Hospital Quality Incentive Payment (HQIP) Program 2026 Measure Details

May 2025

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

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I. 2026 Measures

Measures for the 2026 HQIP program are listed below. Hospitals will be requested to complete all three measure groups. Measures with an asterisk (*) denote modified measures for the 2026 HQIP program year.

A. Maternal Health and Perinatal Care Group

Measure	Measure Basis	Source	Measurement Period
Exclusive Breastfeeding (PC-05)	The Joint Commission/CMS	Hospital Reported	January 1, 2025 to December 31, 2025
Cesarean Section (PC-02)	The Joint Commission/CMS	Hospital Reported	January 1, 2025 to December 31, 2025
Perinatal Depression and Anxiety	Alliance for Innovation on Maternal Health (AIM)	Hospital Reported	In place on April 30, 2026
Maternal Emergencies	National Partnership for Maternal Safety	Hospital Reported	In place on April 30, 2026
Postpartum Discharge Transition Bundle*	Alliance for Innovation on Maternal Health (AIM)	Hospital Reported	In place on April 30, 2026

B. Patient Safety Group

Measure	Measure Basis	Source	Measurement Period
Zero Suicide*	HQIP	Hospital Reported	In place by April 30, 2026
Health Equity Patient Safety Bundle*	AIM & HCPF	Hospital Reported	In place by April 30, 2026
Clostridium difficile (C. Diff)	Center for Disease Control (CDC)	Department/ Hospital Reported	October 1, 2024 to September 30, 2025
Sepsis	HQIP	Hospital Reported	In place by April 30, 2026
Antibiotics Stewardship*	Colorado Department of Public Health and Environment (CDPHE) Antimicrobial Stewardship, CDC Priorities & National Healthcare Safety Network Reporting (NHSN)	Hospital Reported	In place by April 30, 2026
Adverse Event Reporting	HQIP	Hospital Reported	January 1, 2025 to December 31, 2025

Measure	Measure Basis	Source	Measurement Period
Culture of Safety Survey	Agency for Healthcare Research and Quality (AHRQ)	Hospital Reported	Within the 24 months prior to data collection
Handoffs and Sign-outs	HQIP – based on Agency for Healthcare Research and Quality (AHRQ) & The Joint Commission	Hospital Reported	In place by April 30, 2026

C. Patient Experience Group

Measure	Measure Basis	Source	Measurement Period
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)	AHRQ/ Hospital Compare	Department	October 1, 2024 to September 30, 2025

D. 2026 Maintenance Measures

1. Incidence of Episiotomy

Measure Steward	Data Source	Measurement Period
Christiana Care Health System	Department	January 1, 2025 to December 31, 2025

2. Pulmonary Embolism /Deep Vein Thrombosis (PE/DTV)

Measure Steward	Data Source	Measurement Period
AHRQ	CHA Hospital Report Card	January 1, 2025 to December 31, 2025

3. Central Line Associated Blood Stream Infections (CLABSI)

Measure Steward	Data Source	Measurement Period
CDC	Colorado Department of Public Health and Environment (CDPHE)	October 1, 2024 to September 30, 2025

4. Early Elective Deliveries

Measure Steward	Data Source	Measurement Period
The Joint Commission	CMS	October 1, 2024 to September 30, 2025

E. Modified Measures for 2026

2A. Zero Suicide

Measure Criteria Modification

- "Implementation Team" has been updated to "Steering Council" throughout measure

- Deliverable 3e has been modified to ask for confirmation that the system uses the Stanley-Brown Safety Planning Template (or customized safety plan that includes, at a minimum, all elements present in the Stanely-Brown template)
- Deliverable 4a has been split into deliverables 4a1 and 4a2
  - Deliverable 4a1, Warm Hand-Off is a new deliverable
  - A requirement for submission of the monthly Partner Data Entry Form has been added to Deliverable 4a2, Follow-Up

2E. Antibiotic Stewardship

Measure Criteria Modification

- Scoring Groups 3 and 4 have been renamed for the 2026 program year
  - Group 3 renamed Tracking and Reporting
  - Group 4 renamed Application of Antibiotic Use and Resistance Data
- 2 new deliverables have been added to Group 4 in 2026 (deliverables 4a and 4b)
- 2 deliverables have been retired from Group 4 in 2026 (old deliverables 4a and 4b).

3A. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

Measure Criteria Modification

- Care Transitions (Composite 7) has been retired
  - Communication with Nurses (Composite 1) has been added in its place.

II. Scoring Rubric

For the FFY2025-26 program year a total of 100 points are available for the successful completion of the following three measures: Perinatal and Maternal Care, Patient Safety and Patient Experience

A. Maternal Health and Perinatal Care Group

This measure awards up to 21 total points for the successful completion of the following five sub-measures:

Measure	Points Available	Scoring Method	Scoring Levels
Exclusive Breast-feeding (PC-05)	1	Points awarded on an all or nothing basis	All or Nothing
C-section	5	Ranking method –no points awarded to equal to or above threshold rate	3
Perinatal Related Depression	5	Scoring tiered depending on number of elements in place	2
Maternal Emergencies	5	Points awarded for Structure and Process Measures on an all-or-nothing basis	All or Nothing
Postpartum Discharge Transition Bundle	5	Points awarded for Level 1, additional points available depending on having Tier 2 or Tier 3 elements in place	3

B. Patient Safety Group

This measure awards up to 64 total points for the successful completion of the following eight sub-measures:

Measure	Points Available	Scoring Method	Scoring Levels
Zero Suicide	10	Points awarded for Level 1, additional points available depending on number of Level 2- 4 elements in place	4
Health Equity Patient Safety Bundle	15	Points awarded for Readiness; additional points for each additional element, up to 10	2
C. Diff infections	5	Comparison to the national benchmark - “worse, no different than, better” ranking. Points only awarded to those in “no different than” or “better” categories	3
Sepsis	7	Scoring tiered depending on number of elements in place	2

Measure	Points Available	Scoring Method	Scoring Levels
Antibiotics Stewardship	10	Points awarded for Group 1, additional points available depending on number of Group 2-4 elements in place	4
Adverse Event	5	Points awarded on an all or nothing basis	All or Nothing
Culture of Safety Survey	5	Points awarded on an all or nothing basis	All or Nothing
Handoffs and Sign-outs	7	Scoring tiered depending on number of elements in place	4

C. Patient Experience Group

This measure awards up to 15 total points for the successful completion of the following three sub-measures:

Measure	Points Available	Scoring Method	Scoring Levels
HCAHPS composite 1	5	Ranking method—points awarded to top three quartiles only	3
HCAHPS composite 5	5	Ranking method—points awarded to top three quartiles only	3
HCAHPS composite 6	5	Ranking method—points awarded to top three quartiles only	3

III. Measure Group 1: Maternal Health and Perinatal Care Measure Details

Measures for the 2026 HQIP program are listed below. Hospitals will be requested to complete all measure groups.

A. Exclusive Breast-Feeding (PC-05)

This measure is based on activities from January 1, 2025 to December 31, 2025 and is for all patients regardless of insurance coverage.

All hospitals will be required to report The Joint Commission (TJC) PC-05 data (NQF #0480). There is no minimum denominator for this measure.

1. Measure Criteria

Hospitals will submit calendar year 2025 data for The Joint Commission (TJC) PC-05, Exclusive Breast Milk Feeding measure (all patients, regardless of payer). Points will be given for reporting and will not be based upon the hospital's PC-05 rate. Sampling is allowed. There is no minimum denominator for this measure.

2. Scoring

Points earned for reporting PC-05 data (all or nothing).

Exclusive Breastfeeding (PC-05) Scoring Rubric

Total Possible
1

B. Cesarean Section

This measure is based on calendar year 2025 and is for all patients regardless of insurance status.

The Cesarean Section measure is based on the Joint Commission calculation and sampling for PC-02 in the perinatal care measure set. This measure counts the number of qualified births (nulliparous women with a term, singleton baby in a vertex position) delivered by cesarean section. Sampling is allowed. Minimum denominator of 30 is required for this measure.

1. Measure Criteria

In order to receive a score for the hospital's Cesarean Section rate, the hospital will be required to describe their process for notifying

physicians of their respective Cesarean Section rates and how they compare to other physicians' rates and the hospital average. This should be communicated to physicians through a regular report as well as through regular executive and team meetings (or equivalent). The report must be uploaded and must include at a minimum:

- Physician's Cesarean Section rate.
- The individual rates (not aggregated) of other physicians' Cesarean Section rates to provide a peer-to-peer comparison.
- The hospital's average Cesarean Section rate.

The hospital has discretion over how to format the report and disclosures for statistical significance.

Hospitals will be required to upload a blank example of the report that is provided to physicians for this purpose.

2. Scoring

Hospitals that meet the criteria outlined will be eligible to earn points.

Points will be assigned based on relative performance with hospitals performing worse than minimum standard of 23.6% (Healthy People 2030) receiving no points and the remaining divided into terciles. Please note: for this measure a lower rate is better, therefore the lowest tercile is assigned the highest point value.

Cesarean Section Scoring Rubric

Total Possible	Above 23.6%	Upper Tercile	Middle Tercile	Lowest Tercile
5	0	1	3	5

C. Perinatal Depression and Anxiety

Facilities must attest that this measure has been in place since April 30, 2026 and is for all patients regardless of insurance status.

The Perinatal Depression and Anxiety measure is based on the AIM Perinatal Depression and Anxiety bundle. The measure has been revised to better suit the nature of care delivery in hospital environments. The measure is modeled after 4 "Rs": Readiness, Recognition and Prevention, Response, Reporting/Systems Learning.

1. **Measure Criteria**

Hospitals should report the requested information and documentation that addresses each of the four "Rs" (1-4) in the measure. Screening rates under the Reporting/Systems Learning category must be greater than 0 in order to receive points.

Readiness-Clinical Care Setting:

- Provide documentation on the mental health screening tools used in the facility for screening during pregnancy/immediate postpartum period as well as any education materials and plans provided to clinicians and support staff on use of the identified screening tools and response protocol.
- Identify the individual who is responsible for driving adoption of the identified screening tools and response protocol.

Recognition and Prevention-Every Woman:

- Describe the process where the hospital obtains individual and family mental health history (including past and current medications) at intake and how it is reviewed and update as needed.
- Document the validated mental health screening provided at the hospital during patient encounters during pregnancy/immediate postpartum period.

Response-Every Case:

- Submit documentation on the facility's stage-based response protocol for a positive mental health screen.
- Submit documentation on the emergency referral protocol for women with suicidal/homicidal ideation or psychosis.

Reporting/Systems Learning-Clinical Care Setting:

- Describe the policies and processes by which the hospital incorporates information about patient mental health into how it plans care.
- Report the number of patients screened, the number of positive screens and the number of positive screens that resulted in a documented action or follow up plan.

2. Scoring

To be scored and earn points, hospitals must submit complete information on at least three of four "Rs" (1-4).

Scoring will be tiered with points earned for completion of three, or four "Rs" (1-4).

Perinatal Depression and Anxiety Scoring Rubric

Total Possible	Three Rs	Four Rs
5	3	5

D. Maternal Emergencies and Preparedness

Facilities must attest that this measure has been in place since April 30, 2026 and is for all patients regardless of insurance status.

This measure is based on the National Partnership for Maternal Safety Consensus Bundle on Severe Hypertension During Pregnancy and the Postpartum Period.

Hospitals will report on the structure and process measures below through attestation, narratives that describe processes and provide supporting evidence. The Department will calculate the outcome measures based on claims data. The Department will evaluate the structure and process measures based on the AIM Severe Hypertension in Pregnancy 4 "Rs". (Readiness, Recognition and Prevention, Response, Reporting/Systems Learning).

1. Measure Criteria

Structure Measures

Structure Measures will be evaluated through a combination of attestation and uploading of evidence or documentation. In order to receive points for structure measures, hospitals must answer structure measure A regarding hypertension or preeclampsia policy, and two of three remaining structure measures (B, C, or D).

For each structure measure, hospitals are advised to use the following crosswalk as guidance to determine the relevant "R's" and their associated subcomponents in which documents and narratives submitted must address in order to fully satisfy the requirements for this measure.

Relevant "Rs"

Structure Measure	Readiness	Recognition and Prevention	Response	Reporting
A (required)	1, 3, 6	1, 2, 3	1 (a-c), 2 (a-g)	N/A
B	1, 3, 6	1, 2	2 (a-c)	N/A
C	1, 3, 4, 5, 6	1, 2, 3	1 (a-c), 2 (a-g)	N/A
D	N/A	N/A	N/A	1, 2, 3

Structure Measure A

Does the facility have a severe hypertension or preeclampsia policy and procedure updated within the past 3 years that provides a standard approach for measuring blood pressure, treatment of severe hypertension or preeclampsia, administration of magnesium sulfate, and treatment of magnesium sulfate overdose?

Structure Measure B

Have any of the severe hypertension and preeclampsia processes (i.e. order sets, tracking tools) been incorporated into the facility's electronic health record?

Structure Measure C

Has the facility developed obstetric-specific resources and protocols to support patients, families, and staff through major obstetric complications?

Structure Measure D

Has the facility established a system to perform regular formal debriefs and system-level reviews on all cases of severe maternal morbidity or major obstetric complications?

Compliance on the structure and process measures would be based on the 4 "Rs" criteria from the AIM Severe Hypertension in Pregnancy bundle which is listed below:

Readiness – Every Unit:

1. Standards for early warning signs, diagnostic criteria, monitoring and treatment of severe preeclampsia / eclampsia (include order seta and algorithms)
2. Unit education on protocols, unit-based drills (with post-drill debriefs)
3. Process for timely triage and evaluation of pregnant and postpartum women with hypertension including Emergence Department (ED) and outpatient areas
4. Rapid access to medications used for severe hypertension/eclampsia
5. Medications should be stocked and immediately available on L&D and in other areas where patients may be treated. Include brief guide for administration and dosage.
6. System plan for escalation, obtaining appropriate consultation, and maternal transport, as needed

Recognition and Prevention – Every Patient:

1. Standard protocol for measurement and assessment of BP and urine protein for all pregnant and postpartum women
2. Standard response to maternal early warning signs including listening to and investigating patient symptoms and assessment of labs (e.g. CBC with platelets, AST, and ALT)
3. Facility-wide standards for educating prenatal and postpartum women on signs and symptoms of hypertension and preeclampsia

Response – Every case of sever hypertension/preeclampsia:

1. Facility-wide standard protocols with checklists and escalation policies for management and treatment of:
    a. Severe hypertension
    b. Eclampsia, seizure prophylaxis, and magnesium over-dosage
    c. Postpartum presentation of severe hypertension preeclampsia
2. Minimum requirements for protocol
    a. Notification of physician or primary care provider if systolic BP =/> 160 =/> 110 for two measurements within 15 minutes
    b. After the second elevated reading, treatment should be initiated ASAP
    c. (Preferably within 60 minutes of verification)
    d. Includes onset and duration of magnesium sulfate therapy
    e. Included escalation measures or those unresponsive to standard treatment
    f. Describes manner and verification of follow-up within 7 to 14 days postpartum
    g. Describe postpartum patient education for women with preeclampsia

Reporting/Systems Learning – Every Unit:

1. Establish a culture of huddles for high risks patients and post event debriefs to identify successes and opportunities.
2. Multidisciplinary review of all severe hypertension / eclampsia cases admitted to Intensive Care Unit (ICU) for systems issues.
3. Monitor outcomes and process metrics

Process Measures

Process measures must be reported, and points can be earned by reporting data for all three process measures A, B, and C.

Process Measure A

How many drills on maternal safety topics were performed in the facility during the past calendar year?

Process Measure B

What proportion of maternity care providers and nurses have completed a bundle or unit protocol– specific education program on severe hypertension and preeclampsia within the past 2 years?

Process Measure C

How many women with sustained severe hypertension received treatment according to protocol within 1 hour of detection over the past calendar year? Collect the total number of women with sustained severe hypertension as well as the women who received treatment according to protocol within 1 hour of detection.

Outcome Measures

Outcome measures will be calculated by the Department using claims data.

Denominator

All women during their birth admission (excluding those with ectopic pregnancies and miscarriages) with one of the following diagnosis codes:

- Gestational hypertension
- Severe preeclampsia
- HELLP syndrome
- Eclampsia
- Preeclampsia superimposed on pre-existing hypertension
- Chronic hypertension

Numerator

Among those patients counted in the denominator, cases with any Severe Maternal Morbidity code (as detailed on the Alliance for Innovation on Maternal Health website: https://saferbirth.org/wp-content/uploads/Updated-AIM-SMM-Code-List_10152021.xlsx

2. Scoring

In order to receive full points, hospitals must answer all Structure elements and Process elements to earn points. Structure and Process elements are each scored on an all-or-nothing basis.

Maternal Emergencies and Preparedness Scoring Rubric

Total Possible
5

E. Postpartum Discharge Transition Bundle

Facilities must attest that this measure has been in place as of April 30, 2026 and is for all patients regardless of insurance status.

This measure is based on the AIM Postpartum Discharge Transition Bundle, with one element incorporated from the AIM Care for Pregnant People with Substance Use Disorder Patient Safety Bundle. The elements included have been determined by a team of maternal health subject matter experts to be the most relevant to the HQIP program. The complete measure bundle developed for HQIP features 13 elements[1] across 5 "Rs": Readiness, Recognition, Response, Reporting/Systems Learning, Respectful, Equitable and Supportive Care. Deliverables will be tied to each element.

In the 2026 HQIP program year, hospitals will report on deliverables across 5 elements. 3 elements for a 1-point gate, and 4 or 5 elements for either 3 or 5 points.

1. Measure Criteria

Hospitals should report the requested information and documentation that addresses each element deliverable in the measure.

[1] See Appendix D for a full listing of bundle elements.

Readiness:

Element 1: Develop and maintain a set of referral resources and communication pathways between obstetric providers, community-based organizations, and state and public health agencies to enhance services and supports for pregnant and postpartum families.

Resource Mapping/Identification of Community Resources: Has your hospital created a comprehensive list of community resources, customized to include resources relevant for pregnant and postpartum people, that will be shared with all postpartum inpatient nursing units and outpatient OB sites?

- Deliverable 1a: Provide community resource list or link to relevant website. The submitted supporting documentation must include the last date of update to qualify for points.
    - Resources should include specialist care, social driver needs, mental health supports, substance use disorder treatment.

Element 2: Establish a multidisciplinary care team to design coordinated clinical pathways for patient discharge and a standardized discharge summary form to give to all postpartum patients prior to discharge.

Inpatient-Outpatient Care Coordination Workgroup: Has your hospital established a multidisciplinary workgroup of inpatient and outpatient providers that meets regularly to identify and implement best practices on issues related to pregnancy and the postpartum period that cross the continuum of care?

- Deliverable 2a: Provide documentation of multidisciplinary care team membership, meeting cadence, and high-level agendas of each meeting addressing high level topics discussed during the measurement period.

Recognition:

Element 6: Screen each patient for current or history of Substance Use

Percent of patients admitted for live birth screened for current or history of Substance Use or Substance Use Disorder

- Deliverable 6a: Provide the percentage of patients admitted for live birth screened for current or history of Substance Use or Substance Use Disorder
    - Denominator: Pregnant and postpartum people during their birth hospitalization - disaggregated by race/ethnicity
    - Numerator: Among the denominator, those with documentation of having been screened for substance use disorder using a validated screening tool[2] during their birth hospitalization* - disaggregated by race/ethnicity

      *To be included in the numerator, patients had to have answered any question(s) from a validated SUD screening tool.

Element 7: Assess and document if patients presenting in the emergency department are pregnant or have been pregnant within the past year.

Emergency Department (ED) Screening for Current or Recent Pregnancy: Has your ED established or continued standardized verbal screening for current pregnancy and pregnancy in the past year as part of its triage process?

- Deliverable 7a: Provide written documentation of processes and systems for screening for current or recent pregnancy in the emergency department.

Response:

Element 8: Provide patient education prior to discharge that includes life-threatening postpartum complications and early warning signs, including mental health conditions, in addition to individual patient-specific conditions, risks, and how to seek care.

Patient Education Materials on Urgent Postpartum Warning Sign: Has your department developed/curated patient education materials on urgent postpartum warning signs that align with culturally and linguistically appropriate standards?

[2] See Appendix G for additional information on validated screening tools

- Deliverable 8a: Submit materials shared with patients regarding life-threatening postpartum complications
  - Materials should include:
    - Who to contact with medical and mental health concerns, ideally stratified by severity of condition or symptoms.
    - Physical and mental health needs
    - Review warning signs/symptoms with patient and family, explaining the conditions that they may indicate so that the patient/family can self-advocate if seeking care from a non-obstetric provider unfamiliar with postpartum complications.
    - Reinforcement of the value of outpatient postpartum visits
    - Summary of birth events[3] describing any adverse or unexpected events with the patients to help them have a better understanding of the care they received, and any specific after-care that they'll need as a result.
      - For non-complicated births, summarizing the birth should focus on postpartum care plans. This includes what is in the care plan, and why it is important.
    - Home monitoring process and parameters for blood pressure, blood glucose, and/or other monitoring metrics

  Patient Education on Life-threatening Postpartum Concerns: Processes and reporting for counseling on life-threatening postpartum concerns for all maternal discharges following a live birth.
- Deliverable 8b:
  - Provide a narrative of your processes for providing verbal and written education on life-threatening postpartum concerns before discharge from birth hospitalization.
  - Provide a narrative of your processes and capabilities for reporting the percentage of all maternal discharges following a

[3] See the bundle's accompanying Element Implementation Details for additional information

live birth that have had counseling on life-threatening postpartum concerns.

2. **Scoring**

To earn any points for this measure, hospitals must have all deliverables for Tier 1 (gate) measure elements in place. The required Tier 1 deliverables are: Element 1, Deliverable 1a, Element 2, Deliverable 2a, and Element 8, Deliverables 8a & 8b.

Additional points can be earned for this measure based on having additional elements of the bundle in place.

- Hospitals can earn Tier 2 points (3) by having ***either*** Element 6, Deliverable 6a or Element 7, Deliverable 7a in place in addition to the required Tier 1 elements.
- Hospitals can earn Tier 3 points (5) by having ***both*** Element 6, Deliverable 6a and Element 7, Deliverable 7a in place in addition to the required Tier 1 elements.

Postpartum Discharge Transition Bundle Scoring Rubric

Total Possible	Tier 1	Tier 2	Tier 3
5	**1**	**3**	**5**

Scoring Tier	Elements	Deliverables	Points Available
1	1, 2, 8	1a, 2a, 8a, 8b	1
2	1, 2, 8, and 6 **or** 7	1a, 2a, 8a, 8b, and either 6a **or** 7a	3
3	1, 2, 8, and 6, 7	1a, 2a, 8a, 8b, and both 6a **and** 7a	5

IV. Measure Group 2: Patient Safety Group Measure Details

A. Zero Suicide

Zero Suicide was introduced to the Patient Safety measure group in the 2021 HQIP program year. This measure is for all patients regardless of insurance status. Facilities must attest that this measure has been in place as of April 30, 2026. Hospitals will earn points for the successful completion of deliverables. In order to receive the highest points, hospitals must complete all deliverables. Deliverables and levels are not cumulative; however, hospitals must complete Level I to earn points on other deliverables. The levels are:

- Level I: Lead and Plan;
- Level II: Train;
- Level III: Identify, Treat, Engage, and
- Level IV: Transition and Improve.

1. Measure Criteria

Level I: Lead and Plan

Implementation Team

Establish a Steering Council to drive Zero Suicide forward. The team should elevate the voices of those with lived experience of suicidal despair or attempt(s), or of receiving suicide-related care in the health system. Councils should also aim to include representation from all areas of a health system, and may include clinical workforce, non-clinical workforce, IT/data specialist, quality improvement specialist, and/or other roles as relevant for engagement with the framework in your context.

Deliverable 1a: Please describe your Steering Council, clearly defining roles, tasks, and qualifications of team members. Please also share how many members of the Steering Council have lived experience, and how frequently you will meet.

Deliverable 1b: Steering Council must participate in the monthly Zero Suicide Learning Collaborative hosted by the Office of Suicide Prevention (OSP). Meetings are typically held virtually the 4th Thursday of the month

at 10am. For HQIP 2026, Survey hospitals must attend at least 9 meetings of the Zero Suicide Learning Collaborative during the measurement period and follow the procedures to ensure attendance is recorded. The Department will receive a list of hospitals that have attended directly from CDPHE. Please contact cdphe_suicideprevention@state.co.us to get added to the list, or to reach out with any questions, ideas for session topics, focus, guests, etc.

Leadership Buy-in

Leadership drives the dramatic reduction in suicide deaths achieved by organizations implementing Zero Suicide. Leadership must both help staff see and believe that suicide can be prevented and provide tangible supports in a safe and blame-free environment — what is known as just culture. Leaders at all levels should embrace the Zero Suicide ideology, and make themselves available to listen, support, and reinforce the necessary changes to support suicide-safer care within their organization.

- Train management and executive level leadership on new initiative, and provide updates on progress and requests for support.
- Consider ways to link Zero Suicide to other initiatives (e.g., trauma-informed care, substance abuse).
- Encourage leadership participation in Steering Council meetings, as well as various suicide prevention training opportunities, webinars, conferences, etc.

Deliverable 1c: Collect and submit a written commitment from CEO/leadership highlighting that suicide prevention is a core priority of the health system. A sample letter is available at this link: https://zerosuicide.edc.org/resources/resource-database/sample-letter-staff-announcing-adoption-zero-suicide-approach

Organizational Self-Survey

Deliverable 1d: Submit the organizational Self-Study (annually).

Optional Information 1d[4]: Identify any support/resources needed and questions about implementation of improvements in suicide care.

- Support, Resources & Questions: What support or resources from the Office of Suicide Prevention (OSP), Colorado Hospital Association (CHA), or Dept. of Health Care Policy and Financing (HCPF) are needed after completion of the Organizational Self-Study, if applicable? Please reach out at any point with questions.

- Resources available at the following links: General template; Inpatient Template; Organization Self-Study Portal

[4] Submission of this information is optional and will not be scored. The collection of this information will be used by the Office of Suicide Prevention to help inform support/resources available to hospitals in the context of implementation of improvements in suicide care.

Level II: Train

Workforce Survey

The Workforce Survey helps prioritize limited time and training resources, and gauges how prepared/supported staff feels providing care for patients at risk for suicide. An implementation team should use this annual survey to inform opportunities to train and support staff in the ways they need to be trained, and also address bias and stigma in suicide care.

Deliverable 2a: Administer a Workforce Survey, submit results, and use results to formulate training plans and other system changes (annually)

- Resources are available at the following links: Guidelines from Zero Suicide for survey administration and for improving response rates, Survey Template and Online Workforce Survey Request Form

- It is also encouraged that you reach out to the Office of Suicide Prevention to discuss suicide-specific training options available in your area and strategic plans after administering the Workforce Survey. Please contact cdphe_suicideprevention@state.co.us with any questions or concerns.

Non-Clinical Workforce Training

In this context, 'non-clinical training' means training for anyone in your system who might benefit from general awareness and literacy training about mental illness and/or suicide prevention. All non-clinical staff should receive gatekeeper-level or better suicide prevention training on an annual basis. The goal of the program is to train 100% of health system staff in basic prevention: how to recognize suicide risk and suicide behavior, how to respond, and how to refer someone to a professional. Examples of acceptable evidence-based trainings include, but are not limited to:

- Question, Persuade, Refer (QPR): Gatekeeper Training for Suicide Prevention (60-90 minutes, in person or virtual)
- LivingWorks Start (45-60 minutes, online scroll down in link for log-in information)

- SAVE VA Sponsored gatekeeper training (75 minutes, in person or virtual scroll down in link for program information)
- Applied Suicide Intervention Skills Training (ASIST) (2 days, in person)
- Mental Health First Aid (8 hours, in person or virtual scroll down in link for program information)
- To learn more about available training resources in Colorado, please visit https://cdphe.colorado.gov/suicide-prevention-training or contact CDPHE_SuicidePrevention@state.co.us
- Zero Suicide also has a helpful matrix of suicide care training options
- There are also online resources for Counseling on Access to Lethal Means & Safety Planning

Deliverable 2b: Using the results from the Workforce Survey, please describe a non-clinical training plan that includes a) what gatekeeper curricula the system will use for non-clinical staff, b) how trainings will be implemented, c) how they will be tracked, d) plans for sustainability of the training, and e) any additional resources needed to achieve the plan.

Deliverable 2c: Submit an annual update with the number and percentage of non-clinical staff trained (i.e. progress on non-clinical training plan. For each training report the following:

- Name of Training
- Number of non-clinical staff trained
- Percentage of non-clinical staff trained
- Who will receive the training

Clinical Workforce Training

The goal of the program is for all clinicians to receive suicide prevention training relevant to their roles within a system. Trainings should cover core competencies of screening, assessment, safety planning, and lethal means counseling. Some trainings offer more than one of these competencies. Other skills relevant to clinicians' duties, such as workflows, EHR Updates intake, discharge planning, and follow-up

services should be included in training plans to meet varying needs of system clinicians. Examples of acceptable trainings include, but are not limited to:

Screening and Assessment Skills:

- Assessing and Managing Suicide Risk (AMSR)
- Assessment of Suicidal Risk Using the Columbia Suicide Severity Rating Scale (C-SSRS)
- Best Practices Resource for Screening and Assessment

Lethal Means Safety

- Counseling on Access to Lethal Means (CALM)
- Lethal Means Counseling: A Role for Colorado Emergency Departments to Reduce Youth Suicide

Collaborative Safety Planning

- Collaborative Safety Planning Training
- Collaborative Safety Planning Toolkit
- Safety Planning Intervention for Suicide Prevention
- Joint Commission Safety Planning Training
- Crisis Response Planning
- Stanley & Brown Safety Plan
- Safety Planning for Youth Suicide Prevention

Brief Interventions

- Brief Cognitive Behavioral Therapy
- Making it matter with Micro-Interventions from Dr Ursula Whiteside
- Suicide Safe Care from Dr. Ursula Whiteside

Ongoing Clinical Care

- Collaborative Assessment and Management of Suicidality CAMS
- Bite-size DBT Skills with Dr. Ursula Whiteside (gathering confidence and momentum as DBT Skills Expert)

Deliverable 2d: Using the results from the Workforce Survey, please describe a clinical training plan that includes:

- What trainings are selected to meet various needs and core competencies
- How trainings will be implemented
- How they will be communicated to clinical staff
- How they will be tracked
- How trainings will be sustained
- Any additional resources needed to achieve the plan

Deliverable 2e: Submit an annual update with the number and percentage of clinical staff trained (i.e., progress on clinical training plan). For each training report the following:

- Name of Training
- Number of clinical staff trained
- Percentage of clinical staff trained
- Who will receive the training

Level III: Identify, Treat, Engage

Screening

As part of the aspirational goal central to Zero Suicide, ideally all persons receiving care in a system are screened for suicidal thoughts and behaviors at intake and at all subsequent appointments. Whenever a patient screens positive for suicide risk, a full risk formulation is completed for the client. A gold standard for screening would be a system where screening workflows:

- Clearly define the frequency of screening
- Identify which staff will be providing the screening after being trained in standardized screening tools and documentation
- Describe a policy and procedure for connecting patients to clinically trained staff after screening positive for suicide risk
- Ensure that staff are alerted when a patient screens positive for suicide risk
- Embed screening measures into the electronic health record (EHR) system
- Screen patients at discharge in inpatient settings

While the goal is universal screening for clients, Steering Councils should identify the patient population to be screened (if not universal) and any barriers to achieving universal. There are additional screening tool and risk assessment resources available on the Zero Suicide website.

Deliverable 3a: Please describe your policies, procedures, and workflows for screening patients for suicide risk. In your description, please include a) what standardized tool is used for screening, b) which staff administer screening, c) when patients are screened, and d) if the process/tool is embedded in the EHR. Please also identify any future plans towards universal screening of patients, and any obstacles foreseen.

Deliverable 3b: On an annual basis, submit an update including the number and percentage of individuals who were screened for suicide risk and how many of those people screened positive in the prior year.

Assessment

A gold standard for assessment would be a system where assessment procedures/policies/workflows:

- Ensure that 100% of individuals who screen positive for suicide risk are provided with full assessment for safety
- Utilize a standardized assessment tool
- Identify staff providing the assessment
- Embed assessment protocols into the electronic health record (EHR) system

Deliverable 3c: Please describe your policies, procedures, and workflows for assessing patients for suicide risk. In your description, please include a) what standardized tool is used for assessment, b) which staff complete assessment, c) if the process/tool is embedded in the EHR. Please also identify any future plans towards improving assessment of patients screening positive for suicide risk, and any obstacles foreseen.

Deliverable 3d: On an annual basis, submit a report including the number and percentage of individuals who screened positive for suicide risk who received a safety assessment.

Safety Planning

A gold standard for safety planning would be a system where safety planning procedures/policies/workflows:

- Ensure 100% of individuals who screen positive for suicide risk work with a clinician to create an effective and collaborative safety plan and receive counseling on temporary lethal means safety. Providers should collaborate with the patient and patient's relevant support system to:
    - Promote shared understanding of the purpose of the safety plan.
    - Identify and document warning signs.
    - Document internal coping strategies.
    - Identify people and social settings that provide distraction.
    - Identify personal contacts to ask for help.

    - Provide name and contacts of professional services to contact during crisis.
    - Develop a plan for lethal means safety.
    - Explain the best ways to use a safety plan.
- Safety planning procedures and workflows are identified utilizing standardized safety planning tool (i.e. the Stanley-Brown Safety Plan Template)
- Identify which staff will provide the collaborative tool, and provide a plan that the client takes with them
- Are embedded into the electronic health record (EHR) system

Deliverable 3e: Please describe your policies, procedures, and workflows for safety planning with patients at risk for suicide. In your description, please include:

- Confirmation that your system uses the Stanley-Brown Safety Planning Template (or customized safety plan that includes, at minimum, all elements present in the Stanley-Brown template)
- Which staff make safety plans with patients
- If the process/tool is embedded in the EHR. Please also identify any future plans towards improving safety planning practices with patients at risk, and any obstacles foreseen.

Deliverable 3f: On an annual basis, provide an update including the number and percentage of individuals who screened positive for suicide risk and who received a safety plan.

Engagement for Health Equity

While creating, maintaining, and evaluating suicide-related policies and practices, it is vital to solicit input from and work collaboratively with people in the communities you serve. It is particularly important to do this with those particularly affected by historical and ongoing marginalization that leads to health inequities and a disproportionate burden of suicidality, including but not limited to people who are Black, indigenous, people of color, LGBTQIA2S+, veterans, people who experience chronic mental health and substance use disorders, and people with disabilities. As part of this engagement, a hospital should

hold itself accountable to such feedback and regularly incorporate it into any suicide-related policies and procedures.

Note: it is also encouraged that your hospital look at county level indicators to see which local communities may be prioritized for suicide-specific prevention, intervention, and postvention support, accessible via the Colorado Suicide Data Dashboard.

Deliverable 3g: Please describe:

- Any ongoing outreach efforts or initiatives to provide more responsive care the above communities
- How community members (particularly those with lived experience of mental illness, suicide, or receiving care in your system) are consistently included in Zero Suicide implementation efforts
- How input and feedback is regularly received from community members
- The specific actions that have been taken or are planned by the implementation team as a result of this collaborative effort.

Level IV: Transition and Improve

Transition

Care transitions are generally high-risk times for patients, and research shows that patients who receive connections to supportive follow-up care in the days after discharge are less likely to die by suicide. Caregivers and clinicians must bridge patient transitions from inpatient, ED, or primary care to outpatient behavioral health care with warm hand-offs. It is equally important to address suicide risk at every visit within an organization, from one behavioral health clinician to another or between primary care and behavioral health staff in integrated care settings.

All individuals who screen positive for suicide risk should receive non-demand caring follow-up contacts from health system after inpatient, outpatient, or emergency visits

Please access this resource from the National Action Alliance for Suicide Prevention to learn more about best practices in transition and follow-up

care. This self-assessment checklist is a useful guide to understand how your organization's current policies align with best practice, and where opportunities for improvement may be.

Deliverable 4a:

4a1, Warm Hand-Off: Please submit this checklist from the National Action Alliance for Suicide Prevention, along with a work plan for improving collaborative protocols and procedures with outpatient provider organizations to ensure safe, seamless transfer of care.

4a2, Follow-Up: Please provide indication that your health system participates in the Colorado Follow-Up Project and that the hospital submits the Partner Data Entry Form to CU during each month of the measurement period.

(The Colorado Office of Suicide Prevention will confirm participation and submission of monthly data deliverable)

Deliverable 4a2 Follow-Up Alternate: Please submit a written policy and work plan for following up (via phone call, text, email, etc.) within 3 calendar days for clients who screen positive for suicide risk that includes which staff are responsible for making the non-demand caring contact and what system is used to track implementation. On an annual basis, submit a report with the number and percentage of individuals who screened positive for suicide risk who received such follow-up.

Improve

Data-driven quality improvement is essential to ensure improved patient outcomes and better care for those at risk of suicide. Continuous quality improvement can only be effectively implemented in a safety-oriented, "just" culture free of blame for individual clinicians when a patient attempts or dies by suicide. A top priority of any system implementing Zero Suicide should be to develop capability to track key improvement measures and have them be built into the electronic health record system.

Deliverable 4b: Please describe how your hospital is using a data monitoring tool to track implementation of written policies, training

plans, return ED visits, suicide attempts, and suicide fatalities of clients (using the measures identified below, adapted from the Data Elements Worksheet). Also comment on how the hospital tracks both process and outcome measures, as well as any barriers faced in collecting this information. Note: it's also encouraged that your hospital look at county level indicators, accessible via the Colorado Suicide Data Dashboard.

Deliverable 4b continued: Health Equity Data: You should also collect and track data on screening, referral, access to care, and the above metrics among populations in your area most affected by health inequities. Please also describe your current process/plans for collecting and reporting Zero Suicide data relevant (but not limited) to people of color, people who are indigenous, LGBTQIA2S+, veterans, and people with disabilities.

Measures adopted from the data elements worksheet are provided for reference:

- Rate of Deaths by Suicide Among ALL Clients, during the last year
    - Total number of clients who died by suicide during the last year (reporting period)
    - Total number of clients seen over the reporting period
- Rate of Suicide Deaths Among Those with Identified Suicide Risk, during the last year
    - Total number of clients with suicide risk (determined by screening/assessment) who died by suicide during the last year
    - Total number of clients with suicide risk (determined by screening/assessment) during the last year
- Emergency Department Usage, during the last year
    - Total number of clients with suicide risk (determined by screening/assessment) who went to the emergency department for making a suicide attempt
    - Total number of clients with suicide risk (determined by screening/assessment)
- Suicide Attempt Rate Among ALL Clients, during the last year

    - Total number of clients who made a suicide attempt during the reporting period
    - Total number of clients seen over the reporting period
- Suicide Attempt Rate Among Those with Identified Risk, during the last year
    - Total number of clients with identified suicide risk (determined by screening/assessment) who made a suicide attempt during the reporting period
    - Total number of clients with suicide risk (determined by screening/assessment

2. Scoring

Hospitals will earn points for the successful completion of deliverables in the four levels. To be eligible for points, hospitals must successfully complete all criteria for measure Level I. Hospitals can earn additional points by completing deliverables in Levels 2 – 4.

Zero Suicide Scoring Rubric

Total Possible	Level 1	Level 2	Level 3	Level 4
10	1	3	4	2

Zero Suicide Scoring by Deliverable

Level	Deliverables	Score
1	1a – 1d	1
2	2a	1
2	2b & 2c	1
2	2d & 2e	1
3	3a & 3b	1
3	3c & 3d	1
3	3e & 3f	1
3	3g	1
4	4a	1
4	4b	1

B. Health Equity Patient Safety Bundle

Hospitals must report on the current status of initiatives focused on improving Health Equity on a hospital-wide basis. Scoring will be based on having specific components of each "R" in place, or through documentation[5] of a current Joint Commission Health Care Equity Certification. The measurement period should be the hospital's experience as of the date the survey is filled out. Hospitals with labor and delivery will also have the option to include additional responses regarding how they are approaching key aspects of the measure specifically for peripartum patients.

Facilities must attest that this measure has been in place as of April 30, 2026 and is for all patients regardless of insurance status.

1. Measure Criteria

1. Readiness

Leadership

a. Does your hospital have a written, public-facing statement from leadership that supports and prioritizes the implementation and/or administration of a program improving health disparities by ensuring equitable care is provided to all patients?

   Deliverable 1a: Please submit your hospital's written, public-facing statement from leadership that supports and prioritizes the implementation and/or administration of a program improving health disparities by ensuring equitable care is provided to all patients. Additionally, please submit the location of your hospital's public-facing statement (ex: URL to webpage).

b. Does your hospital have a designated individual or individuals responsible for management, implementation, and outcomes of health disparity improvement and healthcare equity initiatives?

   Deliverable 1b: Please submit the name(s), roles, tasks, and qualifications of team members responsible for the management,

[5] See Appendix F: Health Care Equity Certification for documentation details

implementation, and outcomes of health disparity improvement and health equity initiatives.

Collection of Demographic Data

c. Does the hospital's system accurately document self-identified race, ethnicity, and primary language?

   Deliverable 1c: Provide a brief narrative describing how your hospital's systems collects and documents self-identified race, ethnicity, and primary language.

d. Does the hospital provide staff education and training on how to ask demographic intake questions for staff in all settings where someone is registering patients or adding demographic information to a patient's record?

   Deliverable 1d: Provide a brief narrative describing how your hospital provides staff education and training on how to ask demographic intake questions for staff in all settings where someone is registering patients or adding demographic information to a patient's record.

e. Does your hospital provide information to patients on why race, ethnic and language data are being collected?

   Deliverable 1e: Provide a brief narrative describing how your hospital provides education on why race, ethic and language data are being collected.

f. Are race, ethnicity, and language data accessible in the electronic medical record?

   Deliverable 1f: Please submit documentation showing how race, ethnicity, and language data are accessible in the electronic medical record.

Support for non-English Speakers

g. Does the hospital ensure that communications with patients about their medical care in languages other than English meet non-English language proficiency (e.g., Spanish proficiency) requirements?

Deliverable 1g: Indicate from the selections below and provide a brief narrative describing how your hospital ensures that communications with patients about their medical care in languages other than English meet non-English language proficiency requirements. Check all that apply electronic translation services/language line/iPads, certified interpreters, language proficiency assessment of staff who are communicating with patients regarding their medical care.

h. Does the hospital educate all staff responsible for communicating with patients regarding their medical care on interpreter services available within the healthcare system?

   Deliverable 1h: Provide a brief narrative describing how your hospital educates all staff responsible for communicating with patients regarding their medical care on interpreter services available within the healthcare system.

Hospital Education

i. Does the hospital provide education on racial and ethnic disparities and their root causes?

   Deliverable 1i: Provide a brief narrative describing how your hospital provides staff-wide education on racial and ethnic disparities and their root causes.

   (Optional for labor and delivery hospitals) Please describe any staff-wide education your hospital provides on racial and ethnic disparities that is specific to the peripartum population.

j. Does the hospital provide education on best practices for shared decision making?

   Deliverable 1j: Provide a brief narrative describing how your hospital provides education to providers on best practices for shared decision making.
   (Optional for labor and delivery hospitals) Please describe how your hospital provides education to providers on best practices for shared decision making specific to the peripartum population.

Community Engagement

k. Does the hospital engage diverse populations within its community regarding issues of equity in quality and safety to inform the decisions made by quality and safety leadership teams?

   Deliverable 1k: Provide a brief narrative describing how your hospital engages diverse populations within your community regarding issues of equity in quality and safety. Describe how input and information from your engagement is communicated to and informs the decisions made by quality and safety leadership teams. (Optional for labor and delivery hospitals) Does your hospital include stakeholders representing peripartum concerns? Please describe or provide information about these stakeholders and how they are engaged regarding issues of equity in quality and safety for peripartum patients.

Accessibility Regarding Communications Disabilities

l. Hospitals must answer yes to the following question and provide all supporting documentation outlined in the Deliverables section below:
   - Does the hospital have a policy for providing appropriate auxiliary aids and/or services to individuals with a record of, or regarded as, living with a communications disability?

Deliverable 1l: To receive points for this element hospitals must:
- Submit a list of auxiliary aids/services for Individuals who are deaf or hard of hearing (ex: telecommunications devices (TDDs), interpretation services, assistive listening devices, television captioning and decoders, note-takers) that are available to patients at their facility.
- Submit a list of auxiliary aids/services for Individuals living with speech deficits (ex: TDDs, computers, flashcards, alphabet boards, communication boards) that are available to patients at their facility.
- Submit a list of auxiliary aids/services for individuals living with vision impairments (ex: qualified readers, Brailled materials, taped, or large-print materials) that are available to patients at their facility.

- Submit a list of auxiliary aids and services for individuals living with manual impairments (ex: TDDs, computers, flashcards, alphabet boards, communication boards) that are available to patients at their facility.

2. Recognition & Prevention – Every patient, family, and staff member

a. Does the hospital provide staff-wide education on implicit bias?

   Deliverable 2a: Provide a brief narrative describing how your hospital provides staff-wide education on implicit bias.

b. Does the hospital provide convenient access to health records without delay (paper or electronic), at minimal to no fee to the patient, in a clear and simple format that summarizes information most pertinent to patient care and wellness?

   Deliverable 2b: Provide a brief narrative describing how your hospital provides convenient access to health records without delay (paper or electronic), at minimal to no fee to the patient, in a clear and simple format that summarizes information most pertinent to patient care and wellness.

c. Does the hospital have a mechanism for patients, families, and staff to report inequitable care and episodes of miscommunication or disrespect?

   Deliverable 2c: Provide a brief narrative describing your hospital's mechanism for patients, families, and staff to report inequitable care and episodes of miscommunication or disrespect.

3. Response – Every Clinical Encounter

a. Does the hospital ensure that providers and staff engage in best practices for shared decision making?

   Deliverable 3a: Provide a brief narrative describing how your hospital ensures that providers and staff engage in best practices for shared decision making.

   (Optional for labor and delivery hospitals) Please describe how your hospital engages in best practices for shared decision making specific to peripartum patients.

b. Does the hospital have a process to ensure a timely and tailored response to each report of inequity or disrespect?

Deliverable 3b: Provide a brief narrative describing your hospital's process to ensure a timely and tailored response to each report of inequity or disrespect.

Discharge Navigation and Coordination Systems

c.i Does the hospital have discharge navigation and coordination systems post discharge to ensure that patients have appropriate follow-up care and understand when it is necessary to return to their health care provider?

Deliverable 3c: Provide a brief narrative describing your hospital's discharge navigation and coordination systems to ensure that patients have appropriate follow-up care and understand when it is necessary to return to their health care provider?

(Optional for labor and delivery hospitals) Please describe your hospital's discharge navigation and coordination systems post childbirth to ensure that women have appropriate follow-up care and understand when it is necessary to return to their health care provider.

c.ii Does the hospital provide discharge instructions that include information about what danger or warning signs to look out for, whom to call, and where to go if they have a question or concern?

Deliverable 3d: Provide a brief narrative describing how your hospital provides discharge instructions that include information about what danger or warning signs to look out for, whom to call, and where to go if they have a question or concern.

c.iii Does the hospital provide discharge materials that meet patients' health literacy, language, and cultural needs?

Deliverable 3e: Provide a brief narrative describing how your hospital provides discharge materials that meet patients' health literacy, language, and cultural needs.

4. Reporting/Systems Learning

Accountability

a. Does your hospital have a current plan that is to be implemented if your hospital does not achieve or sustain its health disparity improvement and healthcare equity goals?

Deliverable 4a: Please describe the current plan that is to be implemented if your hospital does not achieve or sustain its health disparity improvement and healthcare equity goals.

b. Does the hospital have initiatives in place to build a culture of equity, including systems for reporting, response, and learning?

Deliverable 4b: Provide a brief narrative describing the initiatives in place to build a culture of equity, including systems for reporting, response, and learning.

c. Does the hospital have a process in place for the regular reporting and monitoring of metrics (process and/or outcome) stratified by race and ethnicity and disseminate the information internally to staff and leadership? This could take the form of a dashboard, regularly distributed reports or other reporting and monitoring tools.

Deliverable 4c: Provide a brief narrative describing your hospital's process for the regular reporting and monitoring of metrics (process and/or outcome) stratified by race and ethnicity and disseminate the information internally to staff and leadership.

(Optional for labor and delivery hospitals) Please outline your hospital's process for the regular reporting of metrics stratified by race and ethnicity specific to the peripartum population. Describe the peripartum specific metrics in your response.

d. Does the hospital implement quality improvement projects that target disparities in healthcare access, treatment, and outcomes?

Deliverable 4d: Provide a brief narrative description how your hospital implements quality improvement projects that target disparities in healthcare access, treatment, and outcomes.

(Optional for labor and delivery hospitals) Please describe how your hospital implements quality improvement projects that target disparities in healthcare access, treatment, and outcomes specific to peripartum patients.

e. Does the hospital consider and document the role of race, ethnicity, language, poverty, literacy, and other social determinants of health, including racism at the interpersonal and system-level when conducting multidisciplinary reviews of morbidity and mortality, and other clinically important metrics? For example, does the hospital have a checkbox on the review sheet that asks: Did race/ethnicity (i.e., implicit bias), language barrier, or specific social determinants of health contribute to the morbidity (yes/no/maybe)? And if so, are there system changes that could be implemented that could alter the outcome?

   Deliverable 4e: Please upload supporting documentation showing how you document whether race/ethnicity (i.e., implicit bias), language barrier, or specific social determinants of health contributed to the morbidity and mortality. Please describe how you review and disseminate this information as part of your hospital's efforts around continuous learning and quality improvement.

   Note: Additional resources for this measure can be found in the Appendices.

5. Scoring

To earn points for this measure, hospitals must have elements 1a through 1k of Readiness in place. Additional points can be earned for this measure based on having additional elements of the bundle in place.

Hospitals may also earn full points for this measure by submitting documentation of a current Joint Commission Health Equity Certification.

Health Equity Patient Safety Bundle Scoring Rubric

Total Possible	Readiness	One Point for Each Additional Element
15	5	Up to 10

C. Hospital Acquired Clostridium Difficile (C. diff) Infections

1. Measure Criteria

Hospitals must submit data for this measure to National Healthcare Safety Network (NHSN); this allows for risk adjusting and calculation of an SIR rate. The Department will pull hospital data from CMS.

2. Scoring

For Hospital Acquired Clostridium Difficile infections points will be earned based on hospital performance compared to the national benchmark. The comparison is scored as better, no different, or worse than the benchmark, and points are associated with those scores.

Hospital Acquired Clostridium Difficile (C. diff) Scoring Rubric

Total Possible	Worse	No Different	Better
5	0	3	5

D. Sepsis

This process measure focuses on systems in place for improving the early identification and treatment of sepsis. Facilities must attest that this measure has been in place as of April 30, 2026 and is for all patients regardless of insurance status.

1. Measure Criteria

Hospitals must:

1. Describe the protocols and alerts your facility has in place for identifying sepsis and for treating sepsis. If the protocols are different for different levels of care (e.g., ED vs inpatient), please describe the protocols and their differences.
2. Describe and provide evidence of the training that your facility has in place for orienting new providers and staff to your facility's systems and protocols for addressing suspected sepsis cases.
3. Describe the process of providing regular feedback to providers on sepsis identification and treatment results.
4. Provide process measures and/or outcome measures your facility uses for tracking sepsis identification and treatment as well as any results for the purposes of quality improvement.

2. Scoring

In 2025, hospitals earn points for reporting the measure and additional points for any improvement hospitals can document on self-reported process or outcome measures.

Sepsis Scoring Rubric

Total Possible	Process Measure Only	Process Measure w/ Documented Improvement
7	5	7

E. Antibiotic Stewardship

This measure is based on the elements of the Centers for Disease Control and Prevention's (CDC) Core Elements for Hospital Antibiotic Stewardship Programs and emphasizes priority activities. This measure has four individual groups (i.e., they are not cumulative). To receive points for a group, all level criteria must be met.

Facilities must attest that this measure has been in place as of April 30, 2026 and is for all patients regardless of insurance status.

1. Measure Criteria

Group 1: Accountability and Expertise

Hospitals must answer yes to the following questions and provide supporting documentation:

- Does your facility have physician and pharmacist co-leaders responsible for program management, implementation, and outcomes of stewardship activities?
- Does your facility include stewardship responsibility in job descriptions, contracts, or performance reviews of physician and pharmacy co-leads?
- Do your facility's physician and pharmacist co-leads have relevant infectious disease training or experience (i.e.: infectious diseases specialty training, certificate program, or other training in antimicrobial stewardship). Note: additional information is available in Appendix E.

Deliverables

To receive point(s) on this section hospitals must:

- **Deliverable 1a:** Provide names, titles, and roles of physician and pharmacist co-leaders.
- **Deliverable 1b:** Describe how stewardship responsibility are included in job descriptions, contracts, or performance reviews of physician and pharmacy co-leads
- **Deliverable 1c:** Describe the relevant infectious disease training or experience of the physician and pharmacist co-leads with associated dates (i.e.: infectious diseases specialty training, certificate program, or other training in antimicrobial stewardship).

Group 2: Action

Hospitals must answer yes to the following questions and provide supporting documentation:

- Does your hospital have treatment recommendations adapted to your facility, based on national guidelines and local pathogen susceptibilities (e.g., antibiogram) to assist with antibiotic selection for the following common conditions: pneumonia, urinary tract infection, and skin and soft-tissue infection?
- Does your hospital conduct any of the following broad interventions to improve antibiotic use (must answer yes to at least one)?
    - Does your facility perform preauthorization for specific antibiotic agents? (Preauthorization requires prescribers to gain approval prior to the use of certain antibiotics. The antibiotic stewardship team selects antibiotics for preauthorization based on characteristics such broad spectrum of activity, toxicity, and potential for misuse or overuse in order to improve patient care and prevent antibiotic resistance)
    - Does your facility perform prospective audit and feedback for specific antibiotic agents? (Prospective audit and feedback is an external review of antibiotic therapy by an expert in antibiotic use, accompanied by suggestions to

optimize use, at some point after the agent has been prescribed.)

- Does your stewardship program include at least one member of the stewardship team conducting regular stewardship rounds that include real-time discussions with prescribers (also called “handshake stewardship”)?

Deliverables

To receive point(s) for this section hospitals must:

- **Deliverable 2a:** Upload evidence of implementation of treatment recommendations based on national guidelines for pneumonia, urinary tract infection, and skin and soft-tissue infection.
- **Deliverable 2b:** Provide a thorough description of at least one of the processes for the above intervention(s) (pre-authorization, prospective audit with feedback, or stewardship rounds), including Who, What, Where, When and How, as appropriate, or upload associated policy/procedure if available (preferred).

Group 3: Tracking and Reporting

Hospitals must answer yes to the following questions and provide supporting documentation:

- Does your antibiotic stewardship program share facility and/or individual prescriber-specific reports on antibiotic use with prescribers at least annually?
- Does your antibiotic stewardship program monitor adherence to treatment recommendations for at least one clinical condition?

Deliverables

To receive point(s) for this section hospitals must:

- **Deliverable 3a:** Upload example(s) of how antibiotic utilization information is reported to prescribers. Examples could include: antibiotic utilization reports, screenshots of antibiotic use dashboards, de-identified examples of report cards or e-mails sent to individual prescribers, or summaries of antibiotic prescribing.

Examples must be dated from within the measurement period. (Jan.,1 2025 – April 30, 2026)

- **Deliverable 3b:** Provide a description of how adherence to treatment recommendations is monitored and upload an example of measurement. Examples could include choice of antibiotic, dosing, and/or duration of therapy.

Group 4: Application of Antibiotic Use and Resistance Data

Hospitals must answer yes to the following questions and provide supporting documentation:

- Does your hospital report data from the NHSN Antibiotic Use and Resistance Module to **facility leadership at least annually** during the measurement period Jan.1, 2025 – April 30, 2026?
- Does your hospital report data from the NHSN Antibiotic Use and Resistance Module to the **facility antimicrobial stewardship program at least quarterly** during the measurement period Jan.1, 2025 – April 30, 2026?

Deliverable

To receive point(s) for this section hospitals must:

- **Deliverable 4a:** Upload example(s) of how antibiotic **use and resistance data** from NHSN is reported **to facility leadership at least annually**. Provide the date of reporting (such as meeting date or minutes) and documentation of presentation (e.g. slide deck, report, etc.).
- **Deliverable 4b:** Upload example(s) of how antibiotic **use and resistance data** from NHSN is reported to the **facility antimicrobial stewardship program at least quarterly**. Provide the date of reporting (such as meeting date or minutes) and documentation of presentation (e.g. slide deck, report, etc.).

2. Scoring

Hospitals will earn points for the successful completion of the four groups. To be eligible for points, hospitals must successfully complete all

criteria for measure Group 1. Hospitals can earn additional points by completing Groups 2 – 4.

Antibiotic Stewardship Scoring Rubric

Total Possible	Group 1	Group 2	Group 3	Group 4
10	2	4	2	2

F. Adverse Event Reporting

This measure is based on activities from January 1, 2025 to December 31, 2025 and is for all patients regardless of insurance coverage.

1. Measure Criteria

To be eligible for points in this measure:

- Must allow anonymous reporting.
- Reports should be received from a broad range of personnel.
- Summaries of reported events must be disseminated in a timely fashion.
- A structured mechanism must be in place for reviewing reports and developing action plans.

2. Scoring

Adverse Event Reporting is pay for reporting; points will be earned on an all or nothing basis.

Adverse Event Reporting Scoring Rubric

Total Possible
5

G. Culture of Safety Survey

To receive points, hospitals will attest to using the AHRQ survey OR provide the following:

- A copy of the survey instrument
- A copy of the key findings of the survey highlighting areas where performance is low, and improvements can be made
- A copy of the plan to address low performing areas

1. Measure Criteria

To be eligible for points in this measure:

- Survey must include at least ten questions related to a safety culture.
- Culture of Safety questions must be from a survey tool that has been tested for validity and reliability.

- Survey questions can be part of another survey tool as long as it meets the above criteria.
- Culture of Safety survey has been administered within the 24 months prior to the data collection.
- Action taken in response to the survey should address those survey questions that demonstrated the poorest score on the survey.

2. Scoring

Culture of Safety is pay for reporting; points will be earned on an all or nothing basis.

Culture of Safety Scoring Rubric

Total Possible
5

H. Handoffs and Sign-outs

Facilities must attest that this measure has been in place as of April 30, 2026 and is for all patients regardless of insurance status.

1. Measure Criteria

Step 1

Hospitals must identify the areas of handoffs and sign-outs that they need to improve on and focus on the area that has the most need. Hospitals should look at both areas that have the greatest need for improvement and areas with the highest severity of potential harm. This can be accomplished by reviewing the results of their patient safety survey or by consulting other sources. These handoffs and sign-outs can be between different levels of care, between departments, or other areas where providers transition care between themselves or other hospital staff.

Hospitals must provide a narrative description of the area they are addressing. They should provide evidence that quality needs to be improved in this area. Examples of transitions include:

- Operating room to intensive care unit
- Emergency department to inpatient

- Intensive care unit to floor
- Perioperative services to next level of care
- Intraoperative: provider to provider
- Postoperative: OR to Post Anesthesia Care Unit (PACU)

Step 2

Hospitals must describe the process they are using to address handoffs and transitions by doing the following:

- Identify the leader of the initiative.
- Describe the actions being taken to improve handoffs and sign-outs.
- Document any standardized methodologies or mnemonics being implemented (e.g., IPASS, SBAR, etc.)
- Document any training that has been done in the past year to address this issue or training plans to be conducted.

Step 3

Hospitals must describe how they will measure the implementation and performance of the program and complete the following tasks:

- Describe how it plans to measure progress on this initiative in HQIP 2026
    - Potential measurement strategies include:
        - Tracking how many times a handoff or sign-out uses the appropriate protocol.
        - Reviewing incident reports and documenting the times there are handoff issues pre intervention vs post intervention.
        - Assess the extent of communication issues during handoffs.
        - Note which types of communication issues are attributed to handoffs based on information in incident reports.
        - Handoff direct observation (pre-intervention and post-intervention)
        - Record presence or absence of key elements

        - Analyze quality (presence of distractions, attentiveness of speaker and recipient, asking important clinical questions etc.)
        - Surveys to providers and staff about their perceptions of handoff process/perceived barriers to improvements in the handoff process
    - Hospitals must document the process of communicating feedback on Handoffs and Sign-outs to hospital staff to facilitate continuous improvement.

Examples based on care settings:

Operating Room (OR) to Intensive Care Unit (ICU):

1. Review handoffs using the following:
    1. Handoff assessment tool (checklist of items essential to reports from the transmitting OR team to the receiving ICU team)
    2. Past medical history, reason for ICU admission, allergies, airway, breathing/ventilation, circulation/hemodynamics, inputs, outputs, drains/lines, complications, plan, team contact information, and family information
    3. Score the quality of hand off delivery (concise, clear, and organized hand-offs receive higher scores)
    4. Score the recipient based on eye contact, affirmatory statements, head nodding, note taking, and question asking.

Transfer to ICU:

1. Analyze critical messages (CM) for the following information:
2. Time till Rapid Response Team (RRT) activation
3. Message quality
4. Presence of vitals
5. Quality/timeliness of physician response

2. Scoring

Hospitals can earn Level 4 points by reporting measurement results from previous year. For Handoffs and Sign-outs points will be earned in in tiers by completing the requirements for each of the four steps of the measure.

Handoffs and Sign-outs Scoring Rubric

Total Possible	Level 1	Level 2	Level 3	Level 4
7	3	4	5	7

V. Measure Group 3: Patient Experience Group Measure Details

A. Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS)

1. Measure Criteria

The Department will collect data for three HCAHPS composites from Hospital Compare:

Composite 1: Communication with Nurses

(HCAHPS V19 Questions 1, 2, 3)

- During this hospital stay how often did nurses communicate well with patients. During this hospital stay:
    - How often did nurses treat you with courtesy and respect?
    - How often did nurses listen carefully to you?
    - How often did nurses explain things in a way you could understand?

Composite 5: Communication About Medicines

(HCAHPS V19 Questions 16, 17)

- How often did staff explain about medicines before giving them to patients? Before giving you any new medicine
    - How often did hospital staff tell you what the medicine was for?
    - How often did hospital staff describe possible side effects in a way you could understand?

Composite 6: Discharge Information

(HCAHPS V19 Questions 22,23)

- Were patients given information about what to do during their recovery at home? During this hospital stay
    - Did hospital staff talk with you about whether you would have the help you needed when you left the hospital?
    - Did you get information in writing about what symptoms or health problems to look out for after you left the hospital?

2. Scoring

Each HCAHPS Composite measure will be evaluated independently using a ranking method. Scoring for each composite will be based on "top-box", or the most positive, responses. Points will be earned based on quartile tiering; quartile 4 being the highest will receive 5 points, quartile 3 will receive 3 points, quartile 2 will receive 1, and the lowest quartile will receive no point.

HCAHPS Composite 5-7 Scoring Rubric

Total Possible	Quartile 1	Quartile 2	Quartile 3	Quartile 4
5	0	1	3	5

VI. Maintenance Measures

Maintenance Measures are those measures that are important to quality of care and patient safety but have little room for improvement over current statewide performance levels. The HQIP Subcommittee will continue to review the statewide rates to be sure that gains are maintained. No points are assigned for Maintenance Measures.

- **MM #1: PE/DVT (no points)***. Hospitals do not need to submit data for this measure. The data source for this measure is the Colorado Hospital Report Card.
- **MM #2: CLABSI (no points)**. Hospitals do not need to submit data for this measure. The data source for this measure is the NHSN data submitted to the Colorado Department of Public Health and Environment and will be obtained from the annual Health Care Associated Infections Report in Colorado report.
- **MM #3: Early Elective Deliveries (no points)**. Hospitals do not need to submit data for perinatal care measure set. The data source for this measure is Hospital Compare.
- **MM#4: Incidence of Episiotomy (no points)**. Hospitals do not need to submit data for this measure. This measure is a claims-based outcome measure. The measure is NQF# 0470 Incidence of Episiotomy - Percentage of vaginal deliveries (excluding those coded with shoulder dystocia) during which an episiotomy is performed.

***Data is currently unavailable for the PE/DVT measure. Calculation of this maintenance measure will be suspended as the Colorado Hospital Report Card is transitioning from the Colorado Hospital Association to the Colorado Department of Public Health and Environment**

VII. Sampling

Hospitals can use sampling to report HQIP measures. The size of the sample depends on the number of cases that qualify for a measure. Hospitals need to use the next highest whole number when determining their required sample size. The sample must be a random sample (e.g., every third record, every fifth record, etc.), taken from the entire 12 months of the year and cannot exclude cases based on physician, other provider type or unit. Hospitals can choose to use simple random sampling or systematic random sampling. Hospitals selecting sample cases must include at least the minimum required sample size. The sample size table below shows the number of cases needed to obtain the required sample size. A hospital may choose to use a larger sample size than is required.

Hospitals selecting sample cases for a measure must ensure that the annual patient population and annual sample size for each measure sampled meet the following conditions:

Annual Sample Size

Annual number of patients meeting measure denominator	Minimum required sample size "n"
>=1551	311
391-1551	20% of discharges in denominator
78-390	78
0-77	No sampling, 100% of the patient population is required

Examples:

A hospital's number of patients meeting the criteria for advance care planning is 77 patients for the year. Using the above table, no sampling is allowed – 100% of the cases should be reviewed.

A hospital's number of patients meeting the criteria for advance care planning is 401 patients for the year. Using the above table, the required sample size is 80 cases (401 x .20 = 80) for the year.

VIII. Appendices

The appendices below provide resources for the Health Equity Patient Safety Bundle.

A. Appendix A: Resources on Practices for Collecting Racial, Ethnic and Language Data

American Hospital Association Institute for Diversity and Health Equity (IFDHE) Why Collect Race, Ethnicity and Primary Language. See link: https://ifdhe.aha.org/hretdisparities/why-collect-race-ehtnicity-language

Centers for Medicare and Medicaid Services (CMS): Building an Organizational Response to Health Disparities: Inventory of Resources for Standardized Demographic and Language Data Collection. Available at the link https://www.cms.gov/about-cms/agency-information/omh/downloads/data-collection-resources.pdf

Agency for Health Care Research and Quality (AHRQ): Race and Ethnicity Data Improvement Toolkit See link: https://www.hcup-us.ahrq.gov/datainnovations/raceethnicitytoolkit/data_improve_edu.jsp

American Medical Association (AMA) Collecting Patient Data: Improving Health Equity in Your Practice See link: https://edhub.ama-assn.org/interactive/17579528

Northwest Safety and Quality Partnership: Race, Ethnicity and Language Resources. See link: http://www.wsha.org/wp-content/uploads/REaL-Data-Collection-Resources_WSHA-2021.pdf

B. Appendix B: Information and Resources for Language Proficiency

Section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act, National Standards on Culturally and Linguistically Appropriate Services, Americans with Disabilities Act, and the Hill Burton Act.

Section 1557 is the nondiscrimination provision of the Affordable Care Act (ACA).

On May 13, 2016, the HHS Office for Civil Rights issued the final rule implementing Section 1557. The latest ruling emphasizes the importance of using a qualified medical interpreter and expressly prohibits the use of ad-hoc interpreters, including family members and other untrained bilingual individuals, barring extreme circumstances.

A rights-based framework. Access to health care services is a human right, as defined in numerous international health rights covenants. The United Nations Committee on Economic, Social and Cultural Rights' General Comment 14 states, "Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity". The right to health care should be an organizing principle in our health systems. The use of appropriate language services and the right of a patient with LEP to access health care are inextricably linked. For patients with LEP, the only way to meaningfully access health services is by clearly communicating with health care professionals using their preferred language of care.

In the United States, patients with LEP have a legal right to access health care in their preferred language. The foundation of this right is established in Title VI of the landmark Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance. In health care, Title VI—as enforced by Executive Order 13166, entitled "Improving Access to Services for Persons with Limited English Proficiency"—is a cornerstone for the provision of oral interpretation and written translation services to patients with LEP.

Health care institutions can provide appropriate language services to their patients with LEP by hiring qualified bilingual staff [4]. However, since it is not always possible to hire qualified bilingual staff in all patients' preferred languages, it is essential to have systems for accessing professional language assistance services in place rather than relying on ad hoc interpreters. One solution is for hospitals to employ qualified medical interpreters in the major languages of their patient populations and contract with telephonic or videoconference services for access to additional languages on demand

Standards of practice for medical interpreting. A concern of clinical and ethical importance relates specifically to the risk of errors during a verbal consent process for a patient with LEP that does not involve a qualified medical interpreter [6]. In the United States, the Department of Health and Human Services (HHS) establishes competencies required of a "qualified interpreter" [7]. These competencies include the knowledge of specialized terminology and interpreter ethics and the skills to interpret accurately, effectively, and impartially. HHS requires that hospitals conduct an assessment of individuals claiming to have competencies prior to designating an individual as a qualified interpreter. HHS does not require that hospital staff serving as interpreters possess national certification, which is currently available in just a handful of spoken languages [8]. However, HHS clarifies that "the fact that an individual has above average familiarity with speaking or understanding a language other than English does not suffice to make that individual a qualified interpreter for an individual with limited English proficiency" [9].

Health care professionals should use extreme caution when using ad hoc interpreters. The use of ad hoc interpreters—a broad category that includes a patient's friends or family members and unqualified bilingual staff—can significantly increase medical errors [6]. Health care professionals face potential civil liability when they fail to provide qualified interpreters, if such failure leads to a tort cause of action, such as lack of informed consent, breach of duty to warn, or improper medical care [10]. In contrast, the use of professional interpreters while providing medical care for patients with LEP improves comprehension, service utilization, clinical outcomes, and patient satisfaction [11]

References

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12. National Council on Interpreting in Health Care. National standards of practice for interpreters in health care. Published September 2005. Accessed October 18, 2016. https://www.ncihc.org/assets/z2021Images/NCIHC%20National%20Standards%20of%20Practice.pdf

13. See the link: https://www.ncihc.org/assets/documents/workingpapers/NCIHC%20Working%20Paper%20-%20Linguistically%20Appropriate%20Access%20and%20Services.pdf

14. See the link: https://www.coloradotrust.org/sites/default/files/CT_LanguageAccessBrief_final-1.pdf

Language Proficiency Assessment

1. https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/california/pdf/providers/Language_Proficiency_Assessment-Resources_9.25.18.pdf

2. https://www.coloradolanguageconnection.org/bridging-the-gap

3. http://www.palsforhealth.org/language-assessment.html

C. Appendix C: Additional resources on Racial and Ethnic Disparities, Implicit Bias, Shared Decision Making

Implicit Bias

- Project Implicit see the link: https://implicit.harvard.edu/implicit/education.html

- Training Health Professionals to Understand Implicit Bias linked to Racial and Ethnicity-Based Discrimination, and the Implications for Health Equity: see the link: https://cdn.who.int/media/docs/default-source/world-health-day-2021/4-wonca-presentation-webinat-25march2021.pdf?sfvrsn=75bc4c69_7

Resources from Massachusetts General Hospital Disparities Solutions Center

- See the link: https://www.mghdisparitiessolutions.org/guides-tools

The Commonwealth Fund

- The Commonwealth Fund: In Focus: Reducing Racial Disparities in Health Care by Confronting Racism. See the link: https://www.commonwealthfund.org/publications/2018/sep/focus-reducing-racial-disparities-health-care-confronting-racism

Shared Decision Making

- Agency for Health Care Research and Quality (AHRQ) The SHARE Approach. See the link: https://www.ahrq.gov/health-literacy/professional-training/shared-decision/index.html

D. Appendix D: Postpartum Discharge Transition Bundle – Complete Element Listing

Element Number	Element Description
	Readiness
1	**Develop and maintain a set of referral resources and communication pathways between obstetric providers, community-based organizations, and state and public health agencies to enhance services and supports for pregnant and postpartum families.**[6]
2	**Establish a multidisciplinary care team to design coordinated clinical pathways for patient discharge and a standardized discharge summary form to give to all postpartum patients prior to discharge.**
3	Provide multidisciplinary staff education to clinicians and office staff on optimizing postpartum care, including why and how to screen for life-threatening postpartum complications.
4	Educate outpatient care setting staff on how to use a standardized discharge summary form to review patient data and ensure that recommendations made for outpatient follow-up and community services/resources have been carried out.
	Recognition
5	Establish a system for scheduling the postpartum care visit and needed immediate specialty care visit or contact (virtual or in-person visit) prior to discharge or within 24 hours of discharge.
6	**Screen each patient for current or history of Substance Use**[7]
7	**Assess and document if patients presenting in the Emergency Department are pregnant or have been pregnant within the past year.**
	Response
8	**Provide patient education prior to discharge that includes life-threatening postpartum complications and early warning signs, including mental health conditions, in addition to individual patient-specific conditions, risks, and how to seek care.**
9	Provide each postpartum patient with a standardized discharge summary form that details key information from pregnancy and birth.
	Reporting/Systems Learning
10	Convene inpatient and outpatient providers in an ongoing way to share successful strategies and identify opportunities for prevention of undesired outcomes in the postpartum period, including emergency and urgent care clinicians and staff.
11	Develop and systematically utilize a standard comprehensive postpartum visit template.
12	Identify and monitor postpartum quality measures in all care settings.
	Respectful, Equitable and Supportive Care
13	Engage in open, transparent, and empathetic communication with pregnant and postpartum people and their identified support network to understand diagnoses, options, and treatment plans

[6] Bolded elements are active for the 2025 HQIP program year.
[7] This element is taken from the AIM Care for Pregnant People with Substance Use Disorder Patient Safety Bundle

E. Appendix E: Antibiotics Stewardship – Examples of Relevant Infectious Disease Training or Experience for Physician and Pharmacist Co-Leads

CDC's wording for this priority specifies that "antibiotic stewardship physician and/or pharmacist leader(s) have completed infectious diseases specialty training, a certificate program, or other training on antibiotic stewardship".

While CDC does not identify specific credentials, some examples of acceptable relevant infectious disease training or experience for physician and pharmacist co-leads include the following:

Post-graduate training

- Infectious diseases fellowship (physician)
- PGY-2 infectious diseases residency or infectious diseases fellowship (pharmacist)

Certificate Program on Antibiotic Stewardship

- Infectious Diseases Pharmacy Specialty Certification (BCIDP)
- Society of Infectious Diseases Pharmacists Antimicrobial Stewardship Certificate
- MAD-ID Antimicrobial Stewardship Program

Other Trainings (ex: conferences or online modules on antibiotic stewardship)

- CDC Antimicrobial Stewardship Trainings
    - Antibiotic Stewardship affects all healthcare settings and is important at transitions of care. As such, the HQIP program requires hospitals to complete all 13 modules.
- SHEA Antimicrobial Stewardship

F. Appendix F: Health Care Equity Certification

Hospitals attesting to having a current Joint Commission Health Care Equity Certification (HCEC) in the HQIP DCT will have their certification status confirmed by a Joint Commission Report.

In addition to an attestation and confirmation of HCEC status, hospitals will be required to upload updated copies of the materials below to the HQIP DCT annually. These materials are outlined in the HCEC Review Process Guide.

Required Materials

- The organization's strategic plan and goals for improving health care equity
- Sociodemographic characteristics and health-related social needs of individuals in the community
- Policies and procedures:
    - Addressing the recruitment and retention of staff and leaders that reflect the diversity of the community and patient population
    - Addressing incidents and perceptions of discrimination and bias experienced by staff and leaders
    - Addressing incidents and perceptions of discrimination and bias experienced by patients
    - Addressing qualifications for language interpreters and staff who communicate in languages other than English
- List of educational/training topics provided to staff and physicians to improve health care equity

- System Tracer – Data Use Slides including the following data elements:
    - Data from the organization's Community Health Needs Assessment (or other data sources such as governmental datasets or state/local health departments)
    - Incidents and perceptions of discrimination and bias experienced by patients
    - Incidents and perceptions of discrimination and bias experienced by staff and leaders
    - Review of patient sociodemographic data for missing/inaccurate information
    - Complaint/complaint resolution process by patient sociodemographic characteristics
    - Experience of patient care measures by sociodemographic characteristics
    - Language interpreter use
    - Three quality and/or safety measures for priority clinical conditions by sociodemographic characteristics (e.g., cardiovascular outcomes, cesarean birth rates for nulliparous women with term, singleton baby in vertex position [NTSV], hospital acquired conditions, pressure injury rates, etc.)
    - Comparison of the race, ethnicity, and languages spoken by staff and leaders to the race, ethnicity, and languages spoken by the community
    - Employee opinion survey/culture of safety survey results stratified by race, ethnicity, and language information

Some of the materials listed above may be submitted at the system level (ex: policy and procedure documents if these policies and procedures are the same for all facilities in the system). For other data elements, submissions are only acceptable at the system level. Please see the table below for a breakdown of which elements are required at the facility level, and which elements are acceptable at the system level under specific conditions to meet HQIP program requirements.

Strategic Plan, Sociodemographic Data, Policies and Procedures:

Element	System Level	Facility Level
The organization's strategic plan and goals for improving health care equity	Acceptable if the same across all hospitals	Acceptable
Sociodemographic characteristics and health-related social needs of individuals in the community	Not Acceptable; must be specific to each individual facility	Acceptable
Policies and Procedures: Addressing the recruitment and retention of staff and leaders that reflect the diversity of the community and patient population Addressing incidents and perceptions of discrimination and bias experienced by staff and leaders Addressing incidents and perceptions of discrimination and bias experienced by patients Addressing qualifications for language interpreters and staff who communicate in languages other than English	Acceptable if the same across all hospitals	Acceptable
List of educational/training topics provided to staff and physicians to improve health care equity	Acceptable if the same across all hospitals	Acceptable

System Tracer Data User Slide Elements:

Element	System Level	Facility Level
Data from the organization's Community Health Needs Assessment (or other data sources such as governmental datasets or state/local health departments)	Not Acceptable; must be specific to each individual facility	Acceptable
Incidents and perceptions of discrimination and bias experienced by patients	Not Acceptable; must be specific to each individual facility	Acceptable
Incidents and perceptions of discrimination and bias experienced by staff and leaders	Not Acceptable; must be specific to each individual facility	Acceptable
Review of patient sociodemographic data for missing/inaccurate information	Not Acceptable; must be specific to each individual facility	Acceptable
Complaint/complaint resolution process by patient sociodemographic characteristics	Not Acceptable; must be specific to each individual facility	Acceptable
Experience of patient care measures by sociodemographic characteristics	Not Acceptable; must be specific to each individual facility	Acceptable
Language interpreter use	Not Acceptable; must be specific to each individual facility	Acceptable
Three quality and/or safety measures for priority clinical conditions by sociodemographic characteristics (e.g., cardiovascular outcomes, cesarean birth rates for nulliparous women with term, singleton baby in vertex position [NTSV],	Not Acceptable; must be specific to each individual facility	Acceptable

Element	System Level	Facility Level
hospital acquired conditions, pressure injury rates, etc.)		
Comparison of the race, ethnicity, and languages spoken by staff and leaders to the race, ethnicity, and languages spoken by the community	Not Acceptable; must be specific to each individual facility	Acceptable
Employee opinion survey/culture of safety survey results stratified by race, ethnicity, and language information	Not Acceptable; must be specific to each individual facility	Acceptable

G. Appendix G: Recommended SUD Screening Tools for OB Teams

Recommended Brief Screening Tools:

- Integrated 5Ps: this free tool is intended for use among pregnant patients and utilized by other state PQCs
- AUDIT C+2 – This free tool was adapted by CPCQC to recommend follow-up from disclosure of any prenatal substance use in the past 3 months (score of 1 or higher). (The standard AUDIT-C+2 scoring guidelines apply to the general population and recommend follow-up for a score greater than 1.)
- 4Ps Plus: This tool is the only substance use screener which is validated for use in pregnancy. However, a licensing fee applies per patient screened. Your team may decide this cost is worthwhile because of a) the tool's high sensitivity, b) the tool's validation during pregnancy, c) the option to add on data reporting services to your licensing contract, and d) due to the higher sensitivity of this tool, the number of billable "further screens" your team conducts may increase and thus make this tool cost-effective.

Full Screening Tools:

To see an overview of these further screening tools all in one place, and take an interactive version of each screening questionnaire, visit this page.

- AUDIT (Use if answers to questions #1-3 about alcohol use on the AUDIT C+2 pre-screen are positive)
- CUDIT (Use if answer #4 about marijuana use on the AUDIT C+2 pre-screen is positive)
- DAST (Use if answer #5 about drug use on the AUDIT C+2 pre-screen is positive)

NOTE: The recommended Full Screening Tools above are billable under SBIRT for Colorado Medicaid.

Substance Use Screening Tool for Adolescents:

- CRAFFT 2.1

The CRAFFT 2.1 is the most widely used adolescent screening tool, designed for screening patients ages 12-21.

The CRAFFT 2.1 is available in clinician- and self-administered versions; research indicates the most adolescents feel more comfortable responding to these questions in a self-administered survey. However, guidelines are also offered for clinician administration of the tool.

- Self-Administered
- Clinician Administered
- CRAFFT N (includes a question about nicotine) Clinician Administered
- Clinical Algorithm

If you will be screening adolescents, please see our full guide: CPCQC's Guide to the CRAFFT 2.1 Screener for Adolescents.

Please also see: CPCQC Screening and Brief Intervention Workflow

For technical assistance and further information substance use screening tools in the peripartum population, please contact CPCQC at https://cpcqc.org/contact/