Building Strong Communities with Quality Insights
Webinar Transcript

Krista Davis: Good afternoon everyone, and welcome to today's webinar, Building Strong Communities With Quality Insights. My name is Krista Davis, and I am a Communication Specialist at Quality Insights and your host for today's presentation.

We'll get started in just a few moments but first, a few housekeeping items. All participants entered today's webinar in a listen-only mode. Should you have a question or a comment during today's call, we ask that you please type it into either the chat or the Q&A box to the right of your screen. If you are unable to locate your chat box, hover over the bottom of your screen and click the circle with the speech bubble.

The slides you see today were emailed to everyone who had registered earlier today. They will also be posted on our website before close of business today. You can find the web address in the chat box in just a few moments.

At the end of today's program, you'll be asked to complete a short evaluation. This evaluation will help tell us how we did during this program and how we can help you during this continuing and challenging time.

Today's speakers include Dawn Strawser and Kia Wills, both Quality Improvement Specialists with Quality Insights, and they are working with our Community Coalition. To begin I'd like to turn the program over to Dawn Strawser. Dawn, the floor is yours.

Dawn Strawser: Hi. Thanks Krista. I want to thank everyone for taking the time out of your day to join us today. This slide shows the picture of the United States with the different QIN-QIOs. In November of last year, CMS awarded 12 quality improvement organizations, which we refer to as the QIN-QIOs, contract for the quality improvement work for the next five years.

This slide shows the coverage areas for each of the QIOs. Quality Insights is shown here in purple, and we are the QIN-QIO for the states of Pennsylvania and West Virginia.

Next slide. Increasing performance of the healthcare system by increasing quality is the mission of the QIOs. The four key roles are to champion local level data-driven results using change and best practices with engagement of patients, partners, and other stakeholders. We also will be facilitating learning

and action networks, which we refer to as the LANs, and providing technical assistance and education and to communicate effectively.

Next slide. The objectives for today's webinar are to discuss the goals of Community Coalition work, which are to improve behavioral health, decrease adverse drug events, increase quality of care transitions, and increase chronic disease self-management, and also how to understand how your organization or your practice can function in the Community Coalition work.

Next slide. This slide, it's hard to see here, but it shows the breakdown of the 17 communities in Pennsylvania and West Virginia. What we did was we looked at forming the coalitions around the number of Medicare beneficiaries based on their zip codes. We also looked at rural areas, vulnerable populations, and those individuals with chronic conditions. So there's 12 communities we've defined in Pennsylvania, and then there's five in West Virginia.

Community coalitions can be defined as working together to improve the health and well-being of the community. A coalition can work together within their county or they can add additional counties. They can meet virtually, face-to-face or both, but in this time everyone has been meeting virtually and hopefully at some point in time, we can get to face-to-face community meetings.

Next slide. This slide goes over some of the benefits for joining a Community Coalition. A coalition provides a connection to a network of providers to help support social determinants of health, and these coalitions and everything that Quality Insights does has no cost to organization. Quality Insights will assist with quality improvement efforts, provide resources, educational webinars, we offer CEUs, and we provide data and quality payment support.

Next slide. This slide lists the Community Coalition's goals as defined by CMS. We're going to cover each of these goals in more detail in the upcoming slides.

Goal one is to improve behavioral health outcomes, focusing on decreased opioid misuse. Under this goal is improving access to behavioral care and improve behavioral health outcomes. Also, decrease opioid-related adverse events, including death with a focus on Medicare beneficiaries using opioids. Also implementing pain and opioid use best practices. The ultimate goal is to reduce opioid utilization. Also reducing ER utilization with mental health diagnoses where appropriately to reduce. Also increase in quality and access to care for those who suffer with dementia, substance use disorder and depression.

Some specific interventions Quality Insights will be doing related to this goal are to provide education and technical assistance on implementing the latest guidelines and evidence-based best practices on appropriate opioid prescribing and pain management. Also, supporting the implementation and integration of

evidence-based pain management practices and identifying community-based root causes for high rates of opioid-related harms and high rates of readmissions for opioid overdose, depression, Alzheimer's and substance use disorder.

Next slide. The second goal is to increase patient safety, reducing all cause harm. Included in this goal is to reduce adverse drug events in community settings and nursing homes and reducing C-diff in all settings. Some specific interventions Quality Insights will do here is to help identify ways to increase medication safety in the community to prevent adverse drug events, reduce readmissions and improve care coordination across the provider settings. We're going to help to identify and spread evidence-based best practices on medication safety in the outpatient setting, including medication reconciliation and coordination across provider settings, and also involving the patients and the caregivers. Also, providing education and training on specific interventions related to infection prevention practices, looking specifically at the points of care transition.

Next slide. The next goal that CMS defined is to increase quality of care transitions by improving community-based care transitions to reduce hospital admissions and readmissions. With a sub goal here to reduce the rate of emergency department visits and admissions by the super users, super utilizers. Some specific interventions here would be to perform community specific root cause analyses to identify the drivers in ineffective care transitions, and this can lead to increased utilization of acute care services. Also, identifying strategies to reduce unnecessary hospital admissions and readmissions, come up with methods to identify those super users and interventions to improve their care coordination, and also to identify and implement appropriate community level interventions that improve the coordination of care. I'm going to turn it over to Kia to talk about chronic disease self-management.

Kia Wills: Thanks Dawn. For chronic disease self-management, CMS set national target goals to help millions of people with the prevention and management of chronic disease by supporting the Million Heart Initiative to prevent one million cardiovascular events, prevent beneficiaries from developing diabetes, while improving diabetes management. Last but not least, screen for, diagnose, and manage individuals with chronic kidney disease to prevent progression to end stage renal disease.

When it comes to these three chronic disease listed, they tend to go hand-in-hand, especially with all having a tie to hypertension.

Next slide, please. Cardiac health. According to the Centers for Disease Control and Prevention, each year over 1.5 million people suffer a heart attack or stroke, and more than 800,000 die from cardiovascular disease. Therefore, supporting the Million Heart Initiative is crucial to improving and bringing awareness to blood pressure protocols and other cardiac health interventions.

Next slide, please. Diabetes. More than 84 million US adults, over one-third, have prediabetes, and 90% are unaware of having this condition. Type 2 diabetes account for 90 to 95% of all diagnosed cases of diabetes. Our goal is to prevent the progression of prediabetes to diabetes. We plan on doing this by working within our communities to increase diabetes prevention programs, referrals for our prediabetic. Also, working with the providers in the communities to provide resources surrounding social determinants of health issues, such as health literacy, food insecurity, and building stronger patient provider relationships.

Next slide, please. Leading into our last chronic disease, 30 million adults, or one in seven, have chronic kidney disease, and many are unaware that they have it. Our goal here is to slow and prevent the progression of chronic kidney disease. Our plan on doing this is to work with the clinicians within the communities to identify patients with the early stage of chronic kidney disease.

In conclusion, with the chronic disease self-management goals, I would like to stress that in our effort to improve population health we must all work together across all healthcare settings to increase and support chronic disease self-management within our communities.

Next slide, please. Although many nursing homes participate in our community work, we have a nursing home initiative that provides support for the following CMS goals. Improve quality scores, reduce adverse drug events, reduce healthcare-related infections, and reduce emergency department visits and readmissions for short stay residents.

Next slide, please. We have three Quality Improvement Specialists for our nursing home initiatives. For Pennsylvania, we have Penny Imes and Patty Austin. And for West Virginia, we have Cristen Carson. Our community and nursing home team collaborate across [inaudible 00:12:14] to bridge the gap between the coordination of care.

Now I would like to pass it back over to our moderator Krista. Thank you.

Krista Davis: Thank you, Kia. I would like to direct our attendees' attention to the right side of your screen. I'm going to be opening a poll that we would like you to chime in on, and we're going to be asking you, how can we help your organization, and specifically, what topics would you like us to focus on in the future? You can select as many topics as you like. There are seven potential options there for you. So the poll is open. It will be open for the next 25 seconds or so. We invite you to please go ahead and log your answers.

In the meantime, while we are getting those answers, I would like to remind everyone that if you have a question for either Kia or for Dawn, we invite you to

type them into the chat box or the Q&A box on the right side of your screen. We're going to go ahead and show those poll results. There we go.

Dawn Strawser: Thanks Krista. That's very helpful. If there are other topics that you would like to focus on in the future that's not specifically listed in the poll, if you can just chat down or write it in Q&A other ways that we can help your organization.

Krista Davis: Okay. So we will go ahead and get started with our Q&A. Our first question is, is the focus all Medicare recipients, which would be those 65 and older, as well as others who qualify for Medicare, who may not be 65 or older?

Dawn Strawser: This is Dawn [crosstalk 00:14:35].

Kia Wills: Okay.

Dawn Strawser: No, go ahead Kia.

Kia Wills: I was going to say yes, most of our work covers dual eligibles as well. Dealing with the populations and the work surrounding improvement and quality, we are dealing with more than just the 65 and older Medicare. But we do have a nice percentage that are also dual eligible that qualify, especially when we're collecting measures. There are groups that are not just for the 65 and older community.

Dawn Strawser: I was just going to add that interventions that we do develop resources, it can be used for everyone. It doesn't have to be just the Medicare community or the dual eligible community. We want to benefit everyone in the community.

Krista Davis: Thank you. Our next question is how do I become part of a Community Coalition?

Dawn Strawser: Hi, it's Dawn. There is a join us link on our website, or you can just email Kia or myself. Our email addresses are on this slide here. We didn't mention Natalie Tappe. She is the Quality Improvement Specialist in West Virginia, and myself and Kia or the Quality Improvement Specialists in Pennsylvania. So just send us an email, let us know that you want to join, and we will add you to our communities or go to our Quality Insights website. That link is also here with the link. Just click on that to put your information in and that'll come right to Krista, and she will forward it on to let us know that you are interested. Or you can always give us a call.

Krista Davis: I also added that link to the chat box. So, that join us link, although you can't click on it in the WebEx player, it is now in your chat box and you can click on it in there. Okay. Our next question is, are you going to be providing technical assistance surrounding telehealth, especially during COVID-19?

Kia Wills: Yes. We established a close relationship with the Mid-Atlantic Telehealth Resource Center. We also have a page on our website dedicated to telehealth. If you go to that website, you will see a list of best practices and articles surrounding the codes as well as the billing procedures for telehealth. So if you have any questions or concerns surrounding telehealth, we will gladly help assist you in that area.

Krista Davis: Thank you. Our next question is, if we are a Five-Star nursing home, are we still able to participate in the community?

Kia Wills: Yes, that is strongly encouraged. For our community works, we will need members such as a Five-Star nursing home to help us build that rapport in those communities. Most likely those Five-Star nursing homes already have established themselves in those communities and developed great relationships with those hospitals and home health agencies. So to have them participate will be truly beneficial, not only just to share those best practices to their peers, but to help us really improve in those areas that we touched on at this presentation.

Krista Davis: Thank you. Our next question is what sort of support do you offer as far as data?

Dawn Strawser: Yes, this is Dawn. We do produce a lot of data reports. If you have participated with us in past contract work, we have had many different types of data reports related to HAIs and readmissions. Our data team is very good with getting reports out there for you to review and to show your organization your improvement, or where you need to improve it.

Krista Davis: Thank you. We have no further questions in the queue.

Dawn Strawser: Okay. This is Dawn, and I do want to thank you. I know this is a hard time with getting out of what you're doing at your organizations to listen to a webinar. We did want to keep it short and let a lot of time for different questions related to the Community Coalition work. If you do have further questions, feel free to email us, give us a call, but we do hope that you want to participate with us in our Community Coalition work. We're excited to hopefully get this moving and get started with actually doing work related to the CMS goals that they have asked us to work on for the next four-and-a-half years. Thank you.

Kia Wills: Thank you.

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