



KHC Office Hours for Compass HQIC

June 22, 2022

This material was prepared by the Iowa Healthcare Collaborative, a Compass Hospital Quality Improvement Contractor under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS.

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Agenda

- + Welcome and Announcements
- + Featured Topic: Reaching and Engaging Physicians
- + Data and Program Updates
- + Resources, Upcoming Events, and Next Steps

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KHC Compass HQIC Team and Presenters:



Mandy Johnson
Program Director of Quality Initiatives



Eric Cook-Wiens
Data & Measurement Director



Special Guest

Steven Q. Simpson, MD

Senior Medical Advisor for Sepsis Alliance
Professor of Medicine, The University of Kansas Medical Center



Erin McGuire
Quality Improvement Advisor



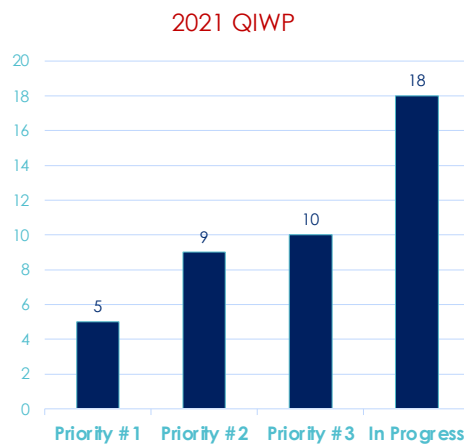
Heidi Courson
Quality Improvement Advisor



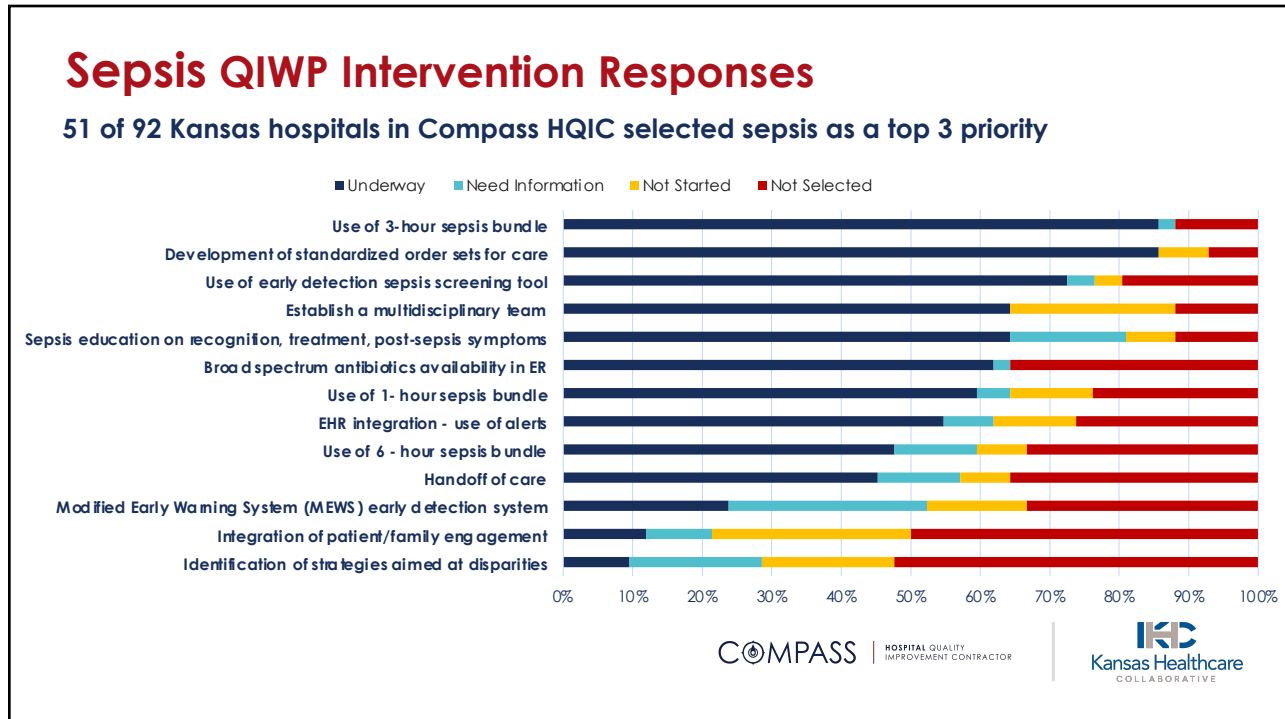
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Sepsis on Quality Improvement Workplan

51 of 92 Kansas hospitals in Compass HQIC selected sepsis as a top 3 priority in 2022



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Guest Speaker



Steven Q. Simpson, MD
Senior Medical Advisor for Sepsis Alliance
Professor of Medicine
The University of Kansas Medical Center

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Sepsis: Reaching and Engaging Physicians

Dr. Steven Simpson



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The Hierarchy of Authorities

ASPR
ASSISTANT SECRETARY FOR
PREPAREDNESS AND RESPONSE

BARDA
BIOMEDICAL ADVANCED RESEARCH AND
DEVELOPMENT AUTHORITY

DRIVE
Transforming Health Security

SOLVING Sepsis

ASPR Saving Lives. Protecting Americans. 9

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Sepsis is a health security risk to the nation.

Sepsis must be solved.

ASPR Saving Lives. Protecting Americans. 10

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Surviving Sepsis Campaign section head:
Screening and Early Treatment

Immediate Past-President CHEST

Senior Medical Advisor BARDA
Senior Medical Advisor Sepsis Alliance

No industry funding for past 18 years


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**Nothing I have to say represents
the views of the U. S.
Government or any other
organization that I work with.
I have no conflicts to disclose.**


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Sepsis: *Reaching and Engaging Doctors*

Steven Q Simpson, MD, FCCP, FACP
Professor of Medicine
Division of Pulmonary and Critical Care
University of Kansas



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Knowledge is the best form of empowerment
And your best tool



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Our Overall Aim

- Our Aim - Fewer people die or are maimed by sepsis
- Our Goal – national level being established
 - Mortality rate; time frame



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The Problem We Face

- Providers – slow to diagnose, slow to treat, dis-organized and non-standard approach to treatment
- Root causes
 - Inadequate knowledge of the signs, symptoms, and findings
 - *A priori* belief that they do understand these things
 - Inertia when these signs are recognized
 - Belief that patient's "don't look that sick"
 - Resistance to "cook book" medicine
 - Inconsistent messaging from national organizations, guidelines groups and government



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Providers– What We Must Accomplish

Americans/patients need providers to:

- Be well informed about sepsis diagnosis and treatment
- Use a standard operating procedure
- Believe the data and understand that sepsis deteriorates quickly
- Be willing to adopt new diagnostic and treatment modalities, e.g. technologies to guide resuscitation, technologies to predict and diagnose sepsis

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The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3)

Mervyn Singer, MD, FRCP; Clifford S. Deutschman, MD, MS; Christopher Warren Seymour, MD, MSc; Manu Shankar-Hari, MSc, MD, FFICM; Djillali Annane, MD, PhD; Michael Bauer, MD; Rinaldo Bellomo, MD; Gordon R. Bernard, MD; Jean-Daniel Chiche, MD, PhD; Craig M. Coopersmith, MD; Richard S. Hotchkiss, MD; Mitchell M. Levy, MD; John C. Marshall, MD; Greg S. Martin, MD, MSc; Steven M. Opal, MD; Gordon D. Rubenfeld, MD, MS; Tom van der Poll, MD, PhD; Jean-Louis Vincent, MD, PhD; Derek C. Angus, MD, MPH

“The current use of 2 or more SIRS criteria to identify sepsis was unanimously considered by the task force to be unhelpful.”

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JAMA. 2016;315(8):801-810.

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What do you do?

P – 75
R – 10
T – 37°

P – 110
R – 20
T – 39.5°

NOW, what do you do?




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Why did you choose something different?

Because you recognize that the latter circumstance – infection with systemic manifestations (SIRS) – is something more than a simple infection.



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“A local lesion, heated by humor
afflux, makes the
whole body become feverish. One
can die because of this, especially on
odd numbered
days”

Hippocrates

BTW, today is the 22nd
Lookout for tomorrow!



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Defining Sepsis

Life threatening organ dysfunction due
to a dysregulated host response to
infection



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Defining Sepsis

Life threatening **organ dysfunction** due
to a **dysregulated** host response to
infection



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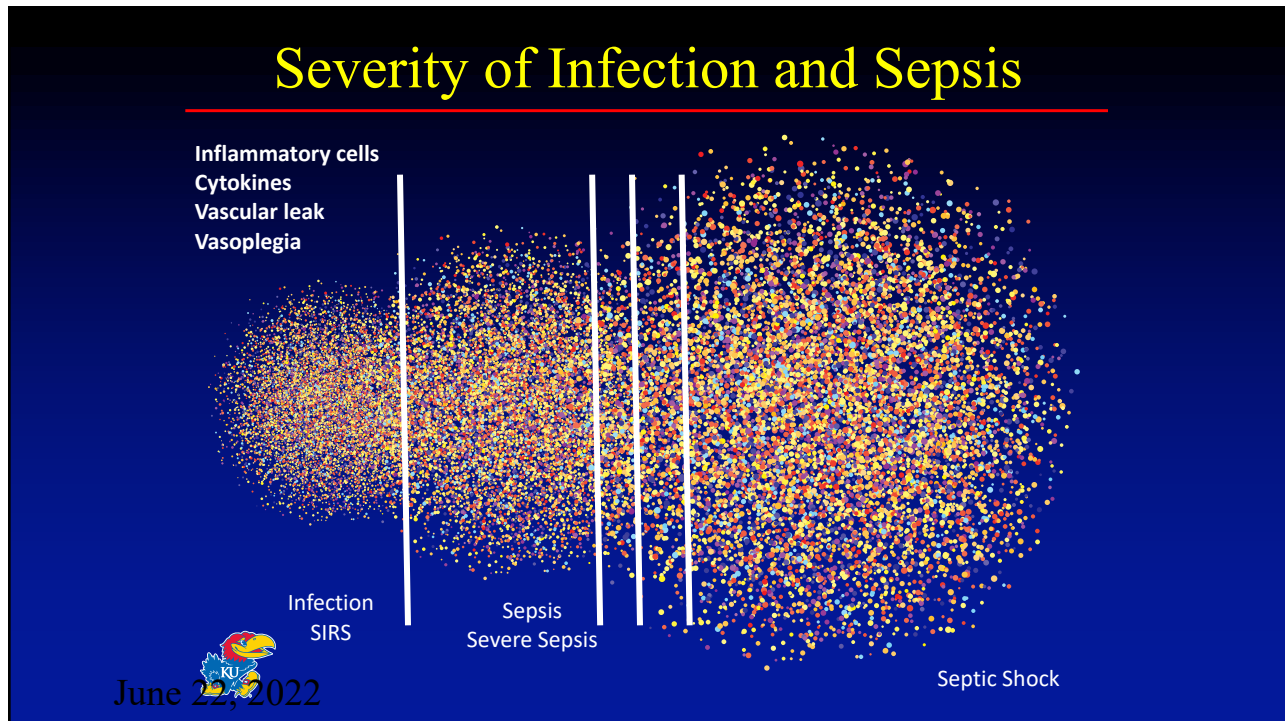
Diagnosis

Everything is vague to a degree you
do not realize til you have tried to
make it precise.

Bertrand Russell (1872 – 1970)

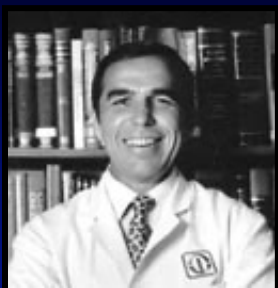


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Sepsis: What Are We Talking About?



Roger C. Bone, MD

- ICD-9: “septicemia”
- Positive blood cultures
- Multiple positive blood cultures
- Positive blood cultures + hypotension
- Syndrome: how shall we define it?



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ACCP/SCCM Consensus Definitions

- Infection
 - Inflammatory response to microorganisms, or
 - Invasion of normally sterile tissues
- Systemic Inflammatory Response Syndrome (SIRS) ≥ 2 SIRS criteria
- Sepsis
 - Infection plus ≥ 2 SIRS criteria
- Severe Sepsis
 - Sepsis
 - Organ dysfunction
- Septic shock
 - Sepsis
 - Hypotension despite fluid resuscitation

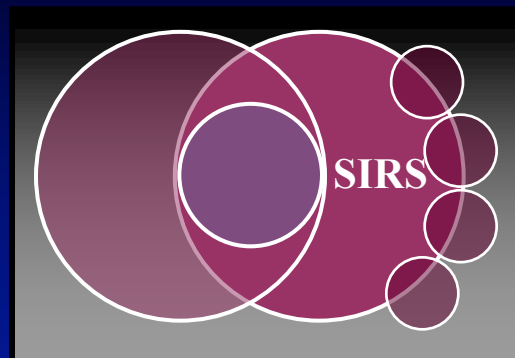
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Bone RC et al. Chest. 1992;101:1644-55.

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SIRS: Systemic Inflammatory Response Syndrome

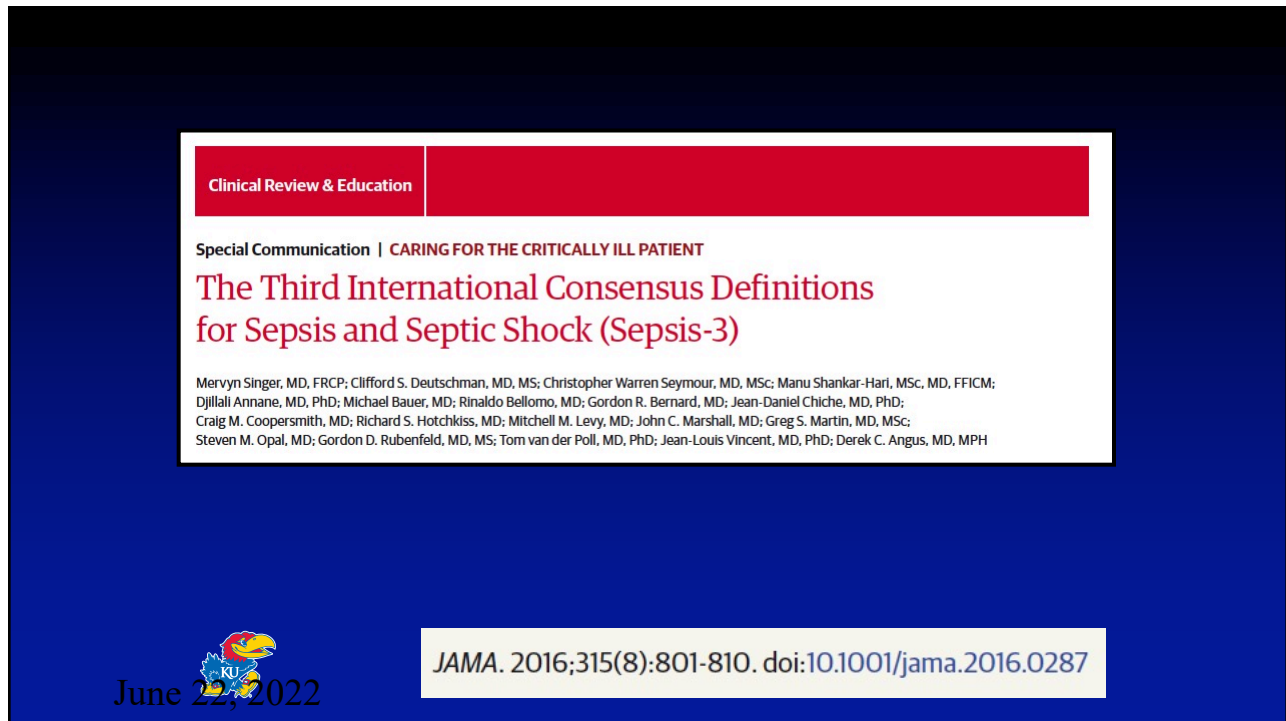
- SIRS: nonspecific, 2 of the following:
 - Temperature $> 38^{\circ} \text{C}$ or $< 36^{\circ} \text{C}$
 - HR > 90 beats/min
 - Respirations > 20 /min
 - WBC $> 12,000/\mu\text{L}$ or $< 4,000/\mu\text{L}$ or $> 10\%$ bands or other



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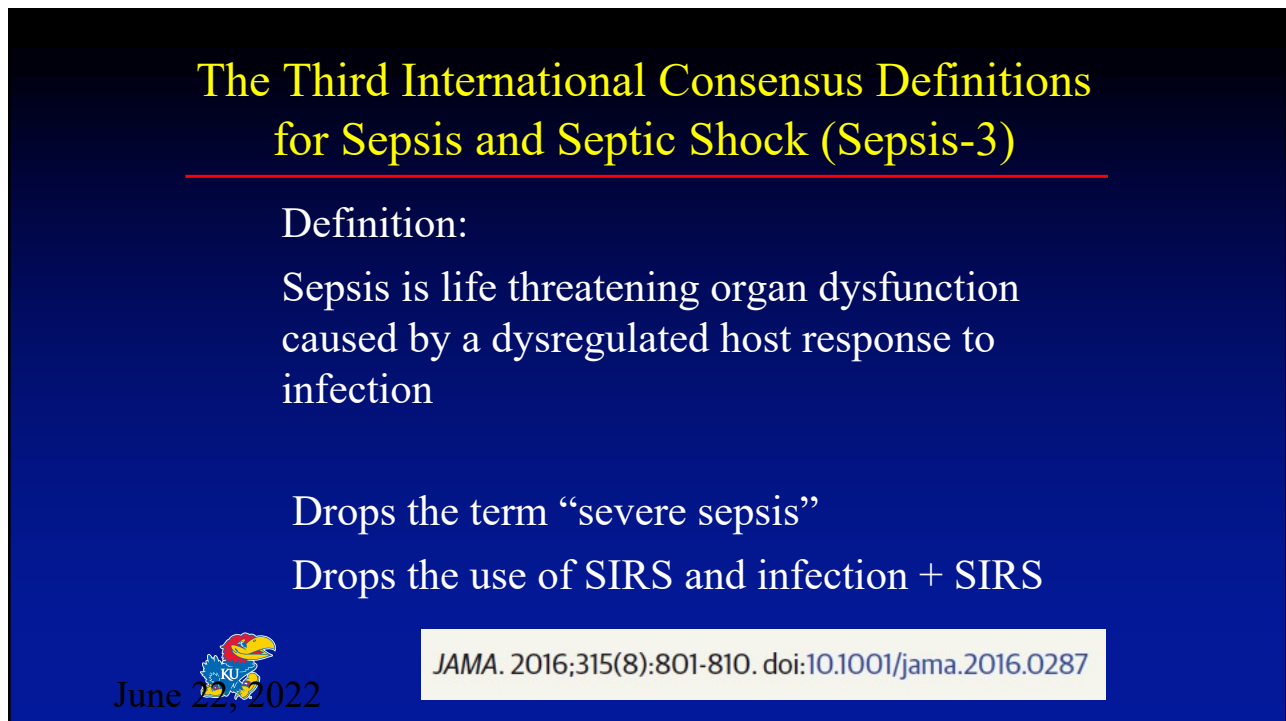
Adapted from: Bone RC et al. Chest. 1992;101:1644-55.
Opal SM et al. Crit Care Med. 2000;28:S81-2.

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This slide thumbnail features a dark blue background. At the top left, a red box contains the text "Clinical Review & Education". Below this, the text "Special Communication | CARING FOR THE CRITICALLY ILL PATIENT" is displayed. The main title, "The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3)", is written in a large, red, serif font. Underneath the title, a list of authors is provided in a smaller, white, sans-serif font. In the bottom left corner, there is a logo for KU (Kansas University) with the date "June 22, 2022". In the bottom right corner, a white box contains the citation: "JAMA. 2016;315(8):801-810. doi:10.1001/jama.2016.0287".

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This slide has a dark blue background. The title "The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3)" is centered at the top in a yellow, serif font, underlined with a red line. Below the title, the word "Definition:" is written in white, sans-serif font. The definition itself, "Sepsis is life threatening organ dysfunction caused by a dysregulated host response to infection", is also in white, sans-serif font. Further down, two bullet points are listed in white, sans-serif font: "Drops the term 'severe sepsis'" and "Drops the use of SIRS and infection + SIRS". In the bottom left corner, there is a logo for KU with the date "June 22, 2022". In the bottom right corner, a white box contains the citation: "JAMA. 2016;315(8):801-810. doi:10.1001/jama.2016.0287".

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The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3)


Condition	Sepsis-2	Sepsis-3
Sepsis	Infection + SIRS	Infection + Δ SOFA ≥ 2
Severe Sepsis	Infection + SIRS + organ dysfunction	NON-EXISTENT
Septic Shock	Infection + Unresponsive Hypotension*	Infection + Unresponsive Hypotension* + Serum Lactate > 2 mmol/L


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*Hypotension that does not respond to volume infusion and requires vasopressor administration


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SOFA Score	1	2	3	4
Respiration PaO ₂ /FiO ₂	< 400	< 300	< 200 With respiratory support	< 100 with respiratory support
Cardiovascular Hypotension	MAP < 70 mm Hg	Dopamine ≤ 5 or dobutamine, any dose	Dopamine > 5 or epinephrine or norepinephrine ≤ 0.1	Dopamine > 15 or epinephrine or norepinephrine > 0.1
Liver Bilirubin (mg/dL)	1.2 – 1.9	2.0 – 5.9	6.0 – 11.9	> 12.0
Renal Creatinine (mg/dL) or urine output	1.2 – 1.9	2.0 – 3.4	3.5 – 4.9 or < 500 mL/24 hr	≥ 5.0 or < 200 mL/24 hr
Coagulation Platelets x 10 ³ /mm ³	< 150	< 100	< 50	< 25
CNS Glasgow Coma Scale	13 - 14	10 - 12	6 - 9	< 6


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Glasgow Coma Scale		
Response	Scale	Score
Eye Opening Response	Eyes open spontaneously	4 Points
	Eyes open to verbal command, speech, or shout	3 Points
	Eyes open to pain (not applied to face)	2 Points
	No eye opening	1 Point
Verbal Response	Oriented	5 Points
	Confused conversation, but able to answer questions	4 Points
	Inappropriate responses, words discernible	3 Points
	Incomprehensible sounds or speech	2 Points
	No verbal response	1 Point
Motor Response	Obeys commands for movement	6 Points
	Purposeful movement to painful stimulus	5 Points
	Withdraws from pain	4 Points
	Abnormal (spastic) flexion, decorticate posture	3 Points
	Extensor (rigid) response, decerebrate posture	2 Points
	No motor response	1 Point


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 Minor Brain Injury = 13-15 points; Moderate Brain Injury = 9-12 points; Severe Brain Injury = 3-8 points

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Quick SOFA

- Also known as qSOFA
- Any two of:
 - Glasgow Coma Scale < 15
 - Respiratory rate ≥ 22 /min
 - Systolic blood pressure ≤ 100 mm Hg


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Misconceptions About SIRS

- The emphasis has shifted from inflammation to organ dysfunction.
- Requiring SIRS to diagnose sepsis misses cases of infection-induced organ dysfunction
- It's not specific to sepsis – “I climb a set of stairs and I get SIRS”

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“The emphasis has shifted from
inflammation to organ
dysfunction”

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Sepsis syndrome: A valid clinical entity

ROGER C. BONE, MD; CHARLES J. FISHER, JR., MD; TERRY P. CLEMMER, MD; GUS J. SLOTMAN, MD:


Previously reported (4, 5). Briefly, the sepsis syndrome was defined by a systemic response to sepsis which is evidenced by hypothermia (temperature <96°F), or fever (>101°F), tachycardia (>90 beat/min), tachypnea (>20 breath/min), clinical evidence of an infection site and

inadequate organ perfusion or dysfunction

tion, hypoxemia (Pao₂ <75 torr), elevated plasma lactate, or oliguria (urine output <30 ml/h or 0.5 ml/kg body weight · h without corrective therapy). The inclusion and exclusion criteria are shown in Tables 1 and 2.

June 22, 2022  Critical Care Medicine 17:389, 1989.

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 **accp/sccm consensus conference**

Definitions for Sepsis and Organ Failure and Guidelines for the Use of Innovative Therapies in Sepsis

THE ACCP/SCCM CONSENSUS CONFERENCE COMMITTEE:


<i>Roger C. Bone, M.D., F.C.C.P., Chairman</i>	<i>Alan M. Fein, M.D., F.C.C.P.</i>
<i>Robert A. Balk, M.D., F.C.C.P.</i>	<i>William A. Knaus, M.D.</i>
<i>Frank B. Cerra, M.D.</i>	<i>Roland M. H. Schein, M.D.</i>
<i>R. Phillip Dellinger, M.D., F.C.C.P.</i>	<i>William J. Sibbald, M.D., F.C.C.P.</i>

“The original consensus conference was set up for

Infection + SIRS was INTENDED to prompt the examination for organ dysfunction

patients who were being missed and if possible at the earliest possible stage.”

Charles Sprung
Personal communication, 2016

June 22, 2022  Chest 101:1644 – 55, 1992.

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Requiring SIRS to diagnose sepsis misses cases of infection-induced organ dysfunction


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Systemic Inflammatory Response Syndrome Criteria in Defining Severe Sepsis

Kirsi-Maija Kaukonen, M.D., Ph.D., Michael Bailey, Ph.D., David Pilcher, F.C.I.C.M.,
D. Jamie Cooper, M.D., Ph.D., and Rinaldo Bellomo, M.D., Ph.D.

Sensitivity of ≥ 2 SIRS for
infection-induced organ dysfunction

87.9%

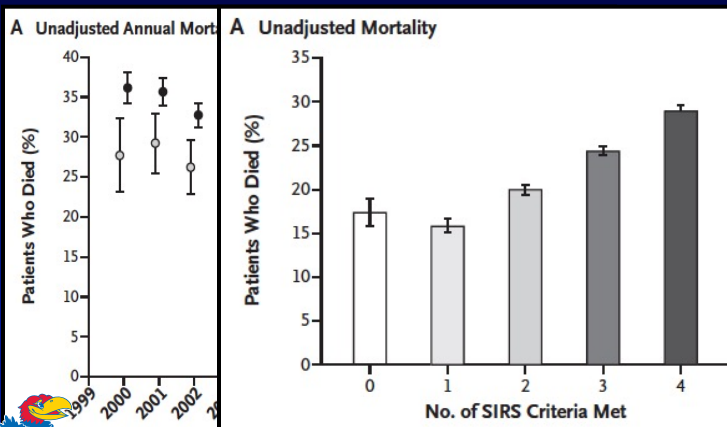

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N Engl J Med 2015;372:1629-38.

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Systemic Inflammatory Response Syndrome Criteria in Defining Severe Sepsis

Kirsi-Maija Kaukonen, M.D., Ph.D., Michael Bailey, Ph.D., David Pilcher, F.C.I.C.M.,
D. Jamie Cooper, M.D., Ph.D., and Rinaldo Bellomo, M.D., Ph.D.

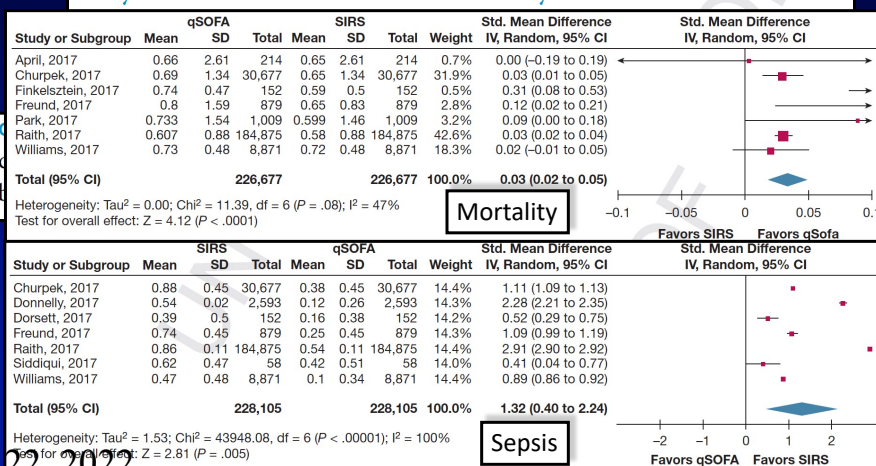


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N Engl J Med 2015;372:1629-38.

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A Comparison of the Quick-SOFA and Systemic Inflammatory Response Syndrome Criteria for the Diagnosis of Sepsis and Prediction of Mortality A Systematic Review and Meta-Analysis



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Requiring SIRS to diagnose
sepsis misses cases of infection-
induced organ dysfunction

Agreed

But then, who ever actually did/does that?



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It's not specific to sepsis –
“I climb a set of stairs and I get
SIRS”

Again, no argument.



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Sepsis syndrome: A valid clinical entity

ROGER C. BONE, MD; CHARLES J. FISHER, JR., MD; TERRY P. CLEMMER, MD; GUS J. SLOTMAN, MD;

previously reported (4, 5). Briefly, the sepsis syndrome was defined by a systemic response to sepsis which is evidenced by hypothermia (temperature $<96^{\circ}\text{F}$), or fever ($>101^{\circ}\text{F}$), tachycardia (>90 beat/min), tachypnea (>20 breath/min), clinical evidence of an infection site and inadequate organ perfusion or dysfunction as expressed by one of the following: poor or altered cerebral function, hypoxemia ($\text{Pao}_2 <75$ torr), elevated plasma lactate, or oliguria (urine output <30 ml/h or 0.5 ml/kg body weight \cdot h without corrective therapy). The inclusion and exclusion criteria are shown in Tables 1 and 2.

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Critical Care Medicine 17:389, 1989.

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Evidence of an Infected Site

Pneumonia – cough, sputum, fever, pleuritic chest pain, consolidation

Cellulitis – fever, painful skin, advancing margin

Pyelonephritis – flank pain, costophrenic angle tenderness

Cholecystitis – RUQ pain, Murphy's sign

Peritonitis – abdominal pain, rebound tenderness

Meningitis – headache, mental status change, nuchal rigidity, Kernig's and Brudzinsky's signs

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But the harder ones...

- Blood stream infection – look for a cut, a scrape, a physical opening in the integument
- Immunocompromised patients
- Isolated mental status change
- Fungal infections often indolent

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Don't Forget Bayes' Theorem

$$p(B|A) = \frac{p(A|B)p(B)}{p(A)}$$

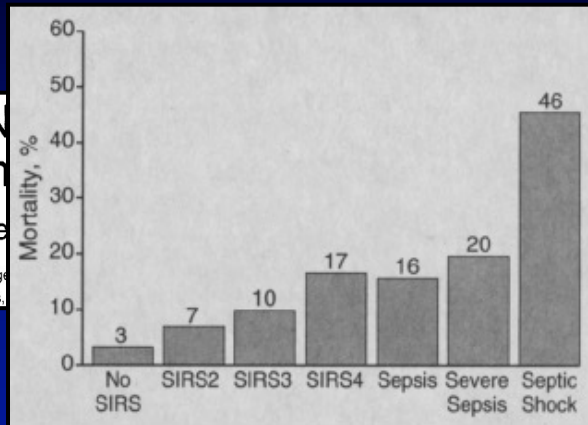
$$P_{\text{sepsis}} | \text{SIRS} \cong \frac{P_{\text{SIRS}} | \text{sepsis} \times P_{\text{sepsis}} \text{ in group}}{P_{\text{SIRS}}}$$

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SIRS Does Add Mortality Information

The N
Inflam
A Prospe
M. Sifrido Rang
Charles S. Davis.

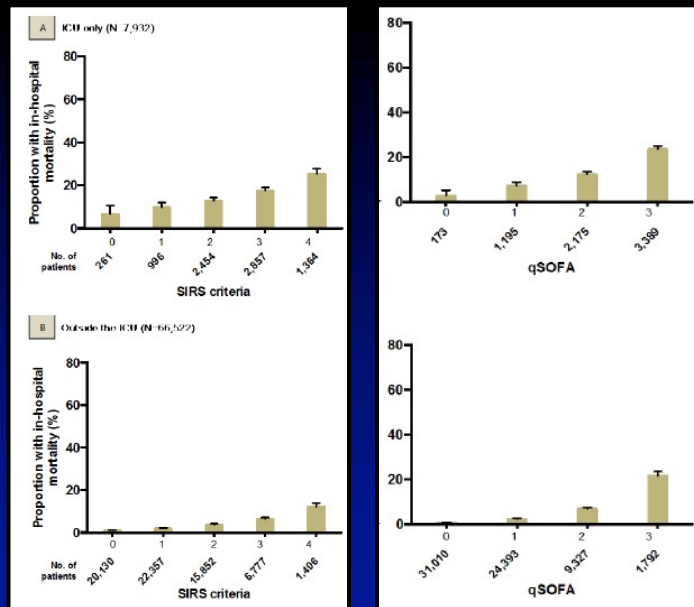


(RS)
JAMA 1995

JAMA 1995 273:117.

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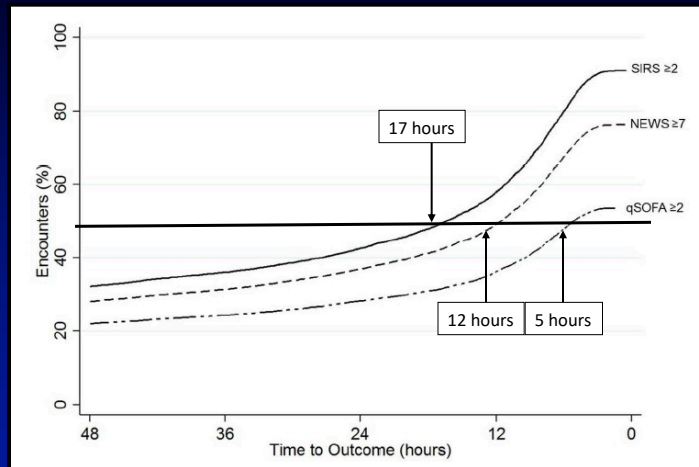
JAMA. 2016;315(8):762-774.

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SIRS Does Add Meaning



Am J Respir Crit Care Med Vol 195, Iss 7, pp 906–911, Apr 1, 2017

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How to Proceed?

Look for the infection - remember that neither SIRS nor qSOFA identifies infection

Infection + SIRS – treat and look for organ dysfunction

Infection + qSOFA – treat and look for organ dysfunction

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To Recap



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Thank You!

ssimpson3@kumc.edu
steven.simpson@hhs.gov

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KHC & Compass Data Updates



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Data Updates

Next data refresh will occur July 8.

Please aim to have your QHi data for May submitted by July 1.

+ Data Refresh

- Data refresh for June reports: June 10, 2022
- Next Refresh: *On or around July 8, 2022*



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QHi Training Session



MyQHi.org

Date: Wednesday, June 29

Time: 1:00 – 2:00 CT

Here is the link to register: <https://cc.readytalk.com/r/dh2tmn0o7cd1&eom>

- Adding New Users
- Select Measures
- Entering and Importing Data
- Running Reports



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QUALITY REPORTING FOR CRITICAL ACCESS HOSPITALS

I work at a Critical Access Hospital, what do I need to report?

MyQHi.org

Quality Programs

Impact of participation

Data submission process

Measure lists

Resources

Acronyms

INTRODUCTION

Since 2001, the QHi benchmarking program has supported rural hospitals and clinics across the country. Critical Access Hospitals comprise over 75 percent of QHi participants. The QHi team developed this guide in response to the often posed question, "As a CAH, what quality measures are required to report?"

There are many benefits to participating in a quality program, the most important being improved quality of patient care. All are voluntary but, depending on the program, participation may result in a financial impact. Federally funded programs often require reporting of particular quality measures as do and local health insurers.

ABOUT THE GUIDE

Quality experts at all levels were engaged to build this guide. We offer special thanks to the Oregon Office of Rural Health, generously sharing their document.

Others volunteered their time and expertise. Contributors resources are listed here. Designed to assist quality staff hospitals, this guide can also act as a template for network state leadership to develop a customized guide supporting regional and state quality initiatives.

CONTRIBUTORS AND RESOURCES

Centers for Medicare and Medicaid Services

Hospital Quality Improvement Contractors (HQIC):

AGCIC

- Natyane Hagmeier, RN

Kansas Healthcare Collaborative (KHC)

- Edie McGuire
- Heidi Coarson, PhD
- Eric Cook-Waters, MPH, CHIQ

Kansas Rural Hospitals Optimizing Performance

- Jennifer Einfeldt
- Susan Burrows

Multi-Based Incentive Payment (MIP)

- Shannon Elch
- CHS Merit-Based Incentive Payment
- Lancy Christensen

QHI:

- Sally Ottmar
- Stu Moore
- Janet Coffey

HOSPITAL QUALITY IMPROVEMENT CONTRACTOR (HQIC)

PROGRAM OVERVIEW

Hospital Quality Improvement Contractor provides targeted quality improvement assistance to rural and critical access hospitals, as well as hospitals serving vulnerable and underserved populations to achieve measurable outcomes with a focus on patient safety, care transitions and opioids.

HQIC is a new Centers for Medicare and Medicaid Services-led initiative which builds upon the Hospital Improvement Innovation Network. There are more than 100 hospitals in Kansas and more than 2,600 nationally identified as eligible to participate in this program.

IMPACTS

This initiative is designed to help hospitals improve in the respective measures and collaborate with other hospital peers to share best practices. This initiative can help facilities collectively promote better outcomes. This program is voluntary and is at no cost to hospitals.

LOCAL SUPPORT

Kansas Foundation of Medical Care
Kansas Healthcare Collaborative

Quality Reporting for Critical Access Hospitals

Introducti

HQIC

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Kansas Hospital ASSOCIATION

<https://www.kha-net.org/DataProductsandServices/DataProducts/d164234.aspx>

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KHC & Compass Resources, Updates, and Upcoming Events



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NEW- Resource

SUMMER IS COMING

HOW CAN WE LAYER PROTECTION TO PREVENT HARM?

CONVERGENCE HEALTH CONSULTING

OVERVIEW

LAYERS OF PROTECTION

- OPIOID STEWARDSHIP
- ADVERSE DRUG EVENTS (ADEs)
- CENTRAL LINE ASSOCIATED BLOODSTREAM INFECTIONS (CLABSI)
- READMISSIONS
- SEPSIS
- HOSPITAL ACQUIRED PRESSURE INJURIES (HAPI)
- CATHETER ASSOCIATED URINARY TRACT INFECTION (CAUTI)
- PATIENT FAMILY ENGAGEMENT PROTECTION

In partnership with **OPPEPartners**

LAYER WITH OPIOID STEWARDSHIP PROTECTION

- REACHABLE & TEACHABLE**
Hospitalization is a reachable and teachable moment for all patients and families on the risk associated with long term opioid use and treatment options.
- ENGAGE PATIENTS**
Engage patients in understanding their pain goals and expectations. Together, weigh the pros and cons of whether and how much opioids should be used for pain management.
- LESS IS MORE**
Continue to present new opioid alerts to encourage alternatives to opioids for pain management. Consider opioids and through evidence based strategies preventing guidelines.
- PATH TO RECOVERY**
Connect patients to treatment and harm reduction services to your hospital and community - national, regional resources, etc.
- WEAVE IN OPIOID SAFETY**
Patients with opioid use disorder (OUD) may also have behavioral health issues and other chronic diseases unless they are frequently identified by your hospital to weave opioid safety into the care you are already doing.

HOW CAN WE LAYER PROTECTION ON PATIENTS TO PREVENT HARM?

Unprecedented surges of hospitalizations, staffing shortages, and limited family visitation have increased the risk for harm during a hospitalization. Summer is Coming is a compilation of practical, tactical advice from subject matter experts and frontline providers across U.S. hospitals to help you layer on protections to avoid patient harm.

LAYER WITH READMISSIONS PROTECTION

IF YOUR DATA
Use your data as your guide - which patient population is readmitted most often, from where, with what diagnosis?

ALL ACTS OF CHANGE
For example, if your hospital's data tells you that patients with COVID are the age of 8 that are discharged to home are most commonly readmitted, what small steps can be taken to make just that patient population?

INTERVIEW PATIENTS
Interview readmitted patients to better understand the real reasons of readmission and how to improve their care transitions.

EDUCATE PATIENTS
Involve low-resource, high-value interventions that help patients and caregivers better understand how to care for themselves during discharge - i.e. home education items, additional one-on-one phone calls, a subscription to a text service with patient care information on a regular basis.

GH UTILIZER PATIENTS
Involve low-resource, high-value interventions to meet social and medical needs, such as genetic counseling, virtual outreach with a physician, home, homecare or physical therapists.

www.khconline.org/june2022-resource



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KHC Office Hours

- + Register once for all remaining sessions.
- + Save recurring appointment to your calendar.
- + Stay abreast of KHC program updates.
- + Learn from subject matter experts and peers.

Up Next!

August 24, 2022, | 10:00-11:00a.m.
Health Equity Organizational Assessment

KHC Office Hours series registration link:
www.khconline.org/officehours

All sessions are held from 10 to 11 a.m. CST.
Sessions will be recorded and posted to KHC
Education Archive at www.khconline.org/archive.



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Event Schedule

Session #1 | April 7, 2022 | 12:00-1:00pm

Session #2 | May 5, 2022 | 12:00-1:00pm

Session #3 | June 2, 2022 | 12:00-1:00pm

Session #4 | July 7, 2022 | 12:00-1:00pm

Speakers



Kellie Wark, MD, MPH
Asst. Prof Inf Diseases, KUMC
HAI/AR expert and AS Co-Lead, KDHE



Nicole Wilson, PharmD, BCIDP, DPLA
AS Program Coordinator, KUMC
HAI/AR expert and AS Co-Lead, KDHE

*Each session is approved for 1 Nursing and/or
Pharmacy Continuing Education credit*



Antibiotic Stewardship Practical Implementation for Kansas Hospitals

Target Audience

Pharmacists | Nurse Leaders | Clinicians | Quality Leaders |
Infection Preventionists | Antibiotic Stewardship team members



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Upcoming KRHOP Education

Quality Corner Calls

August 10
Noon to 1 p.m.
Topic TBD

September 29
Noon to 1 p.m.
Topic TBD

More information at www.krhop.net



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Upcoming Conference

The 6th Annual Kansas Opioid and Stimulant Conference will take place on November 10th, at the Hotel Topeka, formerly the Topeka Capitol Plaza.






Due to the significant rise in psychostimulant overdoses in Kansas, the conference has expanded to include topics related to stimulant prevention, treatment, and recovery for the second year.



DCCCA, the Kansas Department for Aging and Disability Services, the Kansas Department of Health and Environment, and the Kansas Prescription Drug and Opioid Advisory Committee present the conference.

2022 Kansas Opioid and Stimulant Conference
November 10, 2022
Location: Hotel Topeka
Call for proposals open now through August 31

SAVE THE DATE! 11.10.22

6th Annual Kansas Opioid + Stimulant Conference Topeka, KS

 Prescribing	 Treatment & Recovery	 Prevention	 Law Enforcement	 Stimulants
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Save the Date! August 19 — Topeka



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Next Steps

- + Ensure data entry is current and timely
- + Review and update your Q.I. Work Plan
- + Log into iCompass Forum and iCompass Academy to engage and learn
- + Watch your inbox for the Compass Navigator on July 1st

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Care Collaborative Program Staff Contact The University of Kansas Health System

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Have Questions, Need Help?

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Questions?



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Thank you for joining us.

We invite your feedback.
What was a key take-away?
What are 3 next steps based on the information shared?

Please complete our brief feedback survey.

www.khconline.org/june2022-feedback

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No JULY Office Hours

See YOU in AUGUST

VACATION

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KHC Kansas Healthcare COLLABORATIVE

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June 22, 2022

Malea Hartvickson
Executive Director

Mandy Johnson
Interim Director of Quality Initiatives

Treva Borchert
Business Operations Manager

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→ Find contact info, bios, and more at:
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