KFMC provides all the listed services and subject matter expertise to providers in Kansas, but has experience providing each of the services/supports to providers across multiple states through regional quality improvement efforts.

KFMC Area of Expertise

Infection Prevention & Antibiotic Stewardship – KFMC staff have worked with hospital and community provider organizations on infection prevention for nearly 15 years, specifically CLABSI, CAUTI and CDI. KFMC has also led a multi-state regional antibiotic stewardship project as part of the QIN-QIO 11SOW. KFMC has also supported the CDC and KDHE in facilitating NHSN Reporting and Validation. In 2015 KFMC performed external validation of NHSN data in order to provide selected Kansas facilities and KDHE with confidence in using NHSN HAI data and to identify opportunities for quality control. Facility level HAI surveillance data was analyzed by KFMC in the areas of completeness, timeliness and quality as it related to surveillance protocols and definitions. KFMC has extensive experience in conducting Information Control Assessment and Response (ICAR) Program assessments. KFMC assisted KDHE and the CDC with completing ICAR Site Visits for two designated Ebola Response Facilities in 2015 and 2016. KFMC has continued to support KDHE in completing these assessments for both hospitals and nursing homes and has developed an electronic assessment tool to reduce the time spent completing the assessment and reporting findings to CDC and other stakeholders.

Successes:

- KFMC led hospital Catheter Associated Urinary Tract Infection (CAUTI) reduction efforts from 2011 to 2014. In this effort KFMC supported facilities in analyzing NHSN data and implementing interventions; was recognized as an exceptional performer by CMS as part of the Contractor Performance Assessment Reporting System (CPARS) evaluation for achieving the national Standardized Infection Rate (SIR) stretch goal of 0.75 (contract requirement was 1.0).
- KFMC partnered with KDHE to reduce statewide CDI rates. Efforts included direct quality improvement support, the development of tools and best practice education. Facilities participating in the Kansas CDI Prevention Collaborative who were asked to establish a multidisciplinary CDI team, reduced CDI rates to <6/10,000 patient days and to establish or strengthen existing antimicrobial stewardship efforts by April 2016. This work was then redirected by CMS to include work with outpatient facilities on antibiotic stewardship and LTC facilities on CDI surveillance, reporting and improvement. This work shifted the approach to working with 53 Long Term Care providers and 186 recruited outpatient locations (including hospital outpatient and emergency departments). In reviewing the overall *C.diff* SIR, for both Acute Care and Critical Access hospital data from 2017 and 2018, Kansas saw a 24% reduction in the statewide CDI SIR as a result of this effort.
- KFMC saw similar success with antibiotic stewardship adoption in outpatient settings (including hospital outpatient and emergency departments) with 100% of collaborating facilities developing a multidisciplinary team or adding members to an existing infection

prevention committee to address CDI. All participants strengthened existing antimicrobial stewardship programs by formalizing antimicrobial stewardship policies (43%), expanding teams to include additional disciplines (28%), adopting CDI order sets (28%), or implementing alternative treatment or environmental disinfection options (57%).

Care Coordination – KFMC worked directly with hospitals on Care Transitions and Readmission Reduction efforts in the 10SOW (2011-2014). This work included support for CMMI Community Care Transition Program (CCTP) funding applications and reducing both targeted community and statewide readmission rates for all hospitals, PPS and CAH.

Successes:

- KFMC staff worked across the state to improve care transitions and achieved a 14.7% relative improvement rate for statewide readmissions (2% was the contract goal) and was recognized by CMS for exceptional performance as part of the CPARS evaluation process.

Facilitation/Coordination – In 2009, KFMC assisted KDHE in securing ARRA funding for the development of a state plan to reduce HAIs and to implement surveillance and reporting systems. Through this work, KFMC convened a multi-disciplinary stakeholder group to develop plan priorities; this group became the Healthcare Associated Infections Advisory Group which KFMC co-facilitates today along with KDHE. Through this work, the Kansas HAI plan was developed and approved by HHS and CDC as a way to coordinate and report state HAI prevention efforts including improved surveillance capabilities through increased facility reporting to the National Healthcare Safety Network (NHSN). KFMC later convened a stakeholder advisory group to facilitate an update to the Kansas State HAI plan to reflect the current state of the field (effort began in 2015). Along with KHC and KHA, KFMC founded the Kansas Quality Improvement Partnership (KQIP). This partnership has proven to be an effective model for collaboration and coordination of activities across settings, for preventing duplication of effort and for minimizing the potential for participant confusion. KQIP includes representation from the Kansas Hospital Association, the Kansas Healthcare Collaborative, the Kansas Medical Society and the Kansas Department of Health and Environment (State HAI Plan and Rural Health Office). This collaborative model includes established and routine meetings with a defined agenda and is adaptable to all care settings where providers are faced with multiple, competing initiatives. During the 10SOW, this collaborative group coordinated all activities that intersected in the hospital setting (namely HAI and readmission reduction efforts). During the 11SOW this group served as the "All HAC [Healthcare Acquired Conditions] Advisory Group" coordinating HRET HIIN Activities and QIN-QIO activities.

Successes:

- NHSN Participation: in May of 2015, all five KQIP partners issued a position statement recommending the use of NHSN for tracking HAIs and established the goal of achieving a 100% participation rate by January 1, 2016, which was a bold and aggressive goal. Kansas is home to 85 Critical Access Hospitals, more than any other state, and has no mandate for

NHSN participation. KQIP developed data use agreements between partners and consolidated rights-conferral groups to ensure providers participating in multiple projects could report data one time for all projects. The accomplishments of this group are included in the table below, and were last measured in early 2019:

Percent & Number of Hospitals Concurrent1y Reporting Data to NHSN

Time Period	Critical Access Hospitals	IPPS Hospitals	All Hospitals
Baseline (May 2015)	30% (25/84)	98% (55/56)	57% (80/140)
January 2016	38% (32/84)	98% (55/56)	62% (87/140)
Remeasurement (2019)	98% (83/85)	100% (50/50)	99% (133/135)

Tailored Application/Analysis/Tool development to support Burden Reduction - KFMC's approach to project design is predicated on knowledge transfer methods and interventions. Through our project and intervention design, KFMC seeks to organize, create, capture and/or distribute knowledge to participating providers directly. This approach extends the reach of KFMC's multi-disciplinary team, without the provider organization investing any resources in additional staff, training or certifications beyond project participation. This approach also ensures sustainability of the knowledge/expertise outside of direct technical assistance. Several examples of how this has been accomplished are below:

- Critical Access Hospital (CAH) Quality Reporting: During the 10SOW, KFMC worked with all Kansas CAHs to voluntarily report Core Measure data to CMS via CMS Abstraction & Reporting Tool (CART). We quickly identified that many hospitals were also collecting similar (not exact) data for Quality Health Indicators (QHi), a quality benchmarking program used by small rural hospitals and rural health clinics. KFMC staff worked with QHi programming staff to align the metrics in QHi to be identical to those being collected by CMS. KFMC staff also worked with the Software Vendor (QHi vendor) to align upload functions to match CART output reporting. In doing so, hospital staff could report measures one time through CART, providing the advantage of CART algorithms to ensure appropriate data capture and reporting. From CART, hospital reporting staff could run a report for direct upload into QHi, eliminating the need for duplicate entry by additional staff.
- NHSN TAP Feedback Report for CAUTI and CDI: Provided analytic support to leverage the NHSN TAP Report data, coupled with an electronic completion of TAP Assessment to provide a collaborative snapshot of performance, targeted infection ratio/goal setting, and action plan development to achieve/monitor progress toward goals (Sample Collaborative Report attached along with Summary of Feedback Reporting Process).
- Composite Score Calculator: This tool was developed by KFMC project staff. The calculator not only allowed homes to see their current composite score from monthly Certification and Survey Provider Enhanced Reporting (CASPER) data, but also used predictive analytics to support independent goal setting based on desired improvements. While not hospital setting related, the analytic and predictive modeling capabilities built into the tool are translatable to nearly any data/measurement priority, including efforts aimed at harm reduction or hospital event prevention.

- MIPS (Merit-based Incentive Payment System) Calculator: With the onset of the Quality Payment Program, KFMC developed a tool to rapidly disseminate information necessary for successful participation to the large number of providers eligible for participation during transitional year 2017. We recognized that small and rural practices are resource challenged, both in human and capital resources, and they needed a way to determine the individual return-on-investment for participation in order to garner support for technology upgrades, implementations, and practice transformation activities. KFMC created the MIPS Calculator, to assist providers in maximizing their revenue reimbursement opportunities while identifying where to focus and invest their limited resources. The MIPS Calculator is a robust excel-based, scoring and financial projection estimator based on CMS's MIPS Payment Program. Again, while not hospital setting related, the same data analysis, forecasting and ROI evaluation methodology can be applied to other priority areas.
- Development of targeted readmission reports, stratifying hospital readmissions based on admitting diagnosis (with emphasis on Sepsis admissions) and disparities to support targeted root cause analysis and tailored improvement efforts (Sample Readmission Reports Attached)
- Opioid Prescriber Feedback Reports were developed as part of a CMS funded Special Innovation Project. Tailored analytic reports were provided to recruited providers to engage them in awareness, evaluation, and self-monitoring of their personal opioid prescribing practices. Data feedback was considered a foundational component of this project and was subsequently highlighted by CMS leadership on several national calls as an innovative and progressive use of data to drive improvement. CMS provided claims data was used to provide reports in order to reduce the data collection and reporting burden of participating providers.

Patient and Family Engagement - KFMC leverages a robust Patient and Family Advisory Council (PFAC) to provide input and direction to all aspects of our work. This PFAC provides input regarding project direction based on their personal experiences within the healthcare system and guides the development of KFMC's engagement messages to ensure outreach and training material is able to prompt the behavior change we are seeking from consumers. For our Immunization Awareness Campaign during the 2017 Flu Season, KFMC's PFAC provided feedback regarding both the messaging and imagery used in the marketing materials based on what resonated with them and would prompt them to visit with their provider regarding necessary immunizations. The dedicated PFE staff keep the PFAC engaged through lulls in activity to ensure that they are readily available to support and accelerate improvement work as needed. PFE staff also manage the multitude of Self-Management Education programs that KFMC is licensed to provide (Chronic Disease, Chronic Pain, and Diabetes). Most recently, KFMC has been successful in sharing and adapting PFE concepts (i.e. Patient and Family Advisory Councils [PFACs]) to alternative and new settings. PFACs are traditionally thought of, formally, as a hospital or institutional intervention. Recently, to increase adoption of PFACs in the primary care setting, KFMC has had great success with modeling successful interventions for interested providers through development and delivery of implementation toolkits and mock PFAC sessions. In KFMC's CPC+ project work, prior to a September 2017 learning session, only 3% of participating practices (104) had convened a PFAC as required by their participation. KFMC's PFAC SME conducted a mock PFAC learning session, modeling how to facilitate a

PFAC meeting to practice attendees including providing sample tools, resources, and implementation guidelines/interventions to get practices started. By December 1st of 2017, following the PFAC training session and tailored technical assistance, 90% of the practices had held an initial PFAC meeting, with 100% positive feedback from the practices regarding this experience. The approaches deployed in other care settings can be leveraged to elevate the role of hospital PFACs, particularly around alternative and value-based payment models.