Quality Improvement Organizations
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CENTERS FOR MEDICARE & MEDICAID SERVICES

Great Plains
Quality Innovation Network

Introducing the Great Plains Quality Innovation Network & the Launch of the 11SOW

This material was prepared by the Great Plains Quality Innovation Network, the Medicare Quality Improvement Organization for Kansas, Nebraska, North Dakota and South Dakota, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 11S0W-GPQIN-NE-D1-02/1014

11th Scope of Work (SOW) – Program Changes

- CMS separated medical case review from quality improvement work creating two separate structures:
  - **Beneficiary Family Centered Care Quality Improvement Organizations** (BFCC-QIOs)
    - Perform medical case review
    - Organized among five geographic areas across the Nation
  - **Quality Innovation Network Quality Improvement Organizations** (QIN-QIOs)
    - Offer quality improvement and technical assistance
    - QIN-QIOs are regional and cover three to six states
- The QIO contract cycle has been extended to five years (previously was three years)

The Great Plains Quality Innovation Network: A New Entity

- The Great Plains QIN was formed with the following four entities serving as subcontractors; each a QIO in previous scopes:

  - Kansas Foundation for Medical Care
  - CIMRO of Nebraska
  - North Dakota Health Care Review, Inc.
  - South Dakota Foundation for Medical Care

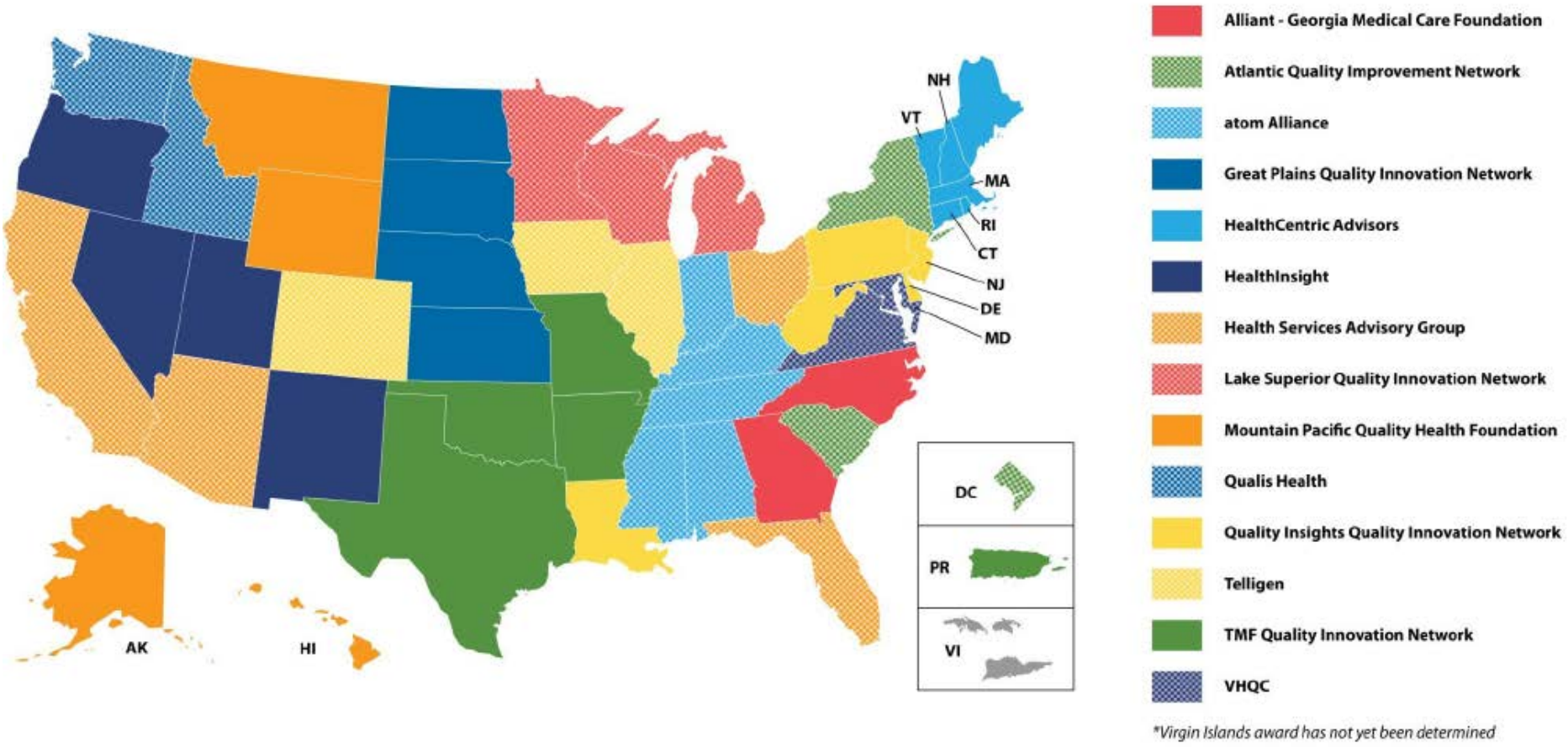
Make-Up of the Great Plains QIN

These four states choose to work together because of:

- commonalities of Medicare consumers
- provider characteristics
- rural and frontier issues
- similar corporate philosophies and general approaches to the QIO work

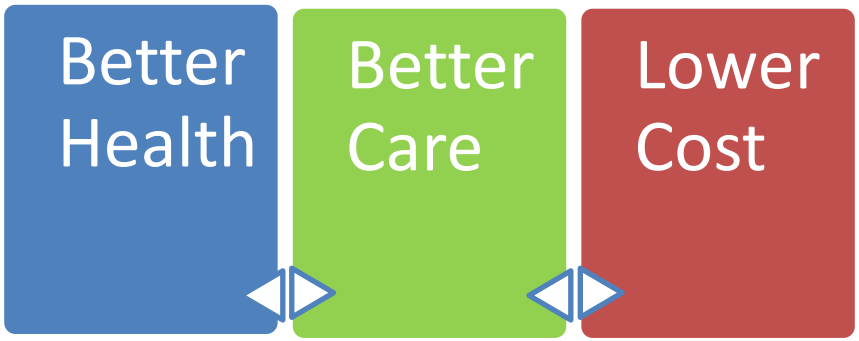
These common factors are strengths in working cohesively

11SOW QIN-QIO Map



The QIO Program's Approach to Clinical Quality

Aims



Foundational Principles:

- Enable innovation
- Foster learning organizations
- Eliminate disparities
- Strengthen infrastructure and data systems

Goals

- Make care safer
- Strengthen person and family engagement
- Promote effective communication and coordination of care
- Promote effective prevention and treatment
- Promote best practices for healthy living
- Make care affordable

Quality Innovation Network (QIN)
QIOs – What Will We Do?

- **Champion local-level, results-oriented change**
  - Data driven
  - Active engagement of patients and other partners
  - Proactive, intentional innovation and spread of best practices
- **Facilitate Learning and Action Networks (LANs)**
  - Creating an "all teach, all learn" environment
  - Placing improvement at the bedside level – e.g., hand washing
- **Teach and advise as technical experts**
  - Consultation and education
  - Management of knowledge so learning is never lost
- **Communicate effectively**
  - Optimal learning, patient activation and sustained behavior change

Introducing the 11SOW AIMS

- During this presentation, we will provide a high-level overview of the AIMS that Great Plains Quality Innovation Network staff will assist with over the next five years

Cardiovascular Health and Million Hearts® Network

- Heart disease and stroke are the first- and fourth- leading causes of death[1]

- Heart disease and stroke cost more than $312.6 billion in healthcare expenditures and lost productivity annually [2]

Our planned improvement efforts align with the national Million Hearts initiative that seeks to prevent one million heart attacks and strokes by 2017

1. *Centers for Disease Control and Prevention*
2. *Million Hearts®*

The Approach

- Offering assistance on the Physician Quality Reporting System (PQRS) cardiovascular measures submission
- Assist home health agencies with measures reporting through the Home Health Cardiovascular Data Registry
- Data analysis and performance improvement activities, including improving performance on clinical quality measures
- Align with the Million Hearts Initiative (www.millionhearts.hhs.gov) to improve preventive care measures, including aspirin use, blood pressure control, cholesterol management and smoking/tobacco education
- We will target disparate populations, including gender, racial and ethnic disparities, to improve cardiac health

Everyone with Diabetes Counts

- Nearly one-third of persons 65 years and older have diabetes [1]
- African-Americans are up to 2.2 times more likely to have diabetes than whites, and Hispanic/Latino Americans have a higher prevalence of diabetes than non-Hispanic individuals [2]
- We plan to expand the reach of effective diabetes education programs through the participation of more healthcare practitioners
- We aim to improve the quality of lives for all persons with diabetes by expanding opportunities for diabetes self-management education

[1] National Institutes of Health and the Centers for Disease Control and Prevention

[2] The Office of Minority Health

Our Approach

- Assist physician practices in improving clinical outcomes of HbA1c, lipids, blood pressure and weight control
- Work to increase the number of Medicare beneficiaries participating in Diabetes Self-Management Education classes utilizing the Stanford Chronic Disease Program
- Work with DHHS stakeholders, organizations and academic institutions to increase the number of diabetes educators, certified diabetes educators (CDEs) and community health workers

Healthcare-Associated Infections (HAIs)

- 200 Americans die every day from healthcare-associated infections (HAIs)[1]
- HAIs are a leading cause of preventable death in the U.S.[2]

[1] Centers for Disease Control and Prevention

[2] HealthyPeople.gov

Approach to Healthcare-Associated Infection (HAI) Prevention

- Facilitate a Learning and Action Network to address:
  - Catheter-Associated Urinary Tract Infections (CAUTIs)
  - Central Line-Associated Bloodstream Infections (CLABSIs)
  - Clostridium Difficile Infections (CDIs)
  - Ventilator Associated Events (VAE)
  - Other national HAI topics as suggested by the CDC and CMS
- Maintain NHSN expertise and support hospital reporting
- Focus on the CMS goals of eliminating disparities, strengthening infrastructure and data systems, enabling local innovations and fostering learning organizations

Nursing Home Quality Improvement

- Building on previous work, QIN-QIO efforts will align with national initiatives:
  - The national Nursing Home Quality Initiative
  - Advancing Excellence in America's Nursing Home Campaign
  - The Partnership to Improve Dementia Care
  - Quality Assurance Performance Improvement (QAPI)

Nursing Home Quality Improvement Goals

- Achieve a score of six or better on the Nursing Home Quality Composite Measure Score
- Improve the mobility of long-stay residents
- Decrease unnecessary use of antipsychotic medications
- Decrease healthcare-associated infections and other healthcare-acquired conditions
- Decrease potentially avoidable hospitalizations

Our Approach

- Recruit 75% of nursing homes to participate in a Learning and Action Network/Collaborative
- Provide technical assistance and support to one-star and two-star facilities
- We will select peer-coaches from high-performing nursing homes to provide best-practice support to other nursing homes, one peer coach shall be a NH resident/beneficiary or family member

Quality Reporting & Incentive Programs

- Will partner with eligible physicians and physician groups to prepare them to meet the requirements of the CMS Value-Based Payment Modifier program
- Offer education and resources to Hospitals on Value-Based Purchasing
- Assist with reporting via the Physician Quality Reporting System (PQRS) and the value-based payment modifier/Physician Feedback program
- Identify gaps in quality care, including disparities and coordination of care

Utilizing HIT to achieve 'Meaningful Use'

- Effective use of Health Information Technology decreases paperwork, provides improved access to medical records and improves care coordination among providers

- Support sustainable system changes and full optimization of Certified Electronic Health Record Technology (CEHRT) capabilities to help participating providers be well positioned for future incentive programs

- Provide technical assistance and innovative tools and resources to help physicians and providers maximize the use of CEHRT and improve patient care and care coordination

Care Coordination

- More than 17 percent of Medicare beneficiaries are re-hospitalized within 30 days of hospital discharge[1]
- 76 percent of readmissions may be preventable[2]

Improving care coordination leads to better patient outcomes, overall satisfaction and reduces avoidable hospital admissions

[1] U.S. Department of Health & Human Services
[2] Medicare Payment Advisory Committee

Care Coordination Goals

- Reduce hospital admission and readmission rates in the Medicare program by 20 percent by 2019
- Increase community tenure by increasing the number of days spent at home by Medicare Fee-for-Service (FFS) beneficiaries by 10 percent
- Reduce the prevalence of adverse drug events, emergency department visits and observation stays or readmissions occurring as a result of the care transitions process

Our Approach

- Convene community providers and stakeholders to collaborate and share time and resources to reduce avoidable hospital admissions/ readmissions and improve care transitions
- Provide data and analytic support to communities to identify gaps in quality, develop strategies for improvement and measure the impact of interventions
- Work with communities to reduce the prevalence of adverse drug events related to anticoagulants, diabetic or opioids

Quality Improvement Initiative (QII)

- The Great Plains QIN may receive a referrals from QIO sources for the following:

  1) quality of care concerns
  2) when data reveals a provider may benefit from assistance
  3) based on their performance score for VBP
  4) survey and certification findings

- Upon referral, Great Plains QIN will work with providers to develop a formal plan to develop the root cause of the problem, framework to address the concern and identify a process for improvement

Learning and Action Networks (LANs)

- Convene stakeholders, providers and improvement experts in an “all teach, all learn” model
- We will be sure to invite and involve Medicare consumers in our efforts
- Provide targeted technical assistance to participating providers, stakeholders and communities
- Through the LAN, the Great Plains QIN will provide educational webinars and conferences, encourage peer sharing, rapid testing of change ideas and support for adapting and spreading successful improvements

How to Get Involved

- We are very excited about this opportunity and will share more details about our work and how you can get involved in the coming weeks
- We look forward to partnering with you and expanding our reach as the Great Plains Quality Innovation Network
- Join our efforts as we strive to achieve better care, better health for people and communities and more affordable care through quality improvement

How We Will Assist

In each of our states, experienced staff will be available to:

- Facilitate and lead regional QIN activities
- Provide individual consultation on quality projects
- Directly support your ongoing quality initiatives or collaborations
- Offer tools, resources and education to help foster efficient clinical processes and improved patient outcomes

Questions?

Hospital VBP Program: FY 2017 Domain Weights & Measures

Patient and Caregiver Centered Experience of Care/Care Coordination

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey

Clinical Care

Outcomes	Process
MORT-30-AMI	AMI-7a
MORT-30-HF	IMM-2
MORT-30-PN	PC-01*

Efficiency and Cost Reduction

MSPB-1

Safety

CLABSI	Hysterectomy
CAUTI	MRSA*
SSI: Colon Surgery and Abdominal	C-*difficile**
	AHRQ PSI-90

An asterisk (*) indicates a newly adopted measure for the Hospital VBP Program.

Hospital VBP Program: Added and Removed Measures

- **Measures Added for FY 2017**
  - MRSA Bacteremia (Safety Domain)
  - *C. difficile* infection (Safety Domain)
  - PC-01: Elective Delivery Prior to 39 Completed Weeks Gestation (Clinical Care/Process Domain)
- **Measures Removed in FY 2017**
  - PN-6 (Clinical Process of Care)
  - SCIP-CARD-2 (Clinical Process of Care)
  - SCIP-Inf-2 (Clinical Process of Care)
  - SCIP-Inf-3 (Clinical Process of Care)
  - SCIP-Inf-9 (Clinical Process of Care)
  - SCIP-VTE-2 (Clinical Process of Care)

Hospital VBP Program: FY 2017 Reporting Periods

Domain	Baseline Period	Performance Period
Safety • Healthcare Associated Infections • AHRQ PSI-90	1/1/2013 – 12/31/2013 10/1/2010 – 6/30/2012	1/1/2015 – 12/31/2015 10/1/2013 – 6/30/2015
Clinical Care • Process • Outcomes	1/1/2013 – 12/31/2013 10/1/2010 – 6/30/2012	1/1/2015 – 12/31/2015 10/1/2013 – 6/30/2015
Efficiency and Cost Reduction	1/1/2013 – 12/31/2013	1/1/2015 – 12/31/2015
Patient and Caregiver-Centered Experience of Care/Care Coordination (HCAHPS)	1/1/2013 – 12/31/2013	1/1/2015 – 12/31/2015

Hospital VBP Program: FY 2017 Performance Standards (1 of 2)

Domain	Measure	Achievement Threshold	Benchmark	Floor
Safety	CAUTI	0.845	0.000	N/A
	CLABSI	0.457	0.000	N/A
	C. difficile	0.750	0.000	N/A
	MRSA Bacteremia	0.799	0.000	N/A
	PSI-90	0.577321	0.397051	N/A
Clinical Care Outcomes	MORT-30-AMI	0.851458	0.871669	N/A
	MORT-30-HF	0.881794	0.903985	N/A
	MORT-30-PN	0.882986	0.908124	N/A
Clinical Care Process	AMI-7a	0.954545	1.000000	N/A
	IMM-2	0.951607	0.997739	N/A
	PC-01	0.031250	0.000000	N/A

Hospital VBP Program: FY 2017 Performance Standards (2 of 2)

Domain	Measure	Achievement Threshold	Benchmark	Floor
Efficiency and Cost Reduction	MSPB-1	Median Medicare Spending per Beneficiary ratio across all hospitals during the performance period	Mean of the lowest decile Medicare Spending per Beneficiary ratios across all hospitals during the performance period	N/A
Patient and Caregiver-Centered Experience of Care/Care Coordination Domain	Communication with Nurses	78.19	86.61	58.14
	Communication with Doctors	80.51	88.80	63.58
	Responsiveness of Hospital Staff	65.05	80.01	37.29
	Pain Management	70.28	78.33	49.53
	Communication about Medicines	62.88	73.36	41.42
	Hospital Cleanliness & Quietness	65.30	79.39	44.32
	Discharge Information	85.91	91.23	64.09
	Overall Rating of Hospital	70.02	84.60	35.99

Hospital VBP Program: FY 2017 Minimum Requirements (1 of 2)

Domain	Domain Minimum	Measure	Measure Minimum
Safety	3 of 6 Measures	CAUTI	1.000 Predicted Infections
		CLABSI	1.000 Predicted Infections
		C. difficile	1.000 Predicted Infections
		MRSA Bacteremia	1.000 Predicted Infections
		SSI	1.000 Predicted Infections on either Abdominal Hysterectomy or Colon
		PSI-90	3 Cases in Any One Underlying Indicator
Clinical Care Outcome	2 of 3 Measures	MORT-30-AMI	25 Cases
		MORT-30-HF	25 Cases
		MORT-30-PN	25 Cases
Clinical Care Process	1 of 3 Measures	AMI-7a	10 Cases
		IMM-2	10 Cases
		PC-01	10 Cases

Hospital VBP Program: FY 2017 Minimum Requirements (2 of 2)

Domain	Domain Minimum	Measure	Measure Minimum
Efficiency and Cost Reduction	**1 of 1 Measure**	**MSPB-1**	**25 Episodes of Care**
Patient and Caregiver-Centered Experience of Care/Care Coordination Domain	100 Completed Surveys	Communication with Nurses	100 Completed Surveys
		Communication with Doctors	
		Responsiveness of Hospital Staff	
		Pain Management	
		Communication about Medicines	
		Hospital Cleanliness & Quietness	
		Discharge Information	
		Overall Rating of Hospital	

Hospital VBP Program: Domain Reweighting Changes

- Hospitals must receive domain scores on at least 3 of the 4 quality domains to receive a Total Performance Score (TPS)
- Clinical Care domain – Process or Outcome subdomains considered as one domain
- Only reweight a hospital's TPS once:
  - If a hospital does not have sufficient data for 1 of the 2 Clinical Care subdomains
  - Will not reallocate weighting of the 2 clinical subdomains within the Clinical Care domain
  - The weighting of the subdomain without sufficient data will be proportionately reallocated across all domains