NATIONAL RURAL HEALTH RESOURCE CENTER

Performance Excellence Framework: Key Questions for Rural Hospitals Assessment

The Baldrige Performance Excellence Framework can be used as a systems-based framework for rural hospitals to develop and support critical success factors in key areas leading to performance excellence across the organization.

Key areas of the framework include:

- Leadership
- Strategic Planning
- Patients, Partners and Communities
- Measurement, Feedback and Knowledge Management
- Workforce and Culture
- Operations and Processes
- Impact and Outcomes

Assess your organizations' current capacity in each of these key areas to help identify opportunities for growth and development of system-based capacity for excellence.

Consider having a team of 6 - 8 people from across your organization complete this assessment independently, then use it as a tool for discussion to bring in perspective from across the organization, to understand varying perceptions, gain buy-in and identify opportunities and priorities for action.

For more information on the Baldrige Performance Excellence Framework and a blueprint for performance excellence in critical access hospitals, please see the Critical Access Hospital Blueprint for Performance Excellence available at:

https://www.ruralcenter.org/tasc/resources/critical-access-hospital-blueprint-performance-excellence

If you have additional questions, please contact the Technical Assistance and Services Center (TASC), a program of the National Rural Health Resource Center at: tasc@ruralcenter.org or (218) 727-9390.

Performance Excellence Framework: Key Questions for Rural Hospitals Assessment

Please check the appropriate box:

Leadership **Our Leadership team…**	**Strongly Disagree 1**	**Somewhat Disagree 2**	**Somewhat Agree 3**	**Strongly Agree 4**
Is aware of health industry trends and changes and how they may impact our facility				
Understands need for systems approach in all aspects of our organization				
Provides ongoing education opportunities for board, internal leadership and managers				
Aligns hospital and medical leadership around values, goals and strategies				
Empowers and motivates hospital employees to achieve performance excellence				
Strategic Planning **Our Organization…**	**Strongly Disagree 1**	**Somewhat Disagree 2**	**Somewhat Agree 3**	**Strongly Agree 4**
Conducts meaningful strategic planning at least annually				
Involves multiple stakeholders to ensure strategic plans reflect community needs				
Uses a systems framework for planning to ensure a holistic approach				
Communicates the plan organization-wide in easy to understand language				
Patients, Partners and Communities **Our organization…**	**Strongly Disagree 1**	**Somewhat Disagree 2**	**Somewhat Agree 3**	**Strongly Agree 4**
Measures and publicly reports data on patient satisfaction				
Excels at customer services as shown by our comparative results on patient satisfaction				
Engages in partnerships with larger systems or rural networks				
Works collaboratively with other types of providers in our service area to improve transitions of care and care continuity				
Collaborates with public and private organizations in the community to assess and improve health of the population				

Please check appropriate box:

Measurement, Feedback and Knowledge Management **Our organization…**	**Strongly Disagree 1**	**Somewhat Disagree 2**	**Somewhat Agree 3**	**Strongly Agree 4**
Uses a strategic framework to manage information (such as a Balanced Scorecard)				
Evaluates strategic process regularly and shares information organization-wide				
Uses data to improve health and safety of patients in the service area				
Workforce and Culture **Our organization…**	**Strongly Disagree 1**	**Somewhat Disagree 2**	**Somewhat Agree 3**	**Strongly Agree 4**
Supports development of a workforce that is change ready and adaptable				
Has an intense focus on staff development and satisfaction				
Supports ongoing staff skill building and education				
Has developed a customer/patient focused staff culture				
Operations and Processes **Our organization…**	**Strongly Disagree 1**	**Somewhat Disagree 2**	**Somewhat Agree 3**	**Strongly Agree 4**
Has developed efficient business processes and operations in all areas				
Continually improves quality and safety				
Uses technology appropriately to improve efficiency and quality				
Ensures continuous process improvement is embedded in the culture				
Impact and Outcomes **Our organization…**	**Strongly Disagree 1**	**Somewhat Disagree 2**	**Somewhat Agree 3**	**Strongly Agree 4**
Regularly documents and assesses outcomes and impact of the care and services we provide				
Reports quality outcomes to federal agencies, community, staff and other stakeholders				
Benchmarks outcomes with peers and internally				
Documents value in terms of cost, efficiency, quality, satisfaction and population health				

Medicare Beneficiary Quality Improvement Project (MBQIP) Measures

	Patient Safety	***Patient Engagement***	***Care Transitions***	***Outpatient***
Core Improvement Initiatives	**OP-27:** Influenza Vaccination Coverage Among Healthcare Personnel (HCP) *(Facilities report a single rate for inpatient and outpatient settings)* **IMM-2:** Influenza Immunization	**Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)** *The HCAHPS survey contains 21 patient perspectives on care and patient rating items that encompass nine key topics:* • Communication with Doctors • Communication with Nurses • Responsiveness of Hospital Staff • Pain Management • Communication about Medicines • Discharge Information • Cleanliness of the Hospital Environment • Quietness of the Hospital Environment • Transition of Care *The survey also includes four screener questions and seven demographic items. The survey is 32 questions in length.*	**Emergency Department Transfer Communication (EDTC)** *7 sub-measures; 27 data elements; 1 composite* • EDTC-1: Administrative Communication (2 data elements) • EDTC-2: Patient Information (6 data elements) • EDTC-3: Vital Signs (6 data elements) • EDTC-4: Medication Information (3 data elements) • EDTC-5: Physician or Practitioner Generated Information (2 data elements) • EDTC-6: Nurse Generated Information (6 data elements) • EDTC-7: Procedures and Tests (2 data elements) • **All-EDTC:** Composite of All 27 data elements	**OP-1:** Median Time to Fibrinolysis **OP-2:** Fibrinolytic Therapy Received within 30 minutes **OP-3:** Median Time to Transfer to another Facility for Acute Coronary Intervention **OP-4:** Aspirin at Arrival **OP-5:** Median Time to ECG **OP-18:** Median Time from ED Arrival to ED Departure for Discharged ED Patients **OP-20:** Door to Diagnostic Evaluation by a Qualified Medical Professional **OP-21:** Median Time to Pain Management for Long Bone Fracture **OP-22:** Patient Left Without Being Seen

Medicare Beneficiary Quality Improvement Project (MBQIP) Measures

	Patient Safety	*Patient Engagement*	*Care Transitions*	*Outpatient*
Additional Improvement Initiatives	**Healthcare Acquired Infections (HAI)** • **CLABSI:** Central Line-Associated Bloodstream Infection • **CAUTI:** Catheter-Associated Urinary Tract Infection • **C. diff:** *Clostridium difficile* Infection • **MRSA:** Methicillin-resistant *Staphlococcus aureus* **Perinatal Care** • **PC-01:** Elective Delivery **Pneumonia** Proportion of patients hospitalized with Pneumonia – potentially avoidable complications **Falls** Potential measurement around: • Falls with Injury • Patient Fall Rate • Screening for Future Fall Risk **Adverse Drug Events (ADE)** Potential measurement around: • Opioids • Glycemic Control • Anticoagulant Therapy **Patient Safety Culture Survey**		**Discharge Planning** *Potential measurement TBD with FORHP* **Medication Reconciliation** *Potential measurement TBD with FORHP*	**ED Throughput** • **ED-1:** Median Time from ED Arrival to ED Departure for Admitted ED Patients • **ED-2:** Admit Decision Time to ED Departure Time for Admitted Patients **Stroke** • **OP-23:** ED – Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival **Surgery/Surgical Care** • **OP-25:** Safe Surgery Checklist Use

Revised on 03/17/2016

Medicare Beneficiary Quality Improvement Project (MBQIP) Measures

	Patient Safety	*Patient Engagement*	*Care Transitions*	*Outpatient*
Additional Improvement Initiatives	**Reducing Readmissions** *(These measures are automatically calculated for hospitals using Medicare Administrative Claims Data)* **Stroke** • **STK-1, STK-8** All retired by the Centers for Medicare & Medicaid Services (CMS) as of 1/1/2016 • Proportion of patients hospitalized with Stroke – potentially avoidable complications **Venous Thromboembolism (VTE)** • **VTE-1, VTE-2, VTE-3** All retired by the Centers for Medicare & Medicaid Services (CMS) as of 1/1/2016			

CAH's Blueprint for Performance Excellence

Rural Hospital Toolkit: Transitioning to Value-Based Health Systems

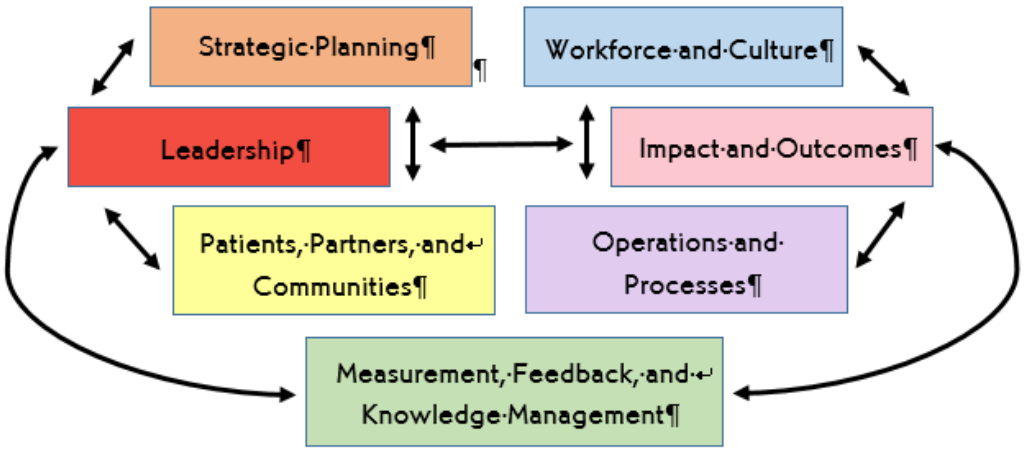
Purpose: Complex change is best managed by using a comprehensive, systems-based framework, including a balanced set of key strategies, initiatives, targets, and measures.

Rationale: Now more than ever, CAHs need to demonstrate the value they provide to patients and their health care systems. Strategies 1 through 4 described below are necessary and cited as needing to exist in a value-based health system.

Challenges: Geographic isolation, small practice size, heterogeneity in settings and patient population, and low case volume make participation in performance measurement and improvement efforts especially challenging for many rural health care providers. Rural hospitals and clinicians participate in a variety of private sector, state, and federal quality measurement and improvement efforts. However, with the exception of the FLEX Program, many quality initiatives available through the Centers for Medicare & Medicaid Services exclude rural health care providers.

Complete the Assessment Tool

1. The self-assessment tool requires responses on a Likert scale: 1 - Strongly Disagree through 4 - Strongly Agree.
2. Working through the assessment is almost more important than the score.
3. Conducting the assessment as a TEAM is imperative. The dialogue will bring issues into perspective, help management understand the team members' perceptions of the organization, gain buy-in, and identify opportunities and priorities.
4. Implement the assessment tool as a multidisciplinary team. A variety of perspectives will bring out the truth about an organization's current state.
5. Thoughtful and meaningful engagement of providers and community stakeholders during the assessment will lead to relationships and partnerships vital to success.
6. Use the assessment tool to identify opportunities and prioritize action steps.
7. Review the tool frequently. Planning at regular intervals keeps the plan fresh and current.



CAH's Blueprint for Performance Excellence

Gap Analysis and Action Steps

1. Build Relationships with Patients, Providers, Communities, and New Partners:

    - Partnerships are an underlying concept of value in health care:
        - Participate in public reporting on quality and satisfaction to show empirical value to patients, community, and potential partners.
        - Conduct a community health needs assessment to reach out, engage, and understand where patients receive services and why.
        - Develop patient portals in electronic health records.
        - Excel at customer service.
        - Provide education to the community.

2. Address Workforce and Culture:

    - Create an engaged workforce that will reduce employee turnover and increase their ability for improved performance and added value.
    - Create a workforce that is adaptable and ready for change.
    - Create a culture that is patient focused and customer driven.
    - Focus attention on staff development and retention.
    - Measure employee engagement regularly.

3. Improve Operations and Processes

    - Streamline operational processes with a goal of improving quality and safety.
    - Develop efficient business processes focused on quality and revenue cycle.
    - Train staff members on improvement methods, encourage their participation in improvement activities, acknowledge and regularly share results, and implement best practices.
    - Health information technology (HIT) is key!
        - Use HIT to improve communication, efficiency, and quality
        - Use technology to develop revenue streams
        - Telehealth can address workforce shortages, enhance provider satisfaction, and provide access to specialty services

4. Evaluate Impact and Outcomes:

    - Demonstrate value to patients, providers, and partners.
    - Initiate/develop/enhance your capability for standard health care reporting.
    - Participate in public reporting and communicating outcomes to the broader community.
    - Document value in terms of:
        - Efficiency
        - Population health
        - Patient experience
        - Provider and employee satisfaction
        - Cost

Critical Access Hospital Blueprint for Performance Excellence; 2013. https://www.ruralcenter.org/tasc/resources/critical-access-hospital-blueprint-performance-excellence
Rural Hospital Toolkit for Transitioning from Volume to Value: 2015. https://www.ruralcenter.org/srht/rural-hospital-toolkit

Ambulatory Care Redesign: Primary Care

In order to meet the growing demand for services, health systems must become more efficient, better-coordinated systems of care. Patient-centered medical homes (PCMH) show promise for improving the efficiency and effectiveness of primary care by leveraging the skills of nonphysicians and sharing responsibilities among a care team. For example, nurse practitioners and physicians assistants are entering the field at a greater rate than primary care providers and can offer increased capacity and quality to the primary care team. By sharing responsibilities among members of the care team, the medical home can relieve the burden on primary care providers and allow all staff to maximize their skills, resulting in enhanced collaborative patient care.

Specific Objectives:

- Increase the number of primary care practices undergoing PCMH transformation; most notably implementing team-based care and better utilization of frontline workers
- Increase provision of preventive health services
- Improve health indicators for patients with chronic conditions, including mental health disorders (MHDs) and substance use disorders (SUDs)
- Increase patient access to care
- Decrease preventable acute-care utilization
- Improve patient experience of care
- Increase staff engagement

System Components:

1. Gap analysis of practice sites within the system.

2. Demonstration of advancement in primary care practices PCMH transformation through the use of a nationally recognized PCMH methodology.

3. Hiring and training of frontline workforce (e.g., medical assistants, community health workers, promotoras, health navigators, or other nonlicensed care team members) to be responsible for coordination of nonclinical services and elements of the care plan.

4. Implement technology-enabled data systems to support:
    - Previsit planning
    - Point-of-care delivery
    - Population/panel management activities
    - Care coordination
    - Patient engagement
    - Operational and strategic decisions
    - Continual performance feedback
    - Rapid cycle improvement for patients, front line staff and senior leadership
    - Implementation of Electronic Health Record (EHR) technology that meets meaningful use standards

5. Ongoing identification of all patients for population management (including assigned managed-care lives):
   - Manage panel size, assignments, and continuity to internal targets
   - Develop interventions for targeted patients by condition, risk, and self-management status
   - Perform preventive care services (including mental health and substance misuse screenings and brief interventions such as PHQ-9 and SBIRT.

6. Enable prompt access to care by:
   - Implementing open or advanced access scheduling
   - Creating alternatives to in-person provider/patient visits
   - Assigning frontline workers to assist with care navigation and nonclinical elements of the care plan

7. Coordinate care across settings:
   - Identify the care coordinators at each primary care site who are responsible for coordinating care within the PCMH and other facilities (e.g., other care coordinators or PCMH/high-risk care managers):
     - Establish onsite care/case managers to work with high-risk patients and their care teams, OR
     - Develop processes for local care coordinators to work with a central complex care management program for these patients
   - Implement processes for timely bi-directional communication and referral to specialty care (including mental health and substance use disorder services), acute care, social services, and community-based services

8. Demonstrate evidence-based preventive and chronic disease management.

9. To address quality and safety of patient care, implement a system for continual performance feedback and rapid cycle improvement that includes patients, front-line staff, and senior leadership.

10. Improve staff engagement by:
    - Implementing a model for team-based care in where the staff perform to the best of their abilities and credentials.
    - Providing ongoing staff training using the team-based care model to ensure effective and efficient patient care (e.g., group visits, medication reconciliation, motivational interviewing, cognitive behavioral therapy, and medication-assistance treatment).

11. Engage patients using care plans, self-management education, and involvement in the design and implementation of this project.

Integration of Physical and Behavioral Health

The prevalence of MHDs and SUDs varies greatly by economic status. Adult members of households below 200% of the federal poverty level are 150% more likely to have a MHD than their more affluent counterparts. Adult members of households below 200% of the federal poverty level are almost twice as more likely to have a MHD than their more affluent counterparts. The prevalence of MHDs also varies greatly by race/ethnicity. Native Americans and Hispanics are the most likely to have MHDs (20%), followed by African Americans (9%), Caucasians (14%), and Asians (10%), who are the least likely to have MHDs. Within distinct cultures and communities of color, stigma and cultural attitudes about behavioral health have a large impact on whether individuals seek care and care plans. This will need to be a factor in designing care teams and treatment plans. MHDs and SUDs reduce an individual's life expectancy by 10 to 25 years, which is equivalent to the reduced life expectancy that results from heavy smoking. People with a MHD and/or SUD die from the same causes as the general population (i.e., heart disease, diabetes, and cancer). However, these diseases are more prevalent among people who suffer from a MHD or SUD, and tend to lead to earlier death. For the entire population, the greatest indicators for such diseases are smoking, obesity, hypertension, poor diet, and low levels of physical activity. Such health risks have an increased prevalence and earlier onset among those with a MHD and/or SUD. Because of the low rate of preventive and treatment services offered to individuals with a MHD and/or SUD, they experience serious health burdens and are at risk of premature death.

Specific Objectives:

- Increase use of screening tools (e.g., PHQ-9, GAD-7, AUDIT, DAST)
- Improve patient adherence to their treatment regimen
- Improve health indicators for patients with both chronic physical and behavioral conditions
- Increase access to MHD and SUD services
- Reduce preventable acute care utilization
- Reduce emergency department (ED) visits for patients with behavioral health conditions
- Improve communication between PCP and behavioral health providers
- Reduce admissions for patients with behavioral health problems through earlier recognition and intervention
- Reduce admissions for physical problems by better managing comorbid behavioral health conditions
- Improve patient experience

System Components:

1. Implement a behavioral health integration assessment tool (baseline and annual measurements).

2. Implement a physical-behavioral health integration program that utilizes a nationally recognized model (e.g., the Four Quadrant Model for Clinical Integration, the Collaborative Care Model, or other IBH resources from SAMHSA).

3. Integrate appropriate screening tools and decision support into the ED to ensure timely recognition of patients with MHDs and SUDs. Enhanced access to primary care and/or behavioral health specialists will be integrated into discharge planning for these patients. Use 24-7 care navigators (e.g., Community Physician Liaison Program) support linkages to PCP, MHD, and SUD specialists and behavioral health and other community services through the discharge process.

4. Physical and behavioral health integration may be an implementation of a new program or expansion of an existing program from pilot sites to hospital and health system primary care sites or from single populations to multiple populations, (e.g., obesity, diabetes, maternal, infant and child care, end-of-life care, chronic pain management).

5. Patient-centered medical home (PCHM) and behavioral health providers will:
   - Collaborate on evidence-based standards of care, including medication management and care engagement process.
   - Implement case conferences/consults for patients with complex needs.

6. Ensure coordination and access to chronic disease (physical or behavioral) management, including self-management support to patients and their families.

7. Ensure systems are in place to support patient linkage to appropriate specialty physical, MHD, and SUD services. Preventive care screenings, including behavioral health screenings (e.g., PHQ-2, PHQ-9, SBIRT), will be implemented for all patients to identify unmet needs. When screenings are positive, providers will take immediate steps, including provision of brief interventions (e.g., MI techniques) to ensure access for further evaluation and treatment when necessary. Preferably, this should include a warm transfer to the appropriate provider if the screening provider is unable to provide the service.

8. Provide cross-systems training to ensure effective engagement with patients with MHD/SUD conditions. Ensure that a sufficient number of providers are trained in SBIRT and/or in other new tools used by providers to ensure effectiveness of treatment.

9. Increase access to medication assisted treatment for patients with alcohol and opioid addiction to assist in stabilizing their lives, reducing urges or cravings to use, and encourage greater compliance with treatment for comorbid medical and MHDs. For alcohol use disorders, these medications include naltrexone, acamprosate, and disulfiram. For opioid addiction, medication-assisted treatment includes maintenance treatment with methadone and buprenorphine.

10. Ensure the development of a single treatment plan that includes the patient's behavioral health and medical issues; substance abuse; social, cultural, and linguistic needs. This means incorporating traditional medical interventions, as well as nontraditional interventions such as gym memberships, nutrition monitoring, healthy lifestyle coaching, or access to culturally and linguistically appropriate peer-led wellness and symptoms management groups.

11. Ensure a culturally and linguistically appropriate treatment plan by assigning peer providers or other frontline workers to the care team to assist with care navigation, treatment plan development, and plan adherence.

12. Ensure the treatment plan:
    - Is maintained in a single shared EHR/clinical record that is accessible across the treatment team to ensure proper care planning coordination.
    - Evaluates and monitors the outcomes for quality and safety for each patient.

13. Implement technology-enabled data systems to support previsit planning, point-of-care delivery, care plan development, population/panel management activities, coordination, and patient engagement. Develop programs to implement telehealth, eReferral/eConsult to enhance access to behavioral health services.

14. Demonstrate engagement of patients in the design and implementation of the project.

15. Increase team engagement by:
    - Implementing a model for team-based care where staff performs to the best of their abilities and credentials.
    - Providing ongoing staff training on care model.

16. Ensure integration is efficient and is providing value to patients by implementing a system for continual performance feedback and rapid cycle improvement for patients, frontline staff, and senior population.

Care Transitions: Integration of Post-Acute Care

The transition from inpatient to outpatient settings is a critical point in the care continuum, where providers can link patients to appropriate, and ongoing care. All too often, patients are discharged from the hospital without an adequate transition plan and, often times, return within the month. According to the Center for Medicare & Medicaid Services (CMS), nearly one in five Medicare patients who are discharged from a hospital are readmitted within 30 days—at a cost of $26 billion each year in Medicare spending. While some readmissions are appropriate, many could have been avoided. Given the complex needs of their patients, health systems must continue to develop robust care transitions programs that equip patients with a clear discharge plan, empanel them in patient-centered medical homes in collaboration with health plans, and link them to behavioral health and community services. Continued investment in care transitions programs is needed to improve coordination between inpatient and outpatient settings and thus reduce avoidable readmissions.

Specific Objectives:

- Improve communication and coordination between inpatient and outpatient care teams
- Increase patients capacity for self-management
- Improve patient experience
- Reduce avoidable acute-care utilization

System Components:

1. Develop a care transitions program or expand an existing program to include additional settings (e.g., ED), and additional populations by using at least one nationally recognized care transitions program methodology.

2. Establish or expand a system to track and report readmission rates, timeliness of discharge summaries, and other transition processes. Investigate and identify specific root causes/risk factors for readmission, using quantitative and qualitative information including physical, behavioral and social factors.

3. Develop and implement a process, including utilization of data and information technology, to reliably identify hospitalized patients at high risk for readmission.

4. Develop standardized workflows for inpatient discharge care:
   - Optimize hospital discharge planning and medication management for all hospitalized patients.
   - Implement structure for obtaining best possible medication history and assessing medication reconciliation accuracy.
   - Develop standardized process for transitioning patients to sub-acute and long-term care facilities.
   - Provide tiered multidisciplinary interventions according to level of risk:
     - Involve MHD, SUD, pharmacy, and palliative care when possible
     - Involve trained, enhanced IHSS workers when possible.
     - Develop standardized protocols to coordinate referrals to community behavioral health and social services (e.g., visiting nurses, home care services, housing, food, clothing, and social support). Identify and train personnel to function as care navigators for carrying out these functions.

5. Inpatient and outpatient teams collaboratively develop standardized transition workflows:
   - Develop mechanisms to support patients in establishing primary care for those without prior primary care affiliation.
   - Develop process for warm hand-off from hospital to outpatient provider, including assignment of responsibility for follow up of labs or studies still pending at the time of discharge.

6. Develop standardized workflows for post-discharge (outpatient) care:
   - Deliver timely access to primary and/or specialty care following a hospitalization.
   - Standardize post-hospital visits and include outpatient medication reconciliation.

7. Support patients and family caregivers in becoming more comfortable, competent, and confident in self-management skills required after an acute hospitalization by:
   - Engaging patients in the care planning process.
   - Predischarge patient and caregiver education and coaching.
   - Written transition care plan for patient and caregiver.
   - Timely communication and coordination with receiving practitioner.
   - Community-based support for the patient and caregiver post-hospitalization, focusing on self-care requirements and follow-up care with primary and specialty care providers.

8. Engage with local health plans to develop protocol for MHD and SUD transition of care to ensure:
   - Coordination of care across physical health.
   - Support for the spectrum.
   - Identification of and follow-up engagement with PCP is established.
   - Covered services including DME will be readily available.
   - Payment strategy for the transition of care services is in place.

9. Demonstrate engagement of patients in the design and implementation of the project.

10. Increase multidisciplinary team engagement by:
    - Implementing a model for team-based care where the staff performs to the best of their abilities and credentials.
    - Providing ongoing staff training on care model.

11. Implement a system for continual performance feedback and rapid cycle improvement that uses standard process improvement methodology and includes patients, front line staff, and senior leadership.

Care Coordination for High Risk, High Utilizing Populations: Chronic Non-Malignant Pain Management

There are 34 million Americans who suffer from chronic nonmalignant pain (CNMP), defined as pain lasting six months or more unrelated to cancer that does not respond to conventional medical treatment. The high prevalence of CNMP results in annual total costs of $85 billion to $90 billion in the United States, including medical costs and loss in productivity. For patients, risks include pain from failure to get treatment, possible addiction to prescribed medication, and a high risk of depression and/or suicide from untreated pain. Over the last decade, deaths involving opioid analgesics has more than tripled, with the majority of those deaths due to prescription drugs. Opiates were the most commonly involved medication, although these medications were often used in combination with other drugs. Drug-related deaths in the U.S. each year now surpass the number resulting from motor vehicle accidents. However, it is equally clear that a significant number of individuals have severe, nonmalignant, and chronic pain that may be disabling. Consequently, there is a pressing need in the health care industry to address the needs of these chronic pain patients using interventions that recognize current or potential substance abuse disorders that can maximize benefits while minimizing risk and potential side effects. Research on effective pain management supports a multimodal approach, incorporating physical and occupational therapy and other complementary disciplines. Health systems can best provide high-quality care to these patients through the adoption of evidence-based protocols and guidelines employing nonpharmacologic treatment. The primary goal is to improve primary care providers' and care teams' ability to identify and manage chronic nonmalignant pain using a function-based, multimodal approach and improve outcomes by implementing appropriate care plans and distinguishing between patients who will benefit from opioids and those who are likely to be harmed by them.

Specific Objectives:

- Improve the function and/or health-related quality of life of patients 18 years of age and older who are suffering with chronic pain.
- Improve the assessment and reassessment of patients 18 years of age and older diagnosed with chronic pain utilizing the biopsychosocial model.
- Improve the use of multimodal pain management strategies, including, but not limited to, physical and occupational therapy, group or individual psychotherapy/counseling, and other complementary and alternative therapies for patients 18 years of age and older who are diagnosed with chronic pain.
- Develop safe and effective prescribing practices for providers caring for patients 18 years of age and older who are diagnosed with chronic pain.
- Improve the effective use of nonopioid medications in the management of patients 18 years of age and older who are diagnosed with chronic pain.
- Improve the rate of identification and treatment of prescription opioid use disorders in primary care patients 18 years of age and older who are diagnosed with chronic pain.
- Decrease the rate of opioid prescriptions for patients 18 years of age and older who have ongoing substance abuse and/or diagnoses who do not warrant opioids (e.g., fibromyalgia, neuropathy, headache, sore throat, uncomplicated neck and back pain, uncomplicated musculoskeletal pain, nontraumatic tooth pain).
- Decrease the rate of ED visits/acute care utilization related to opioid overdose of patients age 18 years and older with chronic pain.
- Increase access to naloxone for patients with chronic opioid prescriptions.

System Components:

1. Develop an enterprise-wide chronic nonmalignant pain management strategy.

2. Demonstrate engagement of patients in the design and implementation of the project.

3. Implement or adapt a state or nationally recognized methodology for the assessment and management of chronic pain.

4. Implement protocols for primary care management of patients with chronic pain including:
   - A standardized pain care agreement.
   - Standard work and policies to support safe prescribing practices.
   - Comprehensive pain history including psycho/social evaluation, functional evaluations, care plan, pain medication risk/benefit informed consents, ongoing monitoring of plan/outcomes (e.g., use of standardized monitoring template for follow-up visits for CNP), aberrant behavior screening, and management protocols.
   - Guidelines regarding maximum acceptable dosing.

5. Provide patients an appropriate level of cultural, linguistic, and literacy education on the pathology of chronic pain, rationale for rehabilitation, and expected goals of treatment.

6. Coordinate a chronic pain care team that minimally consists of a physician champion and medical support staff. Suggestions for care clinicians from other disciplines include occupational, physical therapy, behavioral health, pharmacy, SUD specialists, neurology, occupational medicine, anesthesiology/pain management, home care, social work, physical medicine, and rehabilitation.

7. Implement technology-enabled data systems to support previsit planning, point-of-care delivery and team-based population/panel management and care coordination.

8. Determine population ICD-10 codes for data collection that are unique to patients with chronic pain on opioids. Develop a registry for pain assessments, care agreements, medication refill standing orders, and urine toxicology screening.

9. Use the provider activity care report to provide feedback to providers on how their chronic pain management practice compares to peers and industry benchmarks.

10. Establish a policy for monitoring and maintaining opioid agreements for prescription refills with other clinics, pharmacies, dentists, and specialists.

11. Develop a process for scheduling pain-focused, follow-up patient visits to ensure patients are receiving timely refills, while also allowing providers the opportunity to monitor for signs of diversion or misuse.

12. Develop staff and clinician training regarding the organization's process for managing patients with chronic nonmalignant pain.

13. Train providers to identify signs of prescription opioid use disorders. Provide treatment options for patients diagnosed with opioid use disorders, including subozone treatment, referral to methadone maintenance, referral to inpatient and outpatient substance use treatment facilities, and referral to needle exchanges.

14. Develop and implement protocols for prescribing naloxone to patients receiving opioids for chronic pain.

15. Identify standardized multidimensional pain assessment, functional assessment, psychological assessment, and opioid assessment tools that meet the needs of the care clinicians and are appropriate for patients.

16. Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front-line staff, and senior leadership. Timely, relevant, and actionable data to support patient engagement and drive clinical, operational, and strategic decisions, including continuous QI activities.

Cancer Screening and Follow-Up

Cancer is the second leading cause of mortality, accounting for nearly one out of every four deaths. The risk of developing cancer varies considerably by race/ethnicity. For example, African American men have the highest overall cancer rate, followed by non-Hispanic white men. Non-Hispanic white women are most likely to be diagnosed with cancer; however, African American women are more likely to die of the disease. The reasons for racial/ethnic differences in the risk of developing cancer are likely the result of a complex combination of dietary, lifestyle, environmental, occupational, and genetic factors. Higher mortality rates among some populations are due, in part, to poverty, which may increase the risk of developing certain cancers and limit access to and utilization of preventive measures and screening. Regular screening tests offer the ability for secondary prevention by detecting cancer early before symptoms appear. Screening tests that allow the early detection and removal of precancerous growths are known to reduce mortality of cancers of the cervix, colon, and rectum. Early diagnosis can also save lives by identifying cancers when they require less expensive treatment and have better outcomes. Five-year relative survival rates for common cancers (i.e., breast, colon, rectum, and cervix) are 93% to 100% if the cancer is discovered before it spreads beyond the organ where it began.

Specific Objectives:

- Identify cost-effective standard approaches to breast, cervical and colorectal cancer screenings and completion of follow-up on abnormal screening tests.
- Increase rates of screening and completion of follow-up across targeted prevention services.
- Reduce disparities in receipt of targeted prevention services.
- Reduce variation in performance of targeted prevention services.

System Components:

1. Develop a multidisciplinary task force to identify principle-based, expected practices for screening and follow-up for the targeted services including, but not limited to:
    - Standard approach to screening and follow-up:
        - Enterprise wide standard approach to screening (e.g., ages, frequency, diagnostic tool)
    - Follow-up for abnormal screening exams:
        - Clinical risk-stratified screening process (e.g., family history, red flags)
        - Timeliness (specific time benchmark for time from abnormal screening exam to diagnostic exam)

2. Develop linkages to community resources to enable referrals when patients need additional support:
    - Establish protocols to determine patient needs
    - Develop relationships to ensure support is available to patients who need:
        - Transportation to the clinic or off-site testing center
        - Health education specific to diagnosis
    - Financial assistance programs
    - Prepare a roster with community resource contact information

3. Review and update current workflows (as necessary) associated with cancer screening:
   - Test/referral order placement.
   - Standard timeframe for expected receipt of test results.
   - Responsibility and process for initial receipt of test results.
   - Responsibility and process for notifying ordering provider that test results are available.
   - Responsibility and process for notifying patients of normal test results, including timeframe for notifying patients.
   - Responsibility and process for notifying patients of abnormal test results, including timeframe for notifying patients.
   - Responsibility and process for closed-loop test tracking, ensuring follow-up of tests that are not completed and test results that are not received.

4. Format and prepare specific reports to enable analysis of success with cancer screening services
   - Develop process to codify radiology results.
   - Run exception reports to determine patients in need of preventive cancer screening.
   - Use evidence-based guidelines to determine denominator and timeframes.
   - Run a separate report for each clinician to determine success rates and provide structure for outreach efforts.
   - Analyze reports by race, ethnicity, or language needs to determine disparities in care.

5. Utilize population health management approaches to reduce gaps in receipt of care:
   - Prepare clinician-specific lists of patients in need of the required tests.
   - Run monthly reports and conduct outreach to patients in need of screening tests.
   - Develop strategies for patient engagement in use of patient portal.
   - Develop alerts in patient portal.

6. Develop standards for medical record documentation which provides evidence that:
   - Targeted test results were reviewed by the ordering clinician.
   - Appropriate and timely follow-up has been completed for every patient with an abnormal result.
   - Follow-up in ensure all related treatment and other appropriate services were provided in timely fashion.
   - Clinical outcomes are documented.
   - Provide training to clinic staff on documentation standards.
   - Monitor compliance with standards.

7. Ensure that formal written standardized protocols exist for:
   - Specimen collection and handling.
   - Receipt of test results in the clinic, notification of ordering provider, and acknowledgement by ordering provider.
   - Notifying patients of normal test results.
   - Notifying patients of abnormal test results.
   - Prepare script of notifications to patients to ensure patient returns for follow-up.
   - Follow-up with patients who are difficult to reach via telephone:
     - Trend patient reasons for not following up in timely manner
     - Implement rapid cycle improvement plan.

8. Demonstrate patient engagement in the design and implementation of programs.

9. Collect or use preexisting baseline data on receipt and use of targeted preventive services.

10. Implement processes to provide recommended clinical preventive services in line with national standards, including, but not limited to, USPSTF A and B recommendations.

11. Improve access to quality care and decrease disparities in the delivery of preventive services.

12. Employ local, state, and national resources, and methodologies for improving receipt of targeted preventive services, reducing associated disparities, and improving population health.

13. Adopt and use certified EHR systems, including clinical decision supports and registry functionality to support provision of targeted preventive services. Use panel/population management approaches (e.g., inreach, outreach) to reduce gaps in receipt of care.

14. Based on patient need, identify community resources for patients to receive or enhance targeted services and create linkages to connect/refer patients to community preventive resources, including those that address the social determinants of health, as appropriate.

15. Implement a system for continual performance management and rapid cycle improvement that includes feedback from patients, community partners, front-line staff, and senior leadership.

Complex Care Management for High Risk Populations

A disproportionate share of Medicaid spending in the United States is used to provide care for a relatively small number of patients, with 1% of beneficiaries accounting for the top quartile of total Medicaid expenditures. Among high-cost beneficiaries, approximately two-thirds have co-morbid conditions and one-third have co-occurring physical and mental health conditions. These patients incur frequent ED visits and hospitalizations that might have been prevented with less expensive preventive and primary care. Increasingly, payors and providers are investing in complex care management programs that target super-utilizers with coordinated outpatient care to keep them healthy and out of the hospital. Complex care management programs address patients' physical conditions, as well as the co-occurring behavioral health and socioeconomic challenges that increase their likelihood of hospitalization. Successful complex care management programs can improve quality of life for complex patients while dramatically reducing costly ED and hospital stays. A growing body of literature provides evidence for effective strategies in complex care management. Dr. Clemens Hong, a leader in complex care management research, identifies *seven strategies that are commonly used in successful programs: adopt a patient-centered, customized approach to care; use qualitative and quantitative methods to identify high-utilizing patients; prioritize care coordination; build trust between patients and primary care providers; form care teams that meet the patient's needs; and use technology to enhance care management activities.*

Specific Objectives:

- Improve patients' functional status.
- Increase patients' capacity to self-manage their condition.
- Improve medication management and reconciliation.
- Improve health indicators for chronically ill patients including those with MHDs and SUDS.
- Reduce avoidable acute-care utilization (readmissions, admissions, and ED visits).
- Improve patient experience.

System Components:

1. Develop a complex care management program at one site or with one defined cohort, or expand an existing program from a pilot site to all sites or to additional high-risk groups and demonstrate engagement of patients in the design and implementation of the project.

2. Utilize at least one nationally recognized complex care management program methodology.

3. Identify target populations and develop program inclusion criteria based on quantitative and qualitative data (e.g., acute-care utilization, lack of primary care utilization, number of high-risk MHDs or SUDs, polypharmacy, primary care input, functional status, patient activation, social support, or other factors). Include patient factors associated with a higher probability of being impacted by complex care management.

4. Conduct a qualitative assessment of high-risk, high-utilizing patients.

5. Establish data analytics systems using clinical (e.g., EHR, registries), utilization and other available data (e.g., financial, health plan, zip codes), to enable identification of high-risk/rising risk patients for targeted complex care management interventions, including ability to stratify impact by race, ethnicity and language.

6. Develop a multidisciplinary care team, to which each participant is assigned, that is tailored to the target population and whose interventions are tiered according to patient level of risk.

7. Ensure that the complex care management team has ongoing training, coaching, and monitoring towards effective team functioning and care management skill sets.

8. Implement evidence based practice guidelines to address risk factor reduction (smoking cessation/immunization/substance abuse identification and referral to treatment/depression and other behavioral health screening/etc.) as well as to ensure appropriate management of chronic diseases.
   - Use standardized patient assessment and evaluation tools (may be developed locally or adopted/adapted from nationally recognized sources).
   - Use educational materials that are consistent with cultural, linguistic, and health literacy needs of the target population.

9. Ensure systems and culturally appropriate team members (e.g., community health worker, health navigator, or promotora) are in place to support system navigation and provide patient linkage to appropriate physical health, MHD, SUD and social services. Ensure follow up and retention in care to those services that promote adherence to medications.

10. Implement technology-enabled data systems to support patients and care teams throughout the care management program, including patient identification, previsit planning, point-of-care delivery, and care plan development and population/panel management activities.

11. Implement a data-driven system for rapid cycle improvement and performance feedback to address quality and safety of patient care that includes patients, front line staff, and senior leadership.

Antimicrobial Stewardship

Proper use of antibiotics has become a pressing healthcare quality concern as antimicrobial resistance has been documented across several pathogens in increasing numbers throughout the United States. Infections resistant to antibiotic treatments have put patient health at risk and added to health care costs through extended patient treatment. The Centers for Disease Control has identified antibiotic stewardship as a key strategy to combat pathogen resistance through incorporating best clinical practices based on antibiotic dosing, duration, and route. A stewardship program can be implemented through policies and procedures, training, and an effective reporting system. In addition to reducing resistance, promoting antimicrobial stewardship has proven to lower costs, minimize medication-based adverse events and improve patient quality of care. The goal is to improve the appropriate use of antimicrobials by reducing overall antibiotic use for nonbacterial diseases and optimizing antibiotic use for bacterial infections, with a special emphasis on agents with broad-spectrum activity to improve patient outcomes and eliminate unnecessary patient care costs.

Specific Objectives:

- Reduce broad-spectrum antibiotic use.
- Decrease inappropriate use of antibiotics across hospital and health care system.
- Reduce hospital associated Clostridium difficile infections.

System Components:

1. Utilize state and/or national resources to develop and implement an antibiotic stewardship program, such as the IHI-CDC 2012 Update "Antibiotic Stewardship Driver Diagram and Change Package."

2. Demonstrate engagement of patients in the design and implementation of the project.

3. Develop antimicrobial stewardship policies and procedures.

4. Create standardized protocols for ordering and obtaining cultures and other diagnostic tests prior to initiating antibiotics.

5. Develop a method to inform clinicians about unnecessary combinations of antibiotics.

6. Based on published evidence, reduce total antimicrobial days of therapy by providing standards and algorithms for recommended agents by disease type, focusing on short-course regimens (e.g., three to five days of therapy for uncomplicated cystitis, seven days for uncomplicated pyelonephritis, five to seven days for uncomplicated nondiabetic cellulitis, five-day therapy for community acquired pneumonia, seven to eight days for therapy for VAP or hospital-acquired pneumonia).

7. Develop evidence-based CPOE algorithms and associated clinician training to support antibiotic stewardship choices during order entry. These could include approaches such as guidelines for duration of antibiotics, within drug class auto-switching for specific antibiotics and doses or restriction of specific antibiotics at the point of ordering (e.g., broad-spectrum agents).

8. Implement stewardship rounds focusing on high-yield drugs to promote de-escalation after the drug regimen is started.

9. Improve diagnostic and de-escalation processes to reduce unnecessary antibiotic use based on the length of therapy or antibiotic spectrum such as:
   - Procalcitonin as an antibiotic decision aid.
   - Timely step down to oral antibiotic therapy to support early discharge from the hospital for acute infections.
   - Use of oral antibiotics for osteomyelitis to reduce prolonged IV exposures.

10. Evaluate the use of new diagnostic technologies for rapid delineation between viral and bacterial causes of common infections.

11. Adopt the recently described "public commitment" strategy in outpatient clinics to encourage providers not to prescribe antibiotics for URIs.

12. Publish organization-wide provider level antibiotic prescribing dashboards with comparison to peers and benchmarks. Contribute system level data for a similar dashboard across all public health care systems.

13. Implement a system for continual performance feedback and rapid cycle improvement that includes patients, frontline staff, and senior leadership.