THE MISSISSIPPI QUALITY IMPROVEMENT INITIATIVE II
MSQII-2

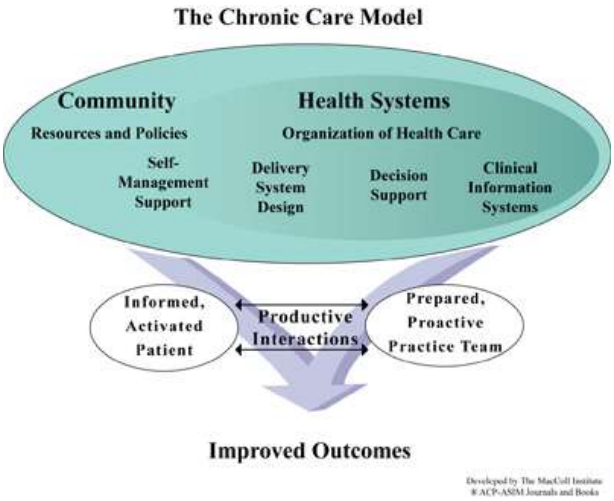
To improve blood pressure and diabetes control in Mississippi, the MSDH Heart Disease and Stroke Prevention Program has established the **Mississippi Quality Improvement Initiative II (MSQII-2)**.

A SOLUTION - ABOUT THE INITIATIVE

The Mississippi Quality Improvement Initiative II (MSQII-2) is a systematic approach to healthcare quality improvement that promotes team-based care and maximizes the use of electronic health records to address high blood pressure, coronary artery disease, and diabetes mellitus among patients. Participating organizations and clinical staff test and measure innovative healthcare practices, then share their experiences in an effort to accelerate learning and widespread implementation of successful change concepts and ideas. The structure of MSQII-2 is based on the Institute for Healthcare Improvement's (IHI) Breakthrough Series Learning Collaborative which involves the Chronic Care Model, and uses the Model for Improvement (Plan-Do-Study-Act method), for organizational quality improvement.

THE CHRONIC CARE MODEL

The Chronic Care Model is an organizational approach to caring for people with chronic disease in a primary care setting. The system is population-based and creates practical, supportive, evidenced-based interactions between an informed, activated patient who is involved in their own care, and a prepared, proactive practice team. The Chronic Care Model emphasizes evidence-based, planned, and integrated collaborative chronic care. The care model is a part of the holistic/ecological system of primary care (*Meet the patients where they are*).



The elements of the Chronic Care Model are the community, the health system, self-management support, delivery system design, decision support, and clinical information systems. The Model can be applied to a variety of chronic illnesses, health care settings, and target populations. The bottom line is healthier patients, more satisfied providers, and cost savings. **More information on the model can be found at www.improvingchroniccare.org**.

MSQII-2 OBJECTIVES

MSQII-2 is about improvement of care for people with chronic disease, not measurement. But measurement will play several important roles throughout the Initiative. Measurement will help us evaluate the impact of changes made to improve delivery of care to the population of focus. Always remember that measurement should be designed to accelerate improvement, not slow it down. Your team needs just enough measurement to be convinced that the changes you are making are leading to improvement.

Required Measures	**Statistic**	**Goal**
Hypertensive Patients with BP <140/90 (**NQF18**)	The number of hypertensive patients 18 years and older that have been seen in the clinic for medical visits at least twice during the reporting year	61.2
Coronary Artery Disease (CAD) – Drug Therapy for Lowering LDL Cholesterol	The number of patients age 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy	70
Document of Self Management Plan/ Follow-up Plan for patients with high blood pressure	The number of hypertension patients 18 and older in the clinical information system (EMR) who were screened for high blood pressure and a recommended follow-up plan is documented based on the BP.	80
Documentation of Current Medications in the Medical Record for Hypertension	The number of hypertension patients 18 years and older that have a documented list of medications in their health record.	80
Documentation of Current Medications in the Medical Record for Diabetes	The number of diabetes patients 18 years and older that have a documented list of medications in their health record.	80
Diabetes A1C Poor control (**NQF59**)	The number of diabetes patients 18 and older with a diagnosis of Type 1 or Type 2 diabetes, whose HbA1c was greater than or equal to 9 at the time of the last reading in the measurement year.	16.2
Learning Sessions	The short term impact of the MSQII-2 learning sessions?	

Optional Measures: Participating teams may choose one or more of optional measures below to track for reporting. Optional Measures can be used to enhance care and increase the ability to achieve the required measures above:

Optional Measures	Statistic	Goal
Screening for Clinical Depression and Follow-up Plan (Adults)	Number of patients 18 and older screened for other mental health conditions using an age-appropriate standardized tool and follow-up plan documented (Dx: Major Depression or Dysthymia)	78.2
Colorectal Cancer Screening	Number of patients 50-75 years of age who have been appropriately screened for colorectal cancer	14.5
Cervical Cancer Screening	Number of patients 50-75 years of age who have been appropriately screened for cervical cancer	7.1
Breast Cancer Screening	Number of women 40-69 years of age who had a mammogram	20.7
Prostate Cancer Screening	Number of men 40-80 years of age who have been appropriately screened for prostate cancer	21.8

PARTICIPATION IN MSQII-2

Healthcare organizations are selected through a competitive process. Each healthcare organization identifies a MSQII-2 clinical team to participate in a kickoff meeting, pre-work period activities, monthly webinars, and four Learning Sessions. The clinical team consists of a Senior Leader, Physician Champion, Clinical/Technical Expert, Technical Support or Data Analyst, and Pharmacist or Community Health Worker. The MSQII-2 clinical teams submit monthly data reports, a Quarterly Senior Leader Narrative Report, and complete a quarterly Assessment of Chronic Illness Care Survey.

WHY PARTICIPATE

The MSQII-2 presents an opportunity for practices to improve the care provided to individuals with diabetes, hypertension, and coronary artery disease. Ultimately, the healthcare organizations become more efficient and create better health outcomes for their patients. Healthcare organizations participating in the MSQII-2 will learn:

- Techniques to improve patient education and self-management skills
- Strategies and methods to improve care coordination between primary care providers and healthcare extenders such as community health workers, pharmacists, and diabetes educators
- The role of the practice “team” in improving care
- Evidence-based guidelines and data to improve high blood pressure and diabetes care

OTHER BENEFITS

- Support from Subject Matter Experts in Quality Improvement and Health Information Technology
- Complimentary continuing education credits
- Become better situated for Value Based Payment Reform, attestation of Meaningful Use, and applying for Patient Centered Medical Home Accreditation / Renewal

- Improve outcome measures for Physician Quality Reporting System (PQRS), Healthcare Effectiveness Data and Information Set (HEDIS), and Uniform Data System (UDS)

PROJECT IMPACT AND OUTCOMES

Reports are indicating that the MSQII-2 is a promising project that will be an effective framework to support improved processes of care and clinical outcomes for patients with high blood pressure and diabetes. Thirteen HCOs are participating in the MSQII-2; originally fifteen, but three later rescinded the offer. The potential reach is approximately 95 clinic sites; 101,875 patients diagnosed with Hypertension or Diabetes in 35 counties. Results so far include an increase in the number of patients diagnosed with high blood pressure who were in control, and a decrease in the number of patients with diabetes who did not have an A1C greater than 9. Furthermore, the short-term assessment of the learning sessions suggests that the sessions enhance knowledge and skills in implementing the Chronic Care Model.

MSQII-2 Partners

The MSDH Heart Disease and Stroke Prevention Program acknowledges the key stakeholders and subject matter experts who serve on the MSQII-2 Leadership Advisory Committee, Project Team Committee, and Evaluation Team for their hard work and dedication. The teams have made significant contributions to the design, implementation, promotion, and evaluation of MSQII-2.

MSQII-2 LEADERSHIP ADVISORY COMMITTEE

- Mississippi State Department of Health
  - Heart Disease and Stroke Prevention Program
  - Mississippi Delta Health Collaborative
  - Diabetes Prevention and Control Program
  - Comprehensive Cancer Control Program
  - Office of Health Promotion and Health Equity
- BC3Technologies, LLC
- Information & Quality Healthcare
- Mississippi Healthy Linkages
- Mississippi Primary Healthcare Association
- Mississippi Rural Health Association
- Mississippi Department of Mental Health
- BLW Consulting, LLC
- University of Mississippi School of Pharmacy
- Central Mississippi Health Services, Inc.
- Family Health Center, Inc.
- Delta Health Center, Inc.
- Family Health Care, Inc.
  MSQII-2 Consultant

MSQII-2 PROJECT TEAM COMMITTEE

- Augusta Bilbro, MSQII-2 Director
- Bettye Daniel, MSHyg, MPM
  MSQII -2 Coordinator
- Alicia Barnes, MBA, CHTM-IS
- Janice Bacon, MD
  MSQII-2 Physician Champion/ Advisor
- Cassandra Dove, MPH

MSQII-2 Chronic Disease Bureau Advisor

- Sonja R. Fuqua, PhD, RN
  MSQII-2 Nurse Champion /Advisor & FQHC Liaison
- Ryan Kelly
  MSQII-2 Rural Health Clinic Liaison
- Meg Pearson, PharmD, MS
  MSQII-2 Pharmacy Advisor
- Tameka Walls, MS
  MSQII-2 Delta /Community Health Worker Advisor

MSQII-2 EVALUATION TEAM

- LaTonya Lott, Ph.D., MPH, MS
  1305 Lead Evaluator
- Vincent Mendy, DrPH, MPH
  MSQII-2 Epidemiologist
- Sheena Gardner, Ph.D.
  MSQII-2 External Evaluator
- Augusta Bilbro, MSQII-2 Director
- Bettye Daniel, MSHyg, MPM
  MSQII -2 Coordinator
- Alicia Barnes, MBA, CHTM-IS
  MSQII-2 Consultant
- Tameka Walls, MS
  MSQII-2 Delta /Community Health Worker Advisor

To learn more about the MSQII-2 and the participating healthcare organizations, visit www.msqii2.net or contact the Heart Disease and Stroke Prevention Program staff at 601-206-1559.