Getting Started with HQIN Quality Improvement Initiative

October 29, 2020

Objectives:

- Overview of QIN-QIO Project and 5 CMS Aims
  - Discuss partners and regions (hospitals, clinics, and organizations)
  - Alignment across national and state programs
- Establishing practice priorities
- Next steps and project timeline
  - Practice Assessment
  - Baseline data and monthly reporting
  - Reports

HQIN Health Quality Innovation Network

Your HQIN Local Improvement Partner

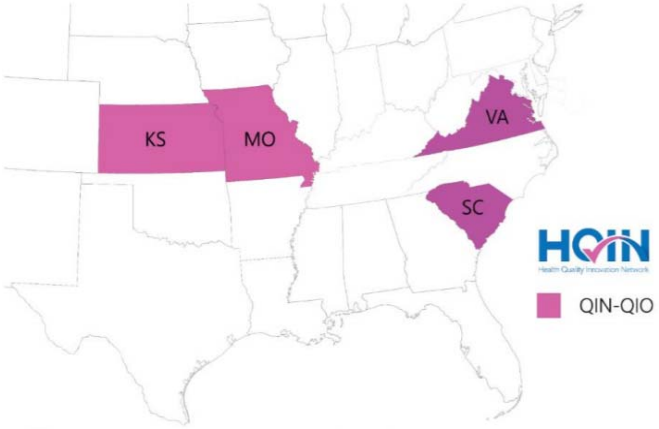
Kansas Healthcare COLLABORATIVE

- KHC equips Kansas to be a role model for health care quality.
- KHC is staffed by health care QI experts who understand your setting of care.

Part of the National QIN-QIO Network

- Designed to improve outcomes, performance and value
- Committed to reaching rural and vulnerable populations
- Powered by local engagement
- Backed by 5 years of CMS funding

HQIN QIN-QIO Coverage Area



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HQIN Partners with KFMC and KHC

KHC will focus on building collaborative community coalitions, including hospitals, clinicians, home health agencies and community-based organizations. Support at the local level will lead to fewer hospital readmissions and improved management of chronic disease.

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Patient & Family Engagement, Rural Health, Health Equity, Vulnerable Populations, Pandemic Response

5 CMS Aims / Programs	12th Scope of Work			
	HQIN QIN-QIO Clinicians, Hospitals, Community	CQIC Clinicians	HQIC Hospitals	KDHE Clinicians and Hospitals
Behavioral Health & Opioids	✓	✓	✓	✓
Patient Safety	✓	✓	✓	✓
Chronic Disease Self-Management	✓	✓		✓
Care Transitions	✓	✓	✓	✓
Nursing Home Quality	✓			

Physician Practice Goals

Opioids & Behavioral Health

1) Implement best practices for pain management and opioid use
2) Decrease opioid-related adverse drug events for patients who take high-risk medications* or have a behavioral health diagnosis

**Anticoagulants, diabetic medications, opioids and antipsychotics*

Physician Practice Goals

Patient Safety

1) Reduce adverse drug events for all patients
2) Reduce adverse drug events for patients who take high-risk medications*
3) Adopt antibiotic stewardship strategies to prevent *C. difficile* in the community

**Anticoagulants, diabetic medications, opioids and antipsychotics*

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Physician Practice Goals

Chronic Disease Self-Management

1) Identify and manage people with chronic kidney disease to slow its progression
2) Refer patients to CDC-recognized diabetes lifestyle change programs
3) Bring hypertension, hyperlipidemia, and hemoglobin A1c levels under control for more of your patients
4) Help more of your patients quit smoking

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Physician Practice Goals

Care Transitions

You also can participate in your community's Care Transitions Coalition to:

1) Reduce avoidable admissions and readmissions
2) Reduce avoidable ED visits and admissions by super-utilizers
3) Reduce avoidable admissions, readmissions and super-utilization

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Physician Practice Goals

Patient Engagement & Experience

When you work on any of these goals, you also will receive support and guidance to:

- Activate patients for greater engagement in decision making and disease self-management
- Improve the way you deliver services to increase your patient experience of care ratings

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How Practices Benefit

1) Increased ability to qualify for a positive MIPS payment adjustment
2) Readiness for success in value-based payment
3) Greater value from your EHR
4) Opportunities to create new revenue streams

Practice Improvement Priorities

1) You will work on the priorities that make sense for your practice
2) Most practices will not work on every priority
3) Your Quality Improvement Advisor will help focus your efforts

Examples of Practice QI Strategies

Area	Focus	Strategy
Opioids & Behavioral Health	Increase non-opioid pain management options	Connect to local resources; e.g., pain self-management education
Patient Safety	Reduce adverse drug events for patients who take high risk meds	Partner with local pharmacy for medication review program
Chronic Care Self-Management	Identify patients with chronic kidney disease	Implement evidence-based CKD screening protocols
Care Transitions	Reduce super-utilization	Implement Transitions of Care Management and connect to community resources
Patient Engagement & Experience	Increase patient activation and engagement	Engage patients and co-create care plans

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Alignment with other KHC projects

- Chronic Care Management
  - Hypertension
  - Diabetics
- Care Transitions
  - Reduce hospital admissions and readmissions
  - Reduce E.D. visits and admissions by super-utilizers
- Reduce adverse drug events (ADEs) and decrease opioid-related deaths

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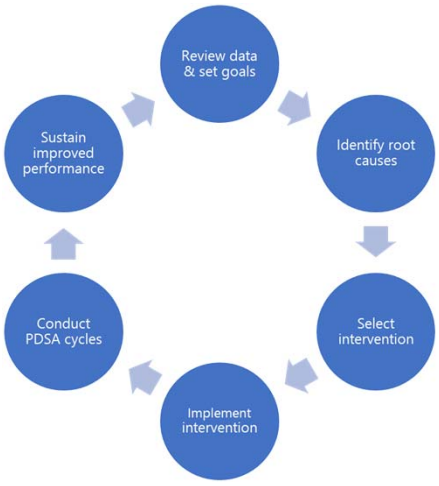
A Collaborative Approach to Improvement



We help by:

- Providing data analyses
- Providing TA
- Recommending QI strategies
- Suggesting tools and resources
- Coaching on implementation
- Building your QI skills
- Facilitating peer-to-peer learning
- Delivering educational content
- Recommending sustainment strategies

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HQIN Community Collaboration

Hospitals / Health Systems

- Opioids
- Behavioral Health
- Admissions/Readmissions
- Observation Stays
- Unavoidable ED Visits
- Adverse Drug Events
- Hospital Acquired CDI

Physician Practices

- Opioids
- Behavioral Health
- Diabetes/CKD
- Cardiovascular Disease
- Antibiotic Stewardship
- Advanced Care Planning
- CCM
- TCM
- Medication Reconciliation

Community Partners

Partner with Hospitals, Physician Practices, patients and families to improve patient outcomes through disease prevention, chronic disease management, and care coordination across the continuum of care

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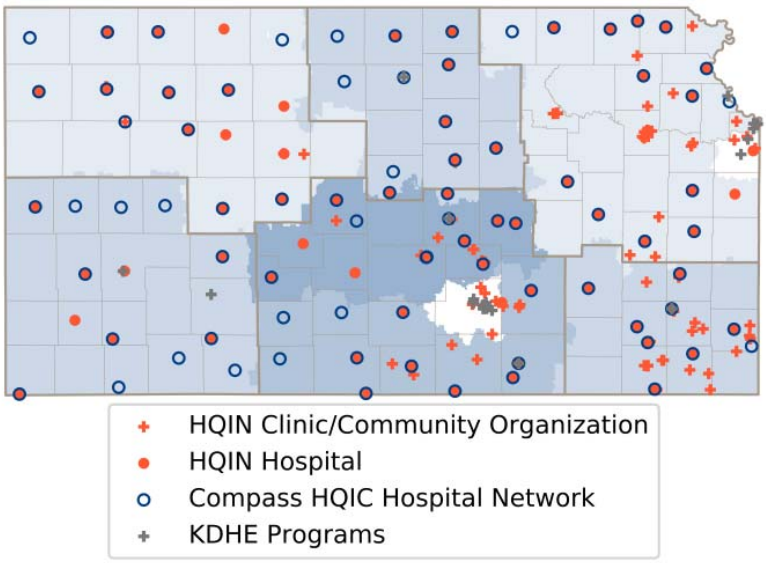

Your QIA Team

Jill Daughhetee
Quality Improvement Advisor

Malea Hartvickson
Quality Improvement Advisor

Mandy Johnson
Quality Improvement Advisor

Patty Thomsen
Quality Improvement Advisor

Rebecca Thurman
Quality Improvement Advisor

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Next Steps

- Complete Practice Assessment
- Report baseline data
- Establish health priorities for your practice/community
  - Identify areas of need
    - Data sources include:
      - Community needs assessment
      - Kansas Health Matters
      - BRFSS
      - Community Commons
      - CDC & others

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HQIN Physician Practice Assessment

Practice Information

Practice Name	
Contact Name/Title	
Preferred method of contact (email/phone)	
If phone, best phone number to use	
Other Contacts (name, role, email)	
Number of Sites	
Number of Clinicians	
EHR Vendor and Version	

Practice Assessment

Preferred methods for learning (e.g. Webinars, One-on-One Coaching, Peer-to-Peer Coaching, In-person Learning Events, Podcasts, Train the trainer, data analytic support, or describe other methods of interest to your organization)	
Do you collect patient feedback on their experience/satisfaction (Yes/No)?	
What tool do you use (i.e., CAHPS)?	
How frequently do you run feedback reports?	
Are you participating in MIPS (Yes/No)?	
What quality initiatives are you currently working on? What are you working on for other payors?	
What measures are you reporting for those initiatives?	
Are there any quality initiatives that you've identified as an opportunity for improvement?	
Are there any additional quality measures outside of the initiatives that you track? (If yes, Specify.)	
How often do you run reports and review quality measures?	
Do you use an EHR registry to track data (Yes/No)?	
Have you reviewed the HQIN Activities & Measures Assessment (Yes/No)?	

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Physician Practice Assessment

HQIN Physician Practice Measure Set

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Measure	NQF	QPP	eCQM	MSSP	UDS
CMS Goal 1: *Behavioral Health Outcomes/Opioids*					
1. Dementia-Associated behavioral and Psychiatric Symptoms Screening and Management	---	283	---	---	---
2. Preventive Care and Screening: Screening for Depression and Follow-Up Plan*	0418	134	2v8	ACO18	6B21
3. Opioid Therapy Follow-Up Evaluation	---	408	---	---	---
4. Use of Opioids at High Dosage in Persons without Cancer	2940	---	---	---	---
5. Evaluation or Interview for Risk of Opioid Misuse	---	414	---	---	---
6. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*	0004	305	137v7	---	---
CMS Goal 2: *Patient Safety/Reduce All Cause Harm*					
1. Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	0058	116	---	---	---
2. Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)	---	331	---	---	---
CMS Goal 3: *Chronic Disease Management/Prevention*					
1. Chronic Care Management (CCM) - Number of medicare Patients Receiving CCM Services	---	---	---	---	---
2. Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up	---	317	22v7	ACO21	---
3. Statin Therapy for the Prevention of Cardiovascular Disease	---	---	347v2	AVO42	6B17a
4. Controlling High Blood Pressure	0018	236	165v6	ACO28	2A2c
5. Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	0421	128	69v7	---	6B13
6. Number Patient referred to DPP Program	---	---	---	---	---
7. CKD Screening for Individuals with Diabetes	---	---	---	---	---
8. Diabetes: Medical Attention for Nephropathy*	0062	119	134v7	---	---
9. Diabetes: Eye Exam	005	117	131v7	---	---
10. Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy - Neurological Evaluation	0417	126	---	---	---
11. Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)*	0059	001	122v7	ACO27	2.C
CMS Goal 4: *Care Transitions/Coordination*					
1. Advanced Care Planning (Documentation in EHR)	0326	047	---	---	---
2. Annual Wellness Visits (AWVs) - Number of Medicare Patients with an AWV	---	---	---	---	---
3. Transition of Care Management (TCM) - Number of Medicare Patients who Receive TCM Services	---	---	---	---	---

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Practice Measure Set

www.khconline.org/HQIN-measure-set

sure	NQF	QPP	eCQM	MSSP	
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Screening for Individuals with Diabetes	---	---	---	---	

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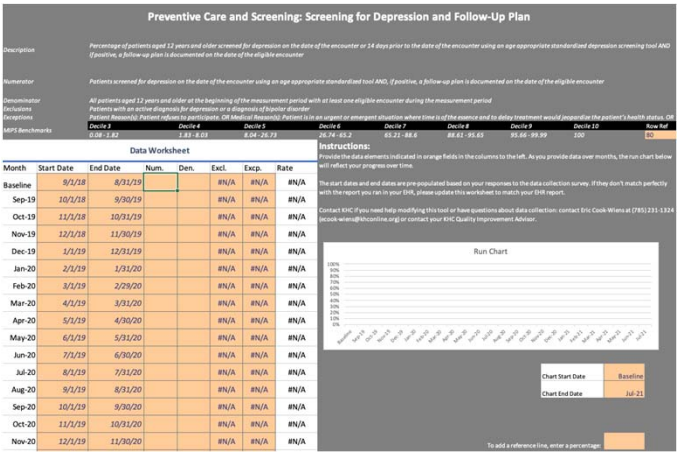
Data & Measurement

How-to video on using your customized HQIN measure worksheet:

www.khconline.org/HQIN-data-demo



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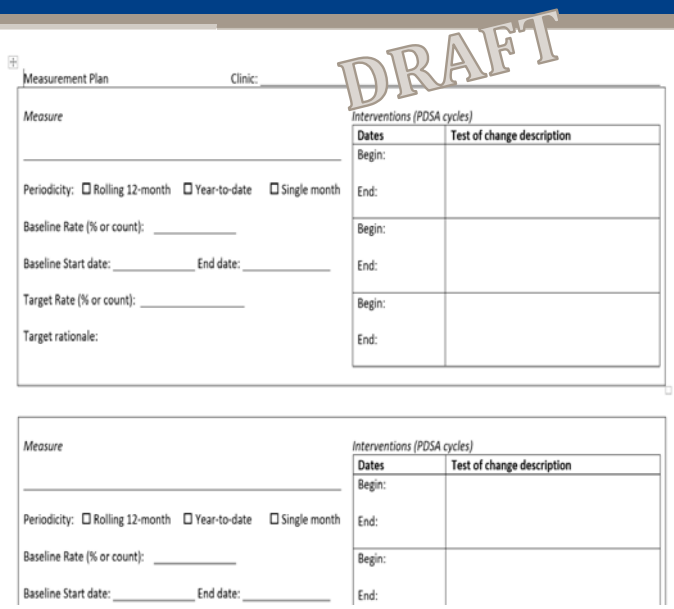
Work Documents Measurement Plan



Measurement Plan Clinic:

DRAFT

Measure

Periodicity: ☐ Rolling 12-month ☐ Year-to-date ☐ Single month

Baseline Rate (% or count):

Baseline Start date: End date:

Target Rate (% or count):

Target rationale:

Interventions (PDSA cycles)

Dates	Test of change description
Begin: / End:	
Begin: / End:	
Begin: / End:	

Measure

Periodicity: ☐ Rolling 12-month ☐ Year-to-date ☐ Single month

Baseline Rate (% or count):

Baseline Start date: End date:

Interventions (PDSA cycles)

Dates	Test of change description
Begin: / End:	
Begin: / End:	

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Reporting Schedule 2021

HQIN Reporting Schedule Through 2021

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Reporting Period		Rolling 12		Year-to-date		Single Month		
Month	Year	Start	Stop	Start2	Stop3	Start4	Stop5	Due date
Baseline		9/1/2018	8/1/2019					10-Nov
October	'20	11/1/2019	10/31/2020		~ 10/31/20	10/1/2020	10/31/2020	10-Nov
November	'20	12/1/2019	11/30/2020		~ 11/30/20	11/1/2020	11/30/2020	15-Dec
December	'20	1/1/2020	12/31/2020		~ 12/31/20	12/1/2020	12/31/2020	15-Jan
January	'21	2/1/2020	1/31/2021	1/1/2021	~ 01/31/21	1/1/2021	1/31/2021	15-Feb
February	'21	3/1/2020	2/28/2021		~ 02/28/21	2/1/2021	2/28/2021	15-Mar
March	'21	4/1/2020	3/31/2021		~ 03/31/21	3/1/2021	3/31/2021	15-Apr
April	'21	5/1/2020	4/30/2021		~ 04/30/21	4/1/2021	4/30/2021	15-May
May	'21	6/1/2020	5/31/2021		~ 05/31/21	5/1/2021	5/31/2021	15-Jun
June	'21	7/1/2020	6/30/2021		~ 06/30/21	6/1/2021	6/30/2021	15-Jul
July	'21	8/1/2020	7/31/2021		~ 07/31/21	7/1/2021	7/31/2021	15-Aug
August	'21	9/1/2020	8/31/2021		~ 08/31/21	8/1/2021	8/31/2021	15-Sep
September	'21	10/1/2020	9/30/2021		~ 09/30/21	9/1/2021	9/30/2021	15-Oct
October	'21	11/1/2020	10/31/2021		~ 10/31/21	10/1/2021	10/31/2021	15-Nov
November	'21	12/1/2020	11/30/2021		~ 11/30/21	11/1/2021	11/30/2021	15-Dec
December	'21	1/1/2021	12/31/2021		~ 12/31/21	12/1/2021	12/31/2021	15-Jan

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Timeline:

Due by November 10, 2020	Complete Practice Assessment Review reporting "how to" video (slide 24) Report baseline data Identify priority areas
December 2020	Meet with KHC QIA (Virtual) Review Community Needs Assessment Identify interventions Develop implementation plans Develop process to report/review monthly data
January & Monthly Moving Forward	Meet with KHC QIA (Virtual) QI projects and interventions work Report/review data

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More Information

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