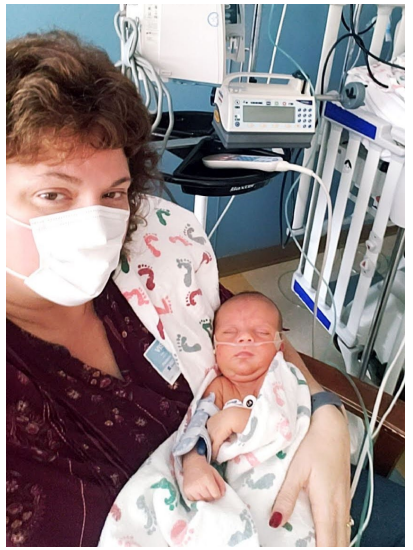
Mountain Pacific Quality Health

NOVEMBER 29, 2023

Mountain Pacific

INNOVATING BETTER HEALTH

Working to Align the Stars



Deb Anderson
Health Information Technology
and Quality Improvement

More Than 10 Years of My Favorite Things!

- Support selection and implementation of electronic health records (EHRs)
- Support interoperability of information to improve care, reduce cost and engage patients
- Support health care quality reporting using certified EHR technology (CEHRT) and electronic clinical quality improvement (eCQI) measures
- Align reporting to reduce burden

- Support measurable improvements in community health
- Data discovery and utilization
- Address health equity and inclusion
- Expand access, including telehealth
- Increase collaboration and collaborative opportunities
- Facilitate collaboration

Wyoming Chronic Disease Prevention Program

Tailored strategies and technical assistance (TA) to improve identification and management of patients with cardiovascular disease, diabetes or pre-diabetes by using CEHRT

TA for EHRs: Wyoming Frontier Information Exchange (WYFI HIE), Community Information Exchange (CIE) and other health information technology (HIT), including vendor interactions relating to quality improvement projects

Access to local, statewide and regional data related to cardiovascular disease and diabetes

Assistance with quality improvement initiatives to enhance processes for recording and reporting data

Assistance with identifying baseline data and data validation for improvement projects

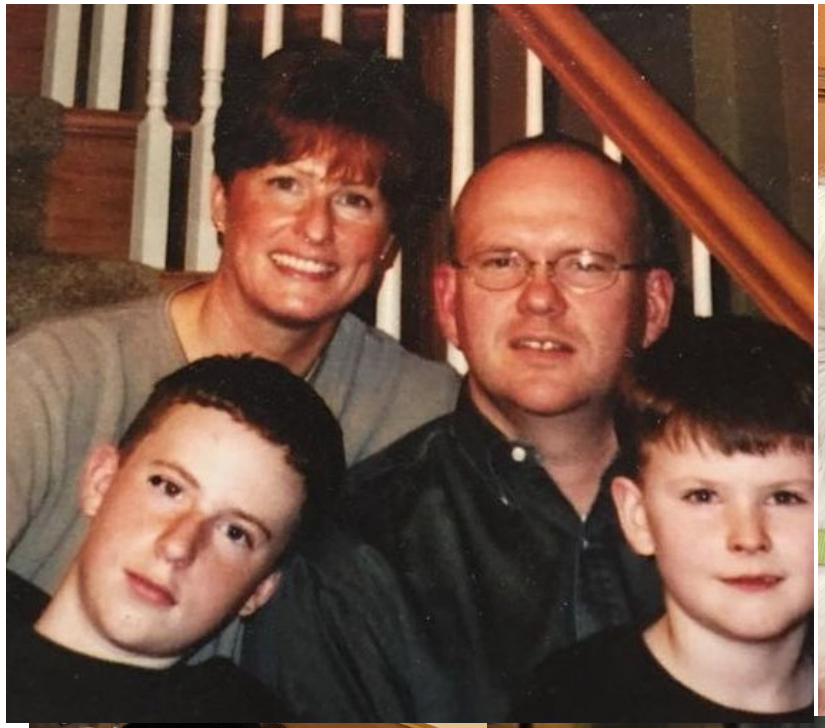
Wyoming Health Systems Technical Assistance Options

- Set up patient registry or dashboard in EHR for patients with chronic conditions
- Use dashboards or registry to identify gaps for screening and/or testing to improve care
- Implement self-measured blood pressure (SMBP) program
- Implement social determinants of health (SDOH) screening tool:
  - The PRAPARE Screening Tool - PRAPARE
  - American Academy of Family Physicians (AAFP) Social Needs Screening Tool
  - A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool: Promising Practices and Key Insights (cms.gov)
- Rapid cycle improvement using plan, do, study, act (PDSA)
- Set up clinical decision support rules or patient alerts
- Set up bi-directional referral to lifestyle change management programs
- Start lifestyle change management program (e.g., diabetes prevention program, SMBP, diabetes self-management program and/or Healthy Heart Ambassador blood pressure self-monitoring program)

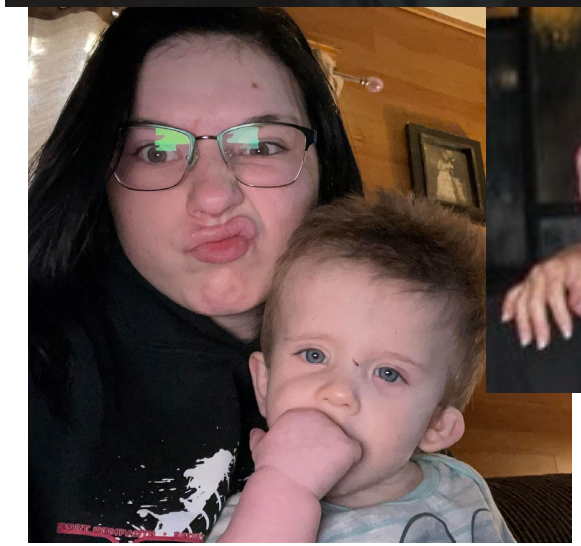
Quality Reporting Assistance

Set-up and validation of one or more clinical quality measures

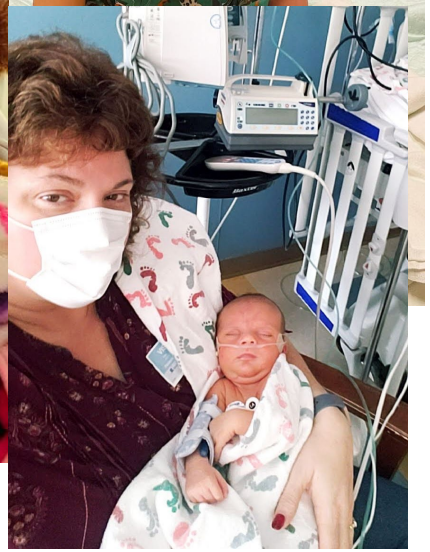
- Quality ID 001 Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%) | AKA CMS122
- Quality ID 117 Diabetes: Eye Exam | AKA CMS131
- Quality ID 126 Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy Neurological Evaluation (cms.gov)
- Quality ID 236 Controlling High Blood Pressure | AKA CMS165
- Quality ID 438 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease | AKA CMS347
- Quality ID 487: Screening for Social Drivers of Health (cms.gov)









This is my WHY!

Moving Forward in Quality Improvement

- Centers for Medicare and Medicaid Services (CMS) new, five-year contract for Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs)
- **Promote optimal health and well-being** through improved quality of care, equity and outcomes for Medicare beneficiaries
- 13 QIN-QIO regions pared down to seven

Facilitate local community coalitions to support:

- Improved care coordination
- Prevention of chronic disease and/or improved self-management
- Prevention of adverse drug events

Support quality care in nursing homes through:

- Staff leadership training and education
- Infection prevention program development

Develop patient and family advisory councils and improve patient engagement

Wyoming Care Management Program

- Wyoming Department of Health partnership
- Our staff evaluate Medicaid members, coordinate services and implement care plans to promote prevention, screening and management of acute and chronic diseases
- Emphasizes prevention
- Provides targeted education and support for improved patient self-management
- Participating members “graduate” when they achieve care plan goals

Wyoming Project Firstline Infection Prevention and Control

- Funded by Centers for Disease Control and Prevention (CDC)
- Empowers frontline health care workers to learn and apply daily infection prevention protocols

We partner with providers in a variety of settings to provide training and education around risk assessment and standard precautions to improve patient safety. We have **supported thousands of health care professionals** with **hundreds of outreach activities**.

- Infection prevention escape room
- Infection training videos via text
- First Project Firstline Infection Prevention Summit in Wyoming

Reducing Hospital Readmissions

Patients return to the hospital within 30 days of discharge for multiple reasons, including:

- Did not receive/understand instructions about their role in their care plan
- Issue with their medications
- Did not receive follow-up care
- Did not use/could not access available community resources

We connect health care professional, community-based organizations, partners, stakeholders, patients and their families to improve care coordination and reduce costs.

Smoking Cessation

Smoking and tobacco use **impacts optimal patient outcomes** for those with heart disease, diabetes, chronic obstructive pulmonary disease (COPD) and other chronic illnesses. Using predictive modeling, our data analytics team assessed and analyzed population success for smoking cessation programs.

7,650
Medicare Beneficiaries accessing smoking cessation treatments

American Indian/Alaskan Native (AI/AN) Medicare beneficiaries are roughly **10% less likely to pursue smoking cessation** compared to other groups.

Hawaii Medicare beneficiaries are **20% more likely to pursue smoking cessation** than beneficiaries living elsewhere.

Contact Information

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