# 2014 QIO Program Progress Report

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Introduction from Dennis Wagner

http://youtu.be/miwdji0r21U

An Introduction from Dennis Wagner, Acting Director of the Centers for Medicare & Medicaid Services (CMS), Center for Clinical Standards and Quality, Quality Improvement Group

Year in Review

Improving How We Serve Medicare Beneficiaries

As of August 1, 2014, CMS redesigned its Quality Improvement Organization (QIO) Program to further enhance the quality of services for Medicare beneficiaries.

The new QIO Program structure follows a functional model with two types of QIOs: Quality Innovation Network-QIOs (QIN-QIOs) and Beneficiary and Family Centered Care-QIOs (BFCC-QIOs). Fourteen regional QIN-QIOs work with providers, community partners and beneficiaries on multiple data-driven quality improvement initiatives to improve patient safety, reduce harm, engage patients and families, improve clinical care and reduce health care disparities. Two BFCC-QIOs manage all beneficiary complaints and appeals across the nation, ensuring that beneficiaries are treated fairly.

This new organizational design and approach separates the regulatory complaint review process from quality improvement work, empowering BFCC- and QIN-QIOs to team with patients and providers in a more efficient way. Although the QIO Program structure has changed, the Program’s commitment to driving rapid, large-scale change that puts patients first and contributes to better patient care, better population health and lower costs through improvement, remains the same.

Locate your local QIN-QIO and BFCC-QIO.
Recent Achievements

“It’s been really exciting to hear the numbers of lives saved, the cost savings, the reduction in avoidable events. And now, as we regionalize the program, we’re able to build on those successes and really accelerate things into the future. At VHQC, as a regional entity, we’re using the QIO Program and the many stakeholders it joins together to accelerate quality.” – Dr. Sallie Cook, Chief Medical Officer, VHQC

Hear HHS Secretary Sylvia Mathews Burwell share national improvements in health care quality, safety and cost in this excerpt from Burwell’s remarks at 2014 QualityNet: The CMS HealthCare Quality Conference.

[Visit this link](http://youtu.be/VBJqjcKrqYg)
Snapshots of Success

Better Health

Engaging Faith-based Organizations to Promote Heart Health

http://youtu.be/zPnuXLdBO8

In Arkansas, faith-based organizations play a key role in beneficiary lives, particularly in African-American communities. The Arkansas Foundation for Medical Care (AFMC), part of the TMF Quality Improvement Network (TMF QIN), combined the Arkansas population’s focus on faith with Million Hearts® goals to develop its Health Ministries online toolkit.

The “Bless Your Heart” toolkit includes consumer and partner fact sheets, as well as resources for participating churches, including how to create health ministry objectives, design programs, deliver messages and write newsletter articles. The response from congregations has been positive and instrumental in recruiting faith-based organizations to partner on Million Hearts efforts. Based on the improved health and well-being of pilot congregations, the Wellness Committee at the Union District Baptist Association in Little Rock embraced the project and spread it to its 66 member churches. Arkansas churches discuss the toolkit’s importance and how it has helped their congregations in this video.

Today, other QIN-QIOs have taken notice, and the “Bless Your Heart” toolkit has been replicated in several other states, including Virginia, Kentucky and Missouri. The TMF QIN also used the “Bless Your Heart” toolkit as the basis for its Healthy Libraries toolkit. Moving forward, participating Arkansas churches are scheduling educational days each month that include a speaker and health screening related to the National Health Observances Calendar.

Maximizing EHR System Benefits for Physicians and Patients

One path QIN-QIOs are taking to help improve the cardiac health of Medicare beneficiaries is through the use of Health Information Technology (HIT). Helping physician practices understand how to capture data from their Electronic Health Record (EHR) system and integrate it into their patient care process can lead to improved patient outcomes.

Working closely with other stakeholders over the past few years, Qsource, the Tennessee organization leading the atom Alliance Quality Improvement Network (atom Alliance QIN), has helped physician practices maximize the benefits they receive from their EHR systems.

Specifically, Qsource has collaborated with the Office of the National Coordinator for HIT’s Regional Extension Center (REC) in as well as other stakeholders to streamline efforts at select physician practices throughout the state – helping them achieve meaningful use (MU) with their EHR, successfully report in the Physician Quality Reporting System for incentive payments, and utilize EHR data to improve care. Staff taught providers the importance of tracking clinical measures, not only to complete the reporting incentive programs but to encourage better quality of care in their practices.

Moving forward, the atom Alliance QIN plans to expand upon Qsource’s successful partnership model to better serve physician practices across its five member states – Alabama, Indiana, Kentucky, Mississippi and Tennessee. The QIN-QIO will work with the RECs to help improve cardiac health across the region by helping practices set up provider alerts and warnings for smoking status, blood pressure and lipids. The organizations will work to improve clinical quality data reporting knowledge through on-site technical assistance, Learning and Action Networks, and webinars. Tools and resources for providers and patients will be easily accessible on the atom Alliance QIN’s website and deployed across the states.
Everyone with Diabetes Counts Program Goes National

The Everyone with Diabetes Counts (EDC) program began in 2007 as a pilot in the state of Florida. Throughout the last eight years, EDC has grown from a regional project to a national program geared toward improving diabetes health outcomes and quality of life among disparate and underserved Medicare populations.

The decision to take the EDC program national was based on population need and the program’s successes over the last eight years. Over the next five years, QIN-QIOs will recruit participants and host Diabetes Self-Management Education (DSME) classes to help Medicare beneficiaries learn to effectively deal with their diabetes.

“These QIOs had passion and dedication, which was reflected in their data and success. They realized this was not just a nine to five job – whether attending health fairs on the weekend or visiting physicians during off-hours – they had to be flexible to make this a high priority, in order to meet the needs of the beneficiaries, providers and communities.” – Sue Fleck, CMS Health Disparities Program EDC Government Task Leader

Partnering With Local Colleges to Train Bilingual Diabetes Educators

Since 2008, IPRO – the New York organization leading the Atlantic Quality Innovation Network (AQIN) – has successfully implemented an EDC program targeting African-Americans and Hispanics with diabetes throughout New York City. To reach the metro area’s large population of people with diabetes, IPRO partners with local colleges to certify students enrolled in community health worker programs as Peer Leaders. This four-day “Train the Trainer” Diabetes Self-Management Program (DSMP) is offered in English or Spanish, and affords students the opportunity to earn college credit toward a Community Health Worker certification once they complete an internship teaching DSMP classes through IPRO. In addition, IPRO facilitates interview opportunities between students and local physician practices, ensuring an ample supply of community health workers to help patients learn about and manage their diabetes.

By providing a sustainable diabetes self-management education program within the community, IPRO serves as a champion for EDC program work, providing a standard for other QIN-QIOs to emulate as they implement their own EDC programs throughout the country.

Community health workers pose with graduates of the Diabetes Self-Management Program led by IPRO
Educating Texans on How to Manage Their Diabetes

Over 3.1 million Texans – or one in three – are affected by diabetes or pre-diabetes. With so many lives impacted, the TMF® Health Quality Institute – the Texas organization leading the TMF Quality Innovation Network (TMF QIN) – set out to improve these numbers and educate individuals on how to control their condition.

Originally conceived in 2010 as a special project called “Salud por Vida/Health for Life,” which focused on educating the Hispanic population, TMF expanded it to reach the African-American population two years later.

As part of its ongoing Health for Life-EDC project, TMF partners with state and local community organizations like the Texas Diabetes Council and provides them with training to set up DSME classes and the marketing know-how to grow their organization and impact even more lives. The classes help people self-monitor and manage their diabetes with behavioral changes. After the first session, individuals already have action plans for what they can do in the next seven days to begin their journey to effective diabetes self-management.

In the four years that TMF has focused on diabetes self-management in Texas, over 14,000 individuals have enrolled in classes, with a 75 to 80 percent retention rate. Now, the TMF QIN plans to educate Medicare beneficiaries and reduce disparities in other states and territories, including Arkansas, Missouri, Oklahoma and Puerto Rico.

Partnership with Local School Pays Off the DSME Classes

During the fall of 2014, the West Virginia Medical Institute (WVMI) – the organization leading the Quality Insights Quality Innovation Network (Quality Insights QIN) – partnered with a local career and technical center to enable intergenerational learning focused on diabetes care.

WVMI invited Medicare beneficiaries with Type 2 diabetes to the diabetes self-management education (DSME) classes at the school. Classes are designed to help beneficiaries effectively self-manage their diabetes by learning about nutrition, exercise, self-monitoring, diabetes medications, community resources and more.

High school students participated in the class with Medicare beneficiaries and earned credits by volunteering their services. For example, marketing students prepared promotional flyers; culinary arts students provided healthy snacks for the classes; and health occupations students provided support to WVMI diabetes educators.

Under WVMI staff’s guidance, several students even presented information on diabetes neuropathies and helped beneficiaries take their blood pressure, measure their weight and waist circumference, calculate their body mass index and use a glucometer.

Moving forward, the Quality Insights QIN – the QIN-QIO for the states of Delaware, Louisiana, New Jersey, Pennsylvania and West Virginia – plans to expand its cooperation with schools in coming years and share lessons learned with others seeking to improve health outcomes and quality of life among disparate and underserved Medicare populations.

“It’s important to create partnerships that are beneficial to everyone involved, and with this new initiative, we wanted to see how well the high school students and the beneficiaries would connect. We were thrilled to see that everyone was enthusiastic, eager to learn and share their learning across generations. This was one of our most successful partnerships yet.” – Natalie Tappe, EDC Task Lead for the Quality Insights QIN
Better Care

Collaboration Helps Hospitals Improve Patient Safety

As an organization committed to reducing health care-associated infections (HAIs) like catheter-associated urinary tract infections (CAUTI) and Clostridium difficile (C. diff), Wisconsin-based MetaStar of the Lake Superior Quality Innovation Network knows that collaboration is king.

In recent years, MetaStar has worked closely with Wisconsin hospitals to develop unique aim statements and SMART (specific, measurable, attainable, realistic, timely) goals, along with an execution plan. “The key is to tailor strategies around an individual hospital’s safety culture and what that hospital can accomplish,” says Eileen Scalise, MetaStar quality consultant. Nurse educators, clinical nurse specialists and infection preventionists have played an important role in strategy development since they are able to put goals into practice at the bedside.

MetaStar also established mentor hospitals, connecting lower-performing hospitals with higher-performing facilities that could share strategies for resolving problems. Beyond one-on-one mentorship, MetaStar facilitated peer-to-peer learning by providing a storyboard template that makes it easy for hospitals to share their experiences and best practices.

Sharing the infection-related performance metrics of hospitals across the state has motivated improvement and helped hospitals focus their resources on the best methods to reduce infection rates. To give a face to the data, MetaStar incorporated the patient voice with stories like those of Rosie and Jerri.

In coming years, MetaStar plans to expand its individualized patient safety plans to multiple hospital units, offering even more targeted advice and support to hospitals working toward safer care.

Creating a Replicable Model for Sustainable Quality Improvement

When Rhode Island-based Healthcentric Advisors of the New England Quality Innovation Network first developed a quality improvement model known as the Holistic Approach to Transformational Change™ (HATCH), it didn’t anticipate that the framework would be adopted by medical systems in other countries. Conceived as a way to help nursing homes achieve sustained and replicable quality improvement, HATCH focuses on six key domains: workplace practices, care practices, environment, leadership, family and community, and government and regulations. HATCH’s basic premise is that care settings need to consider a variety of policy and systems issues – including workforce stability – when attempting to improve the quality of clinical care. Besides developing an educational video about the HATCH concept, Healthcentric Advisors worked with organizations like the Rhode Island Department of Labor and Training to develop toolkits and activities that nursing home directors could share with their staff.

In recent years, a number of QIN-QIOs have adopted the HATCH model, as has a health care system in Canberra, Australia. As new health care priorities like reducing the use of inappropriate anti-psychotic medication have emerged, Healthcentric Advisors has developed supplemental educational and training materials for nursing homes. Additionally, the QIN-QIO has begun applying the HATCH model to other care settings such as hospitals, and physicians’ practices that are implementing patient centered medical homes.

http://youtu.be/DtRnzz4ztbk
Enabling Peer-to-Peer Learning and Sharing for Nursing Home Staff

Committed to improving the quality of life for both residents and staff at 381 nursing homes across Minnesota, Stratis Health of the Lake Superior Quality Innovation Network created Donna’s Diary, an interactive blog-like forum for sharing best practices within the nursing home community.

Donna’s Diary is the online journal of a fictitious director of nursing at a fictitious nursing home that is working to improve its quality of care. The interactive learning and sharing tool enables nursing homes to learn from case examples and share ideas with peers. Stratis Health develops the diary entries around key issues and challenges faced by nursing homes, such as falls and person-directed care, and poses solutions based on best practices.

Conceived to encourage interaction that goes beyond the typical conference call, Donna’s Diary enables nursing home staff to learn and engage on their own time in a nonthreatening environment.

As Donna’s Diary broadens its reach to other states, it will focus on issues like staff stability, mobility, pain and antipsychotic medication reduction — areas of importance to local nursing homes and their residents.

“The diary provides an avenue for people to have a voice and share challenges, strategies and successes. It’s also a tool for nursing homes to gain new perspectives, facilitate conversation and move ideas forward.” – Kathie Nichols, Stratis Health nursing home liaison
Neighbors Helping Neighbors Navigate the Health System

With few local programs available to help older adults navigate the health care system, Selena Bolotin, Director of Patient Safety and Care Transitions for Washington-based Qualis Health Quality Innovation Network (Qualis Health QIN) decided to bring together existing support programs to connect the dots between care coordination and patient engagement.

Partnering with “Volunteer Health Advocates” from existing community volunteer programs, the QIN-QIO developed and piloted the “Volunteer Health Advocate” program in 2014. Its mission is to help patients become active and informed partners in their health care.

Connecting with state and community organizations like the Washington State Health Advocates Association and Senior Services’ Aging Your Way, the Qualis Health QIN is helping provide the volunteers with the training, skillset and curriculum necessary to add this to their community service “menu.” Medicare beneficiaries can tap into the knowledge and tools of the volunteers who serve as guides and advocates, encouraging proactive questions and active involvement by patients in their care.

With the potential to impact and improve the health outcomes of millions of Medicare beneficiaries using the QIN-QIO’s easily replicable model, the Volunteer Health Advocate program is on the fast track to expansion. Two piloted sites are already up and running, and new sites with readily mobilized volunteer networks are under consideration. The Volunteer Health Advocate program is a big idea that hopes to make a lasting impact across the country.

Preventing Adverse Drug Events Via New Processes

Adverse Drug Events (ADEs) are a common reason people are readmitted to the hospital within just weeks of being discharged. Readmissions are a burden on patients and their families, as well as the health care system. Sandra Leal, Clinical Director of Pharmacy at the Broadway Clinic and El Rio Health Center in Tucson, Arizona, explains how partnering with Health Services Advisory Group, the QIN-QIO serving Arizona and four other states/territories, led to the development of processes that helped prevent ADEs and ultimately reduced hospital readmissions. Click on the video and learn how best practices resulting from this collaboration were spread nationally to other health care professionals.

A Tool for Improved Discharge Communications and Fewer Drug Errors

To help improve care transitions and reduce adverse drug events (ADEs) in the state of New York, the clinical pharmacist team at IPRO – the organization leading the Atlantic Quality Improvement Network (AQIN) – developed a user-friendly tool focused on one particular group of commonly used, high-risk drugs: anticoagulants.

Designed for hospitals, nursing homes, rehabilitation centers and home health agencies, IPRO’s Anti-Coagulation Discharge Communication (AC/DC) Audit Tool is a simple one-page form. Medical provider staff quickly fill out the form to evaluate the effectiveness of the facility’s communications with other providers about discharged or transferred patients’ anticoagulation drug use. IPRO has been collaborating with the National Blood Clot Alliance – a patient advocacy group – and the Anticoagulation Forum on potential tool enhancements and related patient education tools.
Piloted at 15 health care facilities in 2014, the AC/DC tool proved that significant improvements are possible in anticoagulation-related communication across multiple care settings, including four hospitals, five skilled nursing facilities and one home health care agency. During their formal project kick-off webinar, three participating facilities reported that they successfully prevented drug errors by using the tool.

Based on this initial success, AQIN began offering the tool to providers participating in its six care transitions communities throughout New York, with plans to expand to South Carolina and the District of Columbia. Moving forward, IPRO’s clinical pharmacists anticipate that the tool could be adapted for other high-risk drugs such as diabetes medications.

Lower Cost

**Reporting Quality Data to Improve Care**

As part of its strategy to promote higher quality and more efficient care, CMS has implemented agreed-upon quality measures, value-based payment and quality reporting programs. The measures assess clinical quality of care, care coordination, patient safety and the patient and caregiver experience of care. Two of the QIO Program foundational principles for quality improvement are strengthening infrastructure and data systems, and fostering learning organizations. These principles come together in the CMS quality reporting and incentive programs, which make Medicare more accessible and affordable to beneficiaries.

**Helping Providers in Multiple Care Settings**

QIN-QIOs will work with eligible physicians, physician groups and other health care providers, inpatient and outpatient hospital departments, acute care and critical access hospitals, Inpatient Psychiatric Facilities (IPFs), PPS-exempt Cancer Hospitals (PCHs), and Ambulatory Surgical Centers (ASCs) to navigate quality reporting, the Physician Feedback/Value-Based Payment Modifier Program, and Quality and Resource Use Reports (QRURs). As part of Medicare’s efforts to improve the quality and efficiency of medical care, the Physician Feedback/Value-Based Payment Modifier Program provides comparative performance information to physicians and medical practice groups. By providing meaningful and actionable information to physicians so they can improve the care they deliver, CMS is moving toward physician reimbursement that rewards value rather than volume. Using workflow analysis and other proven methods, QIN-QIOs will help providers identify and close gaps in care coordination, improve efficiency and quality, and meet or exceed national reporting requirements.

**QIO Program Partnerships**

The following stories exemplify how QIN-QIOs are initiating or joining multi-stakeholder collaboratives that harness the power of many organizations to achieve ambitious health quality goals.

**Hospital Engagement Networks**

**Partnership With State Hospital Association Results in Safer Patient Care**

Closely-aligned values and missions are the basis of the long-standing relationship between the Washington State Hospital Association (WSHA) and Qualis Health Quality Innovation Network (Qualis Health QIN), the QIN-QIO for Idaho and Washington. The organizations’ shared passion for working together and their collective strengths enable providers and patients in the state of Washington to benefit from their partnership.

Together, WSHA and the Qualis Health QIN are tackling common health concerns including hospital readmissions and health care-associated infections (HAIs). Maximizing each organization’s unique strengths in a non-duplicative way has improved patient outcomes. For WSHA, the Qualis Health QIN’s quality improvement expertise, connections with skilled nursing facilities and access to Medicare data are invaluable. For the QIN-QIO, WSHA’s relationship with every hospital in the state is of tremendous benefit; WSHA served as a Partnership for Patients Hospital Engagement Network from 2011 through 2014.

WSHA and the Qualis Health QIN have worked together to create workflows and processes that assure that the partnership is sustained and effective. For example, the organizations hold monthly leadership and team meetings, share educational event calendars and have designed a scripted approach to participation in one another’s webinars.

Thanks to the mutually beneficial partnership, the state of Washington has experienced significant reductions in both readmissions (27 percent relative improvement rate per 1,000 Medicare beneficiaries) and HAIs within the past three-year time period. Using Medicare data, WSHA and the Qualis Health QIN are measuring and communicating improvements in outcomes in a consistent fashion. Health care providers are benefiting from participation in statewide quality improvement programs aligned with the QIO Program.
with key national health quality initiatives. And beneficiaries are experiencing safer and better care.

Moving forward, WSHA and the Qualis Health QIN are partnering to implement an antimicrobial stewardship program and an educational infection prevention program. Once again, the partners will leverage their strengths to help improve the safety of patients in Washington State.

**Centers for Disease Control and Prevention**

**Using Data for Prevention: CDC Partners with QIN-QIOs on HAI Reduction**

To accelerate efforts to meet national goals in reducing health care-associated infections (HAIs), the Centers for Disease Control and Prevention (CDC) conducted a pilot in 2014 with seven Quality Improvement Organizations (QIOs) working to reduce catheter-associated urinary tract infections (CAUTI). Under the pilot program, QIOs used the CDC’s Targeted Assessment for Prevention (TAP) strategy, a metric-based ranking system for identifying and targeting facilities with the greatest need for improvement. The pilot sought to test the feasibility of the TAP approach and to develop tools for targeted implementation of prevention and intervention activities in partnership with the QIOs.

As part of the partnership, the CDC provided ongoing collaborative learning and sharing opportunities for the QIOs, helped evaluate reports, and developed initial facility assessment and implementation guidance tools. For their part, the QIOs created TAP reports, identified at least one facility to target for site visits, conducted the visits, provided feedback on the tools, and participated in debriefing sessions with CDC.

By the end of the pilot, all seven QIOs were able to generate and interpret quarterly CAUTI TAP reports and had conducted over 20 facility site visits. All QIOs felt that the initial facility assessment tool was easy to use and that it was an “eye-opening” and “thought-provoking” supplement to their CAUTI reduction activities. Using TAP enables them to improve sharing of resources and communication across sites and facilities, prioritize intervention and improvement opportunities, and enhance the targeting of educational gaps.

Based on this successful pilot, the CDC is expanding its partnership with the QIO Program to enable all QIN-QIOs to use the TAP strategy for prevention of CAUTI, C. diff infection, and central line-associated bloodstream infection (CLABSI). Ultimately the goal is to create an integrated assessment and implementation guide for all HAIs, so QIN-QIOs have an accurate snapshot of prevention efforts at specific facilities and can determine how best to proceed with reducing HAI rates.

“This experience and tool has allowed the hospital to see that they need to engage the physicians. They actually created a physician-led committee to oversee their CAUTI prevention efforts in addition to the infection preventionists, resulting in a decrease in CAUTIs from 23 to 2 over the last quarter.” – Mary Ellen Jackson, quality improvement specialist from Indiana, one of the participating pilot states and now a part of the atom Alliance Quality Innovation Network
Million Hearts®

Local Campaign Helps Residents Step Up to Better Cardiac Health

QIN-QIOs are adding a community level connection to Million Hearts®, a national initiative launched by the Department of Health and Human Services in September 2011 to prevent one million heart attacks and strokes by 2017.

The initiative aims to help Americans make better choices for their health and encourages health care professionals to incorporate the ABCS of heart health into their care – Aspirin when appropriate; Blood pressure control; Cholesterol management; and Smoking cessation. The goal is achievable by reducing the number of people who need treatment and improving the ABCS for those who are receiving care.

In August 2013, VHQC, the QIN-QIO for Maryland and Virginia, created a local campaign in Virginia supporting Million Hearts. Health outcomes data pointed to the geographic area most in need of improvement: the Crater Health District. VHQC joined forces with the Central Virginia chapter of the American Heart Association, aligning their goals and motivating residents in the district to Step Up to a Healthier Life. VHQC also connected with trusted community partners such as churches, the YMCA, the public library and the local health department.

Step Up Campaign activities included raising awareness about better nutrition habits – like teaching people how to read food labels and about the effect of sodium intake – as well as providing them with heart-healthy cookbooks and showing them how to make their favorite foods in a healthier manner. Explaining the benefits of increased physical activity was a primary component of the Step Up Campaign, and VHQC co-sponsored Zumba classes to get people moving. The classes incorporated blood pressure checks at least twice monthly and provided blood pressure education explaining what the numbers mean and how to control blood pressure. Over 500 people signed the Million Hearts pledge, agreeing to better understand their heart disease risk, get active, learn the ABCS, eat healthy and follow health care provider instructions.

2014 QualityNet Conference

Nearly 400 mentions of the official conference hashtag: #QualityNet14

Twitter conversations reached a potential audience of 35,829 and spread to an additional 16,759 people through retweets.

Most frequently used keywords were vision, patient(s) and change.

@BechtelHealth
It’s not what’s the matter, it’s what matters to you.
#QualityNet14 @maureenbis

@ChisaraAsomugha
“It is better to ask questions first than to rush to judgment.”
// wish more folks would do that.
#QualityNet14

@JenLandLV
QNet closes with Maureen Bisognano, who uses powerful patient stories to evoke laughter, tears, lightbulbs.
#QualityNet14 @HealthInsight

Check out more of the conference buzz at the QualityNet Storify.
QIO Program Goals
Over the coming five years, BFCC-QIOs and QIN-QIOs have set goals for improving health quality. At the heart of those goals lies BFCC-QIOs and QIN-QIOs’ focus on the patient and commitment to achieving better patient care, better population health and lower costs.

QIN-QIO Five-Year Goals
Improve cardiac health and reduce cardiac health care disparities: QIN-QIOs will work with home health agencies, physician practices, clinics and beneficiaries in collaboration with key partners and stakeholders to implement evidence-based practices to prevent heart attacks and strokes. While the QIO Program’s work benefits Medicare beneficiaries of all races and ethnicities, the QIN-QIOs will specifically target African-American, Hispanic, Asian-American, Pacific Islander and other patients disproportionately affected by heart attacks and strokes. Success will be measured by improvement in blood pressure (BP) control, and smoking screening and cessation counseling.

Increase diabetes awareness and education: To support the 27.4% of Medicare beneficiaries aged 65 and older with diabetes, QIN-QIOs will recruit and educate beneficiaries, physician practices, community partners and stakeholders to reduce disparities in diabetes care and engage Medicare beneficiaries in Diabetes Self-Management Education (DSME) classes.

Improve prevention coordination through Meaningful Use of Health Information Technology (HIT): QIN-QIOs will collaborate with Regional Extension Centers to leverage the capabilities of participating providers using Certified Electronic Health Record Technology to collect, track and report data, through use of automated tools for data extraction for prevention and quality improvement as established by the Meaningful Use program and consistent with the CMS Electronic Health Record Incentive Program.

Reduce the number of health care-associated infections (HAIs): More than 200 Americans die every day from HAIs. By aligning existing public and private infection prevention initiatives – to include work with QIO Program partners such as the Agency for Healthcare Research Quality’s (AHRQ) Comprehensive Unit-based Safety Program (CUSP) and CMS Hospital Engagement Networks (HENs) – the QIO Program will work to reduce HAIs.

Improve the quality of resident-centered care and safety: 1 in 5 nursing home residents suffer preventable harm. Throughout the next five years, the QIO Program aims to lower this statistic by uniting nursing homes, key stakeholders and organizations throughout their communities to share tools, knowledge and technology to improve the quality of resident-centered care and safety. By continuing to support nursing homes’ use of the quality assurance performance improvement (QAPI) framework, the QIO Program will work toward achieving system-wide improvement, ensuring every resident receives the highest quality of care.

Reduce the national prevalence of antipsychotic use in long-stay nursing home residents: To reduce the 19.8% national use of antipsychotics in long-stay nursing home residents, the QIO Program will continue to educate, train and provide technical assistance to nursing home facilities.

Support coordination of care: To fully support coordination of care and reduce preventable hospital admissions and readmissions, the QIO Program – using a community approach – will continue to establish and utilize its partnerships with providers across all health care settings, various federal agencies, colleges and universities, and other private and public organizations to identify factors driving avoidable hospital admissions and readmissions and to better coordinate care.

A Look Ahead

http://youtu.be/69xlmnAdzDQ

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