Partnering with Your State Quality Innovation Network/Quality Improvement Organization

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May 24, 2017
Everyone with Diabetes Counts (EDC)

National Council on Aging
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May 24, 2017

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Quality Improvement Organizations (QIOs) History

- QIOs were established as Peer Review Organizations (PROs) in 1972 under an amendment to the Social Security Act (SSA), Sections 1152 – 1154, with an audit/inspection role for the Medicare program.
- In 2002, the name Peer Review Organization was changed to Quality Improvement Organization to reflect their expanding role in the area of population based quality improvement.
- The QIO mission is to improve the effectiveness, efficiency, economy, and quality of health care services delivered to Medicare beneficiaries.
- QIOs are unique, with “boots on the ground” staff.
QIOs to QINs (Quality Innovation Networks)

• QIO program **restructured as of August 1, 2014** (CMS Press Release July 18, 2014) for the 11th scope of work (SOW) contract cycle

Changes:

• **14 organizations**, formerly QIOs, awarded QIN contracts representing 50 states, as well as Washington DC, Puerto Rico, and the US Virgin Islands

• **QINs comprised of 2 – 6 states each, not contiguous/bordering states**

• **Beneficiary and Family Centered Care (BFCC) contracts awarded to 2 organizations for the entire country to perform Medicare case review and appeals; they cannot participate in remaining QI activities:** KePro in Ohio, and Livanta, LLC in MD.

• **Work remains state-based**, but no longer limited to work just within their respective state; QI activities can now be performed across state lines within QINs

• **Contracts** changed from 3 years to 5 years

• Results in sharing/leveraging of resources, economies of scale
Diabetes Prevalence/Medicare Expenditures Attributed To Diabetes

• 60% of Medicare beneficiaries have multiple chronic conditions

• 15% of Medicare beneficiaries have 6 or more chronic conditions; the top 6 are: HTN, High Cholesterol, Arthritis, Diabetes, Ischemic Heart Disease, and Chronic Kidney Disease, which account for 51% of Medicare spending

• 24% of Medicare-Medicaid (dually eligible) beneficiaries have 6 or more chronic conditions (Source for all of the above: CMS Chronic Conditions Among Medicare Beneficiaries Chartbook, 2015)

• 26.9% of Medicare beneficiaries age 65 and older (10.9 million Americans) have diabetes; they account for approximately 32% of Medicare spending (Source: 2013 testimony by the Congressional Diabetes Caucus in the US House of Representatives and the American Diabetes Association)
Diabetes Statistics – Over 65/Diverse Populations

• Adults aged 65 and over have the highest percentage of diagnosed diabetes, compared to any age group (CDC/NCHS Interview Survey 2013)

Diabetes Rates from the CDC National Diabetes Statistics Report 2014:
• Among non-Hispanic whites 7.6%
• Among non-Hispanic Blacks 13.2%
• Among Hispanic adults, 8.5% for Central and South Americans, 9.3% for Cubans, 13.9% for Mexican Americans, and 14.8% for Puerto Ricans.
• Among Asian American adults, 4.4% for Chinese, 11.3% for Filipinos, 13.0% for Asian Indians, and 8.8% for other Asians.
• Among American Indian and Alaska Native adults, the age-adjusted rate of diagnosed diabetes varied by region from 6.0% among Alaska Natives to 24.1% among American Indians in southern Arizona

Rural statistics:
• Diabetes is more common among beneficiaries who live in rural counties (16.7%), than among those who live in urban areas (13.5%). Source: The Rural Health Research & Policy Centers, funded by the Federal Office of Rural Health Policy
Everyone with Diabetes Counts (EDC)

• Started as a one-state pilot **10 years** ago (FL)
• Then expanded to 9 states/territories (NY, GA, LA, WV, TX, MS, MD, Washington DC, U.S. Virgin Islands)
• **National expansion** (50 states, as well as Washington DC, Puerto Rico, and US Virgin Islands) as of **August 1, 2014**. Contract ends July 31, 2019.
• **Largest national** diabetes self-management education (DSME) Program focused on Medicare beneficiaries in underserved minority/diverse, and rural populations.
• EDC is **community-based**.
• EDC is a Program, not a Medicare benefit.
EDC Goals

- Improve health equity by improving health literacy and quality of care among Medicare and Medicare-Medicaid (dually eligible) beneficiaries with pre-diabetes and diabetes through knowledge empowerment, enabling them to become active participants in their care (person/patient engagement)
- EDC is a disparity reduction program; target populations are minority underserved/diverse, lower SES, and rural
- Engage both beneficiaries and health care providers to: Decrease the disparity in diabetes care by improving testing/measures for: **HbA1c**, **Lipids**, **Eye Exams**, **Foot Exams**, **Improve Blood Pressure control and Weight control**
- Improve actual clinical outcomes of the above measures
- Facilitate sustainable diabetes education resources by engaging public/private agency/organization partnerships at the community level; state level; and national level
Challenge of Literacy/Health Literacy

The current literacy rate in the US has not changed in 10 years.

• **14% of US adults cannot read** (defined as being below a basic level)*
• 19% of high school graduates can't read

**Reading Levels - Demographics of Adults who Read below a basic level***

• Hispanic  41%
• African American  24%
• White  9%
• Other  13%

*Basic level - reading at a 4th grade level, and the person should be able to make simple inferences, and interpret the meaning of a word as it is used in the text.

EDC Components

EDC has 5 components:
• 1.) Recruitment and education of beneficiaries
• 2.) Recruitment and education of physician practices/providers and staff
• 3.) Recruitment of community partners/stakeholders
• 4.) Data collection and analysis
• 5.) Sustainability planning/implementation

• Improving the Individual Experience of Care: Beneficiary DSME Classes and Provider Technical Assistance
• **EDC Effect on Health/Quality:** Clinical Data Results
• **EDC Effect on Cost:** Medicare Claims Data
How to Accomplish EDC

- **Recruit**, enroll, and teach **beneficiaries** utilizing evidence-based DSME curricula; Stanford, or DEEP (diabetes education empowerment program from UIC (University of Illinois, Chicago)). Classes teach/promote: healthy lifestyles/behavioral changes, basic anatomy, nutrition, medication adherence, medical monitoring (physician appts., labs, foot and eye exams, etc.), and self-goal setting to achieve favorable outcomes.

- DSME classes: 6 consecutive weeks, 2 ½ hours each class (12-15 hours total); community-based sites; invite guest lecturers (i.e., pharmacists, dieticians); includes cultural competency component; many classes taught by community health workers (CHWs) who reside in the targeted community, or are members of that population group. Classes taught in the preferred language of the targeted population as much as possible; taught for low literacy populations; family member or care-giver encouraged to attend – person and family engagement; “meet people where they are” **Not one size fits all**

- Recruit physician practices, clinics, Medicare Advantage (MA) Plans, Federally Qualified Health Centers (FQHCs) to improve their adherence to standards of care for people with diabetes; improve their data collection and data analysis skills; improve their knowledge of Medicare diabetes prevention benefits, educate provider staff
How to Accomplish EDC continued

- **Recruit community partners/stakeholders** - “spread the word,” by attending community-based activities, i.e., health fairs, to market DSME classes; **partner/stakeholder venues to host classes** (i.e., area agency on aging (AAA) sites, senior centers, grocery stores, pharmacies, libraries, faith-based organizations, police stations); endorsement by trusted sources in the community (i.e., local “celebrity” endorsement, church Pastor endorsement); local TV and radio coverage, i.e., public service announcements (PSAs); partner with **state depts. of health**, with local politicians for endorsement (Mayor, Senator, Governor); with **state medical societies**; with **academic institutions** (schools of Nursing, Pharmacy, Medicine, Programs in Dietetics)

- **Data** – QIN-QIO will obtain **clinical results** of diabetes measures for 10% of beneficiaries who complete DSME, and match to **Medicare claims** data, following beneficiaries longitudinally over time; pre and post DSME **Patient Activation Survey** data
How to Accomplish EDC

Sustainability Planning/Implementation

• Each QIN-QIO develops and implements a **Sustainability Plan** that includes increasing the numbers of certified diabetes educators (CDEs) in their state; increasing the numbers of lay diabetes educators in their state (by training them in DSME curriculum); developing train-the-trainer programs; working to facilitate the use of CHWs in their state; providing **technical assistance** to existing ADA/AADE recognized/accredited programs; and increasing the numbers of new ADA/AADE recognized/accredited **diabetes education programs in each state.**

** Achieving this recognition/accreditation enables the program to bill for the Medicare diabetes self-management training (DSMT) benefit, as well as potentially billing to other insurers/payers for diabetes education.
Medicare Preventive Services/Benefits

- Diabetes self-management training (DSMT) (for Medicare beneficiaries with diabetes)
- Medical nutrition therapy (MNT) (not limited to Medicare beneficiaries with diabetes)
- Diabetes and Pre-diabetes Screening (eligibility depends on risk factors for diabetes)
- Intensive Behavioral Therapy (IBT) Obesity Screening and Counseling (not limited to beneficiaries with diabetes)
- Chronic Care Management (not limited to beneficiaries with diabetes)
- Shared Medical Appointment (not limited to beneficiaries with diabetes)
- Depression Screening (not limited to beneficiaries with diabetes)

EDC Facts and Results

• **National Partners:** CDC (1305 Grantees), ACL (formerly AoA), Office of Minority Health (OMH), ADA, AADE, Stanford, U of Illinois, Chicago (UIC), AMA, NCOA

• **Stanford** – the highest level of trainers (Master-T-Trainees) certified to teach Stanford in Spanish on the East Coast of U.S. are in NY QIN-QIO

• **DEEP** – the highest level of DEEP trainers in the U.S. (Senior Trainers) are in the QIO Program

• To date, from the inception of EDC, > **60,000 Medicare beneficiaries in minority/diverse and rural populations** have completed DSME classes through EDC

• To date > **40,000 individual physicians/health care providers** have participated in EDC

• To date, > **4,000 lay/peer diabetes educators** (CHWs, and lay leaders) have been trained in the DSME curricula used by the QINs

• To date > **7,000 community-based organizations** have participated in EDC

• To date DSME classes in EDC have been hosted at > **10,000 community based sites**

• **QIOs have taught DSME classes in various settings:** out-patient mental health facilities; in SNF facilities; and in dialysis facilities

• **DSME classes have been taught in:** Spanish, Mandarin, Cantonese, Vietnamese, Korean, Russian, French, Portuguese, Somali, Swahili. **Senior Centers** play a vital role in hosting classes, as well as in providing interpreters. Classes have been taught for the visually impaired.
EDC Facts and Results

Foot Care Campaign

• Due to rising lower extremity amputation rates among Medicare beneficiaries with diabetes, the EDC Program has launched a “Foot Care Campaign.”
• Duration: 6 months – April 1, 2017 – September 30, 2017
• Please see: [https://qioprogram.org/edc-foot-care-campaign](https://qioprogram.org/edc-foot-care-campaign) for provider and beneficiary campaign information/flyers re: how to conduct a 3 min. foot exam, how to conduct a self foot exam, how to select properly fitting shoes

Patient Activation Survey (PAS) Self-Attested National Results for One Year:

• [https://qioprogram.org/edc/progress-to-date](https://qioprogram.org/edc/progress-to-date) Scroll Down to, “Click here for more information about PAS results.”
• Statistically significant improvement responses from pre to post DSME completion from 10,092 Medicare beneficiaries
• 37% of respondents (the largest %) were recruited to classes from senior centers
• 53% respondents had diabetes for 4 or more years
• 61% respondents had never received diabetes education previously
• 19% had 8th grade education or less
• 70% reported eye disease (the highest %) as a co-morbid condition
EDC Challenges

- Social determinants of health – poverty, low-literacy/illiteracy
- Language challenges, English may be second language
- Food deserts
- Lack of transportation
- Cultural beliefs: fatalistic/self-fulfilling prophecy of, “my parents died from diabetes, so will I”
- Trust issues in these communities
- Keeping beneficiaries and health care providers motivated and engaged – requires maximum creativity, and continuous interventions
Resources - Websites

- [https://www.qioprogram.org/contact](https://www.qioprogram.org/contact) to locate the QIN QIO in your state, and for general information about QIN QIOs
- [https://qioprogram.org/EDC](https://qioprogram.org/EDC) for general information about EDC, Success Stories, Photos, Data Results
- [https://qioprogram.org/edc/progress-to-date](https://qioprogram.org/edc/progress-to-date) for survey (PAS) Results, Scroll Down to, “Click here for more information about PAS results.”
- [https://qioprogram.org/edc/faq](https://qioprogram.org/edc/faq) for FAQ’s about EDC
- [https://qioprogram.org/edc-foot-care-campaign](https://qioprogram.org/edc-foot-care-campaign) for provider and beneficiary campaign information/flyers re: how to conduct a 3 min. foot exam, how to conduct a self foot exam, how to select properly fitting shoes

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EDC Pictures

Marketing Flyer for EDC Classes

GOT SUGAR?

Help control your diabetes with FREE classes

WHO? Medicare recipients with diabetes, family members and caregivers

WHAT? Free diabetes education classes
Find out about:
• Diabetes and its risks
• Diet and exercise
• Talking with your health care team
• Managing medications

WHERE? In your area

For information on diabetes classes, call

Toll Free 855-276-9232
EDC Master Trainers Class Graduates, Texas
EDC Medicare Beneficiaries
Graduation Ceremony, Bronx, NY
Everyone with Diabetes Counts

Down Home Recipes from West Virginia
HbA1c Molecule
EDC on Front Page of Latino Post, New York City
How to Check Your Blood Sugar

1. Wash your hands with soap and warm water. Rinse well.
2. Gently rub your hands to warm them.
3. Put the test strip into your meter.
4. Prick the side of your finger.
5. Touch your blood drop to the test strip.
6. Write the results in your book.
Cuidando Sus Pies

Mantenga sus pies protegidos y saludables para evitar heridas en los pies y llagas abiertas.

1. Mantenga los pies limpios y secos.
2. No sumerja sus pies durante mucho tiempo.
3. Use calcetines limpios todos los días y siempre use zapatos con punta y talón cerrados.
4. Revise sus pies diariamente por ampollas, enrojecimiento o llagas. Consulte a su médico de inmediato si tiene cualquier llaga.
5. Acostúmbrese a utilizar una lima para afilarse las uñas. Nunca use una navaja o cuchillo.
6. Mantenga los pisos y pintas de acceso libres de objetos para evitar tropiezos con la punta de sus pies.
7. Examine sus zapatos todos los días.
8. Nunca camine descalzo(a) o use chanclas.
Partnering with Your State Quality Innovation Network/Quality Improvement Organization

The Department of Aging and Rehabilitative Services and Health Quality Innovators
Agenda

• Who we are
• CDSME and Everyone with Diabetes Counts (EDC) in Virginia
• History of our partnership
• Roles
• Benefits
• Collaborative examples
• Lessons learned
Who we are

• Provides and advocates for resources and services to improve the employment, quality of life, security, and independence of older Virginians, Virginians with disabilities, and their families. Includes:
  • Adult Protective Services
  • Community Based Services
  • **Division for the Aging**
  • Office of Community Integration
  • Rehabilitative Services
  • State Long-Term Care Ombudsman
  • Wilson Workforce and Rehabilitation Center

• The Virginia Division for the Aging
  • Designated by the federal government to oversee all state programs using Older Americans Act and the Virginia General Assembly funds.

• 25 Area Agencies on Aging contract with the Division.
Who we are

- Independent, non-profit consulting organization founded in 1984; formerly VHQC

- CMS and other government agencies fund HQI as
  - Quality Innovation Network (QIN-QIO) for Maryland and Virginia
  - Practice Transformation Network (PTN)
  - Hospital Improvement Innovation Network partner (HIIN)
  - Accountable Health Community (AHC)
CDSME in Virginia

2005
- Introduced by Virginia Department of Health

March 2010
- ARRA grant from US Administration on Aging to disseminate CDSME to older adults

September 2012
- Three-year grant under the Prevention and Public Health Funds, Affordable Care Act (PPHF-2012)

August 2016
- Two-year PPHF-2016 grant. DARS as the lead state agency; Area Agencies on Aging as leads at the local level
Participation in CDSME Workshops
April 1, 2010 through May 15, 2017
Everyone with Diabetes Counts (EDC) in Virginia

- Contract cycle started Fall 2014

- HQI’s plan
  - Obtain Stanford Multi-site CDSME License
  - Secure Master Trainers
  - Find partnering community organizations
  - Recruit physicians
  - Host/support workshops
CDSME and EDC partnership history

2014

• January: Transitions conference—introduced CDSME
• June: HQI Webinar on care transitions and CDSME
• October: HQI participation in monthly CDSME conference calls begins

2015

• March: AAAs can be under HQI license
• Spring: HQI reaches out on EDC
CDSME and EDC partnership history

2016

• March:
  Contract on HQI financial incentives for EDC deliverables

• November:
  Master training collaboration and shared staffing

Present and ongoing

• Collaboration on fidelity and data collection
  • Connecting with medical community
  • Monthly conference calls and “office hours”
Roles

- Coordinate overall CDSME program and ACL grant projects
- Coaching and technical assistance
- Master training: Registration, site selection/expenses, material expenses, sharing staffing.
- Fidelity assurance and site visits
- Facilitate monthly conference calls
- Administer reimbursement to AAAs for EDC deliverables
- Coordinate contract with and billing of MCO
Roles

- Maintain CDSMP/DSMP license with Stanford
- Provide technical assistance to AAAs on EDC, working with physicians, establishing new partners
- Reimburse AAAs for EDC deliverables
- Liaison with Stanford
- Participation in monthly conference calls
- Lead AAA “office hours”
Benefits to DARS

- Five-year Stanford License covers AAAs
- Master Training resources and support
  - Stanford Fee
  - T Trainer fees
  - Books and manuals
  - Sharing staffing at MT
- EDC incentive funds
- Collaboration and consultation
  - Technical assistance (including “office hours” and Special Conference Calls)
  - Fidelity issues
Benefits to HQI

• DARS provided HQI warm introduction to and continued influence with AAAs
• Introduces HQI to established community organizations and providers
• Streamlines data collection for required EDC components
• Collaboration and consultation
  • Master Training support
  • Technical assistance (including “office hours” and Special Conference Calls)
  • Fidelity issues
Collaborative examples
Participant Information Survey

Participant I.D. (first two letters of your first name, first two letters of your last name, last two numbers of your birth year): __________

1. How old are you today? _____ years

2. Are you: O Male or O Female?

3. Are you of Hispanic, Latino, or Spanish origin? 
   O Yes   O No

4. What is your race? Mark all that apply.
   O American Indian or Alaska Native
   O Asian
   O Black or African American
   O Native Hawaiian or other Pacific Islander
   O White

5. Has a health care provider ever told you that you have any of the following chronic conditions? (Please mark all that apply.)
   O Arthritis/Rheumatic Disease
   O Hypertension (High Blood Pressure)
   O Asthma/Emphysema/Other Chronic Breathing or Lung Problem
   O Kidney Disease
   O Cancer or Cancer Survivor
   O Osteoporosis (Low Bone Density)
   O Chronic Pain
   O Obesity
   O Depression or Anxiety Disorders
   O Schizophrenia or Other Psychotic Disorder
   O Diabetes (High Blood Sugar)
   O Stroke
   O Heart Disease
   O Other Chronic Condition
   O None (No Chronic Conditions)

6. During the past year, did you provide regular care or assistance to a friend or family member who has a long-term health problem or disability? 
   O Yes   O No

Please go to next page
7. Are you deaf or do you have serious difficulty hearing?
   O Yes   O No

8. Are you blind or do you have serious difficulty seeing even with glasses?
   O Yes   O No

9. Because of a physical, mental, or emotional condition, do you have serious difficulty walking or climbing stairs, dressing or bathing, or doing errands alone such as visiting a doctor’s office or shopping?
   O Yes   O No

10. Do you live alone?  O Yes   O No

11. What is the highest grade or year of school you completed?
    O Some elementary, middle, or high school
    O High school graduate or GED
    O Some college or technical school
    O College 4 years or more

12. In general, would you say that your health is:
    O Excellent   O Very good   O Good   O Fair   O Poor

13. Did your doctor or other health care provider suggest that you take this program?
    O Yes   O No

Please go to next page
14. What is your address?

_________________________  __________________
Street number                Street name
_________________________  __________________
City                          State                Zip Code

15. What health insurance do you have?
- Medicare (often a red, white and blue card, also known as “Original Medicare”)
- Medicare Advantage (like an HMO or PPO)
- Medicaid
- Private Insurance
- I don’t have insurance
- I don’t know

16. Do you smoke?  ○ Yes  ○ No

17. Do you speak a language other than English at home?
- Yes  ○ No  If yes, what language? __________________

18. If you have diabetes, please answer the following questions:

a. What kind of diabetes do you have?
- Pre-diabetes  ○ Type 1  ○ Type 2  ○ I don’t know

b. When did your doctor tell you that you have diabetes or pre-diabetes?
- Less than a year ago  ○ Less than four years ago
- Less than two years ago  ○ Four or more years ago
- Less than three years ago  ○ I don’t know/I don’t remember

C. In the last year, about how many times has your doctor or nurse checked your feet?

_________ (write the number of times)  ○ Never  ○ I don’t know

This material was prepared by Health Quality Innovators (HQI), the Medicare Quality Innovation Network-Quality Improvement Organization for Maryland and Virginia, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. HQI[1150W]20161202-203117
Diabetes Self-Management Workshop at BRMC

- Rural setting
- Federally Qualified Health Center
- Medicare beneficiaries or 65+
- High percentage of diabetes and pre-diabetes diagnoses
DSMP workshop overview

• Making an action plan
• Nutrition/healthy eating
• Feedback/problem-solving
• Preventing low blood sugar
• Preventing complications
• Fitness/exercise
• Stress management
• Relaxation techniques
• Difficult emotions
• Monitoring blood sugar
• Depression
• Positive thinking
• Communication
• Medications
• Working with your health care professional
• Skin and foot care
• Future plans
Lessons learned

• Identify what each partner needs and be sure to address that
• Communicate clearly to those on the front lines: We count on them!
• It’s helpful to have a partner in exploring and resolving fidelity issues
• Be willing to prioritize others’ needs before your own
• Patience and persistence work!
Contact us

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