Enhance the Health of Your Community
Partner with the IPRO QIN-QIO

Healthcare Provider Webinar
November 21, 2019
Meet Your Presenters

Marguerite McLaughlin, MA
Nursing Center Quality
Healthcentric Advisors

Marghie Giuliano, R.Ph.
Patient Safety
Healthcentric Advisors

Jennifer B. McCarthy, EdD, EdM, MS, LCPC
Behavioral Health & Opioid Use
Healthcentric Advisors

Lynne Chase
Care Transitions
Healthcentric Advisors

Brenda Jenkins, RN, D.Ay., CDOE, CPEHR, PCMH CCE
Chronic Disease Self-Management
Healthcentric Advisors

Gail Patry, MS, RN
Chief Program Officer
Healthcentric Advisors

Marguerite McLaughlin, MA
Nursing Center Quality
Healthcentric Advisors

Brenda Jenkins, RN, D.Ay., CDOE, CPEHR, PCMH CCE
Chronic Disease Self-Management
Healthcentric Advisors
The IPRO QIN-QIO – Who We Are

The federally funded Medicare Quality Innovation Network – Quality Improvement Organization for 11 states and the District of Columbia

• Led by IPRO
• Joined by Healthcentric Advisors and Qlarant
• Offering enhanced resources and support to healthcare providers and the patients and residents they serve
• Promoting patient and family engagement in care
• Supporting implementation and strengthening of innovative, evidence-based, and data-driven methodologies to support improvements
The IPRO QIN-QIO Region

**IPRO:** New York, New Jersey, Ohio

**Healthcentric Advisors:** Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island

**Qlarant:** Maryland, Delaware, District of Columbia

Working to ensure high-quality, safe healthcare for 20% of the nation’s Medicare beneficiaries
The IPRO QIN-QIO – What We Do

- Work toward better care, healthier people and communities, and smarter spending
- Catalyze change through a data-driven approach to improving healthcare quality
- Collaborate with providers, practitioners, and stakeholders at the community level to share knowledge, spread best practices and improve care coordination
- Promote a patient-centered model of care, in which healthcare services are tailored to meet the needs of patients
Quality Innovation Network – Quality Improvement Organizations (QIN-QIOs)

- Bring together healthcare providers, stakeholders, and Medicare beneficiaries to improve the quality of healthcare for targeted health conditions
- 12 regional CMS QIN-QIOs

Beneficiary and Family Centered Care-Quality Improvement Organizations (BFCC-QIOs)

- Manage all beneficiary complaints, quality of care reviews, EMTALA violations, and reviews of hospital discharge or discontinuation-of-services appeals
- Two regional BFCC-QIOs (Livanta and KePro)
Enhance the Health of Your Community

Partner with the IPRO QIN-QIO

- Align healthcare quality improvement activities with quality reporting and payment focus areas
- Leverage data to identify, track, and quantify improvements
- Improve processes within your four walls and within your community
- Problem solve with experts and peers across 11 states and the District of Columbia
The Whole is Greater Than the Sum of its Parts

Learning & Action Network
- Invitation only spotlight on success sharing, affinity groups and ECHO sprints with national subject matter experts
- Network and collaborate in peer-to-peer shared learning across states

Community Coalitions*
- Apply a collaborative approach to improve the overall health of community

Individual Providers
- Refine processes and improve outcomes with evidence-based tools/resources

* In applicable communities
Focus Areas Impact the Health of our Communities

- Behavioral Health & Opioid Use
- Patient Safety
- Chronic Disease Self-Management
- Care Transitions
- Nursing Home Quality
Nursing Homes

Working with **1,750** of the nursing homes in the region

Community Coalitions

- Communities that encompass at least **65% of the Medicare beneficiaries** in the state
- Members collaborating to improve outcomes for the communities they serve
  - Acute Care Hospitals
  - Critical Access Hospitals
  - Federally Qualified Health Centers
  - Home Health Agencies
  - Skilled Nursing Facilities
  - Physician Practices
  - Pharmacies
  - Community-based Organizations
Technical Assistance From QI Experts

- Root cause analysis (RCA)
- Evidence-based and best practice intervention selection & implementation
- Rapid cycle improvement via Plan-Do-Study-Act (PDSA)
- Measurement strategy and data analytics
- Access to clinician, patient and care partner education resources, e.g., webinars, ECHO® programs, learning and action networks, mobile apps, subject matter experts
Leverage Data to Quantify Improvement

Data Dashboards
IPRO QIN-QIO goal: Every QI intervention can incorporate a health information technology solution through:

- Providing assistance with integration of electronic health record ready tools and solutions for:
  - Data sharing & reporting
  - Clinical Decision Support (CDS) & Order Sets

- Use of evidence-based and best practice resources:
  - AHRQ Patient Centered Clinical Decision Support – Trusted Framework and Opioid Learning Network
  - AHRQ CDS Connect
  - AHRQ Care Transformation and Learning Health Systems

- Use of existing suite of EHR ready mobile apps for:
  - Management of Anticoagulation in the Peri-Procedural Period
  - Chronic Kidney Disease identification and management

- Providing access to nationally recognized clinical and health informatics subject matter experts
Behavioral Health & Opioid Use: A Public Health Issue

Approximately 26% of Medicare beneficiaries have mental health needs (including mental illness and cognitive disorders)

- 1 out of 4 primary care patients suffer from depression
- Medicare beneficiaries account for 16% of all suicides

46,298 opioid overdose deaths in 2017
- 1 person dying every 11.4 minutes
- Increasingly, the source of opioid deaths include combinations of prescriptions, heroin and/or synthetic opioids

Adverse drug events (ADEs) due to prescription opioids
- Contribute to costly emergency department use and hospitalization
- Largely preventable

Sources:
http://www.medicareadvocacy.org/medicare-and-mental-health/
Use innovative, evidence-based and data driven methods to reduce opioid deaths and adverse drug events (ADEs) by

- Decreasing opioid prescribing for prescriptions ≥90 MME daily across hospitals, long-term care and outpatient facilities
- Reducing opioid utilization, where appropriate
- Assisting in implementation of pain management and opioid use best practices
- Increasing access to behavioral health services
Behavioral Health and Opioid Use

Intervention Strategies

- Engage patients and care partners in the development and execution of interventions
- Provide access to subject matter experts who are leaders in their field
- Participate in topic-specific Project ECHO® programs

- Provide and/or develop resources based on facility/system baseline and ongoing data analysis
- Offer technical assistance for electronic health record modifications and reporting templates
Patient Safety: A Public Health Issue

The prevalence of Emergency Department (ED) visits for ADEs

- 4 ADEs per 1000 patients
- ~27% of these ADEs result in hospitalization
- Anticoagulants, diabetes agents, and opioids were implicated in ~60% of ED visits for ADEs in patients older than 65 years old

According to the Centers for Disease Control and Prevention...

- *Clostridioides difficile* (also known as *C. diff*) is estimated to cause almost half a million illnesses in the United States each year.
- About 1 in 5 patients who get *C. diff* will get it again.
- Within a month of diagnosis, 1 in 11 people over age 65 died of a healthcare-associated *C. diff* infection

Sources:
Increase Patient Safety: Reduce All-Cause Harm

Use innovative, evidence-based and data driven methods to:

• Reduce ADEs due to high risk medications in community and long term care settings

• High risk medications include anticoagulants, diabetes medications, and opioids, or a medication class otherwise prioritized by the HHS National Action Plan for ADE Drug Event Prevention

• Reduce *Clostridioides difficile* infection in all settings by promoting the identification, prevention and treatment of *C. difficile* and the initiation/expansion of antibiotic stewardship
Data and Measurement Strategy

• Assessment of baseline and ongoing measures using all-payer and Medicare claims data

• Collaboration with healthcare providers to establish, augment, and/or expand current electronic health record data reports

• Provide benchmarking reports at the QIN region, state, county, healthcare network, practice and individual provider levels for comparative analyses
### Chronic Disease Self-Management: A Public Health Issue

#### Diabetes
- 26.9% of Medicare beneficiaries have diabetes; 32% of Medicare spending
- People living with diabetes are twice as likely to develop heart disease or a stroke
- It’s the leading cause of kidney failure, lower limb amputations, and adult onset blindness

#### Chronic Kidney Disease
- 30 million in the United States are affected (10% of the population)
- 96% don’t know they have it
- Mortality rates for patients with CKD more than double those without CKD

#### Cardiovascular Health
- Stroke is the leading cause of serious long-term disability in the United States
- Each year over 1.5 million people suffer a heart attack or stroke
- > 800,000 die from cardiovascular disease (CVD) each year

---

**Sources:** cdc.gov; kidney.org; millionhearts.hhs.gov; stroke.com
Increase access to evidence-based Chronic Disease Self-Management

• Engage patients and their families to encourage better decision making and self-efficacy

• Work with coalitions to strengthen clinical-community linkages by building capacity to expand sustainable self-management interventions in vulnerable populations and rural communities

• Receive customized technical assistance on how to implement sustainable chronic disease self-management programs that may help decrease staff burden improve patient outcomes and satisfaction, decrease costs and help meet quality measures
Facilitate clinician-community linkages that will increase access of evidence-based Chronic Disease Self-Management interventions to improve health outcomes, reduce costs and improve care transitions in the following areas:

1. Support and promote best practices from the Million Hearts® Initiative - Promoting best practice strategies on the ABCs of stroke and heart disease prevention (Aspirin and Anticoagulation therapy, Blood pressure & Cholesterol control and Smoking cessation). Decrease smoking prevalence and improve uncontrolled high blood pressure and access to self-measured blood pressure monitoring programs

2. Prevent Medicare beneficiaries from developing diabetes - Offering technical assistance to clinical partners to increase Medicare Diabetes Prevention Program (MDPP) referrals

3. Improve management of diabetes for Medicare beneficiaries and those who are at high risk for complications - Create sustainable diabetes self-management programs by assisting communities and clinical partners to increase their training and education capacity
Facilitate clinician-community linkages that will increase access of evidence-based Chronic Disease Self-Management interventions to improve health outcomes, reduce costs and improve care transitions in the following areas:

4. Improve access to non-pharmacological interventions to help decrease opioid use for Medicare beneficiaries living with chronic pain - Providing technical assistance on capacity building and train-the-trainer programs to implement and promote Chronic Pain Self-Management education

5. Increase early screening, timely diagnosis and self-management of CKD - Capacity building and train-the-trainer on CKD-self-management programs. Facilitate clinical decision and patient engagement through CKD mobile applications
18% of Medicare patients discharged from the hospital have a readmission within 30 days, accounting for $15 billion in healthcare spending.
Improving Care Transitions: Reducing Readmissions

The Right Thing to Do
Better Care for Our Residents and Patients

- Patient Quality & Safety
- Patient Satisfaction
- Provider Wellness
- Public Reporting
- Maximal Reimbursement
Under the Hospital Readmission Reduction Program (HRRP), CMS withholds up to 3% of reimbursement for hospitals with higher-than-expected number of 30-day readmissions for:

- Chronic lung disease
- Coronary artery bypass graft surgery
- Heart attacks
- Heart failure
- Hip and knee replacements
- Pneumonia

2,599 hospitals (82% of participants) will receive reduced reimbursement under the Hospital Readmissions Reduction Program (HRRP) in FY 2019.
Improving Care Transitions: Reducing Readmissions

It’s not just hospitals...

CMS' Skilled Nursing Facility (SNF) Value-based Purchasing (VBP) Program
Started Oct 1, 2018

- 73% of SNFs received a penalty the first year of the program

- Home health agencies in nine states are part of the five-year home health VBP pilot program
- CMS plans to make VBP mandatory nationwide in 2022
…Working together, we can enhance care transitions

- Facilitate coordination of care within the four walls of your organization and among your community partners
- Promote effective communication and information transfer
- Engage patients and families in the transitions planning process
- Reduce unnecessary hospitalization (ED visits, observation stays, admissions and readmissions)
  Focus on super-utilizers
- Reduce ADEs
Working with the Super-Utilizer Population

5% of the population accounts for 50% of the cost

# A Framework for Root Cause Analysis

<table>
<thead>
<tr>
<th>Medical</th>
<th>Behavioral Health</th>
</tr>
</thead>
</table>
| • Compounded Medical Problems  
• Complex symptom management  
• Competency and complex surrogate decision makers | • Psychiatric Diagnoses  
• Substance Use Disorder  
• Compounded Trauma, Grief and Loss  
• Behaviors as a symptom |

<table>
<thead>
<tr>
<th>Social</th>
<th>System</th>
</tr>
</thead>
</table>
| • Housing  
• Transportation  
• Food Security  
• Legal History  
• Health Literacy  
• Language  
• Cultural Preference  
• Safety | • Insurance Barriers  
• Complex Eligibility Requirements  
•Disconnected Services  
• Lack of Access  
• Inexperience with navigating and coordinating with social services cross continuum |

Adapted from The National Center for Complex Health and Social Needs
Nursing Home Quality Improvement (QI) Focus using current best practices and person-centered approaches:

- Decrease opioid prescribing
- Reduce adverse drug events (ADEs)
- Reduce hospitalizations for nursing home onset *C. difficile*
- Reduce healthcare-acquired infections
- Reduce emergency department visits & readmissions for short stay nursing home residents
- Improve the mean Total Quality Score for all nursing homes
Nursing Home Quality Improvement Intervention

Technical Assistance
Solutions for your most pressing challenges; customized one-on-one support; innovative, evidence based solutions; trauma-informed care implementation

Educational Resources
Access to subject matter experts, learning collaboratives, QI Resource Library, subject specific change packages, webinars, and educational forums

Data Driven Approach to Quality
Provide customized data analysis, tracking and trending progress reports and dashboards; transform data into practical improvement strategies
Benefits of Participation

- Improve quality measures and problems that hinder Star rating success
- Transform data into practical improvement strategies
- Improve the culture of safety that could be effecting your bottom line
- Develop strong care teams that are adept at Quality Assurance & Performance Improvement (QAPI)
- Receive customized support from our team of skilled clinicians, administrators, subject matter experts and change agents who have personal experience in the nursing home or healthcare industry
- Link to:
  - Peer to peer organizational knowledge sharing
  - Evidence-based resident safety quality practice and standardized approach
  - Health information exchange technologies
• Greater focus on individualized care leading to improved satisfaction
• Fewer infections
• Fewer trips to the emergency department or hospital
• Increased collaboration with residents and their families
Together We Can Make a Difference

We invite you to...

- **Join our team** to improve the quality of care across our network

- **Be part of the solution** for improving healthcare outcomes for 20% of the Medicare beneficiaries in the nation
Next Steps

- **Recruitment**
  - Skilled Nursing Facilities
  - Community Coalitions

- **Provider Engagement**
  - Share information and contacts in newsletters, provider meetings, member communications
  - Letter of support to encourage providers to participate & sign Participation agreement with IPRO QIN-QIO

- **Collaboration & Planning**
  - 1:1 outreach for shared goal and planning discussions
  - Integration of individual statewide initiatives
  - Environmental scan information
For More Information

New England
Gail Patry, Chief Program Officer
Healthcentric Advisors
gpatry@healthcentricadvisors.org

Massachusetts & Vermont
Lynne Chase
lchase@healthcentricadvisors.org

Maine & New Hampshire
Danielle Hersey
dhersey@healthcentricadvisors.org

Rhode Island & Connecticut
Kathy Calandra
kcalandra@healthcentricadvisors.org

This material was prepared by the IPRO QIN-QIO, a collaboration of Healthcentric Advisors, Qlarant and IPRO, serving as the Medicare Quality Innovation Network-Quality Improvement Organization for the New England states, NY, NJ, OH, DE, MD, and the District of Columbia, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents do not necessarily reflect CMS policy. 12SOW.IPRO.NE.TA.AA.2019.9