecurity, limited access to healthcare, caregiver stress, and elder abuse to identify those who may benefit from care plan modification. The assessments are performed on admission and again prior to discharge.
- B. Positive screens for social vulnerability (including those that identify patients at risk of mistreatment) are addressed through intervention strategies. These strategies include appropriate referrals and resources for patients upon discharge.

Domain 5: Age-Friendly Care Leadership

The identification of an age-friendly champion and/or committee can ensure consistent quality of care for older adults by working to ensure compliance with various components of the Age Friendly Hospital measure.

Attestation Statements

- A. Our hospital designates a point person and/or interprofessional committee to specifically ensure age friendly care issues are prioritized, including those within this measure. This individual or committee oversees such things as quality related to older patients, identifies opportunities to provide education to staff, and updates hospital leadership on needs related to providing age friendly care.
- B. Our hospital compiles quality data related to the Age-Friendly Hospital measure. These data are stratified by demographic and/or social factors and should be used to drive improvement cycles.

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Resources

Disclaimer: Any of the recognitions or accreditations below cannot be used in lieu of completing the CMS attestation, nor do they ensure that all domains are met.

- [Geriatric Emergency Department Accreditation | American College of Emergency Physicians](#)
- [Geriatric Surgery Verification | American College of Surgeons](#)
- [Age-Friendly Health Systems | American Hospital Association](#)
- [Medicare Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes | Federal Register](#)
- [The Need For Geriatrics Measures; April 2023 | Health Affairs](#)
- [Guide to Using the 4Ms in the Care of Older Adults in Hospitals and Ambulatory Care Practices | IHI](#)
- [Age-Friendly Health Systems Recognition | IHI](#)
- [Age-Friendly Care | The John Hartford Foundation](#)
- [Cognitive Impairment in Older Adults: Screening | United States Preventive Services Taskforce](#)