Top Readmissions Triggers in Arkansas
Melodie Zipfel, MSN RN
The TMF QIN-QIO works with health care providers in a region encompassing Arkansas, Missouri, Oklahoma, Puerto Rico and Texas.

TMF has subcontracted with strong, experienced quality improvement partners to provide expert technical assistance and quality improvement support for participating health care providers across this region.

- Arkansas Foundation for Medical Care
- Primaris (Missouri)
- QIPRO and Ponce Medical School Foundation (Puerto Rico)
- TMF Health Quality Institute (Texas and Oklahoma)
Arkansas- AFMC

Leading rapid, large-scale change in health quality:

• Goals are bolder
• The patient is at the center
• All improvers are welcome
• Everyone teaches and learns
• Greater value is fostered
11SOW QIN-QIO Map
Care Transitions and Medication Safety Overall Goals by 2019:

- Reduce Medicare Hospital Readmission Rates by 20%
- Reduce Medicare Hospital Admission Rates by 20%
- Increase community tenure by increasing the days Medicare FFS Beneficiaries spend at home by 10%
- Reduce Adverse Drug Events (Related Readmissions and Utilization), Emergency Department Visits, Observation Stays occurring as a result of the care transitions process.
One in five Medicare beneficiaries will leave the hospital today only to return within one month.

Only $\frac{1}{2}$ of the patients hospitalized within 30 days had a physician visit before readmissions.

11% of readmissions are due to medication non-adherence, at a cost of nearly $100 billion annually.
30-DAY READMISSION RATES TO U.S. HOSPITALS

Healthcare Cost and Utilization Project (HCUP) data from 2010 provide the most comprehensive national estimates of 30-day readmission rates for specific procedures and diagnoses. Examples include:

**By Procedure**

Nearly **one in five** patients with these common procedures was readmitted:
- 23% Amputation of lower extremity
- 19% Heart valve procedures
- 19% Debridement of a wound, infection, or burn

Nearly **one in three** patients with these less frequent procedures was readmitted:
- 29% Kidney transplant
- 29% Ileostomy and other enterostomy

**By Diagnosis**

Nearly **one in four** patients with these common diagnoses was readmitted:
- 25% Congestive heart failure
- 22% Schizophrenia
- 22% Acute and unspecified renal failure

Nearly **one in three** patients with these less frequent diagnoses was readmitted:
- 32% Sickle cell anemia
- 32% Gangrene

**Readmission Rates by Payer**

Medicaid and Medicare patients have a higher percentage of readmissions than other payers.

- **Procedure:** Amputation of lower extremity
  - Medicare: 26%
  - Medicaid: 22%
  - Privately Insured: 17%
  - Uninsured: 13%

- **Diagnosis:** Congestive heart failure
  - Medicare: 30%
  - Medicaid: 25%
  - Privately Insured: 20%
  - Uninsured: 17%

*Readmissions were for all causes and did not necessarily include the same procedure or diagnosis as the original admission (index stay).*
LAST MONTH I TRANSPORTED
72 PATIENTS

426 TIMES.....
A Community-Based Approach:

The problems associated with poor transitions of care and 30-day hospital readmissions are not solely the responsibility of the community hospitals; they often result from a breakdown in communication. Weaknesses include the transfer of information between providers and patients at the time of transition, a failure to assure patients and/or caregivers they can self-manage their condition during transition and a lack of standard processes to effectively manage the transition of the patient between settings.

To address these issues, we are focusing on processes of care at a community level to engage providers and stakeholders across the continuum of care, not just in the hospital. This includes home health agencies, dialysis facilities, skilled nursing facilities and physician offices, as well as patients, families, payers and community stakeholders.
ARKANSAS Activity

- 9 designated Arkansas Care Transitions (ACT) coalitions covering 68 of the 75 counties and representing 96% of the total population of Arkansas and 96% of the Medicare beneficiaries in the state (approximately 426,000 consumers).

- 255 unique providers/facilities/companies (prospective partners) including 17/29 Critical Access Hospitals and 43/47 Acute Care Hospitals in the state.

- Coalition activities focus on all payer sources as well.
Cohort A: ACT Delta/ACT East
Cohort B: ACT North Central/ACT Northwest
Cohort C: ACT Ozarks, ACT Southwest, ACT Central, ACT South Central, ACT River Valley
What do we do first?

- DATA
- Root Cause
- Case Studies
- Readmission Interviews
Trigger #1: Resources
Aunt Bertha

Search for free or reduced cost services like medical care, food, job training, and more.

Zip 90210  Search

929,159 people use it (and growing daily)

By continuing, you agree to the Terms & Privacy.
www.auntbertha.com

- Founded in Austin, TX in 2010 as a Public Benefit Corporation
- **Mission:** “To connect all people in need with the programs that support them with dignity and ease”.
- Nation’s largest search and referral platform for free and reduced cost social programs such as food, housing, transportation, and goods.
- **Over 1M users as of February 2018**
- Supported in over 100 languages
- Can be used on any device, anywhere
- Date vetted upon entry and every 6 months.
- New suggestions/Proposed Changes vetted and available on site within 48 hours.

- **Free Monthly Online Training:**
  https://about.auntbertha.com/community-training
Search, Identify, Connect & Measure

• Easily search by entering any ZIP code within the United States
• Filter by hours of operation, languages spoken, or demographics
• Ability to screen directly through Aunt Bertha for social needs and the platform will automatically identify services in the patient’s community
• Connect to the program by text, email, or Aunt Bertha electronic referral
• Close the loop on referrals via three-way communication between patient, navigator, and service provider
• Report on service gaps and community needs by ZIP code
Arkansas Search Data

Searches by Zipcode

Most Searched Counties

<table>
<thead>
<tr>
<th>COUNTY</th>
<th>SESSIONS</th>
<th>SEARCHES</th>
</tr>
</thead>
<tbody>
<tr>
<td>PULASKI</td>
<td>719</td>
<td>2,377</td>
</tr>
<tr>
<td>CRAIGHEAD</td>
<td>169</td>
<td>643</td>
</tr>
<tr>
<td>WASHINGTON</td>
<td>151</td>
<td>511</td>
</tr>
<tr>
<td>BENTON</td>
<td>106</td>
<td>388</td>
</tr>
<tr>
<td>WHITE</td>
<td>84</td>
<td>332</td>
</tr>
</tbody>
</table>
## Arkansas Search Data

**Searches by Category - AR**

[Diagram showing search categories with percentages]

**Most Common Search Terms**

<table>
<thead>
<tr>
<th>TERM</th>
<th>SEARCHES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 food pantry</td>
<td>284</td>
</tr>
<tr>
<td>2 emergency food</td>
<td>212</td>
</tr>
<tr>
<td>3 financial assistance</td>
<td>209</td>
</tr>
<tr>
<td>4 help pay for housing</td>
<td>164</td>
</tr>
<tr>
<td>5 free meals</td>
<td>148</td>
</tr>
<tr>
<td>6 transportation</td>
<td>126</td>
</tr>
<tr>
<td>7 dental care</td>
<td>109</td>
</tr>
<tr>
<td>8 food delivery</td>
<td>106</td>
</tr>
<tr>
<td>9 help find housing</td>
<td>100</td>
</tr>
<tr>
<td>10 help pay for food</td>
<td>72</td>
</tr>
</tbody>
</table>
Trigger #2: Nutrition
“I Spent Years Studying Nutrition In Med School”

Said No Medical Doctor Ever
Malnutrition

• Annual burden of disease in older adults (65+) $51.3 billion
• Poor health outcomes
  › Risk for infections
  › Falls
  › Pressure sores/skin breakdown
  › Delayed wound healing
  › Longer stays in the hospital (4 to 6 days longer)
  › Readmissions (54%)

MALNUTRITION IS ASSOCIATED WITH A HIGH BURDEN OF DISEASE, INCREASED COMORBIDITIES, AND SIGNIFICANT ECONOMIC COSTS.

1 in 3 patients are malnourished upon hospital admission\(^1,2\).

Up to 65 percent of older adults admitted to hospital may be malnourished\(^3\).

Malnutrition increases length of stay by 4 to 6 days\(^4\).

Malnutrition increases costs by up to 300 percent\(^5\).

Malnutrition is Often Under-Diagnosed

- **36 million** U.S. hospitalizations per year¹
- **15% – 60%** are malnourished²
- **7%** are diagnosed with malnutrition²
- **4 million – 19 million** cases left undiagnosed and therefore untreated³

Contributing Factors that Lead to Malnutrition among Older Adults

- Disease-Associated Risk Factors
- Function-Associated Risk Factors
- Social & Mental Health Risk Factors
- Hunger & Food Insecurity Risk Factors

Who is at largest risk?

- Age 50+
- Highest risk 60-69
- Lower incomes/living in poverty
- High school dropout
- Caring for a grandchild
- Renter
- Frail (decreased physical functioning)/having a disability
- African-American or Hispanic
- Reside in southern states
- Separated, divorced, or are living alone
Health Risk/Health Outcomes Associated with Food Insecurity/Malnutrition

- Depression
- Poor self-reported health status
- Heart conditions
- Malnutrition
- Obesity
- Hypertension
- Hyperlipidemia
- Non-adherence
- Increase of hospital admission and readmission (54%)
Obesity

% of adults 65 and older with a body mass index of 30 or higher based on reported height and weight

https://www.americashealthrankings.org/learn/reports/2016-senior-report/state-summaries-arkansas
Validated 2-Item Food Security Screening Tool
Recommended for Routine Screening in Primary Care

• I’m going to read you two statements that people have made about their food situation. For each statement, please tell me whether the statement was often true, sometimes true, or never true for your household in the last 12 months:

  › 1. “We worried whether our food would run out before we got money to buy more.” Was that often true, sometimes true, or never true for your household in the last 12 months?

  › 2. “The food that we bought just didn’t last, and we didn’t have money to get more.” Was that often true, sometimes true, or never true for your household in the last 12 months?

• A response of “often true” or “sometimes true” to either question is an indication of food insecurity

EVERYBODY IS SICK AND I'M LIKE

Y'ALL NEED FRUITS AND VEGETABLES
Referrals

- Ask permission to refer patient for additional food assistance
- Outreach, external community partners, nonprofits social service agencies, food banks, SNAP, other food assistance programs
- Follow up on referrals at subsequent visit
- HIPPA compliance

http://www.aarp.org/content/dam/aarp/aarp_foundation/2016-pdfs/FoodSecurityScreening.pdf
Trigger #3: Handoff/Information Transfer
“I want you to find a bold and innovative way to do everything exactly the same way it’s been done for 25 years.”
### When Do Most Readmissions Occur?

<table>
<thead>
<tr>
<th>State and Community</th>
<th>Setting</th>
<th>Number of Discharges</th>
<th>% of All Discharges</th>
<th>30-day Readmits</th>
<th>Rate of 30-day Readmits</th>
<th>0-7 Days</th>
<th>8-14 Days</th>
<th>15-21 Days</th>
<th>22-30 Days</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td><strong>Your State</strong></td>
<td></td>
<td><strong>Home Health Agency</strong></td>
<td>4,376</td>
<td>14.3%</td>
<td>842</td>
<td>19.2%</td>
<td>230</td>
<td>27.3%</td>
<td>232</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Home</strong></td>
<td>17,905</td>
<td>58.7%</td>
<td>3,104</td>
<td>17.3%</td>
<td>1,237</td>
<td>39.9%</td>
<td>743</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Hospice</strong></td>
<td>1,415</td>
<td>4.6%</td>
<td>29</td>
<td>2.1%</td>
<td>12</td>
<td>41.4%</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Inpatient Rehabilitation Facility</strong></td>
<td>2,156</td>
<td>7.1%</td>
<td>401</td>
<td>18.6%</td>
<td>127</td>
<td>31.7%</td>
<td>98</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Long-Term Acute Care</strong></td>
<td>311</td>
<td>1.0%</td>
<td>51</td>
<td>16.4%</td>
<td>15</td>
<td>29.4%</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Skilled Nursing Home</strong></td>
<td>4,338</td>
<td>14.2%</td>
<td>962</td>
<td>22.2%</td>
<td>320</td>
<td>33.3%</td>
<td>258</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>All</strong></td>
<td><strong>30,501</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>5,389</strong></td>
<td><strong>17.7%</strong></td>
<td><strong>1,941</strong></td>
<td><strong>36.0%</strong></td>
<td><strong>1,353</strong></td>
</tr>
</tbody>
</table>
Provider to Provider Communication

- 36% of AR Readmissions occur within the first 7 days post discharge.
- New Jersey, Massachusetts, Colorado
- Clear Purpose: Patients’ right to continuity of care
- Broad outreach to stakeholders
- Transparent, democratic process
- Truly Universal
- Trial “test drive”
- Don’t let the “perfect” halt the “good”

*2016 Q4 Arkansas Medicare Readmissions Data provided by TMF
FIGURING OUT HOW TO GIVE A SUCCINCT REPORT ON A PT THATS BEEN IN THE HOSPITAL 6 MONTHS AND TRANSFERRED 27 TIMES BETWEEN UNITS
Universal Transfer Form (UTF)
WHEN THE DRESSING REPORTED AS CLEAN, DRY, & INTACT...

..IS ACTUALLY NONE OF THOSE....
Who Uses the UTF?

Work Smarter, Not Harder, It’s Easier!

<table>
<thead>
<tr>
<th>To / From</th>
<th>From / To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>Hospital</td>
</tr>
<tr>
<td>Hospital</td>
<td>SNF, NF, ALF, Sub-acute</td>
</tr>
<tr>
<td></td>
<td>Care, Home Care</td>
</tr>
<tr>
<td>SNF, NF, ALF, Sub-acute</td>
<td>SNF, NF, ALF, Sub-acute</td>
</tr>
<tr>
<td>Care, Home Care</td>
<td>Care, Home Care</td>
</tr>
</tbody>
</table>
Why is this important?

- NH Patient in APS Custody
- Not made confidential b/c of no handoff from NH to hospital.
- Floor nurse called the daughter to see if she would sit with the patient b/c she was wandering.
- SW recognized the name (from months ago) and that she was a confidential patient during her last visit.
- SW checked on it and got her switched to confidential as well as moved to another floor.
Patient with commercial insurance

Denied payment - stay not medically necessary

There were notes documented that stated clinical presentation at the NH and even from the EMS personnel but no documents came with the patient that "told the story".

Had we been able to provide the UTF and necessary documents that it states to attach, the hospital may have been reimbursed for the stay.
UTF Future State

- Integrate electronically wherever and whenever possible.
  - Major EHRs

- Harvest UTF content from EHR

- “Instant” UTF
  - Print
  - On Internet
  - E-mail
  - Give to patient
Trigger #4: Behavioral Health Related Illnesses
Arkansas Medicare Readmissions – Top DRGs

<table>
<thead>
<tr>
<th>State and Community</th>
<th>DRG Code</th>
<th>DRG Description</th>
<th>Number of Discharges</th>
<th>30-day Readmits</th>
<th>Rate of 30-day Readmits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arkansas</td>
<td>871</td>
<td>Septicemia or severe sepsis w/o mv &gt;96 hours w mcc</td>
<td>1,489</td>
<td>285</td>
<td>19.1%</td>
</tr>
<tr>
<td></td>
<td>291</td>
<td>Heart failure &amp; shock w mcc</td>
<td>1,058</td>
<td>278</td>
<td>26.3%</td>
</tr>
<tr>
<td></td>
<td>190</td>
<td>Chronic obstructive pulmonary disease w mcc</td>
<td>574</td>
<td>114</td>
<td>19.9%</td>
</tr>
<tr>
<td></td>
<td>189</td>
<td>Pulmonary edema &amp; respiratory failure</td>
<td>524</td>
<td>111</td>
<td>21.2%</td>
</tr>
<tr>
<td></td>
<td>885</td>
<td>Psychoses</td>
<td>453</td>
<td>99</td>
<td>21.9%</td>
</tr>
</tbody>
</table>

AR Overall MCR Readmissions Rate: 17.7%

AR IPF MCR Readmissions Rate: 21%

Time Period 7/1/2017 – 9/31/2017
Integrated behavioral health care is an emerging field within the wider practice of high-quality, coordinated health care. In the broadest use of the term, “integrated behavioral health care” can describe any situation in which behavioral health and medical providers work together.

- Several Co-Morbidities, including Depression.
- Especially patients over age 65.
- Inpatient Psych Admissions
- Total Picture
So, what is an IPF readmission?

Data Sources:
1. Part A: Medicare Claims

Methodology:
The IPF 30-day readmission rate is calculated as the percent of live discharges readmitted within 30 days of discharge from the index hospitalization. The IPF 30-day readmission rate is an all-cause readmission rate. Therefore, the readmission can be for any reason and can be at any short term hospital, critical access hospital, or IPF. Same-day transfers are not counted as readmissions. In cases where a transfer is involved, the final hospital in a transfer sequence is considered the index hospital. Any recruited IPF that was not open for the entirety of the baseline timeframe or for at least six months of the remeasurement period is excluded from analysis.

\[
\text{Readmission Rate} = \frac{\# \text{ of 30 day readmissions}}{\# \text{ of live discharges}}
\]
Behavioral Health Related Readmissions

AR DRG with Highest Readmission Rate for IPFs at 29%:
Alcohol/drug abuse dependence w/o rehabilitation therapy

AR DRG with Highest Number of Contributable Discharges at 960:
Psychoses

Time Period 7/1/2017 – 9/30/2017
Rolling 4-Quarter 30-Day IPF Readmission Rates
Arkansas

30-Day IPF Readmission Rate

*Rate is aggregated for all G.1 recruited IPFs within state

This material was prepared by Telligen, the Quality Innovation Network National Coordinating Center, 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. [115OW-QINNCC-02047-04/18/18]
Readmissions by Diagnosis Category
Arkansas
01/01/2017-12/31/2017

Same BH diagnosis*  Different BH diagnosis*  Non-BH diagnosis*

<table>
<thead>
<tr>
<th>Diagnosis Category</th>
<th>Discharges</th>
<th>Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood disorders</td>
<td>306</td>
<td>43</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>129</td>
<td>36</td>
</tr>
<tr>
<td>Cognitive disorders</td>
<td>676</td>
<td>180</td>
</tr>
<tr>
<td>Alcohol-related disorders</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Substance-related disorders</td>
<td>6</td>
<td>1</td>
</tr>
</tbody>
</table>

*Compared to the diagnosis category associated with the initial discharge
State totals are aggregated for all C.1 recruited IPFs within the state

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Overall Intervention Strategies

- Utilize data to drive change
- Identify Community Resources
  - Connect patients to PAC and LTSS
  - Aunt Bertha
- Follow-Up Appointments w/Outpatient Provider
- Discharge planning education
- Evidence-based treatments
Transitioning from IP to OP Setting

- pre- AND post-discharge patient psychoeducation
- structured needs assessments
- medication reconciliation/education
- transition managers
- in-patient/out-patient provider communication
Using a READMIT tool

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Variable</th>
<th>Value</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;R&quot; Repeat Admission (lifetime)</td>
<td>Number Prior to Index</td>
<td>3 to 5</td>
<td>5</td>
</tr>
<tr>
<td>&quot;E&quot; Emergent Admission</td>
<td>Threat to Others</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Threat to Self</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Unable to Care for Self</td>
<td>Yes</td>
<td>2</td>
</tr>
<tr>
<td>&quot;A&quot; Age</td>
<td>Age Group (years)</td>
<td>65 to 74</td>
<td>3</td>
</tr>
<tr>
<td>&quot;D&quot; Diagnosis and Discharge</td>
<td>Primary Diagnosis</td>
<td>Psychosis or Bipolar</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Any Personality Disorder</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Unplanned Discharge</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>&quot;M&quot; Medical Morbidity</td>
<td>Charlson Comorbidity Score</td>
<td>1 to 2</td>
<td>1</td>
</tr>
<tr>
<td>&quot;I&quot; Intensity (past year)</td>
<td>Outpatient Psychiatric Visits</td>
<td>2 or more</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Emergency Department Visits</td>
<td>1 or more</td>
<td>3</td>
</tr>
<tr>
<td>&quot;T&quot; Time in Hospital</td>
<td>Length of Stay (days)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear All Values</td>
<td>Total Possible Score</td>
<td>20</td>
<td>Medium</td>
</tr>
</tbody>
</table>

There are seven Risk Factor categories within the form, containing 12 total Variables.
# FY 2019 IPF Quality Reporting (IPFQR) Program

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Measure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBIPS-5</td>
<td>Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification (NQF #0560)</td>
</tr>
<tr>
<td>N/A</td>
<td>Transition Record with Specified Elements Received by Discharged Patients</td>
</tr>
<tr>
<td>N/A</td>
<td>Timely Transmission of Transition Record</td>
</tr>
<tr>
<td>FUH</td>
<td>Follow-Up After Hospitalization for Mental Illness (NQF #0576)</td>
</tr>
<tr>
<td>N/A</td>
<td>30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)</td>
</tr>
</tbody>
</table>
Value Proposition of CT

- **Patients-**
  - Better health and quality of life
  - Less fractured, more comprehensive care

- **Clinicians-**
  - Better health of patient, care satisfaction
  - More compliant with EB guidelines

- **Care Managers/SW-**
  - Transition from IP to OP and reduce costs

- **Administrators-**
  - Avoid financial loss from 30-day readmissions
  - Advanced prep for IPFQR changes to include pay for performance
Behavioral Health Resources- AR

- Behavioral Health Network
  - https://www.tmfqin.org/Networks/Behavioral-Health

- Arkansas Community Resources and Services Directory
  - https://www.tmfqin.org/Networks/Behavioral-Health/ar-resource-directory

- Bite-Sized Learning
  - https://qioprogram.org/behavioral-health-bite-sized-learnings
Join the TMF QIN-QIO Website

- Provides targeted technical assistance and will engage providers and stakeholders in improvement initiatives through numerous Learning and Action Networks (LANs)

- The networks serve as information hubs to monitor data, engage relevant organizations, facilitate learning and sharing of best practices, reduce disparities and elevate the voice of the patient.

http://www.TMFQIN.org
Learning and Action Networks (LANS)

- Antibiotic Stewardship
- Behavioral Health
- Cardiovascular Health and Million Hearts
- Chronic Care Management
- Health for Life - Everyone With Diabetes Counts
- Immunizations
- Meaningful Use
- Medication Safety

- Nursing Home Quality Improvement
- Patient and Family
- Quality Improvement Initiative
- Quality Payment Program (MACRA/MIPS/PQRS/APMs)
- Readmissions
- Sepsis
- Value-Based Improvement & Outcomes (hospitals, surgery centers, inpatient psych)
Thank you for having us today!

Melodie Zipfel, MSN, RN
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TMF QIN-QIO serving Arkansas
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