Building Strong Communities With Quality Insights

An Introduction to Medicare's Newest Quality Improvement Initiatives

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Quality Insights

Today's Speakers

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The New Shape of QIN-QIOs

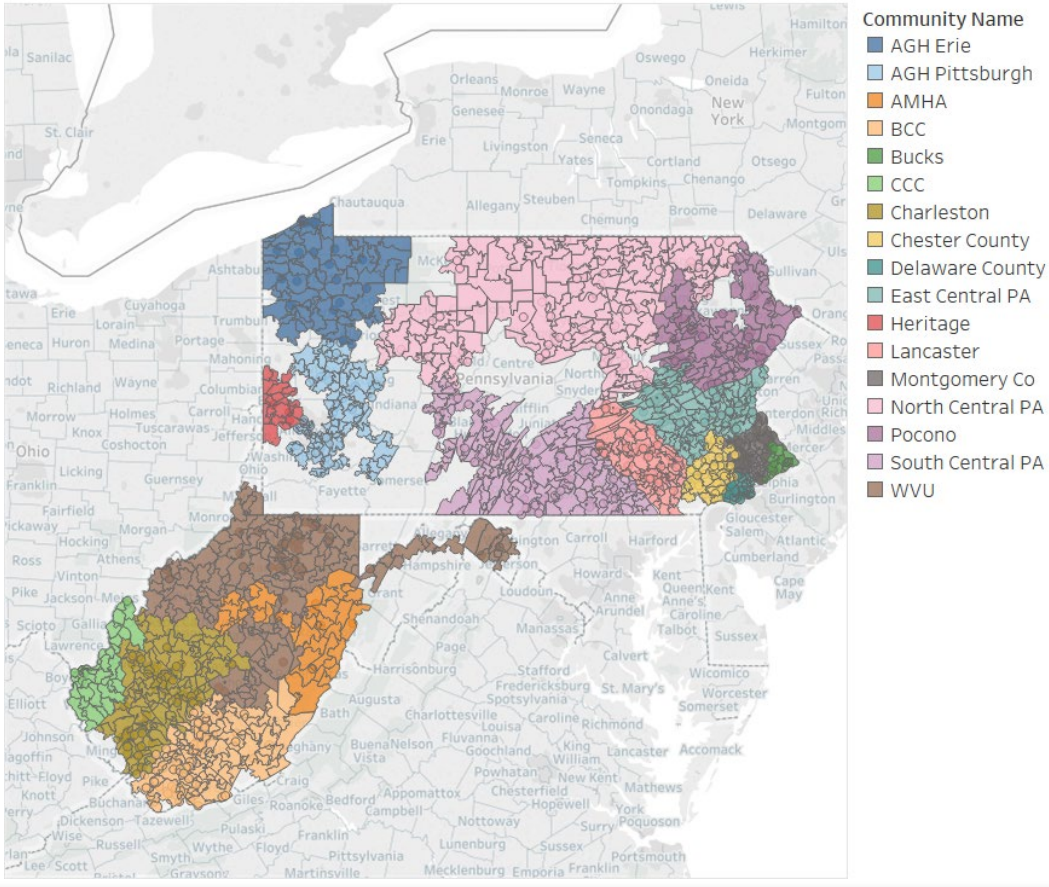
Four Key Roles of QIN-QIOs

- Champion local-level, results-oriented change
  - Data-driven – help us build the free data support you need in your facility, agency, or practice.
  - Active engagement of patients and other partners
  - Proactive, intentional innovation and spread of best practices that “stick”
- Facilitate Learning and Action Networks (LANs)
  - Create an “all teach, all learn” environment
- Teach and advise as technical experts
  - Consultation and education
  - Management of knowledge so that learning is never lost
- Communicate effectively
  - Optimal learning, patient activation and sustained behavior change

Webinar Objectives

- Familiarize yourself with CMS' new healthcare quality improvement goals
  - Improve behavioral health
  - Decrease adverse drug events
  - Increase quality of care transitions
  - Increase chronic disease self-management
- Understand the function of community coalitions to position your practice/organization to:
  - Collaborate and work across settings
  - Become involved with community coalitions

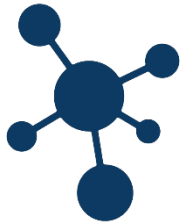
Community Coalitions



Community Coalitions

- Organizations working together to improve the health and well-being of the community
- One county or multiple counties
- A few organizations or many organizations
- Meetings face-to-face, virtually or both
- Existing coalitions, join other community groups or create a new coalition

Benefits of Participation



- Connection to a network of providers to help support social determinants of health *at no cost to your organization*
  - Support with Quality Payment Program
  - Data support
  - Education (with CEUs) and resources
  - Assistance with improvement efforts

Community Coalition Goals

- Improve Behavioral Health Outcomes
  - Opioid misuse
  - Best practices – pain management & opioid use
  - Access to behavioral health services
- Increase Patient Safety
  - All cause harm
  - Adverse drug events (ADE)
  - C-diff
- Increase Chronic Disease Self-Management
- Increase Quality of Care Transitions
  - Avoidable admissions/readmissions
  - ADEs
  - Emergency department visits
- Improve Nursing Home Quality

Improve Behavioral Health Outcomes, Focusing on Decreased Opioid Misuse

- Decrease opioid related adverse events
- Implement pain and opioid use best practices
- Increase quality and access to care for behavioral health services
- Reduce ER utilization where appropriate for mental health diagnoses

Increase Patient Safety

- Reduce all cause harm
- Reduce adverse drug events (ADE) across all settings
- Reduce C-diff in all settings

Increase Quality of Care Transitions

- Avoidable admissions/readmissions
- ADEs
- Emergency department visits

Chronic Disease Self-Management

- Education, technical assistance, tools, and resources will be provided for the following chronic disease self-management initiatives including:
  - Cardiac health
    - Million Hearts Initiative
  - Diabetes education
  - Chronic kidney disease

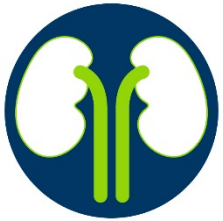
Cardiac Health

- Provide technical assistance to clinicians who are willing to provide ABCS data on a monthly basis
- Promote blood pressure protocols and other cardiac health interventions
- Provide tools and resources to assist in the success of cardiac measures

Diabetes

- Goal: Prevent the progression of pre-diabetes to diabetes
- Action plan:
  - Work with communities to increase diabetes prevention program referrals for pre-diabetics
  - Work with providers/communities to provide resources surrounding social determinants of health issues, such as:
    - health literacy
    - food insecurity
    - patient/provider relationships

Chronic Kidney Disease (CKD)



- Goal: Slow and prevent the progression of CKD
- Action plan:
  - Work with clinicians within our communities to identify patients with:
    - A dual diagnosis of hypertension (HTN) and diabetes (with at least one diagnosis being uncontrolled)
    - CKD patients staged 1-3
  - Hold education sessions in a variety of formats
  - Provide educational tools on the risk factors for:
    - CKD (specifically a dual diagnosis of HTN) AND
    - Diabetes (with at least one of these being uncontrolled)

Nursing Home Initiatives

- Improve quality scores
- Reduce adverse drug events (ADE)
- Reduce healthcare-related infections
- Reduce emergency department (ED) visits/readmissions for short stay residents

Nursing Home Team

- Pennsylvania
  - Penny Imes – pimes@qualityinsights.org
  - Patty Austin – paustin@qualityinsights.org
- West Virginia
  - Cristen Carson – ccarson@qualityinsights.org

POLL: How Can We Help your organization?

What topics would you like us to focus on in the future?

Q & A

Let's Do This! Next Steps…

- Email
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- Call
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- Visit
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