SUPERIOR HEALTH QUALITY ALLIANCE

Transforming Health Care Delivery Report

November 2019-November 2024

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

SUPERIOR HEALTH
Quality Alliance

Table of Contents

Achieving National Health Care Quality Goals in Michigan, Minnesota and Wisconsin

Superior Health Quality Alliance (Superior Health), as the Quality Innovation Network-Quality Improvement Organizations (QIN-QIO) for Michigan, Minnesota and Wisconsin relentlessly pursued our mission to improve the health of Medicare beneficiaries throughout the last five years. We have ensured essential health care programming reaches communities across the upper Midwest through our partnerships with the Centers for Medicare & Medicaid Services (CMS) and with trusted health care organizations, state agencies, professional and trade associations and others.

I'm so proud of the way our teams and communities stepped up to collaborate, innovate and provide person-centered quality improvement initiatives that are truly integrated across settings and services—all during a time of immense need. With this report, I'm pleased to share the outcomes of these efforts. Specifically, I want to share the areas where Superior Health made significant contributions, including:

1. **Commitment to Health Equity and Person and Family Engagement:** Ensuring people from all backgrounds are equal and active partners in their health.
2. **Care Coordination:** Streamlining communication and collaboration among health care providers to ensure patients receive seamless and coordinated care.
3. **Chronic Disease Management:** Implementing innovative programs to empower individuals with chronic conditions to manage their health effectively.
4. **Infection Prevention and Control:** Championing best practices and initiatives to minimize the risk of healthcare-associated infections.
5. **Medication Safety:** Promoting safer prescribing practices and alternatives to opioids.
6. **Quality Improvement Initiatives:** Continuously evaluating and refining health care delivery systems to deliver the highest quality of care.
7. **Hospital and Health System Support:** Reducing all-cause harm in rural and other acute care hospitals.

Superior Health prioritized a person-centric approach across all initiatives, focusing on understanding the evolving needs of the communities we serve. This report not only reflects our achievements but also serves as a roadmap for the future, guiding us as we strive to anticipate and deliver the health care solutions that will have the greatest impact on the well-being of Medicare beneficiaries.

Sincerely,

Tania Daniels, PT, MBA
Chief Executive Officer

Numbers of Participants by Setting

1,084
Nursing Homes

389
Clinics

134
Hospitals/ Health Systems

394
Community Organizations

Harms Avoided
268,656

Return on Investment (ROI)
Over $1.02B

Nursing Homes ROI
Over $6.9M

Relative Improvement Rates (RIR)

20% Blood Pressure Management

58% Diabetes Management

21% Hospital Readmissions

69% COVID Vaccination

Quality Focus Areas

- Commitment to Health Equity and Person and Family Engagement
- Care Coordination
- Chronic Disease Management
- Infection Prevention and Control
- Medication Safety
- Quality Improvement Initiatives
- Hospital and Health System Support

Commitment to Health Equity and Person and Family Engagement

Ensuring people from all backgrounds are equal and active partners in their health

Health equity means ensuring everyone has the opportunity to live a healthy, quality life, regardless of their background and where they live. Advancing health equity requires coordination and commitment from all partners in all settings including payers, providers, policy makers, regulators, community-based organizations and communities.

Our Goal

To support our network of participants to provide more equitable and person-centered care by offering guidance, resources, strategies and interventions to make health equity a strategic priority.

Top Initiatives:

1. **Community Health Disparities Reduction Partnership (CHDRP):** Designed to invest in and provide technical assistance support to Wayne County (Michigan), Ramsey County (Minnesota) and Milwaukee County (Wisconsin), this initiative aims to reduce disparities in health care outcomes within these communities.
2. **Culturally and Linguistically Appropriate Services (CLAS):** Helped organizations improve service quality across racial, ethnic, linguistic and gender minorities, and individuals with disabilities. By supporting the implementation of CLAS standards, Superior Health fosters connections between health care professionals and diverse populations to better address their needs.
3. **Person and Family Engagement (PFE):** Focused on involving patients, residents and their families in the design, delivery and evaluation of their care. Superior Health promotes person-centered care by fostering proactive communication, partnered decision-making, and collaboration across health care players through the Person and Family Advisory Council (PFAC).

Our team's commitment to health equity and person-family centered care has resulted in significant achievements, including the successful implementation of the Superior Health Community Health Disparities Reduction Partnership, the development of the Health Equity Community Conversations series, and the deployment of the CLAS Standards Guidance Webinar Series. These initiatives have not only addressed health disparities but have also fostered a more inclusive and person-centered health care environment."

— Ewa Panetta, Superior Health PFE Lead

I chose to become a Superior Health advisor because I believe the work of the PFAC is important. Participating gives me the opportunity to help improve health care based on my personal experience and knowledge."

— Jill Jonas, Superior Health PFAC Beneficiary/Caregiver Advisor, Wisconsin

Care Coordination

Enhancing care across the continuum

The Care Coordination team develops and implements strategies to improve coordination of care across settings and among providers, aiming to reduce hospital readmissions and preventable emergency department (ED) visits.

Our Goal

To foster cross-care collaboration and implement evidence-based practices that enhance patient transitions and reduce preventable health care utilization.

Top Initiatives:

1. **Sepsis Sprint:** Implemented a program across multiple care settings to improve early identification and treatment of sepsis. This included four webinars, evidence-based tools and technical assistance, leading to successful implementation of sepsis screening tools in 10 nursing homes.
2. **Readmissions/Transitions in Care Sprint:** Created a four-part webinar series designed to reduce hospital readmissions and improve care transitions for hospitals and dialysis facilities.
3. **Home Healthcare Agencies (HHA) Workgroup:** Convened HHAs to develop strategies and the Call Us First Toolkit to impact readmission and ED measure rates.

Outcomes:

121 Participants: Engaged in the Sepsis Sprint, leading to successful implementation of sepsis screening tools in 10 nursing homes.

9% Reduction: In readmission rates for dialysis facility participants compared to Network and National trends.

721 ED Visits Prevented: From October 2022 to July 2023 across short-term and critical access hospitals and inpatient psychiatric facilities.

Cross-Setting Collaboration

Reducing Readmissions

The Cross-Setting Readmissions/Transitions in Care Improvement Sprint was a four-part webinar series designed to help hospitals and kidney dialysis facilities reduce avoidable readmissions and improve care transitions. Participants could identify improvement areas and implement evidence-based recommendations through utilizing gap analysis tools. Dialysis facility sprint participants achieved a 9% reduction in readmission rates compared to network and national trends, demonstrating the effectiveness of the program in improving patient outcomes.

Improving Sepsis Response

The Cross-Setting Sepsis Improvement Sprint was a four-part online engagement series aimed at helping health care providers in various settings, including dialysis facilities, home health care agencies, hospitals and long-term care facilities, improve the early identification and treatment of sepsis. The Midwest Kidney Network experienced a relative improvement rate of 6.25% in reducing sepsis hospitalizations, while the 19 Sepsis Sprint participants achieved a notable 15.7% reduction. This initiative is crucial for reducing hospital readmissions and improving the health of Medicare beneficiaries.

Chronic Disease Management

Improving care for chronic conditions

The Chronic Disease Management (CDM) team partners with health care providers to improve the quality of care and health outcomes for Medicare beneficiaries with chronic conditions.

Our Goal

To develop and implement comprehensive strategies that enhance the management of hypertension, cardiovascular disease, diabetes and chronic kidney disease (CKD), while promoting cardiac rehabilitation and tobacco cessation.

Top Initiatives:

1. **Self-Measured Blood Pressure (SMBP) and ABCS of Heart Health Collaboratives:** Conducted three collaboratives on SMBP, training providers to implement at-home blood pressure monitoring, resulting in over 900 views of instructional content and supported use of best practices related to the ABCS (aspirin, blood pressure, cholesterol, smoking cessation) of heart health.
2. **Diabetes Affinity Group:** Hosted virtual education series focused on patient-centered diabetes care, addressing hyperglycemia, hypertension and related conditions, that generated over 1,000 views.
3. **Chronic Kidney Disease Collaboratives:** Shared techniques for early detection and management of CKD, leading to over 1,900 views of resources on managing the transition from CKD to end-stage renal disease (ESRD).

Outcomes:

20% Relative Improvement Rate: Increase in Medicare beneficiaries with controlled blood pressure (<140/90 mmHg).

58% Relative Improvement Rate: Reduction in Medicare beneficiaries with diabetes and HbA1c ≥ 9.0.

24% Relative Improvement Rate: Improvement in screening, diagnosing and managing CKD to prevent progression to ESRD.

These sessions are helpful to ensure we are addressing the correct actions in our SMBP program and to identify ways we may improve. We have found that motivational interviewing is key to our success as facilitators as well as when we talk to potential participants about the SMBP program."

— SMBP Collaborative participant

Superior Health Connect

Superior Health Connect is a member-only online platform designed to facilitate collaboration and knowledge sharing among health care professionals. It was originally created as a space for individuals working on similar interventions to connect and learn from each other but has evolved to offer a range of benefits. These include enhanced accessibility, adaptability and opportunities for real-time interaction and education. The platform has experienced steady growth, with an average of 15 new members joining each month. Currently, Connect boasts a membership of more than over 880 individuals.

Infection Prevention and Control

Mitigating harm for patient safety

The Infection Prevention and Control (IPC) team focuses on reducing harmful infections in nursing homes by providing education, technical assistance and supporting emergency preparedness.

Our Goal

To enhance infection control practices and outcomes, targeting infections like *Clostridioides difficile,* COVID-19, sepsis, urinary tract infections (UTIs) and pneumonia, while strengthening system-level emergency preparedness in nursing homes.

Top Initiatives:

1. **Front Line Forces:** Creating training modules and resources covering 25 topics to empower direct care staff by building the confidence and skills they need to deliver quality care with a resident-centered approach.
2. **Emergency Preparedness Learning Series:** Created a nine-part series addressing critical aspects of emergency preparedness, with 191 registrants and 1,366 video views.
3. **Table-Top Exercises:** Facilitated virtual exercises focusing on cybersecurity incidents, attended by 216 nursing home representatives, to meet CMS requirements for emergency preparedness.

Outcomes:

7,486 Quizzes Completed: Across 25 topics in the Front Line Forces training modules.

852 Plans Reviewed: Using a Superior Health template, feedback was provided to nursing homes for improving emergency preparedness plans.

600+ Participants: Engaged in the Nursing Home Leadership Roundtable series, supporting leaders across the region.

As a dedicated advocate for high-quality care in nursing homes, I am thrilled to express my admiration for the Front Line Forces training modules. These concise and user-friendly modules offer an invaluable solution for nursing home providers seeking to update and enhance their education and training content. The Front Line Forces series excels in delivering targeted, relevant training that seamlessly integrates into existing orientation and training programs."

— Lori Koeppel, Executive Director
Wisconsin Director of Nursing Council – Education Forum Inc.

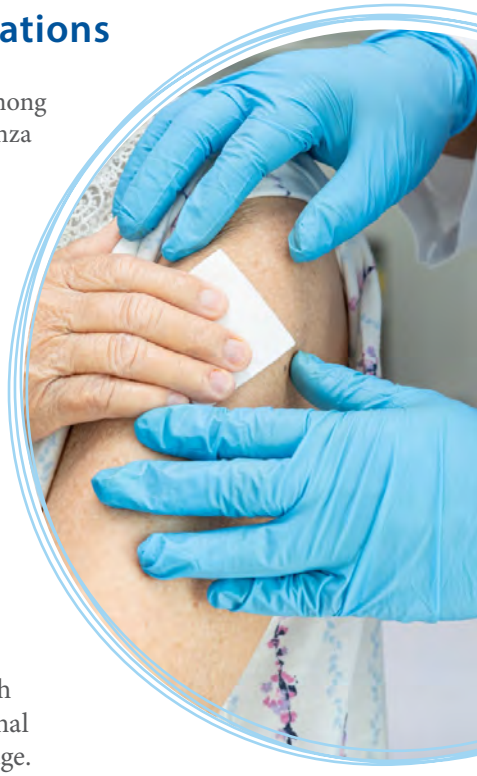
Front Line Forces

We recognized the critical role of front line staff in long-term care during the pandemic which prompted us to launch Front Line Forces. This initiative provides accessible, bite-sized, on demand modules on infection control. The program's success led to its expansion, covering chronic disease management, medication safety and more. Over 5,500 participants have benefited, enhancing their skills and confidence, ultimately improving care for Medicare beneficiaries. Front Line Forces directly aligns with our mission by equipping front line staff with the knowledge and skills needed to deliver high-quality, person-centered care.

Infection Prevention and Control

Immunizations

Enhancing immunization rates for vulnerable populations



The Superior Health immunization team is committed to increasing vaccination rates among nursing home residents, staff and Medicare beneficiaries, focusing on COVID-19, influenza and pneumococcal vaccines.

Our Goal

To boost vaccine accessibility and uptake through mobile clinics, education and technical support, ensuring high immunization rates across our target groups.

Top Initiatives:

1. **Free Mobile Vaccination Units:** Partnered with organizations across three states to provide mobile units offering free COVID-19, influenza and pneumococcal vaccines, reaching underserved areas throughout our region.
2. **Educational Modules:** Deployed interactive educational modules targeting nursing home staff, residents, family members and Medicare beneficiaries to encourage timely vaccinations.
3. **1:1 Technical Assistance:** Provided individualized support to nursing homes with low COVID-19 vaccination rates, helping them navigate programs like the National Healthcare Safety Network (NHSN) to improve vaccination reporting and coverage.

Outcomes:

Since November 2023, the following number of nursing home residents and staff received vaccinations through our mobile vaccination clinics.

	Residents Vaccinated	Staff Vaccinated
COVID-19	**2,823**	**386**
Influenza	**206**	**37**
Pneumococcal	**430**	**5**

Through our one-on-one technical assistance, we achieved a 77.1% RIR for resident COVID-19 vaccinations and a 90.7% RIR for staff COVID-19 vaccinations.

In regard to a mobile vaccination clinic. This process was so quick and efficient. Both the Superior Health team member and pharmacy were easy to work with and assisted to ensure our residents were vaccinated in a timely manner. Thanks to Superior Health for streamlining this connection."

— Adriana Westrom, Assistant Director of Nursing/Social Services Designee/Infection Preventionist, Minnewaska Lutheran Home

Medication Safety

Promoting safer prescribing practices and alternatives to opioids

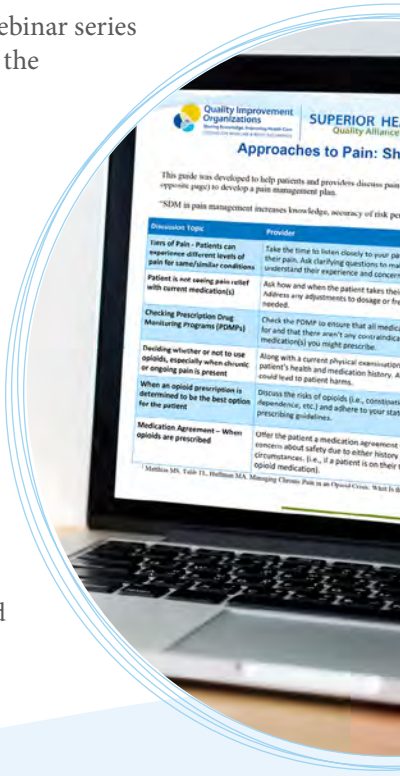
Our Medication Safety team focuses on reducing stigma associated with opioid use disorder (OUD) and increasing awareness about its impact on adverse drug events (ADEs), while promoting safer prescribing practices and alternatives to opioids.

Our Goal

To decrease ADEs among high-risk Medicare beneficiaries in nursing homes and decrease opioid-related ADEs, including fatalities, among Medicare beneficiaries across the spectrum of care.

Top Initiatives:

1. **Shine a Light on Stigma Campaign:** Developed to reduce the stigma that prevents people from accessing treatment for OUD. Includes a dedicated website with resources, a pledge campaign, a podcast, the Medications for OUD (MOUD) Series and coordinated outreach with nursing home teams.
2. **Ensuring MOUD Through the Care Continuum Series:** Co-led a national nine-part webinar series focused on ensuring access to MOUD across care settings. The series included tools like the Alternatives to Opioids (ALTO) resources to shift prescribing and monitoring patterns.
3. **ADE Power-Up and Workflow Implementation:** Conducted an in-depth analysis of nursing homes with high rates of ADEs related to opioids, diabetic agents and anticoagulants. Developed an ADE algorithm and Front Line Forces module to assist nursing homes in correctly identifying and managing ADEs.



Outcomes:

188 Pledges Through Stigma Campaign: As of July 29, 2024, pledges were signed from 19 states and 25 of Superior Health's communities.

775 Participants in National Webinar Series: The series featured 34 speakers and hosts from across the country, receiving high engagement and positive feedback.

33 Nursing Homes Engaged: Engaged nursing homes in identifying ADEs, resulting in a new workflow and training module to improve the accuracy of ADE reporting and management leading to the creation of resources for broader dissemination.

Shine a Light on Stigma Campaign

The Shine a Light on Stigma campaign aims to combat the harmful stigma surrounding substance use disorder. The campaign seeks to improve access to treatment and enhance the well-being of individuals struggling with addiction, through the promotion of person-centered language and fostering a more supportive environment. More than 188 individuals and organizations across 19 states have taken the pledge, demonstrating widespread support for the campaign's mission. By combating stigma and promoting person-centered language, the campaign addresses a significant barrier to accessing quality health care.

Quality Improvement Initiatives

Supporting better infection control in nursing home facilities

The Quality Improvement Initiatives (QII) team partners with nursing facilities to assess infection control programs and develop targeted Quality Assurance and Performance Improvement (QAPI) projects to address identified gaps.

Our Goal

To improve infection control practices in nursing homes by conducting assessments, providing targeted education and implementing process improvement plans through collaboration with nursing home leadership and infection preventionists.

Top Initiatives:

1. **ICAR Assessments and QAPI Projects:** Completed infection control assessments and projects with 903 nursing facilities, including outbreak reviews and Directed Plans of Correction, leading to significant reductions in infection control citations.
2. **Onsite Infection Control Support:** Partnered with IPC Well to conduct 650 onsite visits, providing targeted education and support, focusing on observing infection control and prevention behaviors in daily operation and redirecting harmful practices in real time.
3. **Targeted Educational Resources:** Created toolkits, webinars and workgroups based on data trends from over 900 facilities, used these identified trends to target specific learning opportunities for participating facilities and their infection preventionists. One specific example is the Infection Preventionist Affinity Series.

Outcomes:

903 Facilities Assessed: With an 86% reduction in F880 citations and a 100% reduction in F887 citations among homes reviewed in FY2024.

25% Citation Reduction: Among a subset of high-risk nursing homes receiving ongoing in-person infection control education and support.

400 Facilities Engaged: In Infection Prevention Affinity Series, with 125 infection preventionists receiving direct training, and 100% of attendees reporting the education as applicable to their daily work.

I am thankful for the support and resources that the Superior Health team have provided. Collaboration with this organization has helped me navigate changing regulations and provided best practices to deliver the best education possible to my staff and to develop best practices across our organization."

— Danielle Mleczko, Director of Clinical Services, Preferred Care, Michigan

Hospital and Health System Support

Improving patient safety and reducing harm

The Hospital Quality Improvement Contractor (HQIC) team supports hospitals by enhancing patient safety processes and facilitating quality improvement strategies. Our efforts focus on reducing all-cause harm in rural, critical access and acute care hospitals serving vulnerable populations across Michigan, Minnesota and Wisconsin.

Our Goal

To strengthen patient safety and quality, by reducing all cause harm and focusing on high-priority safety issues aligning with CMS's eight core harm areas.

Top Initiatives:

1. **Improvement Sprints:** Conducted five targeted improvement sprints focusing on central line-associated bloodstream infections (CLABSIs), opioids, sepsis, readmissions and transitions in care, engaging multiple health care settings to drive better patient outcomes.
2. **Roadmaps for Harm Reduction:** Provided hospitals with roadmaps in eight harm areas, offering evidence-based strategies and benchmarks to guide quality improvement efforts and reduce patient harm.
3. **Community-Based Care Transitions:** Focused on reducing hospital readmissions through enhanced care transitions, particularly in rural and critical access hospitals, ensuring smoother patient transitions and reduced readmission rates.

Outcomes:

9% Opioid ADE Reduction: Achieved an 8.87% RIR in reducing opioid-related ADEs, including deaths.

46% ADE Reduction: Secured a 46.03% RIR in reducing anticoagulant-related and hypoglycemia-related ADEs.

3% Readmission Reduction: Improved community-based care transitions, resulting in a 3.17% RIR in reducing all-cause hospital readmissions.

The HQIC has greatly assisted me in my role transition from Inpatient Nurse Director to Director of Quality and my professional growth to Executive Director of Quality. The HQIC has great resources and gave me personalized guidance and truly has assisted me and my team to help keep our organization moving forward."

— Participant feedback from the Readmissions/Care Transitions Sprint in 2023

Looking Ahead

As we look ahead, Superior Health remains committed to innovation, collaboration and a relentless pursuit of excellence. We are confident in our ability to adapt to the changing health care landscape and continue to deliver exceptional value to the communities we serve. By understanding the evolving needs of our beneficiaries, we can ensure Superior Health remains a vital force in improving the health of Medicare populations in the Midwest.

This material was prepared by the Superior Health Quality Alliance, a Quality Innovation Network-Quality Improvement Organization under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. 12SOW-MI/MN/WI-CC-24-289 100124

Additional resources from the work included in this report can be found through this QR code or by visiting, **superiorhealthqa.org/resources-library**

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

SUPERIOR HEALTH
Quality Alliance