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2018 QIO Program Priorities
Introduction

Dennis Wagner & Jeneen Iwugo

An introduction from Dennis Wagner, Director, and Jeneen Iwugo, Deputy Director, Quality Improvement and Innovation Group (QIIG), Center for Clinical Standards and Quality, Centers for Medicare & Medicaid Services (CMS).

QIO Program Structure: How We Serve Medicare Beneficiaries

The Quality Improvement Organization (QIO) Program structure follows a functional model with two types of QIOs: Quality Innovation Network-QIOs (QIN-QIOs) and Beneficiary and Family Centered Care-QIOs (BFCC-QIOs). Fourteen regional QIN-QIOs work with providers, community partners, beneficiaries and caregivers on multiple data-driven quality improvement initiatives to improve patient safety; reduce harm; engage beneficiaries, families and caregivers; improve care and reduce health care disparities. Two BFCC-QIOs manage all beneficiary complaints and appeals across the nation, ensuring that beneficiaries are treated fairly and helping them exercise their right to high-quality health care across care settings.

Locate your local QIN-QIO and BFCC-QIO.

The QIO Program aligns with the six priorities of the CMS Meaningful Measures Framework

- Make care safer by reducing harm caused in the delivery of care.
- Strengthen person and family engagement as partners in their care.
- Promote effective communication and coordination of care.
- Promote effective prevention and treatment of chronic disease.
- Work with communities to promote best practices of healthy living.
- Make care affordable.
In 2017, QIN-QIOs were especially successful in performing meaningful and impactful work in person and family engagement, and achieving results in the areas of medication safety, immunizations, care coordination, diabetes care and nursing home care. BFCC-QIOs exceeded established targets for the timely review of beneficiary complaints and continued to implement resolutions that fostered beneficiary and provider engagement.

QIN-QIOs

**ANTIBIOTIC STEWARDSHIP**
QIN-QIOs are working to combat antibiotic resistant bacteria by increasing awareness of the importance of proper antibiotic use and delivering technical assistance that builds the capacity of outpatient providers to monitor, reduce and prevent misuse and/or overuse of antibiotics.

7,600+ Outpatient settings recruited
48.7%
Of outpatient settings have implemented all 4 of the CDC’s Core Elements and/or Quality Improvement activities: commitment; action for policy and practice; tracking and reporting; education and expertise

**BEHAVIORAL HEALTH**
Six regional QIN-QIOs provide technical assistance and educational interventions to help primary care providers screen for and increase the identification of people with alcohol use disorder and/or depression. In addition, QIN-QIOs work with inpatient psychiatric facilities to improve transitions of care and reduce readmissions for these and other patients after discharge.

5,050+ Practices recruited to increase number of alcohol and depression screenings
306,600+ Alcohol screens conducted among beneficiaries with primary care visits
837,800+ Depression screens conducted among beneficiaries with primary care visits
140+ Inpatient psychiatric facilities (IPFs) recruited to reduce readmissions

**CARDIAC HEALTH**
QIN-QIOs work to implement evidence-based practices to improve cardiovascular health and support the Million Hearts® initiative’s goal to prevent one million heart attacks and strokes by 2022.

2,700+ Practices recruited, representing 9,600+ clinicians
2,000+ Recruited practices implementing blood pressure protocols
64.2% Blood pressure control rate achieved, exceeding the 30% target*
75.7% Tobacco users provided with cessation counseling, exceeding the 45% target*
2,150+ Home health agencies (HHAs) recruited
1,650 HHAs implementing blood pressure protocols

**CARE COORDINATION**
QIN-QIOs help providers and communities reduce avoidable hospital admissions and readmissions by improving the quality of care transitions.

380+ Communities engaged
23M+ Beneficiaries potentially affected
50,900+ Readmissions avoided
DIABETES CARE / EVERYONE WITH DIABETES COUNTS
QIN-QIOs work to provide diabetes self-management education and support to beneficiaries, including in minority, rural and impoverished communities; improve clinical outcomes; and increase adherence to clinical guidelines. QIN-QIOs also provide technical assistance to participating practices, partners and other stakeholders interested in developing sustainable diabetes education programs through Medicare.

**2,800+** Practices recruited

**47,800+** Beneficiaries completed DSMES

**5,300+** Diabetes educators (“train-the-trainers”) trained by QIN-QIOs

17 languages in which DSMES classes have been taught, including English, Spanish, French, Cambodian, Armenian, Russian, Mandarin, Cantonese, Korean, Vietnamese, Swahili, Somali, Portuguese, Hmong, Tagalog, Cherokee and Choctaw

**200+** Providers, partners and stakeholders that have achieved American Association of Diabetes Educators (AADE) accreditation or American Diabetes Association (ADA) recognition** with technical assistance from the QIN-QIOs

IMMUNIZATIONS
QIN-QIOs work to improve immunization rates among minority and underserved populations in 37 states and territories nationwide (based on greatest need), helping increase their rates of influenza and pneumonia vaccinations.

**350+** Facilities recruited

**1,150+** Home health agencies (HHAs) recruited

**2,150+** Practices recruited, representing 7,550+ clinicians

**800+** Pharmacies recruited

**4.7M+** Recruited Medicare beneficiaries impacted through education/outreach*

**312,550+** Pneumonia immunizations administered by recruited clinicians and practices

**600,000+** Flu immunizations administered by recruited clinicians and practices

MEDICATION SAFETY
QIN-QIOs work to improve medication safety and to reduce or prevent adverse drug events via improvement processes and education on proper medication use and patient engagement.

**2.3M+** Beneficiaries at high risk for an adverse drug event (ADE) were screened for ADE

**1.4M+** Medication-related adverse outcomes were identified for opportunities of harm avoidance (potential ADEs)***

**15,600+** Severe ADEs avoided in the Medicare high risk population

**7,450+** Facilities, clinicians and practices are working with QIN-QIOs on improving medication safety and preventing adverse drug events

NURSING HOME CARE
Through the National Nursing Home Quality Care Collaborative, now in its second phase and known as Collaborative II, QIN-QIOs seek to eliminate health care-acquired conditions and ensure that every nursing home resident has the highest quality of care. In Collaborative II, QIN-QIOs will provide participating nursing homes with training in strategies and tools to enhance performance and resident safety; antibiotic stewardship principles and practices; and Clostridium difficile management and prevention techniques. QIN-QIOs also will join with their state coalitions that work with and support the National Partnership to Improve Dementia Care in Nursing Homes and encourage nursing homes to actively engage with them to reduce antipsychotic medication use.

**12,200+** Nursing homes recruited (more than 78% of all nursing homes in the U.S.)

**26%** Relative improvement reduction in antipsychotic medication use has been achieved among nursing homes across the nation, resulting in an estimated 54,500+ fewer long-stay nursing home residents who received unnecessary antipsychotic medications on a quarterly basis
QUALITY REPORTING/QUALITY PAYMENT PROGRAM

QIN-QIOs provide Quality Payment Program (QPP) technical assistance (TA) to groups of 16 or more Eligible Clinicians. This TA includes support that allows Eligible Clinicians to easily comply with their QPP requirements, such as meeting reporting requirements, successfully submitting data and utilizing appropriate feedback reports. QIN-QIOs also support the ability of hospitals and clinicians to report quality data to CMS through various quality reporting programs, consequently helping providers use data to drive improvement.

377,500+ Eligible Clinicians received direct TA****
750+ Hospitals received TA regarding outpatient quality improvement
800+ Hospitals received TA regarding inpatient quality improvement
1,300+ Other facilities (ambulatory surgical center, inpatient psychiatric facilities, Prospective Payment System-Exempt Cancer Hospitals, and Critical Access Hospitals) received TA

TRANSFORMING CLINICAL PRACTICE INITIATIVE

The Transforming Clinical Practice Initiative (TCPI) is preparing 140,000 clinicians for successful participation in Medicare Alternative Payment Models like Accountable Care Organizations and bundled payment programs. QIN-QIOs partner with the Practice Transformation Networks in their region to assess the progress of participating practices through the five phases of practice transformation. The QIN-QIOs assess progress by conducting baseline and ongoing assessments.

7,050+ Baseline assessments completed
11,550+ Follow-up assessments completed

Numbers are based on the most recent data sources available to the Quality Innovation Network National Coordinating Center as of January 31, 2018, unless otherwise noted.

*Data reported for Calendar Year 2016, as reported annually in July 2017.

**To receive reimbursement from Medicare for the Medicare diabetes self-management training benefit, a diabetes education program must achieve either AADE accreditation or ADA recognition.

***Potential ADEs (pADEs) are reported by QIOs quarterly, and an individual beneficiary may have multiple pADEs per quarter.

****More than 300,000 MIPS Eligible Clinicians (eligible as individuals or as part of a group practice) will need to be reached by the QIN-QIOs as part of the target population for the 2017 transition year in the QPP.
BFCC-QIOs conducted more than 40,000 reviews for quality of care concerns and identified more than 23,007 opportunities for quality improvement across a variety of health service providers. The primary quality of care concern, representing 17% of concerns identified, was not establishing an appropriate treatment plan. More than 494,443 discharge appeal reviews were completed, resulting in more than 99,000 beneficiaries not being discharged earlier than necessary.

BFCC-QIOs worked in partnership with QIN-QIOs to perform and report more than 1,606 successful Quality Improvement Initiatives (QIIs) that improve health care quality by assisting providers and/or practitioners to identify the root cause of a concern, develop a framework in which to address the concern, and improve a process or system.

Numbers are based on the most recent data sources available to the Beneficiary and Family Centered Care-National Coordinating Center as of January 31, 2018.
Quality Payment Program Launch

The Centers for Medicare & Medicaid Services (CMS) formally launched the Quality Payment Program (QPP) in January 2017. Throughout 2017, CMS made efforts to reach all eligible clinicians, including by implementing an education initiative for rural practices to ensure that small physician practices could transition smoothly to new payment models. Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) have provided technical assistance to large practices participating in the Quality Payment Program and are supporting CMS’s efforts to reduce provider burden. For example, QIN-QIOs are helping clinicians select meaningful measures that align with their patient populations and participation in other reporting programs, and are providing timely, informed responses about QPP requirements.

Kickoff of Second CMS National Nursing Home Quality Care Collaborative

The National Nursing Home Quality Care Collaborative, led by CMS and QIN-QIOs, is spreading quality and performance improvement practices in nursing homes serving beneficiaries; working to eliminate health care-acquired conditions (HACs); and improving resident satisfaction by focusing on the systems that impact quality. By the start of the second collaborative in April 2017, known as Collaborative II, more than 12,200 nursing homes (more than 78 percent of all nursing homes in the nation) had joined the collaborative. That number includes more than 2,600 nursing homes with a one-star rating in CMS’s Five Star Quality Rating System, representing the nursing homes that are most in need of quality improvement. Collaborative II is building upon successes and lessons learned through sharing of best practices by QIN-QIOs. The second collaborative supports the creation of a culture of resident safety in nursing homes. QIN-QIOs are providing participating nursing homes with training in TeamSTEPPS; antibiotic stewardship principles and practices; and Clostridium difficile (C. diff) management and prevention techniques. Older adults who take antibiotics and receive medical care are particularly at risk for developing C. diff infections, which can be deadly. In coordination with the Centers for Disease Control and Prevention (CDC), QIN-QIOs are helping nursing homes collect and report infection data to the CDC’s National Health Care Safety Network database to establish a national baseline for C. diff infections in nursing homes.

Preparation for Future QIO Activities

In April, CMS held a special session at CMS’s headquarters in Baltimore, Maryland—simultaneously webcast for other health care quality stakeholders nationwide—to help inform the priorities and aims of the next phase of the Quality Improvement Organization (QIO) Program, known as the 12th Scope of Work, beginning on August 1, 2019. Executives from the CMS Center for Clinical Standards and Quality’s Quality Improvement and Innovation Group sought stakeholder input on emerging goals and approaches, like how to maximize national impact while empowering state flexibility and local leadership. Click here to view presentations from the special session, listen to a recording or download an audio transcript. Additional feedback can be submitted to QIOProgram@cms.hhs.gov.
Campaign for Meds Management: Phase II

The Quality Innovation Network National Coordinating Center launched phase two of the Person and Family Engagement program for medication safety: the Campaign for Meds Management (CMM). The CMM is a national effort that aims to learn from beneficiaries and their experiences, and that shares person-centered resources and information to help achieve better health care outcomes and reduced adverse drug events. The initiative hosts frequent national learning events that feature beneficiaries, beneficiary advocates and caregivers who want to share their experiences and health care journeys so that others can learn and be inspired to do more. Learn more at http://qioprogram.org/campaign-meds-management.

Beneficiary Healthcare Navigation Program Debut

The Beneficiary and Family Centered Care-Quality Improvement Organizations (BFCC-QIOs) kicked off the Beneficiary Health Care Navigation Program in September 2017, helping beneficiaries with complex health care needs make their way through difficult medical systems and treatments. The navigators—including nurses, social workers and others—assist with health care coordination in various settings such as physician offices, hospitals and nursing homes.

Special Innovation Project Awards

In October 2017, CMS awarded 14, two-year Special Innovation Projects (SIPs) to 11 QIN-QIOs. Projects were required to address issues of quality occurring within the QIN-QIOs’ local service area, or focus on expanding the scope and national impact of quality improvement interventions that have proven but limited success. SIPs cover a range of topics, including opioids, obesity and behavioral health. Read more about a SIP led by Alliant Quality QIN-QIO.

Engaging Persons and Families

CMS is committed to integrating Person and Family Engagement (PFE) into policy and program development through its Person and Family Engagement Strategy. In 2017, the QIO Program implemented Beneficiary & Family Advisory Councils (BFACs) across all segments of the Program, empowering Medicare beneficiaries to take an active role in managing their health and health care services.

The Beneficiary & Family Centered Care National Coordinating Center’s BFAC uses the personal perspectives and experiences of its members to add an end-user perspective to the BFCC-QIO work, such as the rollout of the recently added Beneficiary Health Care Navigation services. The Council is the representative voice of millions of people who receive Medicare benefits. The examples and feedback from advisors shape the BFCC-QIOs’ efforts toward person-centeredness in all beneficiary engagement projects, while also supporting the core value of BFCC-QIOs—protecting Medicare beneficiary rights.

The Quality Innovation Network National Coordinating Center’s BFAC incorporates the diverse perspectives of its members from across the country into quality improvement initiatives, like the Program’s Campaign for Meds Management. The Council also offers valuable and actionable feedback to QIN-QIOs, which meaningfully includes Medicare beneficiaries in their work locally.

Celebrating 2017 Success at the 2018 CMS Quality Conference

At CMS’s largest-ever gathering of health care quality stakeholders, CMS leadership discussed the Agency’s “Patients Over Paperwork” initiative, which is designed to reduce unnecessary burden on providers, enabling them to spend more time with CMS beneficiaries across settings of care. Attendees shared and celebrated successes from 2017, and CMS officials highlighted their 2018 and long-term roadmap to tackle the opioid epidemic; convened a diverse panel of beneficiaries, advocates, caregivers and clinicians sharing stories on “Putting Patients First”; and presented the first-ever Health Equity Awards.
Snapshots of Success
Stories of QIN- and BFCC-QIOs in action

CARDIAC HEALTH: Atlantic Quality Innovation Network Promotes Cardiac Prevention Among High-Risk Population

According to a 2015 Centers for Disease Control and Prevention (CDC) report, the cardiovascular disease (CVD) mortality rate in Washington, D.C. was 187.6 per 100,000 residents. The national mortality rate was 168.5 per 100,000. Additionally, a comparison of CVD mortality rates by race shows that African Americans in Washington, D.C. are twice as likely to die from CVD than their white counterparts. Heart disease continues to rank as the number one cause of death for residents of the District of Columbia.

To help address this public health crisis, the Atlantic Quality Innovation Network—Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for New York, South Carolina and Washington, D.C.—teammed with the District of Columbia Department of Health to initiate a cardiovascular disease (CVD) reduction program specifically tailored to the nation’s capital.

Inspired by the national Million Hearts initiative pioneered by the U.S. Department of Health & Human Services, the DC Million Hearts Learning Collaborative brings together public and private organizations on a monthly basis for networking and sharing of best practices as they relate to health care quality improvement, and to discuss interventions and provide resources to patients with chronic diseases. The collaborative includes both national and regional organizations, local health care systems, academic organizations and community organizations working toward the common goal of reducing mortality caused by heart disease among residents of Washington, D.C.

One participant in the collaborative is the Medical Home Development Group (MHDG), a medical clinic that practices in an underserved area of Washington, D.C. Based on recommendations from the collaborative, MHDG implemented a comprehensive and scalable program to enhance CVD screening for its high-risk, largely African-American patients, many of whom have co-occurring mental health and substance abuse disorders. To treat these complex combinations of diseases, MHDG is integrating substance use disorder treatment with chronic care management.

“We have a motto of the whole person approach to care,” said Dr. Melissa Clarke, vice president of population health and provider contracting at MHDG. “Although we do have initiatives specific to certain areas, we view everything within the context of a person’s overall well-being.”

Clarke said her practice has found it critical to identify the social determinants of health, including housing instability, food insecurity, mental health, smoking and transportation to care facilities, in order to deliver effective care for its patient population. Many patients face barriers in more than one of these areas and cannot easily resolve them.

Bearing this in mind, MHDG fully integrated patient-centered technology applications in its practice to expand access to on-demand specialty care and chronic care management, and to address social barriers outside of the care facility. These applications include an extensive health assessment tool that was embedded into MHDG’s health records system, allowing clinicians to identify the need for interventions within their patient population. Based on this knowledge, MHDG decided to use alternative measures to determine the success of population health interventions.

“We consider hypertension to be a manifestation of some of the socioeconomic factors that determine health,” said Clarke. By addressing cardiovascular disease in the clinical setting, patients are made aware of the factors that drive poor health, enabling them to come to a consensus with their doctor on the best care path forward.

The DC Million Hearts Collaborative has recruited five home health agencies, 21 practices, and 137 clinicians in 37 locations to begin similar cardiac prevention programs.
CARDIAC HEALTH: Great Plains QIN’s Virtual Training Program Spurs Rural Clinic to Develop Hypertension Management Protocol

Many health clinics in rural areas of the United States face unique challenges in sharing best practices in quality improvement due to their limited ability to network in-person with other health care professionals.

In the state of Nebraska, the Great Plains Quality Innovation Network—the Quality Innovation Network-Improvement Organization (QIN-QIO) for Kansas, North Dakota, Nebraska and South Dakota—sought to improve communication among clinicians by implementing a virtual program to convene clinical communities across the state.

Between September 2016 and March 2017, the QIN-QIO hosted three virtual clinical training sessions, enabling providers from across Nebraska to convene and share insights on health care quality improvement.

Among the participants in the training sessions was Grand Island Clinic of Grand Island, Nebraska. Prior to participating in the virtual trainings, the Grand Island Clinic had few employees with backgrounds in formalized interventions, was uncertain of its own goals in this area and had no formalized programs to focus specifically on improving health care outcomes and quality of care.

“No one ever expected how quality encompasses all aspects of the clinic,” said Patricia Enck, the administrator of Grand Island Clinic. “Our providers wanted to enhance patient care by utilizing the unique information that we were seeing in our quality measure reporting through the Meaningful Use Initiative.”

As part of its virtual training sessions with the Great Plains QIN, Grand Island completed clinical “to-do” assignments between learning sessions. Based on one of the assignment’s recommendations, Grand Island decided to implement a team-based approach to quality improvement in which clinical protocols are established for nurses and clinicians to standardize processes for clinical activities.

Since blood pressure management is a big focus for Grand Island Clinic, the quality improvement team decided to create a protocol for that area. The facility implemented simple interventions such as establishing common practices in measuring blood pressure by asking patients to put two feet flat on the floor and placing their arms at heart level. Through these interventions, Grand Island Clinic was able to successfully standardize blood pressure measurement and yield better data on patient needs in their care community.

Quality data from EMR reports allowed the clinic to review medical records of all patients with hypertension to identify necessary interventions. If necessary, the clinic contacted patients about rechecking their blood pressure or recommended changing their medication.

Through this process, Grand Island Clinic determined that nurses would benefit from training to appreciate the value of the interventions, while patients would benefit from the ability to self-monitor their blood pressure without the supervision of a licensed care professional. The clinic’s Patient Care Coordinators contacted pharmacies in the area to determine which ones could provide self-monitoring devices to patients at cost. This outreach resulted in a partnership with U Save Pharmacy on-site, which enabled hypertension patients to receive self-monitoring equipment at an affordable rate on the day of their appointment, without having to leave the facility.

In 2017, Grand Island Clinic hired a full-time quality improvement professional to help coordinate and implement Quality Improvement. This on-site coordinator is currently developing written clinical quality improvement policies to improve overall hypertension rates among the clinic’s patients and within its care community.
DIABETES CARE: HSAG’s Faith-Based Partnership Brings Diabetes Self-Management Education to Florida Churches

Racial, ethnic and other minority populations are at a higher risk for diabetes, which is more common among those living in rural communities. Compared to the 9.4 percent median county-level prevalence of diagnosed diabetes in the United States, Hendry County, Florida, has a diabetes prevalence of nearly 14 percent, putting Medicare beneficiaries living there at increased risk of heart attack and stroke, kidney disease and lower extremity amputations.

HSAG, the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Arizona, California, Florida, Ohio and the U.S. Virgin Islands, is equipping pastors and health ministers to deliver diabetes self-management education to African-American Medicare beneficiaries in Florida through its partnership with the Progressive Missionary Baptist Church Conference.

The doors to this partnership opened through a grassroots effort that began in 2014 with HSAG staff approaching known church families, attending pastor breakfasts, and using word-of-mouth to launch diabetes classes and recruit diabetes peer educators within the church communities. Churches, HSAG learned, are often the support networks for people living throughout the state and particularly in rural areas of Florida. As pastors and health ministers found out about HSAG’s diabetes training for congregants, they contacted pastors and health ministers at fellow churches to let them know about this valuable resource.

“Developing this partnership has been a long process, and we’ve had to be persistent,” said Laura Gamba, CBA, BA, director and senior trainer for the Diabetes Education Empowerment Program™, at HSAG. “We’re starting to see our hard work pay off.”

HSAG’s persistence was rewarded when its staff met a pastor considered to be a leader within the church community, whose personal connections led to a meeting for HSAG with the Church Conference. That meeting led to an invitation to the Church Conference’s five-day annual meeting in Panama City. At that meeting, HSAG provided peer educator training to pastors and health ministers. The training included an overview of HSAG, the QIO Program’s Everyone with Diabetes Counts Program, and coaching on the DEEP™ model—one of two evidence-based Diabetes Self-Management Education (DSME) curricula. To make the training more engaging, HSAG offered experiential learning by demonstrating the DEEP™ model, so pastors and health ministers could experience what church members would as DSME class participants.

“As a result of this learning experience, many churches stepped up and asked for training for their pastors and health ministers,” said Gamba.

The training was so well received that HSAG was invited to provide the Church Conference with DEEP’s™ three-day train-the-trainer session at a smaller regional meeting. Because many pastors and health ministers attending those meetings were also leading breakout sessions, they couldn’t participate, so HSAG extended invitations to them to attend one of the QIN-QIO’s three-day train-the-trainer sessions offered throughout the state.

Now, HSAG is focused on expanding peer educator training to churches from central Florida down to the Keys and up through rural areas of the Panhandle. HSAG has also offered peer education training sessions throughout the Panhandle, as needed, to help reduce travel costs for churches.

Church conferences represent churches throughout expansive geographic areas, including disenfranchised rural areas. Working at the local level with individual churches provides immediate opportunities to increase DEEP class outcomes. Efforts at the Church Conference level have resulted in greater spread and sustainability, as churches in regional areas understand the need for health ministers trained as DEEP peer educators to provide diabetes training to their own congregations, as well as to other regional congregations without health ministries. HSAG has also created and uses a variety of faith-based outreach documents, designed to be personalized by local trainers, to assist with recruitment and enrollment.
DIABETES CARE: Qualis Health Leverages Community Relationships to Build a Sustainable Diabetes Self-Management Program in Rural Idaho

Although nearly 29.1 million people in the United States—approximately 9.3 percent of the general population—have diabetes, many patients are not aware of the best ways to manage and treat the disease. Diabetes Self Management Education (DSME) is an evidence-based intervention for empowering individuals with diabetes to take an active role in managing it.

In summer 2014, the state of Idaho had no community-based DSME program. Qualis Health—the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Idaho and Washington—saw the opportunity to fill this care void and build a platform through which Idaho residents with diabetes could learn how to better manage their health and maintain fulfilling lives.

With a desire to build on the existing chronic disease program in the state, Qualis Health evaluated top evidence-based programs and decided that Stanford University had the best DSME model to meet the state’s needs. On top of Idaho’s want for an established DSME program, its rural communities were in need of better and more accessible care. Qualis Health recognized that diabetes management programs were primarily supporting urban areas via clinics and that Idaho’s rural communities should be a focus as its DSME program expanded over the next year.

Building strong relationships with community members and organizations, and training local volunteers were Qualis Health’s top priorities as it launched the program. After kicking off its first master training, the QIN-QIO was able to provide effective education of local workshop leaders by assimilating four master trainers and 24 active leaders serving various regions of the state.

Qualis Health also was able to significantly improve self-management skills in people with diabetes and prediabetes by facilitating 36 six-week DSME workshops, 20 of which took place in 2017, primarily in rural communities. Nearly 300 Idaho residents completed a DSME workshop, including 164 total residents in 2017 (105 of whom were Medicare beneficiaries with diabetes and prediabetes).

Workshop participants have seen a 46 percent increase in knowledge of healthy ways to handle stress related to diabetes; a 30 percent increase in asking for support on how to live with and take care of their diabetes; and a 36 percent increase in feeling they can make a plan with goals that will help control their diabetes.

Sustainability was the most notable goal of 2017, as Qualis Health transitioned from an active leadership role to a support one. As the DSME program grew and became established throughout Idaho, the QIN-QIO used sustainability as its foundation by finding partners that can train leaders and become leaders themselves. The purpose is to have members continue to take the program forward and keep it viable.

Over the course of 2017, Qualis Health strengthened its partnerships, resulting in another DSME license (for a total of five) and three DSME grants to community organizations, including a tribal group in Eastern Idaho, which is planning to have its first workshop in 2018. In October 2017, Qualis Health held a DSME cross-training for the tribal group and other community associations. The QIN-QIO also held three leader trainings in February, March and December 2017, bringing it closer to its goal of creating a new and sustainable community-based DSME program across the state.

In addition to the success of the DSME program in Idaho, Qualis Health has started an accreditation path for a Federally Qualified Health Center (FQHC). In preparation for this path, two of the FQHC Community Health Workers (CHW) attended a four-day DSME leader training. The plan is for the CHW to use the training to offer the DSME program to their patients, and then the FQHC will use the DSME program to work toward meeting accreditation requirements. This will provide their staff with the knowledge and skills to better serve their patients with diabetes.
NURSING HOME CARE: atom Alliance Guides Nursing Home to Minimize Antipsychotic Medication Usage

To ensure every nursing home resident receives the highest quality of care, Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) like atom Alliance— the QIN-QIO for Alabama, Indiana, Kentucky, Mississippi and Tennessee—participate in the Centers for Medicare & Medicaid Services’ (CMS) National Nursing Home Quality Care Collaborative (NNHQCC). The NNHQCC, CMS’s core strategy for nursing home improvement, is carried out by a breakthrough “all teach, all learn” collaborative methodology.

The use of antipsychotics in older adults may present high risk for serious adverse consequences, including altered mental status, increased confusion, stroke, falls and even death. These risks are especially prevalent in persons with dementia. As a result, reducing the use of antipsychotics in nursing homes is a key focus for CMS Quality Improvement Organizations. Through the collaborative, atom Alliance’s quality improvement advisors in Tennessee helped NHC Oak Ridge, a long-term care facility in Oak Ridge, Tennessee, lower the number of residents on antipsychotic medications and improve their quality of life.

“Our team used the atom Alliance composite score reports from the previous 12 months to identify opportunities for improvement. We saw an opportunity to reduce these kinds of medicines and provide better care for our residents,” said Jeff Tambornini, administrator at NHC Oak Ridge.

Commonly used strategies to decrease the use of unnecessary antipsychotic medications include routine provider and pharmacist reviews of patient medication charts, weekly psychiatric evaluations and recurring multidisciplinary meetings to discuss antipsychotic medication issues and trends. Ongoing education for staff around accurate charting, behavioral changes and alternative therapies is also helpful.

“atom Alliance assisted us by providing us regular Composite Score data reports that we monitored,” said Angie Sumner, director of nursing for NHC Oak Ridge. “We also attended the Collaborative webinars, which were really helpful.”

As a result of the nursing home’s participation in the collaborative, NHC Oak Ridge staff began analyzing monthly reports of patients who were prescribed antipsychotic medications. The nursing home also sought to prevent unnecessary prescriptions with more accurate chart keeping. They used daily report data to determine which residents might be ready for a medication reduction and where they might employ alternative solutions for behavioral issues.

NHC Oak Ridge hired a psychiatrist to assist with gradual dosage reduction (GDR) for antipsychotic medications.

“Adding a psychiatrist to our team gave us an advantage,” said Sumner. “We had a dedicated person reviewing charts for these kinds of medicines and following up with staff and family members to create a plan to reduce the dosage.”

The psychiatrist educated the residents, family members and other caregivers involved on the benefits of removing the medication and how the GDR process works. She followed up on a weekly basis to get feedback on how residents were feeling. She also met with the nursing staff to listen to their concerns and questions.

NHC Oak Ridge also hired a licensed social worker to visit residents weekly and discuss their fears or concerns. The psychiatrist and nursing staff provided a list of residents to the social worker each week based on behavior they observed for each resident.

These actions led to an almost 20 percent reduction in antipsychotic medication use, from 28.6 percent during first quarter 2015 to 8.9 percent during first quarter 2017. The statewide rate in Tennessee for the first quarter of 2017 was 17 percent, while the average among collaborative participants was 16.8 percent.

Tambornini said they have seen additional benefits to the nearly 100 residents at their facility, including improved communication between residents and providers. This has helped their staff humanize patient data and arrive at solutions that are best for everyone involved.

“We’re proud of our success over the past two years,” said Tambornini. “As a result of this work, we have been able to take residents completely off of antipsychotic medications while still giving them the care they need.”

Learn more about their improvement efforts [here](#).
**CARE COORDINATION: Mountain-Pacific Quality Health Breaks Down Rural Health Care Coordination Barriers in Wyoming and Montana**

Rural and frontier communities have unique health care needs and opportunities. According to the Health Resources and Services Administration (HRSA), “Rural areas generally have a greater elderly population than urban areas… with physical access to care the greatest challenge that many elderly rural patients face.”

This is particularly true in Wyoming and Montana, where the population is aging at a faster rate than other parts of the country, meaning more people are facing multiple chronic conditions and an increased need for coordinated care. Patients and providers in these locations deal with additional barriers to coordinated health care, such as distance from providers and basic necessities; few safety net resources; turnover and shortages of providers and specialists; geography and weather; and lack of infrastructure supporting collaboration.

In March 2017, Mountain-Pacific Quality Health, the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Alaska, Hawaii, Montana, Wyoming and the U.S. Pacific Territories of Guam, American Samoa and the Commonwealth of the Northern Mariana Islands—in collaboration with the University of Wyoming’s Wyoming Center on Aging (WyCOA)—was awarded a Centers for Medicare & Medicaid Services (CMS) Special Innovation Project (SIP) to support this unique care transitions need with clinically based Project ECHO (Extension for Community Healthcare Outcomes). The project’s mission is to expand Montana’s and Wyoming’s capacity to safely and effectively provide best practice care for chronic, common and complex diseases in the rural and underserved areas.

The ECHO model breaks down walls between specialty and primary care through a hub-and-spoke model. Mountain-Pacific developed a Hub Team—or an inter-professional community of regional and national care coordination experts, including a pharmacist, geropsychologist, patient engagement expert and more. This team holds face-to-face meetings with spoke sites—primary care physicians in local communities—to foster positive relationships and encourage practice change in the field of care transitions.

Since launching the project, Mountain-Pacific has seen a decrease in providers feeling isolated in Wyoming and Montana. Also, there has been a notable increase in knowledge of best practices for effective transitions of care, and comfort and self-efficacy in dealing with care coordination.

Notably, 91 percent of ECHO participants feel they gained new information from presentations, and 87 percent feel an increased connection with providers across the state. Participants also report the intent to change their practice by providing better care to patients, improving communication between providers and patients/caregivers, improving the education of patients, and educating other providers.

Mountain-Pacific plans to hold bi-weekly sessions with primary care providers through August 2018 to continue reducing isolation barriers and providing access to quality care for patients.
MEDICATION SAFETY: Telligen and Partners Bring Health Information Exchange (HIE) Access to Colorado Pharmacists

Pharmacists play a crucial role in patient care and ensuring that patients don’t have to return to the hospital or doctor’s office to get answers to important questions. Despite the essential functions they perform, pharmacists don’t often have access to health information exchange (HIE) networks, resulting in potentially fragmented care or compromised patient safety.

To address this dilemma, Telligen—the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) serving Colorado, Iowa and Illinois—partnered with the Colorado Regional Health Information Organization (CORHIO) on a year-long pilot project to test and measure pharmacist queries of patient information in the CORHIO PatientCare 360® portal.

“Medications are the only thing that truly follows the patient through the care continuum,” said Katy Brown, PharmD, clinical pharmacy specialist at Telligen. “CORHIO was the ideal partner for this project, since both of our organizations are committed to sharing information to improve health.”

The pilot program included 20 pharmacists from different work settings like hospitals, ambulatory care pharmacies, community pharmacies and consulting pharmacies. Together, they learned how to use PatientCare 360® to access patient data and record their experiences. The group met periodically and took monthly assessments to share challenges and successes.

Before the pilot began, medication records were missing from most health records, and pharmacists could not access full patient information when dispensing medication. This was a medication safety issue, as pharmacists and other health care providers were making decisions about patient care with incomplete data. CORHIO provided real-time access so pharmacists could review key information—like therapy changes and medication allergies—to make more informed decisions and recommendations.

The pilot participants were able to find valuable information within ambulatory care summary documents, as well as hospital and lab records. They identified several potential uses of the CORHIO portal as they completed care transitions, medication reconciliation, record reviews from prior provider visits and medication therapy management. Pilot participants also benefited from the ability to review lab results for patients, which in some cases, enabled them to make medication adjustments.

Overall, 69 percent of the pilot pharmacists agreed that their ability to provide care improved with HIE access. Because of the pilot’s success, CORHIO is inviting more pharmacists to participate in the network.
ANTIBIOTIC STEWARDSHIP: Health Quality Innovators and Atlantic Quality Innovation Network Collaborate to Reduce the Threat of Antibiotic Resistance

Prescribing antibiotics when they aren’t necessary—such as for colds or sinus infections—or prescribing the wrong type, can contribute to antibiotic resistance. According to the Centers for Disease Control and Prevention, antibiotic-resistant infections, once rare outside of the hospital setting, are becoming more common in outpatient settings including doctors’ offices and emergency departments. 

Health Quality Innovators (HQI), the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Maryland and Virginia, and the Atlantic Quality Innovation Network (AQIN), the QIN-QIO for the District of Columbia, New York and South Carolina, have been helping MedStar Health—the largest health care provider in Maryland and the Washington, D.C. region—reduce the threat of antibiotic resistance. The QIN-QIOs are accomplishing this by educating medical staff about the importance of appropriate antibiotic prescribing and by helping MedStar’s outpatient facilities implement an antibiotic stewardship program.

HQI and AQIN hold strategy calls to determine the best way to deliver resources and technical assistance. “We want to help MedStar approach antibiotic stewardship from the system level,” said Katie Richards, improvement consultant at HQI. “Since HQI and AQIN both serve MedStar, it’s important for us to work together to avoid duplication of efforts and to provide consistent messaging, data reports, tools and resources to each of MedStar’s outpatient facilities.”

There are four core elements of antibiotic stewardship:

- **Commitment**, in which leadership demonstrates support for implementing an antibiotic stewardship program at the organization
- **Action**, whereby the organization implements an antibiotic stewardship policy
- **Tracking and Reporting**, including monitoring antibiotic prescribing
- **Education** of providers and patients

Together, HQI and AQIN worked to get commitment from MedStar to work on antibiotic stewardship and to identify a stewardship leader, which fulfilled the first core element. The QIN-QIOs also developed an outpatient antibiotic stewardship toolkit, including resources for achieving each of the four core elements, examples of antibiotic stewardship policies, and educational posters.

Working closely with MedStar’s stewardship leader Dr. Ryan Anderson, MPP, associate medical director for quality and safety, HQI and AQIN helped MedStar achieve the second core element by providing best practices for antibiotic prescribing and offering guidance on MedStar’s draft antibiotic prescribing guidelines. The QIN-QIOs also developed a prescriber information resource to help clinicians determine the appropriate type of antibiotic, duration and dosage. HQI and AQIN are working with MedStar to meet its goal of building an antibiotic order set into its electronic health record (EHR) system, a task the health system has started within its hospital setting but is still developing for its outpatient clinics and providers. Order sets are important because they help “promote safe, efficient, evidence-based patient care,” according to a study published in PubMed.

Through quarterly data reports, HQI and AQIN are helping MedStar achieve the third core element, Tracking and Reporting. Each report highlights the total number of antibiotics prescribed, notes potentially inappropriate prescribing practices and identifies possible adverse drug events associated with antibiotics.

“HQI and AQIN have been valuable partners in improving MedStar’s stewardship of ambulatory antibiotic use, said Anderson. “The data these organizations provide give us a better understanding of where our practices vary in their adherence to best practices. Understanding variability is a key component to improving quality.”

While education, the fourth core element, is ongoing with MedStar providers, HQI and AQIN have developed a patient education presentation for MedStar facilities to use with specific patient populations. “The presentation explains what antibiotic resistance is and why it’s a concern, highlights the differences between bacteria, viruses and fungi, and emphasizes the importance of the patient’s role in understanding antibiotic stewardship as part of the care team,” said Jennifer Thomas, Pharm.D., medication safety, immunizations, and antibiotic stewardship lead at AQIN-DC. The next step is to distribute an animated video based on the presentation for MedStar facilities to share with patients in their waiting rooms.
QUALITY REPORTING/QUALITY PAYMENT PROGRAM: New England QIN-QIO Eases Clinician Participation in CMS Quality Payment Program

2017 marked the first year of the Centers for Medicare & Medicaid Services’ (CMS) Quality Payment Program, which aims to improve care delivery by supporting and rewarding clinicians as they find new ways to engage patients, families and caregivers, and to improve care through population health management.

To help eligible clinicians prepare for and participate in the program, Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) like the New England QIN-QIO— which represents the states of Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont—provided technical assistance to clinicians in the form of outreach and education, resource development, and support. While the New England QIN-QIO conducted some traditional forms of outreach to clinicians, including webinars, in-person learning sessions and content documents, the QIN-QIO felt that something was missing.

“Clinicians are a really tough group to engage face-to-face, so we tried to find alternate ways of sharing information with them,” said Nancy Kelly, communications lead for the New England QIN-QIO.

Kelly’s colleague Leila Volinsky—regional Quality Payment Program lead—and her team weighed other options for helping clinicians decide how to best participate and what measures to use for reporting in the Quality Payment Program. One of the ideas they decided to pursue was a blog. Launched in February 2017, “QIN-intelligence” features a variety of Quality Payment Program-related topics, from information on quality measures, to proposed rule changes, to reminders for clinicians to capture data by the deadline. By the end of December 2017, the QIN-QIO’s blog had 2,344 page views, 1,858 of which were unique.

“Clinicians have different learning styles, schedules and levels of understanding and desire, so our tailored approach has helped tremendously,” said Volinsky. “We’re trying to help clinicians avoid paying a penalty and to minimize the burden on them,” she added. Clinicians seem to appreciate the New England QIN-QIO’s efforts. “This service has saved our practice a significant amount of time and money,” said one testimonial. Another clinician credited the QIN-QIO with bringing “incredible knowledge and information to our group.”

From an overall outreach perspective, the New England QIN-QIO also has been quite successful. Through the organization’s work targeting physician practices with more than 15 clinicians, the QIN-QIO conducted outreach to 75% of the region’s 50,000 eligible clinicians, and 100% of them plan to participate in the Quality Payment Program for 2017.

Moving forward, the New England QIN-QIO will continue making blog posts to help communicate important information about the Quality Payment Program to clinicians in 2018 and beyond. The QIN-QIO also plans to continue holding regular webinars.

The relationships that the New England QIN-QIO and other regional QIN-QIOs have developed with clinicians in the past year may expand as the physician practices become more aware of the QIN-QIOs’ other clinical quality improvement activities in which they can become involved. “So many practices were unaware of us and our work,” said Kelly. “Now they’re grateful.”
IMMUNIZATIONS: How Quality Insights is Helping Improve Vaccine Database Reporting in Louisiana

In early 2017, Melinda Jones, a quality improvement specialist with Quality Insights—the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) serving Delaware, Louisiana, New Jersey, Pennsylvania and West Virginia—noticed that only two of the 90 home health agencies in Louisiana were documenting their vaccine administrations in the state immunization registry. Further, Quality Insights found that only a few were even aware of—or had access to—that database, known as the Louisiana Immunization Network for Kids Statewide, or LINKS, which is operated by the Louisiana Department of Health.

One of the main reasons for this knowledge gap is that health care providers in the state are not required to submit adult vaccination information to the database, even though it can store such information. As a result of inconsistent reporting, some older adults have received multiple doses of the same vaccine while others have received the wrong vaccine—or none at all. These oversights can have serious consequences for one’s health, especially for older adults. Also, when someone unnecessarily receives multiple doses of the same vaccine, it can add significant costs to a state’s health care system.

To help address the gaps in vaccine reporting at home health agencies, Jones contacted the Louisiana state immunization program manager, and together they developed a plan to introduce agency staff to the LINKS system. Their first step was to recruit a pilot group of five home health agencies and work with them to create internal processes that support staff in consistently entering the data.

In March 2017, Jones and the state immunization project manager provided the pilot group with training on the LINKS database and a quick reference guide on how to enter their agency’s data. Additionally, the pilot agencies were given region-specific immunization information system contacts for further assistance with enrollment.

Bunkie HomeCare, a small home health agency about an hour and a half northeast of Baton Rouge, was one of the five pilot agencies. Becky Thompson, a registered nurse at the agency, helped lead the project on the ground and quickly found value in the new database. Explaining how the agency altered its internal processes, Thompson said, “Upon every patient admission or recertification to home health, information is obtained regarding vaccinations the patient has received.”

If the patient or caregiver is unsure of what vaccines were received, home health staff consult LINKS.

“LINKS has helped us identify patients who have had vaccines but who can’t remember if or when they had them. It’s been an invaluable resource for us in our effort to improve the quality of care for residents,” said Thompson.

Since then, Quality Insights has worked with more than 25 home health agencies to help them gain access to the LINKS database. This work is helping home health agencies get a jump-start on new state mandates.

During the 2017 legislative session, the Louisiana State Legislature passed a resolution that requires, starting in early 2018, all health care providers who administer vaccines in the state to use the LINKS database to report immunizations for both kids and adults.
BEHAVIORAL HEALTH: Lake Superior QIN Helps Local Clinics Use Electronic Health Records to Improve Use of Behavioral Health Screenings

Behavioral health is one of the most critical issues facing the Medicare population. According to the American Psychological Association, one in four older adults experiences a mental health problem such as depression, anxiety, schizophrenia or dementia. In addition, substance abuse among older adults is rising. The National Council on Aging estimates that the number of older adults with substance abuse problems, including alcohol misuse, is expected to double to five million by 2020.

With this in mind, the Lake Superior Quality Innovation Network—the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) serving Michigan, Minnesota and Wisconsin—is working to increase the number of clinics that are screening patients for depression and alcohol use disorders during primary care visits.

“Older adults experiencing depression often have a harder time managing other chronic conditions that diminish their overall health,” said Jane Gendron, program manager with the Lake Superior QIN in Minnesota. “Screening for behavioral health issues is a critical first step towards treatment.”

In Minnesota, the Lake Superior QIN recruited more than 200 clinics within 18 health systems in both rural and urban areas to participate in its behavioral health screening and reporting initiative. The clinics are leveraging electronic health records (EHRs)—instead of Medicare claims data—to reduce the burden of reporting and optimize the timely collection and use of data.

“Using EHRs to track when screenings occur provides them with real-time data that support physicians' efforts to consistently identify behavioral health issues,” added Gendron. “Because data collection is timelier, it allows health systems to monitor the impact of process changes and improve more rapidly.”

Since not all EHR systems work the same, Lake Superior QIN staff helped clinics to identify modifications needed. These changes let clinics capture clinically relevant data to show whether their efforts increased rates of screening for patients.

These efforts are paying off. In 2016, 69 percent of Medicare beneficiaries seen in participating primary care clinics in Minnesota received depression screenings, surpassing the 25 percent goal set by the Centers for Medicare & Medicaid Services. While complete screening data from 2017 won’t be available until July 2018, Lake Superior QIN saw a similar upward trend in depression screenings that year. Moving forward, the QIN-QIO aims to extend its learnings from depression screening to support increased screenings of Medicare beneficiaries for alcohol misuse.
TRANSFORMING CLINICAL PRACTICE INITIATIVE: TMF Quality Innovation Network Collaborates With Other QIN-QIOs on Transforming Clinical Practice Initiative

The Transforming Clinical Practice Initiative (TCPI) is designed to help clinicians achieve large-scale health transformation. With more than 140,000 clinician practices involved in sharing, adapting and further developing their comprehensive quality improvement strategies, the initiative aims to strengthen the quality of patient care and spend health care dollars more wisely.

Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) like the TMF Quality Innovation Network—the QIN-QIO for Arkansas, Missouri, Oklahoma, Puerto Rico and Texas—are collaborating with TCPI in several areas, including working with 700 of the 140,000 participating clinician practices in analyzing their data, assessing where they are in the transformation process, and providing coaching and connections. Under the Centers for Medicare & Medicaid Services’ (CMS) Quality Payment Program, this collaboration increased in 2017 as all organizations providing technical assistance began sharing one consistent message with clinicians.

In early 2017, Vizient Practice Transformation Network (PTN)—one of the peer-based learning networks designed to coach, mentor and assist clinicians in developing core competencies—referred a practice within St. Luke’s Health System to the TMF QIN. Through conversations with Vizient and St. Luke’s leadership, as well as initial contact with the practices, the QIN-QIO realized that the work would span into Kansas, beyond its region of Missouri.

To conduct all the necessary assessments, the TMF QIN partnered with the Great Plains Quality Innovation Network, the QIN-QIO for Kansas, North Dakota, Nebraska and South Dakota. Together, they coordinated a strategy to have the assessments scheduled and completed with the practice managers of the health system at the same time. Some of the practice managers supervise practices in both states, so it was important that they not have to speak with two organizations to complete the assessments.

Overall, about a dozen of the TMF QIN’s nearly 75 total assessments overlapped with the Great Plains QIN’s region. The TMF QIN instituted the same process in late 2017 to complete six-month follow-up assessments in coordination with the Great Plains QIN. This partnership led to an increase in the number of assessments toward both QIN-QIOs’ goals, as well as movement toward their shared goal of strengthening collaboration within a broad community of practices that creates, promotes and sustains learning and improvement across the health care system.

Another benefit of the TMF QIN’s partnering strategy is that it has been put to use by additional QIN-QIOs. When Vizient informed the TMF QIN that the Quality Insights Quality Innovation Network—the QIN-QIO for Delaware, Louisiana, New Jersey, Pennsylvania and West Virginia—was facing the same predicament in having to conduct work outside its designated region, the TMF QIN arranged a call with its fellow QIN-QIO to share how it orchestrated its plan of action.
SPECIAL INNOVATION PROJECT: Alliant Quality Uses Patient Stories to Help Emergency Department Staff Better Treat Sickle Cell Disease

Alliant Quality—the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Georgia and North Carolina—is helping hospital emergency department (ED) staff understand the needs of patients with sickle cell disease.

Sickle cell disease (SCD), the most common genetic disease in the United States, mostly affects the African-American population. Patients with SCD have pain due to a vaso-occlusive crisis (VOC). VOC—which develops from the obstruction of blood vessels by sickled red blood cells—is a common but extremely painful complication of SCD. VOC is the top reason that people with the disorder go to the ED or hospital. While people with SCD are living longer than ever before, their lives have been impacted by the unpredictable, intermittent or constant pain from VOC, which is often poorly managed in EDs.

To address this problem, Alliant Quality lets the patients speak for themselves, giving voice to the more than 100,000 individuals suffering with the disease.

“It was all about storytelling. We used the journey of the story as a resource for emergency departments to understand what patients with SCD go through every day,” said Jacqueline Brown, project lead for Alliant Quality’s Sickle Cell Quality Improvement program.

The QIN-QIO works with partners to recruit hospital EDs that want to improve care for adults with SCD who are experiencing VOC. The participants complete learning sessions, share best practices and barriers on monthly calls, and participate in a quality improvement project of their choice. Each learning session begins with a patient presenting his or her story about a care episode for VOC, and is followed by a discussion of what went well or could be done differently.

The virtual learning sessions, supported by national subject matter experts, provide participants with access to resources, such as podcasts, webinars and video casts on important aspects of SCD management.

“Although the sessions were for the benefit of the emergency departments, patients were an integral part and learned a lot as well,” Brown said.

The program has been a success and is on track to produce tangible results for EDs and those suffering from SCD. The sessions have provided resources for emergency departments that will lead to decreased ED return rates and admission rates.
PERSON AND FAMILY ENGAGEMENT: Engaging Patients and Families Impacts HealthInsight’s Initiatives

Person and family engagement is an integral part of health care quality improvement and a priority for the Centers for Medicare & Medicaid Services and the Quality Improvement Organization (QIO) Program. Involving people in their own care decisions improves communication between patients/consumers and providers, helps providers deliver better care, and results in better patient outcomes. While the QIO Program is engaging Medicare beneficiaries at the national level through its Beneficiary and Family Advisory Councils, QIOs across the country are engaging beneficiaries and their families locally through their own Patient and Family Engagement Councils (PFACs).

Through its PFACs, HealthInsight—the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Nevada, New Mexico, Oregon and Utah—is capturing the voice of patients, families and caregivers to better meet the needs of Medicare beneficiaries in each of the four states in its region.

In Utah, the PFAC has been instrumental in helping HealthInsight broaden its quality improvement work in the areas of behavioral health and immunizations. Feedback and ideas from PFAC members have helped HealthInsight identify ways to meet community needs for behavioral health, and reach diverse rural, ethnic and minority groups in the state. HealthInsight also has learned it needs to do more outreach to engage older adults with disabilities, so they have a convenient way to access immunizations—a perspective the QIN-QIO may not otherwise have captured.

“Our PFAC has given us the voice and perspective we were missing,” says Joan Gallegos, community engagement director at HealthInsight Utah. “Suddenly we’ve started looking at our efforts in a way we hadn’t before.”

In New Mexico, the PFAC provides an opportunity for advisors to serve as ambassadors for HealthInsight’s quality improvement work, educating hundreds of people in places like community and senior centers, and with neighbors, friends and families. One PFAC advisor has presented at an Area Agency on Aging conference, explaining the importance of understanding antimicrobial stewardship and how people can reduce the risk of antimicrobial resistance by learning about antibiotics and asking their doctor why they are being prescribed.

With the help of HealthInsight’s PFAC in Nevada, 390 new patients have received diabetes self-management education. Initially, HealthInsight was struggling to recruit enough individuals to hold in-person classes at a community-based location. Based on input from the PFAC, HealthInsight began piloting multisite education sessions, so individuals interested in diabetes self-management education— but unable to travel—could participate locally.

In Oregon, HealthInsight’s PFAC has helped improve flu vaccination marketing to reach older adults more effectively. The flu can be dangerous for all age groups, but older adults are at an increased risk of complications. When asked how the QIN-QIO could motivate more older adults to get their flu vaccine, PFAC members suggested reminding them that the flu shot protects both them and their grandchildren. HealthInsight incorporated this message in marketing materials for physician offices, and printed posters on plain paper using large text—two additional suggestions made by the PFAC.

HealthInsight continues to see the impact of engaging patients and families in its work, and its efforts have not gone unnoticed. Recently, HealthInsight was nominated by a PFAC member and awarded the Patient Family Centered Care Partners’ Harry Orme, MD Partnership Award. Established in 2013, the award recognizes PFACs whose partnership has resulted in a culture and practice of patient-centered care.

A video explaining Patient and Family Advisory Councils at HealthInsight.
BENEFICIARY AND FAMILY-CENTERED CARE: Immediate Advocacy Helps Patients and Families Quickly Resolve Confusion About Their Care

Sometimes Medicare patients and their families/representatives need to make quick decisions or find themselves in circumstances that require pressing action. To assist, the two Beneficiary and Family Centered Care-Quality Improvement Organizations (BFCC-QIOs) offer a voluntary service for people with Medicare called the Immediate Advocacy process.

Immediate Advocacy is an informal dispute resolution process used to quickly resolve a verbal complaint a Medicare beneficiary has regarding the quality of Medicare-covered health care. It is a voluntary process for both the Medicare beneficiary and the provider. Through this process, BFCC-QIO staff makes immediate, direct contact with a provider and/or practitioner on behalf of beneficiaries and their families or representatives to obtain the information they need to make important decisions. Below are two examples of Immediate Advocacy success stories.

Clarifying Miscommunication

One example of the importance of Immediate Advocacy involves a patient receiving home health care in New Hampshire. The patient’s wife heard the home health aide explain how she should fill her husband’s pill box with medications and monitor his blood pressure. Concerned about taking on these tasks herself and believing that the home health aide should provide this medical care, the wife contacted 1-800-MEDICARE to express her concern. The call center transferred the wife’s call to Livanta—the BFCC-QIO for New Hampshire and 19 other U.S. states and territories—for Immediate Advocacy.

The BFCC-QIO contacted the director of the home health agency to discuss the wife’s concerns, which identified the root of the miscommunication. The director explained that the aides intended to educate family members about what the aides would be overseeing: medications in the pill box, the dates and times to take the medications, and how blood pressure is taken and monitored. The aides never meant to teach family members how to administer the care themselves. Understanding the potential for misunderstanding, the director promised to educate her staff about clearly communicating the agency’s role to patients and family members. When the BFCC-QIO called the patient’s wife to explain the misunderstanding and the home health agency’s plan of care, she expressed relief and thanks.

“We know that individuals acting as caregivers frequently feel anxious about their caregiving responsibilities,” says Jennifer Bitterman, director of communications for Livanta. “Anytime we can help alleviate some of that stress as quickly as we do through Immediate Advocacy is a huge benefit to caregivers.”

Determining a Clear Path Forward

Another Immediate Advocacy example comes from KEPRO—a BFCC-QIO representing more than 30 U.S. states. KEPRO answered a call from a Medicare beneficiary’s son who needed help determining whether he could appeal his mother’s hospital discharge. An appeal can be filed if the Medicare patient has inpatient status at the hospital; an appeal cannot be filed if the patient is considered an outpatient in observation. The status of this patient was not clear to the family since she had been moved back and forth between observation and inpatient status several times. KEPRO reached out to the provider and learned she was considered an inpatient and assisted the son with the appeal process.

The son expressed appreciation for the clarification that he was not able to obtain on his own. The hospital discharge planners also expressed gratitude to the BFCC-QIO for alerting them to the communication issue of which they had been unaware.

Empowering Patients and Families

“In the past, BFCC-QIOs addressed only quality of care complaints, which are very structured and regulated. Quality of care cases only reviewed what could be found in a medical record, to evaluate right from wrong,” says Rita Bowling, Area 3 program director for KEPRO. “But we found that a lot of things being complained about would never be written in a medical record. Most difficulties people have with health care are not related to standards of care being met but to their experience of care. Person and Family Engagement activities like Immediate Advocacy open up whole new avenues for us to be able to assist beneficiaries.”

After the Immediate Advocacy process concluded, KEPRO invited the patient and his son to be part of the Beneficiary Health Care Navigation Program offered by both BFCC-QIOs to help guide the family through the care transition from hospital to rehabilitation facility and beyond. “We listen, give support, and teach beneficiaries and their families how to become self-advocates and to better prepare them to navigate the health care system,” Bowling says.
2017 QIO Program Progress Report

BENEFICIARY AND FAMILY-CENTERED CARE: BFCC-QIOs Support Beneficiaries and Families During Back-to-Back Hurricane Disasters

The Centers for Medicare & Medicaid Services’ (CMS) two Beneficiary and Family Centered Care-Quality Improvement Organizations (BFCC-QIOs) are known for empowering beneficiaries to exercise their right to quality health care; however, the BFCC-QIOs’ responsiveness and person-centered care skills were put to the ultimate test in 2017 when three back-to-back extreme weather events caused turmoil for beneficiaries in several U.S. states and territories.

As Hurricane Harvey approached the Gulf Coast in late August, KEPRO—the BFCC-QIO representing 34 states, including Texas and Florida—tracked weather developments and preemptively sent its outreach team to communities in the hurricane’s path to make sure beneficiaries could find local resources.

In their work with stakeholders, KEPRO listed resources on their website that would be helpful before, during and after the storm for the Medicare beneficiaries. Outreach staff partnered with two Area Agencies on Aging to be onsite at their offices following the storm to respond to questions.

Not long thereafter, Hurricane Irma began churning toward Florida. This new hurricane presented a different set of problems for residents; while Harvey had produced mass flooding in low-lying areas near Houston, Irma caused long power outages, disrupting the lives of patients in hospitals, as well as nursing home residents.

In one case, KEPRO was instrumental in helping someone find a missing family member. That beneficiary had been a resident of the Florida nursing home where 14 deaths occurred due to power outages. In addition, efforts to reach a nursing home were unsuccessful to discuss a review, so KEPRO contacted local authorities and the fire department to ensure the facility was open and operating safely.

Meanwhile, in mid-September, Livanta—the BFCC-QIO representing 19 states and territories—faced a whole different set of obstacles during Hurricane Maria, which ravaged Puerto Rico and the U.S. Virgin Islands (USVI). Although neither island was easily accessible, Livanta made sure that beneficiaries knew where to turn if they needed help.

“It was difficult communicating,” said Thomas Bond, task manager with Livanta. “The grid was completely blown out. We’d never seen anything like it.”

Livanta had begun its community outreach prior to Irma hitting the islands. The BFCC-QIO contacted the Quality Innovation Network-Quality Improvement Organizations in both Puerto Rico and the USVI to obtain feedback on the level of care being administered on the islands. Livanta also sent posters to health care facilities containing helpful information, including phone numbers that residents could call for assistance.

Many of the calls Livanta fielded in the weeks during and after Irma were from individuals seeking basic necessities like food and water, or numbers for Federal Emergency Management Agency (FEMA) resources. The BFCC-QIO’s bilingual call center staff members worked hard to make sure that non-English speakers received the same level of care as others did.

“The whole event was eye-opening,” Bond said. “It changed the way in which we communicate. Now we have a much more consistent dialogue with beneficiaries, families and partners in those regions.”

KEPRO and Livanta’s biggest roles were in assisting the CMS regional offices in communicating information to beneficiaries, especially as the hurricanes receded and patients were left wondering if and when they would be discharged from health care facilities. The BFCC-QIOs helped not only with disseminating information but assisting in the effort to make sure that beneficiaries were discharged properly and in a timely manner.

“The most important thing for us is to stand with our partners. If there is a question, we are there to provide answers,” said Scott Fortin, KEPRO’s senior communications director. “Beneficiaries and their families appreciate it when you stand with them. That goes a long way toward cementing strong relationships with them.”
In the year ahead, the QIO Program will focus on achieving its top objectives: aligning its work with important national health care priorities and continuing to improve the quality of care for Medicare beneficiaries nationwide. Following are some of the pressing health care priorities that Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) will be helping address at the community level in collaboration with partners and other stakeholders.

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<th>CLINICAL PRIORITIES</th>
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<td><strong>The Opioid Epidemic</strong></td>
<td>Current estimates show that over two million people suffer from opioid use disorder, with a prevalence in Medicare of six out of every 1,000 beneficiaries. In 2015, opioids—which include prescription drugs like methadone and illicit substances like heroin—killed more than 33,000 people, the highest number in recorded history. Methadone-related deaths in particular showed an increase in the 65+-year-old population. Source: <a href="https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/CMS-Opioid-Misuse-Strategy-2016.pdf">https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/CMS-Opioid-Misuse-Strategy-2016.pdf</a></td>
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<td><strong>Behavioral Health, Prevention &amp; Treatment</strong></td>
<td>About 25 percent of adults aged 65 years or older have some type of mental health problem, such as a mood disorder not associated with normal aging. Although social ties are one of the strongest predictors of well-being, about 12 percent of adults aged 65 or older report that they “rarely” or “never” receive the social and emotional support they needed. Additionally, excessive alcohol use, including binge drinking, accounts for more than 21,000 deaths among adults 65 or older each year in the United States. Excessive drinking increases a person’s risk of developing high blood pressure, liver disease, certain cancers, heart disease, stroke and many other chronic health problems, as well as a person’s risk of car crashes, falls and violence. Excessive alcohol use can also interact with prescription and over-the-counter medications, and affect compliance with treatment protocols for chronic conditions, thus undermining the effective management of chronic diseases. Source: <a href="https://www.cdc.gov/aging/pdf/State-Aging-Health-in-America-2013.pdf">https://www.cdc.gov/aging/pdf/State-Aging-Health-in-America-2013.pdf</a></td>
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<td><strong>Burden Reduction &amp; Physician Support</strong></td>
<td>The American Hospital Association recently published a report showing that health systems, hospitals and post-acute care providers must comply with 629 mandatory regulatory requirements, and these entities spend nearly $39 billion a year solely on administrative activities. The report also showed that an average-size hospital dedicates 59 full-time employees to regulatory compliance, over one-quarter of which are doctors and nurses. Additionally, across CMS’s hospital quality reporting programs, inpatient hospitals report up to 61 quality measures, 12 of which are “chart abstracted,” meaning that hospital staff must manually enter the values. Some family practitioners have to report nearly 30 measures to seven different payers, leading to less time focused on patients and contributing to clinician burnout. Source: <a href="https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-10-30.html">https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-10-30.html</a></td>
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<td><strong>Patient Safety</strong></td>
<td>Based on preliminary data, hospital inpatients experienced an estimated 3.8 million harm events in 2015, accounting for more than $43 billion in costs and leading to 170,000 deaths. It is estimated that about 44 percent of these events and deaths were preventable. Source: <a href="https://www.ahrq.gov/professionals/quality-patient-safety/pfp/2015-interim.html">https://www.ahrq.gov/professionals/quality-patient-safety/pfp/2015-interim.html</a></td>
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<td><strong>Long-Term Care Quality</strong></td>
<td>Just over 1.4 million residents were living in U.S. nursing homes on December 31, 2014, corresponding to 2.6 percent of the over-65 population and 9.5 percent of the over-85 population. A recent fall resulting in injury has been experienced by 5.3 percent of residents, and an additional 11 percent of residents have had a non-injurious fall. Both injurious and non-injurious falls are more common among those with greater cognitive impairment. Pressure ulcers of Stage 2 or greater were present in 5.1 percent of nursing home residents, a 10 percent decline since 2011 (5.9 percent). Physical restraint use has become quite rare, with 1 percent of residents having any restraints in the past seven days. Antipsychotic use, however, is quite common, with more than one out of five residents (21.7 percent) receiving an antipsychotic medication at least once in the past seven days. Source: <a href="https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/nursinghomedatacompendium_508-2015.pdf">https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/nursinghomedatacompendium_508-2015.pdf</a></td>
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<td><strong>Care Transitions</strong></td>
<td>Medicare Fee-for-Service beneficiaries experienced 1.7 million readmissions within 30 days in 2015; we estimate that about one million of these readmissions were potentially preventable at a cost to Medicare of nearly $14 billion. In addition, we project that approximately 15 percent of 9.8 million hospital admissions in 2015 were for potentially preventable conditions. Source: <a href="https://innovation.cms.gov/initiatives/CCTP/">https://innovation.cms.gov/initiatives/CCTP/</a></td>
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| **Chronic Disease Self-Management**                     | Each year, over **1.5 million** people have a heart attack or stroke; **1.5 million** adults develop diabetes; and more than **800,000** die from cardiovascular disease (CVD). **Twenty-six percent** of Medicare beneficiaries have diabetes, which accounts for **32 percent** of Medicare spending. By 2020, an estimated **52 percent** of the adult population will have diabetes or pre-diabetes. **Thirty million** adults or one in seven have chronic kidney disease (CKD), and **96 percent** do not know they have it.  
| **Population Health Improvement, Health Equity & Rural Health** | Americans in rural areas have higher rates of cigarette smoking, hypertension, obesity and physical inactivity, which can lead to lower life expectancy. Residents of rural areas have a life expectancy of **76.7** years compared with **79.1** years for residents of metropolitan areas.  