An Introduction to Quality Insights Quality Innovation Network

August 28, 2014

Operator: Good afternoon and welcome to an introduction to the Quality Insights Quality Innovation Network, a new approach to Medicare Quality Improvement. We're pleased that so many of you joined us for today's live presentation. Please note that this webinar is being recorded and we will share a link with you after it concludes. That way you can refer back to any of the information presented today at any time.

We have a wide array of experts on deck to share our plans for improving the health of the people we serve throughout our network. Due to the extremely high volume of participants, we will keep all phone lines muted throughout today's webinar. Many of you are likely listening through your computer speakers as well. So that you can have an opportunity to ask questions and share your input, we ask that you submit your questions to the Q&A box in your WebEx player. We'll get to as many as time allows during today's live presentation.

Again, thank you for joining us for today's presentation. Without further a due, it is my great pleasure to introduce our Organizational Chief Administrative Officer, David Lambert. Dave?

Dave Lambert: Thank you, Shannon. Good afternoon everyone. It's my pleasure to welcome you to this afternoon's call. About 900 healthcare providers and other stakeholders have registered for this kick-off webinar. We appreciate your interest in learning about the next phase of the Medicare Quality Improvement Organization program.

In a moment I will turn the program over to Becky Cochran, who was the QIO Program Director for Quality Insights. Becky will explain some significant changes that CMS, the Centers for Medicare and Medicaid Services has made to the QIO program effective August 1st.

I like to briefly mention three of the changes that we are excited about and believe will enable us to serve you better. First, we have a new name and organizational structure. We are now the Quality Insights Quality Innovation Network. CMS has regionalized the QIO program. There is no longer a separate QIO for each state. West Virginia Medical Institute and Quality Insights Company previously served as the QIO for West Virginia. Our affiliated organizations, Quality Insights of Pennsylvania and Quality Insights of Delaware served as the QIO's for these two states.

Our new QIO service area includes West Virginia, Pennsylvania and Delaware and also adds New Jersey and the Louisiana. And you will hear more about in a few minutes, we are partnering with South Quality Strategies Inc., the former QIO in New Jersey and EQ Health Solutions, the former QIO in the Louisiana to provide on the ground QIO services in these two states.

So you will continue to be served by experienced and known clinical staff located in the five states of our new network. By consolidating our resources, we will be able to assist large numbers of providers and Medicare beneficiaries and serve you more efficiently.

Secondly, our services going forward will have a narrower focus. CMS had separated out medical reviews of individual cases including discharge of PO's and quality of care compliance. CMS has awarded new contracts to other organizations to provide these case review services.

We will focus primarily on systematic quality improvement on assisting you as providers and stakeholders to improve the quality of care in measurable ways. We will do those through Learning and Action Networks, using some new and exciting technology and through individualized technical assistance. We will also work with you to engage Medicare beneficiaries to participate more fully in their healthcare decisions and to better self manage their own health.

CMS is referring to the new regional QIO to focus on quality improvement as Quality Innovation Network, QIS, that's our new name as the Quality Insights Quality Innovation Network. Finally the new QIO contract affords QIO's greater flexibility to address issues of particular concern to the local community. Initially our energies will be observed in starting up this specific quality improvement initiatives identified in our new QIO contract.

Once these are underway we look forward to collaborating with you to identify special needs in your community or state, developing innovative approaches to address them and proposing these as special projects to CMS.

Turning to the agenda for the day, we will begin with an overview of changes to the QIO program as I noted presented by Becky Cochran. Following that, we will offer brief outlines of the seven specific quality improvement initiatives in the new QIO contract in which we hope to work with you. Each of these presentations will be led by the Quality Insights Network Task Lead who will be coordinating our services for that particular initiative.

The presentations overall will last about an hour and at the end we will provide information on how you can get involved. And we've allowed an additional 30 minutes to answer any questions that you may have.

I will conclude by saying we look forward to serving you under our new structure at the Quality Insights Quality Innovation Network. And please reach out to us at any time and let us know how we can make our services more beneficial to you and your Medicare patients.

We are here to be a resource to you and to function as a trusted partner in your ongoing efforts to deliver the highest quality care. So thank you and I hope you find today's webinar informative.

Operator: Thank you Dave. Up next to describe in more detail of our new Centers for Medicare and Medicaid Services, 11th Scope of Work that's changed the QIO program is Quality Insights Quality Innovation Network Director Becky Cochran. Becky?

Rebecca Cochran: Thanks Shannon and Dave. This afternoon I would like you to discuss how the 11th Scope of Work is going to be changing the QIO program. Dave has given you some highlights about the changes that we have and I will provide some more detail during the presentation.

Just for a brief overview, with 10th Scope of Work we had a QIO program that was administered by 53 state based organizations that were held by contractors in 41 organizations. And we focus on three drivers for the 10th Scope of Work. Supporting and convening Learning and Action Networks, providing technical assistance to those we worked with in collaboration and care improvement to Innovation Spread.

The 11th Scope of Work is different in a change that for CMS they decided to split the contracts out and as Dave alluded to earlier, we have a Beneficiary and Family-Centered Care Quality Improvement Organizations or BFCC-QIO. And these are organizations that perform the medical case review that was previously done by our all five of our organizations. As Quality Improvement Organizations, we had the case review function and we had the quality improvement function. These are now split off into two different organizations. The BFCC is organized amongst our geographic areas across the nation and we have two organizations LIVANTA and Ohio KEPRO serving as the BFCC's in five regions.

We also have the Quality Improvement Network which is a Quality Improvement Organizations which we're going to talk about today. And we offer quality improvement in technical assistance and these can be from two to six state networks.

As of August 1st, the BFCC work and the QIN work were split apart, the contracts were awarded and they're for five years now and before the contracts have been for three years. It should be noted that organizations can not hold both contracts, you must either be a BFCC or QIN-QIO. And all of our organizations decided to be QIN-QIO's.

The QIO's program to clinical quality is basically based on three things, the triple aim which was developed by Don Berwick when Don was at IHI and then moved over to CMS during his tenure as the Administrator of the Center for Medicare and Medicaid Services, its better health, better care and lower cost. The founding principles are enabling innovation, fostering learning in organizations, eliminating disparities in healthcare and strengthening infrastructure and data subsystems to support quality improvement.

We need our goals for the 11th Scope of Work to make care safer, strengthen person and family engagement and this is a new area for all the QIO's in the 11th Scope of Work. We did some patient and family engagement in the 10th Scope of Work, but it's really stressed in the 11th Scope of Work and we will be working with a consultant to help us to really strengthen in this area to – from all of our state based organizations.

We want to promote effective communication and coordination of care across settings and eliminate silos of care, promote effective prevention and treatment, promote best practices for healthy living and make care affordable.

The four key roles of the QIN-QIO's are the champion local-level results oriented change. Our activities will be data driven. We will have active engagement of our patients, families and partners and I said before this is a new area we will be spread our best practices so that we can spread those across the network and across state.

We facilitate Learning and Action Network or LANs which we did use in the previous Scope of Work, we will be creating an "all teach, all learn" environment. We will really push the impetus for improvement as a bedside level such as the hand washing protocol to prevent health care acquired infections in the hospitals for example.

We will teach and advise as technical experts. We will provide consultation and education in our various clinical settings and we will have the management of knowledge so learning is never lost. We will communicate effectively and we will have optimal learning, patient activation and sustained behavioral change.

The next slide, we will how a map of the QIN-QIO's. And if you look at the golden area, you will see that the Quality Insights win is gold and we're up in the northeast section of the U.S. and then we have Louisiana down next to Texas which is a new partner with us in our QIN. We're excited about this work and we look forward to working with everyone as a Quality Improvement Network in our five states.

As far as the BFCC-QIO Scope of Work role, there are the five defined areas that we talked. We're required to maintain a local presence, the BFCC, QIN's, their business hours are seven days a week and they're required to be open during nine to five Monday through Friday in the time zone that they were operating in and weekend coverage from 11 AM to 3 PM. They do have an answering machine that will take calls after the normal business hours during the week and on the weekends.

On May 9th as we said CMS awarded the BFCC contract to KEPRO which received 33 states and the District of Columbia and LIVANTA which has 17 states including the U.S. Virgin Islands and Puerto Rico.

And the next slide shows the map of the various regions and in our QIN LAVANTA as the beneficiary, BFCC-QIO for New Jersey and Pennsylvania and KEPRO as the BFCC for Delaware, West Virginia and Louisiana.

Next slide please. These are some important contact information for you about the appeals process in the area and who to contact if you do have questions about the BFCC work and there are 1800 numbers, fax numbers and addresses for the various region.

Next, and then for EMTALA points of contact, LIVANTA will be – this is their contact information. They will be handled our Las Vegas operations and Ohio KEPRO, our Cleveland will be handling the KEPRO activities that's related to EMTALA.

Next, quality management team for our state program directors, the way we're organized, we have a state program director each day responsible for the activities, for the quality improvement network in that state and we also have network task leads across – the work across the network as consultants and resources on the clinical topics. Jan Lennon is directing the operations for our Delaware contract, Debra Rushing for our Louisiana contract, Diane Babuin for the New Jersey contract, Donna Balsley for the Pennsylvania contract and Carla VanWyck for the West Virginia contract. And these will be the chief operating people in the states for the QIO activities for the next five years.

The Quality Insight Network task lead as I said every state in the QIN has at least one person who is serving as a task lead. Task lead based up on their clinical expertise and they serve as a content expert and consultant to the state based staff in each state working on a particular clinical topic. Kevin Massino from Pennsylvania is serving as the task lead for improving cardiac health and reducing cardiac health disparity. Natalie Tappe from West Virginia is serving as a task lead for everyone with diabetes counts project. Kathy Rivard from our Delaware office is serving as a task lead for our improving prevention coordination through meaningful use with the use of health information technology. Eve Esslinger is serving as healthcare associated sections and hospital coordinator and he is based in our Pennsylvania contract. Beth Hoover from Louisiana is serving as a lead for reducing healthcare acquired conditions in nursing home.

The rest of the network has leads include Andy Miller who is out with our New Jersey operation and Andy will be serving for the coordination and care which is our old care transitions task in the 10th Scope of Work. And Nicole Skyer-Brandwene is a Pharmacist and she will be working on the Adverse Drug Event prevention as the network task lead and Nicole is also with the New Jersey operations. And last is Dawn Strawser who is based with our Pennsylvania contract and she will be the network task lead for quality improvement through value-based payment, quality reporting and physician feedback reporting program.

As far as partners in the Quality Innovation Network, we're decided to collaborate with our partners. We think we bring a lot of experience as Dave said as Quality Improvement Organizations in the five states previously in – previous scopes of work in contracts. All five states makes QIO and the network have over 98 years experience serving as Quality Improvement Organizations. We will coordinate across our states network activity and provide a local booth on the ground support and service in the states that we are serving in our network to five states.

Next side please? As Dave has already talked about, WVMI is serving as the lead organization, we also have Quality Insights of Pennsylvania, Quality Insights of Delaware and we also have Healthcare Quality Strategies, HQSI through New Jersey and eQ Health Solutions from Louisiana.

Next, and we bring a new partner to the collaboration that we're really excited about which is the partnership with Pittsburgh Regional Health Initiative or PRHI. We're excited about this partnership and what we think the PRHI will be able to bring to the table for us as an innovative learning tool to work with our collaborators and providers in the Scope of Work.

PRHI is a nationally recognized leader in adapting quality improvement processes such as Lean for healthcare and embedding these processes with an HIP platform and that platform is called Tomorrow's HealthCare. You will be able to access Tomorrow's HealthCare through the Quality Insights website homepage which is www.qualityinsights-qin.org. Once you will be able to access this after you sign up to collaborate with us on one of the clinical projects or one or more clinical projects that we will be working on in the 11th Scope of Work and we will provide more information later on this.

PRHI brings to us four modules in the Tomorrow's HealthCare. Quality improvement, which gives us resources to do quality improvement. Education, it brings resources to learn about support quality improvement. We also have communities which will be communities based upon our clinical topics and we have the resource of the women's community foster collaboration. And we have eight portfolio which will allow you to track what you've done as far as managing educational components that you may have taken. It will be able to alert you that you start at a class such as it is such a lean class and you may not complete it if you get caught away from your desk. It will let you know that you started that class. And we're really excited about what we think that PRHI and Tomorrow's HealthCare can bring to all of the group four collaboration improving the quality of care and the services that we provide.

Next slide please. We will be as I think Dave said Learning and Action Network in addition to Tomorrow's HealthCare. We will provide targeted technical assistance to providers, stakeholders and communities for the CMS, Quality Improvement Initiative and we will engage providers and stakeholders to in improvement initiatives through web-based LANs.

Next slide please, the QIO-QIN Learning and Action Network, similar thing, there will the hub for our regional quality improvement work for each project. We plan on offering on activities across the region and so that we will be able to collaborate together in the Learning and Action Network. And we did that in our previous Scope of Work in our states of West Virginia, Delaware and Pennsylvania very successfully.

The Learning and Action Network to provide project information, you will have information about upcoming events, you will be in discussion board with – forum with boards. We will have a resource library. We will be able to provide a focused coaching, technical assistance, knowledge transfer. We will have a provider-focused data portal where you will be able to get reports that you're collaborating with us and how you're performing on your project managers and it's a little bit different, because the we send those reports out, but now we have a six-year portal where you will be able to go and get your data report and share best practices. We will have videos and podcasts. We will

have recorded events, provider-focused coaching and rapid segment improvement with testing of change ideas.

And the nice thing about using on a Learning and Action Network is like I said that will be recorded and we all know in our busy day we can't always get to a LAN when it's scheduled over a webinar and you will be able to go back and access that information off of our website.

Learning and Action Networks that will be sponsoring during this Scope of Work including improving cardiac health and reducing cardiac disparities, improving prevention through meaningful use of HIP, healthcare associated infections and hospitals, reducing healthcare acquired conditions in nursing homes, coordination of care which is care transition, adverse drug prevention and quality improvement through value based-payments, quality reporting and physician feedback reports.

Operator: Thank you for the presentation Becky. As we mentioned at the beginning of today's webinar, we're now going to hear from each of the experts who serve as our network task leads for the areas that we'll be working with in the 11th Scope of Work. Our next presenter will be the Quality Insights Network Task Lead for our improving cardiac health and reducing cardiac disparities initiative Pennsylvania based Kevin Massino. Kevin?

Kevin Massino: Thanks so much Shannon and thank you again everyone for joining the call today. We're really looking forward to working with you on the cardiac projects in the next five years.

The first part of our projects, we will focus on cardiovascular health in Million Hearts. For those of you who don't know the Million Hearts initiative was started by the Department of Health and Human Services in 2011 with the goal of reducing the incidence of strokes and heart attacks by 1 million by the year 2017. If you're not familiar with the website, I would strongly encourage you to go out and I've listed on this slide here and become a partner of Million Hearts.

We plan on continuing the work that we did in the 10th Scope of Work with the cardiac practices and looking – working with family practice, primary family care and cardiologists and then enlarging our network from the people that we've worked with historically to get a expanded audience.

As Becky said we will engage state-specific and national partners to increase the spread of our work and the impact as well as continuing to provide technical assistance and education for data collection and analysis.

The second part which we're really excited about is the cardiovascular health focus on disparities. So we're going to target disparate populations, focusing specifically on gender, racial and ethnic disparity. And looking where are those gaps in the care and how we can focus on improving the cardiac health for this population.

We also plan on addressing social determinants that may contribute to poor health outcomes, for example, low income, lack of access to a primary care provider, poor nutrition and any other barriers that might be an issue for this disparate population. And then neutralizing the Plan-Do-Study-Act, PDSA cycle to evaluate our interventions and see how we did and what we can change moving forward.

Our target audience starts with the home health agencies and we're really excited because in the last two scripts of work we haven't been engaged with the home health agencies. And we're looking forward to reestablishing those relationships and assisting the home health agencies on collecting data with home health quality initiative – I'm sorry, quality improvement national campaign. And looking at the cardiac measures that that campaign has developed and helping the home health agencies extract that data and submit it to the home health cardiovascular data registry.

The second part of our audience are physician officers who are using EHRs currently for PQRS and meaningful use and continuing to assist them with their data collection on their cardiac measures.

In the last contract we focused on a lot of that data extraction and this time our focus will really be on shifting those current rates and improving the screening rates on hypertension, smoking screening infestation, aspirin therapy and cholesterol control.

And our last audience will be beneficiaries and families and especially when we're looking at our disparate populations, we want to know what matters to these people and we want to engage them and then gain their input on ways in which their cardiac health can be improved.

Some of our strategies will be to provide monthly LAN activities as Becky mentioned collaborating with other physician office projects and as you will hear some of the speakers go after me, you will see where some of that alignment will make sense. Recruiting both providers and stakeholders with whom we have worked historically as well as developing new relationships and continuing to provide comparative reports to show our providers where they currently stand, where they've been and what their trend is for their improvement.

And the last slide here is my contact information again and then the contact information with each state. And if you have any questions that aren't answered on today's webinar, please feel free to reach us to myself or the person within your state and we will be happy to assist you.

Operator: Thanks so much Kevin. This is great information for providers throughout our network. Now we go live to West Virginia to learn more about our upcoming diabetes related work with Quality Insights Network Task Lead for the reducing disparities and diabetes care: Everyone with Diabetes Counts initiative Natalie Tappe. Natalie?

Natalie Tappe: Thank you Shannon and good afternoon. I first wanted to start by showing you a startling statistic related to diabetes care and why it is so important that there is now a national campaign addressing the epidemic of diabetes in our country.

The American Diabetes Association estimates that total cost of diagnosed diabetes have risen to $245 billion in 2012 from $174 billion in 2007, when the cost was last examined. This represents almost a 41% increase over a five-year period.

Most of the cost for diabetes as you can see in the United States, 62.4% is provided by government insurance which is Medicare and Medicaid. The rest is paid for by private insurance and by the uninsured.

I would like to now begin by giving you an overview of the CMS diabetes disparities reduction program called Everyone with Diabetes Count. EDC began seven years ago as a pilot in Florida. It is now the largest national Medicare Diabetes Self-Management Education program. West Virginia along with New York and Texas participated in EDC in the 10th Scope of Work.

The goals of EDC are to improve health literacy and quality of care among Medicare and dual-eligible beneficiaries with pre-diabetes and diabetes in minority and rural populations. It also wants to decrease the disparity of diabetes testing in minority vulnerable populations by improving the frequency of testing for the hemoglobinA1c, dilated eye exams, lipid profile, foot exams and blood pressure. We also want to improve actual clinical outcomes of these diabetes measures.

It is our goal to recruit physicians whose practices include Medicare and dual-eligible beneficiaries with diabetes who are members of a minority and/or rural populations and educate them on the availability of Diabetes Self-Management Education program and initiatives. We also help to recruit, enroll and teach Medicare and dual-eligible beneficiaries utilizing an evidence-based Diabetes Self-Management Education program curriculum. We are using a program called DEEP, which is the Diabetes Education Empowerment Program. With this program we hope to encourage those beneficiaries taken active role in their own health and healthcare.

All classes are taught in the community and include cultural competency components. The classes are very interactive and challenged with beneficiaries to actively engage in each class. For recruitment purposes, we would like to involve physician practices to be able to teach their staff about Diabetes Self-Management and Education so that they can then teach their patients. The resources that we use and have used before and will like to continue to use are of course are our medical offices, our physician's offices, senior centers, health fairs, community partnerships such as grocery stores or faith based organizations. In the 10th Scope of Work these partnerships were very helpful to us for enrolling our beneficiaries.

DEEP also has a program that allows us as trainers to go out and teach community health workers and/or peer educators within our communities who intern can also teach beneficiaries. In some of our states we actually have community health worker

organization that actually are paid workers to go out and teach DSME to beneficiaries. Most states don't have those, but some states do.

We also want to utilize and involve certified diabetes educators who are already teaching diabetes education and encourage them to help us reach more beneficiaries. We don't want to take away from what the certified diabetes educators are already doing, we want to partner with them to reach the most beneficiaries possible throughout our communities. And lastly we hope to engage community business and partner organizations throughout all of our communities.

And the last slide includes our contact information for each state. If you have any questions, please use the chat line to ask questions about EDC and thank you very much.

Operator: Thank you so much Natalie. It sounds like there will be a lot of exciting grassroots improvement opportunities in all five states throughout our network. Just one note before our next speaker, we will be sending through the chat box a link to today's slides for those of you who are interested in acquiring a copy of the presentation. Additionally once the recording is posted, you will also be notified of the location at that time.

Now to shift gears a bit and to talk about health information technology, Kathy Rivard, the Quality Insights Network Task Lead for our improving prevention coordination through meaningful use of HIT initiatives joins us from Delaware. Kathy?

Kathy Rivard: Thank you Shannon and good afternoon everyone. I'm so excited that CMS included meaningful use of Health Information Technology in our new contract. It's very timely since 2014 is the last year that a Medicare eligible provider can enter the EHR and so incentive program and a test by October 1 of this year to avoid the 2015 penalty for not meaning meaningful use.

For those of you on the call not familiar with meaningful use, it evolved in 2009 when President Obama signed the American Recovery and Reimbursement Actions Law. The act was designed to encourage providers to implement electronic health records in their practice setting. Incentives were offered to offset the cost. But in order to receive an incentive the provider must meet specific measures and report these to CMS to demonstrate that their electronic health record is being utilized in a meaningful manner.

So who are we going to go ahead and ask to work with us? Well we're going to ask all eligible providers, eligible hospitals and eligible critical access hospitals that utilize the certified electronic health record. If you're participating in the Medicare electronic health program, eligible providers consists of physicians which can be either MDs or DOs, a Doctor of Dental Surgery or Medicine, a Podiatrist, an Optometrist or a Chiropractor. Eligible providers in the Medicaid EHR incentive program includes physicians which can be MDs or DOs, nurse practitioners, certified nurse midwives, dentists and physician's assistants if they lead a federally qualified health center or a rural health clinic.

So what is the collaborative project involved? What we want to do is build a community of providers, stakeholders, partners and patients. We want to focus on clinical quality measures that address prevention services such as colorectal screening and immunization or treatment of chronic conditions like coronary artery disease and diabetes. The diabetes measures that Natalie just talked about for example.

If you carefully select the nine clinical quality measures that are required to report for meaningful use, you can also fulfill reporting requirements or PQRS that you will hear about soon and it allow you to also participate in the Million Hearts initiative that Kevin just talked about earlier. The second big area of our focus is to increase patient engagement by helping you implement a patient portal and the increased patient utilization of the portal.

So why is this project important? Well because effective use of health information technology will improve the body of care you give to your patient such as using real time clinical decision support and sending automatic reminders to patients for preventive care. Utilizing an EHR will improve care coordination among providers by allowing for electronic transmissions of the patient summary of care document when a patient is referred to another provider, discharged from the hospital or transferred to a different setting. Everyone including patients will have immediate access to their medical records. They no longer have to call the office to see what their lab results are or ask to have their chart copies.

Inclusion of patients in our Learning and Action Network events will help our goals to make healthcare more patient-centered. Achieving the meaningful use is more important now than ever since CMS will begin imposing penalties to Medicare providers that do not meet meaningful use this year. The 1% penalty adjustment in 2015 will increase annually each year up to a possible 5% payment adjustment in 2019. If you add this percentage to the penalties for other federal quality program requirements such as PQRS, it could substantially affect a provider's income.

So how are we going to help you? We are going to go ahead and provide innovative tools and resources and post them on Tomorrow's HealthCare that Becky talked about. We're going to organize and host quarterly Learning and Action Network. We were going to have a all five states involved in this project and our goal is to recruit almost 16,000 practitioners, hospitals in critical access areas from these five states. There will definitely be a lot of best practice and barriers to discuss in these meetings.

We're going to collaborate with Regional Extension Centers and partner with the EHR vendors. Basically we want to help you in anyway we can to support your system changes that optimize the efficiency of your electronic health record in your practice study.

So how do you need to join? What will happen is a member from your state will be contacting you to see if you are interested in participating in our project. We have designed two different participation agreements, one is meant for hospitals and critical access hospitals and the other one we have designed is for physician offices. And as the

quality improvement network, we have streamlined our effort to make physician practices only find one agreement form so that you can participate in this meaningful use project, the cardiac health project that Kevin talked about and the PQRS and value-based modifier project with John will be talking about shortly.

Here is a list of the state lead contact for the meaningful use of HIT project and we hope that we will be able to work with a lot of you in the future. Please contact me if you have any questions. Thank you.

Operator: Thank you Kathy. We really appreciate the information. It's now my pleasure to introduce Quality Insights Network Task Lead for our reducing Healthcare-Associated Infections in hospitals initiative, Pennsylvania based Eve Esslinger. Eve?

Eve Esslinger: Thanks Shannon. This is Eve and I will be sharing information on reducing Healthcare-Associated Infections in hospitals or HAIs. The HAI project will focus on four HAIs. These are Central Line-Associated Bloodstream Infections or CLABSI, Catheter-Associated Urinary Tract Infections or CAUTI, Clostridium difficile infection or CDI and Ventilator-Associated Events or VAE.

You may choose to participate in the HAI project. I've been focused on the HAI or HAIs that are of most concern to your hospital. However, you will still receive data reports and assistance on all of the HAIs in the project. Which HAI you target is really up to you, but we will assist you by reviewing your data and advising as needed. We encourage you to begin projects by focusing on one or more units then spreading evidence-based strategies hospital wide.

Background, I will share some background about the HAI project. Many of you know about the Health and Human Services National Action Plan to prevent Healthcare-Associated Infections: roadmap to elimination. Phase-I of this roadmap addresses HAIs and acute care hospitalizations – I'm sorry, acute care hospitals. Goals were set for 2013 and there has been national success with meeting the CLABSI goals and SSI goals for 2013 then not meeting the CAUTI and CDI targets.

There is a proposed plan for another five years with robust targets or goals for 2020. I have the link on the screen in case you would like to refer to the roadmap. Hospitals participating in the Quality Insights HAI projects will prevent – will help prevent HAIs and help our nation reach these goals. Also, in previous phases of our work or what we call Scopes of Work, SOWs, state QIOs worked on HAIs including MRSA and the 9th Scope of Work that's going back six years ago, we also worked on the Surgical Care Improvement Project of SCIP, now that's not an HAI but the SCIP process measures help prevent HAIs. The last three years found us working more closely on specific HAIs CAUTI, CDI, SSI and some states also worked on CLABSI.

Outcomes, our outcomes are to prevent and reduce HAIs through evidence-based data driven and patient centered strategies. For example, we are going to offer training and tools on antibiotic stewardship, hand hygiene, nurse driven catheter removal protocols and then on later bundles. Hospitals that participate will receive current data reports that

show HAI rates and will work with you to get your data in the right direction acting on data that turns higher. One strategy that is in our oven for all of 11th Scope of Work projects is patient centered strategies. We will provide training and expertise to ensure that all participants develop infection prevention plans that are patient centered.

In addition we will work with you to ensure your infection prevention plan and strategies are sustainable. We know that sustainability begins our lay. Our plan for sustainability helps ensure the work you're doing upfront will not just continue, but have lasting impact.

And as a part of the National Action Plan to prevent HAIs, the Quality Insights aim is to decrease the national HAI Standardized Infection Ratio or SIR. The SIR is a risk adjusted major that compares the observed number of infections to the expected number of infections and can be used to track HAIs overtime both at a national and state level or even a local level.

Coordination of HAI prevention, first we will align with partners and stakeholders who are also working with HAI prevention. We understand that there is more than one HAI prevention project available to you. This doesn't limit your involvement rather we will work with other partners and stakeholders to prevent duplication of effort. We want you to have the maximum benefit of being involved with the projects not so pressured to listen to similar webinars and so forth.

We will work through the CDC's National Healthcare Safety Network or NHSN system. As the data requirement to report HAIs through NHSN grows we can use the hospital specific data to provide you with current reports. We will provide targeted goals and month-to-month trend so you can monitor your data. We'll also monitor your data and provide support as needed. As a participant, you will be part of a Learning and Action Network or what we call a LAN. In the LAN there will be hospitals that are high performers and hospitals that are struggling with high HAI rates as well as many in-between. We will learn from each other and some hospitals can even serve as mentors.

Benefits, there are many benefits to joining the HAI project. We will provide education and training on evidence-based strategies to stop HAI transmission like unit-based patient safety protocols such as the Comprehensive Unit Based Safety program or CUSP and we will provide education and training on patient and family engagement. By getting the patient and family onboard we will truly have patient centered care.

We will provide NHSN help to Roddy Summers, an analyst with expert knowledge of NHSN. You will receive current data reports showing trends and being able to respond early when necessary. And finally this is a shared learning opportunity. Everyone benefits whether you're a high performer or a hospital struggling to reduce your rates. The collaboration you will receive as a member of the project will be a win-win for all participants. We know from past projects that participants really like to hear from each other and we will encourage that.

How to join? There is a specific HAI agreement that needs to be signed by an executive member and board of directors. We also ask that the infection control practitioner sign this form as well. We need a new agreement signed even if you are participating with this over the past three years. Also so we can make this a data driven project, we need you to confer right so that we can have access to NHSN data. This is a simple matter, if you've been participating with this you will only need to reconfer rights. Even if you are new to the HAI project, the process is easy and we will help you if needed.

Contact information, on the screen is our contact information. I'm the network task lead. You're welcome to contact me and also Roddy Summers, the lead data analyst and NHSN group administrators. So if you have trouble conferring rights, that's who you need to contact. And then on the next screen is the state task leads of the HAIs in your state. I would encourage you to contact any of us with any questions, thank you. Shannon?

Operator: Thanks so much Eve. As a remainder we will have a Q&A session a little later in the presentation where you can submit your enquiries and feedback through the Q&A window in your WebEx player. We will get to as many questions as time will allow for during today's live presentation.

Up next we're going to Louisiana to hear from Quality Insights Network Task Lead for our reducing healthcare acquired conditions in nursing homes initiative, Beth Hoover. Beth?

Beth Hoover: Thank you Shannon and welcome everyone. The purpose of the nursing home task is to align the following efforts. First we will engage consumers and families in healthcare decisions that will enhance good quality of care. Our goal is being to have consumers and families serving and actively contributing on the LAN.

Secondly we will use QAPI or the Quality Assurance Performance Improvement framework for all quality improvement methods that we will implement. We will focus on system wide improvement to decrease healthcare acquired conditions and improve resident satisfaction.

Continuing on, we will create strategic approaches through partnerships in the LAN. We will facilitate the transformation of healthcare through innovation and involvement into Collaboratives, Collaborative I and Collaborative II. These Collaboratives will continue to foster relationships with the current stakeholders that we are working with and we will embrace relationships with new key stakeholders. These collaboratives will actively participate with the Quality Insights Quality Innovations Network and will also participate with the National Nursing Home Quality Care Collaborative.

What are our goals? The first national goal for the nursing home task will be to recruit nursing homes to participate – to achieve a composite score of six or better with lower being better. These nursing homes will participate with the national nursing home composite quality measure and this – these measures consist of 13 individual measures that we will be focusing on.

Secondly, we would like to improve the rate of mobility for long stay patients. We will be working on reducing these of antipsychotic medications in dementia patients and you will hear further on down the presentation how we will be partner with another task as well. We will recruit nursing homes, all nursing homes for participation in the national nursing home quality care collaborative and this will be done by intense target recruitment. Lastly we want to recruit high performing nursing homes who can be peer coaches and who will service mentors for the lower performing facilities.

How are we going to accomplish these goals? In order to do this, we will leverage partnerships and increase nursing home participation in the LAN. These partnerships will include that won't be limited to your state survey agencies, from nursing home trade associations and we will actively participate stakeholders and they will be encouraged to serve on these lands as well.

We will collaborate with communities and initiatives with a light focus such as those who are working to reduce readmissions and those also focusing on reducing healthcare associated infections. If you're interested in how you can participate in this work, please mark your calendars for an upcoming nursing home HAI kick-off call. This call will be held Tuesday September 16th at 2 O'clock Eastern, 1 PM Central. There is going to be a link to this. Join this event on the Quality Insights website.

The nursing home team which is on the next page can be contacted if you have or would like to participate in any of the nursing home projects, feel free to contact myself or any of the five state leads in those areas. Thank you.

Operator: Thank you Beth, fantastic information. And just a reminder to save the date for the reducing healthcare associated conditions in nursing homes kick-off webinar, Tuesday September 16th from two to three Eastern, one to two Central. Our next presenter comes to us from New Jersey and is Quality Insights Network Task Lead for our coordination of care initiative, Andy Miller. Andy?

Andy Miller: Thank you Shannon and good afternoon. Nicole Skyer-Brandwene who is the Network Task Lead for Medication Safety and Adverse Drug Event Prevention was not able to be on the call today. So I will be speaking to her area also.

Hospital readmission rates for Medicare beneficiaries are problem across the country. Last year 18% or more than one out of every six Medicare fee-for-service patients nationwide who are discharged from an acute care hospital were back in the hospital within 30 days. Now some readmissions are planned such as for a follow up procedure and some are not preventable. But on the other hand some parts of the country have much lower readmission rates than others which implies that many readmissions could be prevented.

During 2013, our network had a collective readmission rate of 18.5% which as you can see is higher than the national average and that's it's a lot higher than the low readmission areas of the country. Also many admissions could be prevented with good

coordination of care. We don't have to wait for patients to be admitted to the hospital to identify them as being at high risk.

Talking about readmissions and admissions makes it sound like this is a hospital problem, but it's not. Improving coordination of care is a community problem. Besides hospitals, other providers need to be involved such as nursing facilities, rehab facilities, home health agencies, hospices, dialysis facilities, pharmacies, physician practices. And also other non-medical providers and other organizations need to be involved in order to improve coordination of care and reduce readmissions. So such as assisted living facilities, behavioral health providers, social service providers including area agencies unaging and ADRCs, religious organizations and importantly patients and their families.

So what will Quality Insights be doing? We will be working to build community coalitions to improve coordination of care between healthcare providers as well as others who serve Medicare beneficiaries in their communities. We will be helping communities identify beneficiaries who're at high risk of readmission or admission such as patients who have multiple chronic conditions, dual-eligible, patients with behavioral health issues or with Alzheimer's disease or individuals whose social economic status puts them at higher risk.

We will also be working with rural communities across our network. Now many of you who are on the call today have participated in community coalitions during the last Scope of Work. We are planning to continue to work with those communities as well as to recruit additional ones. In many cases the same people from your former QIO will be working with you again. During this Scope of Work, we will be asking communities to develop interventions that not only involve providers working to reduce readmissions and admissions, but also to develop and be involved in initiatives that include multiple providers working together such as for example setting up systems for improving communications as patients move between different healthcare settings.

As Becky mentioned, we will also be having our care coordination Learning and Action Network that will invite you to join and actively participate in. Medication issues play a huge role in causing readmissions as well as complicating care when Adverse Drug Events occur. It's estimated there were about 1.5 million preventable ADEs each year in the United States. In some medication such as anticoagulants and drugs with free diabetes often cause ADEs.

During this Scope of Work we will be working to incorporate medication safety surveillance and medication error prevention into our care coordination activities. We will be developing and promoting best practices to reduce ADEs and we will be focusing on anticoagulants, diabetes drugs and opioids. And we will be monitoring ADE rates with a goal of reducing them significantly.

Quality Insights will be hosting a webinar devoted specifically to care coordination in the Adverse Drug Event prevention on Wednesday, September 24th at 2 PM Eastern, 1 PM Central. We will be sending out invitations shortly, but if you want to register right now you can go to the Quality Insights website and click on the connect tab, connect C-O-N-

N-E-C-T near the top of the page. And the next two slides list the state care coordination and ADE contacts for our network. And we encourage you to reach out to them also, thank you.

Operator: Thanks so much Andy. And just a reminder again, if you would like to register for the Care Coordination/Adverse Drug Events webinar, you can visit qualityinsights-qin.org. Click on the connect button and there is also a link in your chat window as well where you can click there now and register for that event that will take place Wednesday, September 24th, 2 PM Eastern, 1 PM Central.

The next presenter who will round out our panel of experts is Pennsylvania based Dawn Strawser who is Quality Insights Network Task Lead for our quality improvement through value-based payment, quality reporting and the physician feedback reporting program initiative. Dawn?

Dawn Strawser: Thanks Shannon. Hi everyone. I'm going to provide an overview of the quality improvement through quality reporting initiative. Aim, the overall aim of this task is to provide better care at lower costs with the ultimate goal of making care more affordable.

We will be working with eligible physicians and physician groups, hospital impatient and outpatient departments, Critical Access Hospitals, Inpatient Psychiatric Facilities, Ambulatory Surgical Centers and Perspective Payment Exempt Cancer Hospitals. We will be working with these providers to assist and improving the quality of care and efficiency of care through outreach and education.

Benefits, specifically we will be providing technical assistants with the Physician Quality Reporting System known as PQRS and the value-based payment modifier and the use of the quality and cost measure information as contained in the Quality and Resource Use Reports, these are known as the QRURs. We will provide education about CMS hospital and physician value-based payment programs and the physician feedback reporting program.

Next slide, in addition to the technical assistance in education is the quality improvement components. We will be working with hospitals to improve their performance on hospital value-based payment measures, hospital outpatient departments and critical access hospitals to make improvements in their reported quality measures. We will be recruiting ambulatory surgical centers and inpatient psychiatric facilities to improve quality on lower performing quality measures.

We're recruiting the PPS-exempt cancer hospitals to improve on performance measures included in their quality reporting program and we will be working with the physician in the physician groups to make improvements in their quality of care measures. This will be done by identifying the gaps in the quality of care, utilizing improvement strategies to improve quality metrics and networking through the Learning and Action Networks to share best practices.

And this last slide is my contact information along with state's specific contact information. Please contact us if you would like any additional information.

Operator: Excellent presentation Dawn. Thank you so much. Now that you've heard about all of the areas where we will be improving health throughout our network, it's my pleasure to turn today's session back over to Quality Insights Quality Innovation Network Director Becky Cochran.

Rebecca Cochran: Thanks Shannon and thanks to everyone that's present and done such an excellent job explaining our Quality Improvement Network and our five state focus. So well I hope you're saying now to yourself what's next, how do I sign up. Well to get involved, in each of our states we have experienced staff, many of which from the previous Quality Improvement Organizations you've worked with all along who will be available to facilitate your participation. And our regional QIN activity provide individual consultation on quality project, directly support your ongoing quality initiative to collaborations and help you sign up for our initiative to work with us on the various projects.

Next slide please, to get involved you can go to our website which is http://www.qualityinsights-qin.org. You can go the get local tab, select your state tab to get local and there is a screenshot here for that and this will connect you with the Quality Improvement Specialist or project coordinator for your state to become involved. And they will be able to make contact with you to sign you up, explain our initiatives and just explain what we are doing in the next Scope of Work.

Next please, to say informed we can go to our sign to sign up for – to receive our E-newsletters which we will be circulating starting later next month. They will be task-specific and network-wide and again go to the website and click on connect and you can then sign up for the E-newsletters sign up.

Operator: Thank you so much Becky. This is truly an exciting partnership that we're going to be undertaking with all of you throughout West Virginia, Pennsylvania, Delaware, New Jersey and Louisiana. Now we move to the interactive portion of today's session. Please submit your questions through the Q&A box in your WebEx player and we will get to as many as time allows for during today's live presentation.

Our first question is for Andy and asks will we be expected to report any data to participate in the project and if so could you give an example of what type of data would be requested?

Dave Lambert: Sure, thanks Shannon. We will expect providers to – as an example report data on interventions that they put in place in their organization. So that if an organization is number one, we like people to track what they're doing. So if you're saying we're going to make follow up phone calls to patients who are discharged from our nursing facility, to track whether those calls are made, whether people have been able to be reached, so number one is the intervention being implemented as planned. And number two, to report outcomes data, we will be sharing data also, but we need

information from you as to whether your patients have been admitted to the hospital or readmitted to the hospital for example or whether they did get to see a physician for follow up after they were discharged.

Operator: Thanks so much Andy. Our next question would most likely be for Becky and this question asks, is there an MOA required for the QIN?

Rebecca Cochran: Shannon?

Operator: Yes.

Rebecca Cochran: This is Becky. No, there was not. We will be doing a consent that we will ask the participations to sign spelling out what – the expectations for the QIN will be for to support them and what we expect them to do. But as formal which we had before as for an MOA for our BFCC work, we will not require that but there will be a consent for the project.

Operator: Our next question is for Beth and it asks; how does this fit into the advancing excellence program?

Beth Hoover: With the work that we will be doing with the nursing homes, a lot of you have already received from education on advancing excellence. We will be continuing that education that we started in the 10th Scope of Work and it's founding upon that we all our individual path with each of them.

Operator: I will toss this next question out for whomever who would like to answer. When do we confer rights again with the NHSN? Do you let us know when to do this?

Eve Esslinger: This is Eve and yes, we will let you know. You will be getting contact information from someone in your state that that will be happening. If you've already been with us, it will be a simple matter of reconferring rights. And it – as I had said in my presentation, it will be a fairly simple seamless process.

Operator: We have another question for you related to this Eve that asks will our facility be asked to report any additional data for the HAI project other than what is reported to NHSN?

Eve Esslinger: We are pulling all of our information from NHSN. I believe that that's what they're asking, yes. So it will be just what – the data we – of course we pill out will be pulled from NHSN.

Operator: I will toss this question out for the group. Regarding hospital readmission, will there be any discussion with survey agencies regarding sending residents for evaluations at a hospital versus being sighted for a possible delay in care well trying to manage a resident in a nursing facility?

Andy Miller: Hi Shannon, Beth may want to answer, but I will take a shot at this. This is Andy. I think that's a good question in terms of there is attention between we don't want to send a patient to the hospital if they – if we can manage them here and we also don't want to be dinged for a readmission. So it's possible that a nursing facility could keep a patient longer than it is good for the patient. I think survey and survey agencies will certainly be looking for this. We would hope that facilities would be providing the care that's best for their patient. So whether there is a nursing assessment or consultation with the physician to determine whether care can continue to be provided in the facility or the patient needs to be sent to the emergency room to be seen and/or to be readmitted. So there will be communication in all our states with our survey agencies.

Operator: Thank you Andy. Anything you would like to add to that Beth?

Beth Hoover: I would only like to add that as we go forward there will be modules and some excellent tools and resources to do with this specific topic. We have some pocket cards and some resources we can be providing to the nursing homes that will help that staff know when it's time to go on to the hospital and as Dr. Miller we will be coordinating across the task with that end.

Operator: Thank you Beth. The next question is for Kathy in Delaware and it asks will Quality Insights Quality Innovation Network help practices complete their security risk assessment for meaningful use?

Kathy Rivard: Hi. That is one of the meaningful use measures required for attestations which will not be really addressed by the QIN. What we would have to do is probably collaborate and refer you to your regional extension center in your state to actually be able to go ahead and perform that for you.

Operator: Our next question would most likely be for Becky and it asks what is required to join LAN.

Rebecca Cochran: It will be to go to our website and sign up to the – a participant in the project and sign a participation agreement. Your – once you sign up our probably special, we will be contact with you and explain the project to you and obtain the participation consent from you and then you will be in the LAN and also have access to the PHRI at Tomorrow's HealthCare website.

Operator: And we have a similar question that also asks is it possible to join a LAN for more than one project or focus area?

Rebecca Cochran: Yes, and we're going to try to be working with LANs as Andy talked about and I think Beth and Eve also talked about that across the area so that if you're in one setting that we can work across the setting so we don't have file to care, but it is possible to join the LAN for more than one setting.

Operator: We will shift back to Natalie right now and ask is there a fee for physician practices or patients to participate in the diabetic self-management classes?

Natalie Tappe: Hi Shannon, no, there is not. They're absolutely free.

Operator: Great to know. Let's shift back to Eve for a moment for a question that asks can – could you clarify about the HAI project. You said that we could select what HAI we need to work on, what if this changes in a couple of years and we need to work on another HAI.

Eve Esslinger: That's a really good question and I – that really makes this project nice, because for example if you're H – like your CAUTI rate is really high rate now, you need to work on it. We will work with you on that, but let's say it goes down and then your CDI rate is a problem in a couple of years, then being in the project you can work on any of these HAIs so you don't have to switch from one to the other. And I will just clarify something I had said earlier, maybe expand on it, because you are focusing on one does not mean that you won't get the education information on all of them. But we will certainly work with you on the HAI project or HAI that you're most concerned about.

Operator: Let's go back to Louisiana for a – question for Beth that asks could you clarify what a peer coach would do in our facility.

Beth Hoover: Our goal for the peer coaches is to connect the nursing homes that are achieving very good scores and have very high star ratings to be basically a mentor for those nursing homes who maybe struggling in one or more areas. So we will be looking for facility peer coaches as well as patient and family peer coaches to cross and provide some education and some – how we did well in these areas, information to those other homes that are struggling.

Operator: I will toss this question out to the group that asks can someone address how the new QIO – QIN-QIO program measures with the Hospital Engagement Network or HEN program.

Eve Esslinger: This is Eve. I will at least address part of that and during my presentation I had mentioned that we are going to be partnering with other organizations that we are absolutely aware that hospitals have an opportunity to be in more than one project for HAI. So we will be partnering not duplicating work, so you can – so we won't have a webinar that maybe the HEN did recently. So we won't do things back-to-back or duplicate. And so we will be very aware of what's available in your state, in your local area so it's a maximum benefit to you. I don't know if anyone else wants to address the rest of that question or part of that question.

Rebecca Cochran: This is Becky. We are working with the various HEN contractors and meeting with them on a regional level so that we can coordinate our efforts. And that we will not be duplicating efforts with the various clinical settings in the hospitals, because we know that everybody is coming at every one thing, work with we on this, work with we on that. So we are in working with the various HENs across our service area.

Operator: Thank you Becky and Eve. For the questions regarding handouts from today's session, if you refer to your chat window there is a direct link to download the slides we used in today's presentation. And all attendees will also receive an email after today's webinar which will contain a link to the handouts. We will have a posting of the recording available soon as well so you can refer back to today's entire presentation.

So we're back to New Jersey now for a question that came in for Andy that asks our facility already monitors ADEs, what will be different about this project.

Andy Miller: We're still getting the details worked out about that in terms of what specifically we will be looking at. We will be focusing on as I had mentioned anticoagulants, antidiabetic medications and opioids. But we will be looking overall at other ADEs and we're looking on a community basis too, so not just from an institution. But if the facilities already collecting this information, we would hope to be working with you to provide comparative information or support the data collection that you're doing.

Operator: Let's move just slightly west to the first state of Delaware for a question for Kathy that asks would your state project staff be able to assist us with troubleshooting related to our EHR vendor?

Kathy Rivard: Yes, we would definitely be able to do that.

Operator: Excellent. Back to New Jersey for a question that asks will Quality Insights still be sending us data reports like we received during the last Scope of Work?

Andy Miller: The answer to that is yes. Well yes, we will be producing reports and we will be making them available through a secured portal. We will be rather than just sending reports directly, we would be notifying providers that new reports are available and people will be able to go on to our website to the secured portal and pull down those reports.

Operator: And as a reminder for all participants who are enquiring about the handouts, the email that will be sent after today's session will be automatically generated through your registration for the WebEx. No need to send your email address, you will receive it. Thanks so much for your eagerness to have a copy of the handout and learn more about today's session.

We have a question where somebody asked could you please define nursing home acquired conditions, most likely that would be for Beth.

Beth Hoover: I can attempt to do this. Nursing home acquired conditions, if you were a participant and the last Scope of Work was focused on a couple of particular topics, mainly being restraint and pressure alters. This Scope of Work is moving more to a coalition of nursing homes participating together like I said earlier some peer coaching. I think as we get into the Scope of Work that CMS was going to give us a little more guidance on what particular topics we maybe focusing on. We will focus some of our

work based on the 13 requirements of the composite score which includes false, pressure alters and a couple of other items. So we will be going from those two suggestions.

Operator: Next question is for Eve and it asks will there be a component of your project that will develop standardized patient education tools to help reduce infections?

Eve Esslinger: That's a really good question. I love for that person to email me their ideas. I mean we are obviously in the early planning project part of this. So if they have an idea we would love to hear it. We certainly want to hear from our participants what is helpful to them.

Operator: Thank you Eve. Let's go back to Becky for a moment. I knew you had touched on the Tomorrow's HealthCare component of the Quality Insights Quality Innovation Network, this person asks how and when do I sign up for Tomorrow's HealthCare.

Rebecca Cochran: Tomorrow's HealthCare, you had to sign up for a project to work with us and then you will be able to get access to sign up for Tomorrow's HealthCare.

Operator: Another question for you Becky. This asks what is the definition or what is considered technical assistance? Do you have an example of what is considered technical assistance or any one of the tasks?

Rebecca Cochran: Technical assistance could be working with the hospitals on PDSA doing cause analysis, providing evidence-based interventions to a provider, to help them with improvement.

Operator: Thank you Becky. Let's shift back to West Virginia for Natalie and this question asks where are the diabetic self-management classes held?

Natalie Tappe: The classes are actually held in the community. They can be in a multitude of places if there is no specific set – wherever – whoever your host is where you're going to be having the classes. We had them in senior centers, senior high vises, we had them in physician's offices, we had them in hospitals, we had them anywhere basically, libraries, restaurants, golf courses, any place that we had an availability of a room, we held classes.

Operator: Thank you so much Natalie.

Natalie Tappe: Thank you.

Operator: Next we go back to Eve. This question asks could you tell me a little bit more about what types of reports will be available for HAI?

Eve Esslinger: Yes, thanks Shannon. We're going to be giving providers monthly reports. They will be able to retrieve them on a secured online portal. And they will reflect data on CAUTI, CLABSI, CDI and eventually VAE. They will show data such as

the CAUTI rates, they will show Catheter Utilization and the rates of the other HAIs that I've been talking about. And we also will show the hospitals where they are in comparison to the national – the rate – the ratio, standardized infection ratio that I talked about during my presentation.

Operator: Thanks Eve. Let's go back down to Louisiana for Beth and this question asks how are peer coaches chosen?

Beth Hoover: Peer coaching is going to be based on some of our analysis of the data that we have that if you participated in the last Scope of Work and you feel that you meet the goals of being a peer coach, being a high performer in the nursing home please contact us so we can talk to you about what all that might entail.

Operator: Next question is for Becky, it asks how will performance reports be shared with us.

Rebecca Cochran: We will have a secure portal where you the provider will login and get their performance reports.

Operator: Next question is for Natalie in West Virginia, this is also about our diabetes program and that says will your diabetes related resources be evidence-based?

Natalie Tappe: Yes, they are. The DEEP program is out of the University of Illinois, Chicago and in an evidence-based program recognized by CMS.

Operator: Thank you Natalie. We have time for a couple more questions and here in the queue. The next one is back to Eve in Pennsylvania and this question asks can you confirm that we need to sign a new agreement to participate in your project and if so how can I do this.

Eve Esslinger: Yes. The HAI task has a specific agreement, it has to be signed by executive level board of director and also we ask that the infection preventionist sign that agreement also and just contact either myself or the state contact person and we will get to that agreement.

Operator: Thank you Eve. This next question will be for Becky and this is somewhat similar to the question we had earlier about whether it's possible for someone to participate in more than one LAN. But this question asks will there be joint LANs across various tasks.

Rebecca Cochran: Yes, Shannon. Where it's possible, we will have LANs across the task where we will share ideas. An HAI LAN, Healthcare Acquired Infection LAN to be held across with nursing homes, hospitals and home health agencies for example. So we will have them across LANs wherever possible. I know in the previous contract for our three states of West Virginia, Pennsylvania and Delaware we had many LANs across the task on things such as health literacy, health disparities that we plan on whatever possible to have lands across the task where we're working on similar issues and measures.

Operator: Final question for today's live presentation will go to Andy in New Jersey and it asks are you only interested in Medicare fee-for-service beneficiaries or can you help us with interventions that also target Medicare HMO members, commercially insured patients or Medicaid patients.

Andy Miller: We can work with all types of patients. Our primary responsibility is working with Medicare fee-for-service patients, but that's mainly because that has – where CMS can measure through claims whether we're having an impact on readmission and admission rates. But we're also responsible for and we want to work with patients who are Medicare advantage, in Medicare HMOs, who are commercially insured, who are Medicaid. So yes, we are open to working with patients regardless of their insurance source.

Operator: Thanks so much Andy. That's all the time we have for today. But on behalf of the entire Quality Insights Quality Innovation Network, we sincerely thank you for joining us today for the presentation and learning more about our new approach to Medicare quality improvement. We look forward to partnering with you to improve the health of the people we serve throughout all five states in our network. Those of you who signed up for our E-newsletter while registering for this session will receive a link soon with the recording of today's webinar.

And we ask that you please take a moment to complete the evaluation that you will be automatically directed to upon exiting the webinar. Your input is very valuable to us. We also invite you to visit us online at qualityinsights-qin.org to learn more or contact any of our experts at any time. Thank you for your participation. Have a great afternoon.