



Proceedings

“Quality Improvement Organization Person and Family Engagement Initiatives in New York State” A Symposium

February 27, 2018

HOSTED BY



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Quality Improvement Organization Person and Family Engagement Initiatives in New York State

A symposium on person and family engagement initiatives and the impact on healthcare quality in New York State

Hosted by

CMS, Livanta, and IPRO (AQIN-NY)

February 27, 2018

8:30–11:30 a.m.

CMS Regional Office

**26 Federal Plaza
New York, NY**

**Conference Room A
(6th Floor)**

AGENDA

8:00 a.m. **Registration Opens**

8:30 a.m. **Introductions / Greetings**

Anthony Wisniewski, Esq., Chairman, Livanta
Gilbert Kunken, DMD, MPH, Deputy Regional Administrator, Centers for Medicare & Medicaid Services, Region 2
Theodore O. Will, MPA, Chief Executive Officer, IPRO

8:40 a.m. **Livanta Initiatives**

Lance Coss, MS, MEd, CGC, Program Director, Livanta

9:00 a.m. **IPRO Initiatives**

Patricia Gagliano, MD, Vice President for Quality Improvement, IPRO
Sara Butterfield, RN, BSN, Senior Director for Quality Improvement, IPRO
Janice Hidalgo, Director, Center for Healthcare Consumer Engagement Programs, IPRO

9:20 a.m. **Q&A for the QIOs**

9:30 a.m. **Quality Improvement Panel**

Anthony Wisniewski, Esq., Moderator

Panelists:

Anne Myrka, BS Pharm, MAT, Director, Drug Safety, IPRO
Steve Stein, MD, Medical Director, Livanta
Jed A. Levine, Executive Vice President, Director of Programs & Services, CaringKind-The Heart of Alzheimer's Caregiving
Anderson Torres, PhD., President and CEO of Regional Aid for Interim Needs (R.A.I.N.), Total Care Inc.
Carol Levine, Director, Families and Health Care Project, United Hospital Fund
Nilsa Gutierrez, MD, MPH, FACP, Chief Medical Officer, Region 2, CMS

10:30 a.m. **Panel Summation / Q&A**

Clare B. Bradley, MD, MPH, Chief Medical Officer & Senior Vice President, IPRO

10:40 a.m. **Break**

10:50 a.m. **CMS Presentation / Q&A**

Jeneen Iwugo, MPA, Deputy Director, Quality Improvement and Innovation Group, Center for Clinical Standards & Quality, CMS

11:25 a.m. **Final Remarks / Adjournment**

Theodore O. Will, MPA, IPRO
Anthony Wisniewski, Esq., Livanta

Meeting Purpose

Person and Family Engagement Initiatives were the topics of a morning symposium sponsored by IPRO and Livanta, New York's two Quality Improvement Organizations (QIOs), February 27 at the Centers for Medicare & Medicaid Services (CMS) Regional Office at Federal Plaza in Manhattan.

The event highlighted Medicare-funded Special Innovation Projects (SIPs) the two organizations are currently undertaking in New York, including efforts to provide extra support services to seniors recently discharged from acute care hospitals and to improve care transitions communications among healthcare providers across the care continuum.

As the Beneficiary and Family Centered QIO (BFCC-QIO) for New York, Livanta's contract focuses on protecting Medicare beneficiaries through activities such as reviewing discharge and termination of service appeals and quality-of-care complaints lodged by Medicare patients and families. A Quality Innovation Network QIO (QIN-QIO), IPRO's contract centers primarily on working with providers to improve clinical care processes. IPRO conducts this work in New York State as the Atlantic Quality Innovation Network (AQIN-NY).

Keynoting the conference was Jeneen Iwugo, MPA, Deputy Director, Quality Improvement and Innovation Group, Center for Clinical Standards & Quality, CMS.

Symposium proceedings follow on Page 5.

About IPRO and Livanta

QIOs serve as the largest federal program dedicated specifically to improving healthcare quality at the community level. The program focuses on work with patients, caregivers, healthcare providers, and community partners to support the development of healthy people in healthy communities, resulting in better care and lower costs.

IPRO

Leading the Atlantic Quality Innovation Network (AQIN), the CMS-funded Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for New York, South Carolina and the District of Columbia, IPRO works to improve the quality of care provided to Medicare beneficiaries. IPRO's efforts focus on initiatives that support CMS goals to drive greater connectivity and coordination

across all healthcare settings to transform healthcare delivery. IPRO works to catalyze change through a data-driven and results-oriented approach to improving healthcare quality. IPRO works with healthcare professionals, partners, patients and families at the community level to share knowledge, spread best practices and improve care integration. As part of the national QIO program, IPRO is committed to a patient-centered approach to improving health, improving healthcare and reducing healthcare costs for all Americans. www.IPRO.org

LIVANTA

Livanta LLC is the CMS-designated Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) in Areas 1* Area 5**. Medicare beneficiaries who receive healthcare services in these states and territories, or their representatives, can contact Livanta to:

- Appeal a decision to discharge a beneficiary from the hospital when there is a concern that the discharge is happening too soon;
- File a complaint or concern about the quality of healthcare they received in the past, or are undergoing now;
- Appeal a decision to end a course of treatment, such as rehabilitation, nursing home, home health, or hospice care, when there is a concern that the beneficiary still needs skilled care.

In addition to the roles described above, Livanta reviews medical records to verify that the coding is accurate, and that the care provided was medically necessary and was delivered in the most appropriate setting. More detail about Livanta's coding validation, utilization review, and Emergency Medical Treatment & Labor Act (EMTALA) review work can be found in this report. Livanta understands and respects beneficiaries' rights and concerns, and is dedicated to protecting patients by reviewing appeals and quality complaints in an effective and efficient patient-centered manner. www.Livanta.com

* Area 1 consists of New York, New Jersey, Pennsylvania, Connecticut, Rhode Island, Massachusetts, Vermont, Maine, Puerto Rico and the U.S. Virgin Islands.

** Area 5 includes Arizona, Nevada, California, Hawaii, Oregon, Washington, Idaho, Alaska and the Mariana Islands.

Proceedings

INTRODUCTIONS/GREETINGS

Anthony C. Wisniewski, Esq., Chairman of the Board, Chief of Government & External Affairs, Livanta, LLC

Gilbert Kunken, DMD, MPH, Deputy Regional Administrator, Centers for Medicare & Medicaid Services (CMS), Region 2

Theodore O. Will, MPA, Chief Executive Officer, IPRO

Mr. Wisniewski expressed his pleasure that Livanta and IPRO, New York's two Medicare Quality Improvement Organizations (QIOs), could jointly host the meeting. He stated that Lance Coss from Livanta would later give an overview of the organization's person and family engagement programs, with a special emphasis on reducing avoidable hospital readmissions. He briefly introduced Livanta's role as the Beneficiary and Family Centered Care (BFCC) QIO for CMS Areas 1 (Northeast and Caribbean) and 5 (Western U.S.), which covers New York and 18 additional states and territories. BFCC-QIOs review the concerns of Medicare beneficiaries and their families and handle discharge appeals and quality of care complaints.

Mr. Wisniewski stated that Livanta has been proud to support quality improvement for nearly four years, during which time the organization's staff have managed 251,072 quality of care complaints and appeals, 45,254 of which have been in New York.

He thanked Mr. Will and CMS staff participating in the program: Jeneen Iwugo, MPA, Deputy Director, Quality Improvement and Innovation Group, Center for Clinical Standards and Quality; Nilsa Gutierrez, MD, MPH, Chief Medical Officer, Region 2; Dr. Kunken; Annette E. Kussmaul, MD, MPH, FACPM, Associate Regional Administrator for the Division of Quality Improvement, Boston Regional Office, CMS; and Danielle Liss, External Affairs Team Leader, Office of the Regional Administrator, who helped develop and facilitate the program. He expressed thanks to New York's Congressional delegation for their support. U.S. Senators Charles E. Schumer and Kirsten Gillibrand sent letters of support, and Alpheia John, Constituent Services Representative for Congresswoman Yvette Clarke, joined the meeting. Additionally, he acknowledged the critical participation of representatives of New York advocacy groups, minority health organizations, healthcare providers, partners and other stakeholders.

Dr. Kunken discussed the longstanding relationship that CMS has had with QIOs. He thanked Livanta,

Mr. Wisniewski and his staff, and IPRO, Mr. Will and Clare B. Bradley, MD, MPH, IPRO's Chief Medical Officer & Senior Vice President, with whom he's worked on many projects. Dr. Kunken expressed his appreciation to IPRO for hosting CMS staff in its Long Island offices following the events of 9/11. He also acknowledged Ms. Liss for all of her work in pulling the symposium together.

He concluded his remarks by telling those in attendance that CMS would be issuing new Medicare cards that do not contain Social Security numbers. The cards will be distributed starting in April and continuing for about a year.

Mr. Will welcomed attendees and acknowledged CMS staff who were present, as well as staff from the Boston Regional Office listening in on the webcast. He discussed IPRO's role as the Quality Innovation Network (QIN) QIO for New York, and its leadership of the Atlantic Quality Innovation Network, which also includes Washington, DC and South Carolina. QIN-QIOs bring Medicare beneficiaries, healthcare providers and communities together in data-driven efforts that increase patient safety, make communities healthier, better coordinate post-hospital care and improve clinical quality.

Mr. Will emphasized that IPRO and Livanta work closely together to help Medicare beneficiaries and their families: when Livanta identifies quality concerns, IPRO works with the providers in question to develop improvement plans. Through its Center for Healthcare Consumer Engagement, IPRO puts patients and families first, by using evidence-based methods to address how to prevent deadly infections like sepsis; support pharmacists on issues related to opioid dispensing and patient education and preventing adverse events from opioids and other high-risk drugs; improve care transitions and thereby reduce unnecessary hospital readmissions, and educate and empower patients to better control their diabetes and other chronic conditions.

LIVANTA INITIATIVES

Lance Coss, MS, MEd, CGC, Livanta BFCC-QIO Program Director

Mr. Coss discussed how Livanta has partnered with IPRO for years and stated that most people see Livanta as providing quality assurance vs. the quality improvement that IPRO and other QIN-QIOs focus on. He discussed two special innovation projects (SIPs), which encompass Livanta's Patient Navigation Program:

1. **Patient and Family Engagement (started Oct. 2016) is Tier I of the Patient Navigation Program.** Livanta proposed this program to CMS because patients who file a discharge or termination of service appeal are three times as likely to be readmitted to an acute care hospital within 30 days, and many providers are missing an opportunity when patients say they aren't ready to be discharged.

- In CMS Area 1, Livanta has focused on discharge appeals from acute care settings, i.e., hospitals.
- In Area 5, Livanta has focused on appeals filed in post-acute care settings.

In this program, patients get support through the appeals and discharge process. Social workers call within hours of the patient filing an appeal, and help patients and their caregivers navigate the healthcare system and help advocate for them for 30-40 days.

2. A year into this program, CMS acknowledged how well the program was going and provided funding for another longer-term project – now known as the **Care Management Improvement Initiative (CMII), or Tier II of the Patient Navigation Program.** This program extends Livanta's support past the initial 30 days. For patients who have a higher level of disease severity, Livanta works with them past the initial 30-day period, to support the patients in managing their health conditions and to ensure they understand the services available to them.

Results

- In Area 1, Tier I, this led to a drop in 30-day hospital readmission rates from 66.2% to 21.8%.
- Previously, 75% of patients in nonacute care (Area 5/ Tier I) were readmitted within 30 days. It is now down to 13.3%.

Lessons

Mr. Coss stated that, after a year of these initiatives, Livanta's major lessons were

- **This is the future.** Patients love getting assistance in helping them navigate the healthcare system. The system is complicated for those who know it, and even more complicated for people who don't and are encountering changing issues and barriers.
- **Measurements based on claims data analysis can be challenging,** as data are only available for Medicare Fee-for-Service beneficiaries, not for those in Medicare

Advantage (HMO) plans. Livanta is supporting Medicare Advantage patients, but does not have a mechanism to measure the impact, because the organization has no access to these patients' claims.

- **Determining the baseline to measure ER readmissions is difficult.** This is not something that CMS has measured before. Therefore, Livanta will need to continuously evaluate the data to ensure that the QIO is measuring the number of times a patient that Livanta is working with goes to the ER during the reporting period.
- **Livanta needs data for durable medical equipment (DME), Part B claims data and data for outpatients.** CMS believes that patients who need DME are at a higher level of severity (acuity), but Livanta cannot identify these patients without access to the claims data. Additionally, there is much to be learned from monitoring all claims for a patient, including Part B claims, but Livanta does not have access to these claims either.

Moving Forward

- Staff are teaching patients and caregivers how to navigate the system and advocate for themselves with providers.
- Livanta is hiring teams of professionals who specialize in chronic diseases such as cardiovascular disease, diabetes and chronic kidney disease, who will be able to best address the complaints and appeals of special populations immediately.
- Livanta plans to do immediate advocacy to help patients across areas, in order to expand support to patients who are outside of the SIP.

Mr. Coss concluded by telling two stories that illustrate the breadth of Livanta's person and family engagement.

- Puerto Rico is within Livanta's BFCC-QIO service area. When it comes to patient advocacy there may be no better example of how Livanta went the extra mile to try to save a life a month after Hurricane Maria devastated Puerto Rico and knocked out most of the island's power. Livanta's role in aiding desperate Puerto Rican seniors began with a frantic phone call from the daughter of a woman who urgently needed medical care and advocacy. The daughter made a call to a special Puerto Rico telephone line set up for Medicare Quality-of-Care Complaints. Her mother had a series of health and mobility issues and needed to get to a healthcare facility. Her house was flooded, she had no electricity, was on an oxygen tank and could not walk.

The family had to act quickly; they put the mother in an office chair and wheeled her to the nearest facility, which was struggling to stay open, yet admitted the patient. The daughter heard that her mother was going to be discharged. With power restoration weeks away and only intermittent access to potable water, a discharge was out of the question and the daughter called Livanta and filed an appeal. Her mother was immediately enrolled in Livanta's innovative Patient Advocacy Program.

The Livanta Patient Advocate learned that the patient was going to be discharged to another facility, but identified significant communications breakdowns between facilities, as the new facility lacked equipment necessary for her continued care. After extensive discussions with the patient's daughter, the care team and the admissions team aboard U.S. Navy hospital ship USNS Comfort the decision to transfer the patient to the ship was approved, to ensure a safe continued care setting and allow time for a longer-term solution. Livanta had to navigate a sea of red tape to make this happen, but sadly, the mother did not make it: she passed away while transport plans were being made. Although her mother did not survive, the daughter thanked Livanta profusely for going the extra mile to comfort and advocate for her mother.

The lesson from this story is that Livanta advocates for the best interest of the patient. The family could not have known that the Navy ship was available, let alone an option for their mother. Livanta provided this information to the family, received agreement from them and then began work with the family to implement the plan.

- A second story shows the bond Livanta's advocates have with patients. The story began with a patient who had just received a terminal diagnosis. The patient's wife was in shock and concerned about making the right decisions. During the discharge process, the Livanta Patient Advocate worked with the patient's wife to understand all of the options being presented by the provider. The wife and patient elected hospice and over the course of several weeks the Patient Advocate developed a strong relationship with the patient through conversations about the care plan. When the patient was dying, the Livanta advocate received a phone call from the patient, who asked if the advocate could figuratively "hold their hand" over the phone. At the time of the patient's death, Livanta's Patient Advocate offered gentle consolation by phone as the patient passed away.

Livanta's staff understood the needs of the caregiver and offered the support that was needed in this case. Every case Livanta deals with is different, but the goal of staff is to understand what is needed and to provide the support that is within their power. Sometimes that extends to the emotional support that is needed by the patient and caregiver.

IPRO INITIATIVES

Patricia Gagliano, MD, Vice President for Quality Improvement, IPRO

Sara Butterfield, RN, BSN, Senior Director for Quality Improvement, IPRO

Janice Hidalgo, Director, Center for Healthcare Consumer Engagement Programs, IPRO

Dr. Gagliano discussed IPRO's New York-based person and family engagement initiatives in its role as leader of the Atlantic Quality Innovation Network (AQIN), which is one of 14 QIN-QIOs covering the U.S. and its territories. IPRO collaborates with patients, providers and stakeholders to promote patient-centered care across New York.

In addition to its many years of working with healthcare providers on quality improvement projects, IPRO has more than 10 years of experience in **providing chronic disease self-management classes and developing health education workshops**. IPRO receives consumer input to guide and inform initiatives via focus groups and a multicultural community advisory panel.

IPRO engages a diverse community of patients and caregivers and offers its chronic disease self-management education programs and workshops in multiple languages, meeting cultural competency and health literacy standards. Evidence-based self-efficacy and behavior change tactics are employed in IPRO's interactive educational classes.

Ms. Butterfield discussed IPRO's **coordination of care coalition models**. IPRO's **Care Transitions** (coordination of care) project was developed initially as a CMS-funded Special Innovation Project (SIP). Due to its success, CMS expanded the program – which relies on a person-centered model with family caregiver involvement - nationwide.

IPRO looks at an entire community, which may consist of a large geographic care referral area. More than one million beneficiaries reside in the selected coordination of care community, primarily in rural and semi-rural areas of New York.

- IPRO has developed 24 care coordination coalitions. The coalitions – which represent every sector of healthcare – meet monthly and use formal and informal protocols that address all factors that affect patients (including socioeconomic status) who transition from one healthcare setting to another – or return home.
- The coalitions develop collaborative relationships, based on the Marshall Ganz model, which emphasizes removal of care setting “silos” and working with community providers and stakeholders to help them understand each other’s organizational and regulatory challenges.
- Coalition members go back to their organizations and develop processes that improve communication and ensure that systems are put in place that emphasize care coordination and thereby support improved patient outcomes.
- The project focuses on effective communication, information transfer, medication management and care coordination to ensure patient-centered care.
- The program seeks to engage and empower patients to be more involved in their healthcare, especially as they make these transitions.
- In the 24 coalition communities, the project has achieved as much as a 5.5% relative improvement rate in readmissions and a 4% relative improvement rate in all hospital admissions.

IPRO is also working with the **United Hospital Fund’s Next Step in Care project**, which provides free guides and checklists for family caregivers on a variety of topics, with a special focus on transitions between care settings. As part of this ongoing collaboration, IPRO was invited to be part of the development of a **CARE Act Toolkit** to support hospitals in implementation of the CARE Act. The act requires hospitals to work with patients upon admission to identify a lead caregiver and to involve that caregiver in all aspects of education and discharge planning.

The IPRO team is educating community based providers on the CARE Act and working with hospital and community providers to carry that caregiver information over to the community so that the same person is involved in the patient’s care post-hospital discharge.

Ms. Butterfield discussed a second Special Innovation Project – the **Community Based Sepsis project**, which started in 2015. Sepsis is the third leading cause of death in the U.S., and sepsis mortality has been shown to increase by as much as 8% for every hour patients aren’t treated. Studies demonstrate that sepsis is not being identified

early enough in the community: CDC notes that **7 in 10 patients with sepsis had recently interacted with healthcare providers or had chronic diseases requiring frequent medical care**. More than 80% of sepsis cases originate in the community.

The project has two goals: (1) encourage providers to use sepsis recognition and treatment protocols; (2) put patients first, and make the public aware of sepsis’ early warning signs.

- IPRO started by offering education on warning signs to skilled nursing facilities, home health agencies, primary care physicians and dialysis centers.
- A provider toolkit was created along with a “train-the-trainer” educational program and resources.
- IPRO launched a mass media campaign, to drive consumers and providers to www.StopSepsisNow.org.
- More than 10,000 clinical and non-clinical skilled nursing facility, home health, physician practice, and dialysis center staff have participated in 903 training sessions, with a 50% rate of absolute improvement in sepsis knowledge post-training.
- Over 500 Medicare Fee-For-Service beneficiaries attended educational programs with 100% absolute improvement in sepsis knowledge.
- In terms of the mass media campaign, a Nielsen survey commissioned by the Sepsis Alliance found that pre-intervention, 63% of respondents in the target communities responded “yes” to the question “Have you heard of the term ‘sepsis’?”, while 73% responded “yes” to this question post-intervention.

To increase its reach and sustain the momentum, IPRO partners with the Centers for Disease Control & Prevention, New York State Department of Health, The Rory Staunton Foundation, National Sepsis Alliance and Home Care Association of New York State.

Ms. Hidalgo discussed IPRO’S 17 years of direct patient and family engagement initiatives through the IPRO Center for Healthcare Consumer Engagement. These initiatives have been funded primarily by CMS, many of them SIPs. Among these has been a public education campaign targeting **African-American beneficiaries with diabetes**, urging them to speak with their physicians about recommended medical exams, in order to reduce health disparities. In 2010, during the 10th Scope of Work, IPRO received CMS special innovation project funding for a **Hypertension Self-Management Program**.

The **Everyone with Diabetes Counts** diabetes self-management education program was launched by IPRO in 2008 through a SIP project and is now national. By directly engaging people with diabetes, and focusing primarily on racial/ ethnic minorities, IPRO has helped more than 10,000 individuals. For program participants who agreed to submit clinical data, average **hemoglobin A1c rates went down by more than one point** after program completion. Participants completing pre- and post-program surveys reported **significant increases in self-care knowledge** and confidence about managing their diabetes.

Another current chronic disease self-management program – also a SIP -- focuses on **chronic kidney disease**, with the aim of enrolling 1,000 beneficiaries. IPRO works with individuals at high risk for developing CKD, such as those with hypertension and diabetes, as well as those with late stage CKD who are at risk for developing end-stage renal disease, to educate them about how lifestyle contributes to diabetes and its prevention and progression. The **American Diabetes Association** works closely with IPRO on both the diabetes and CKD disease self-management education projects.

These programs are evidence-based and follow cultural competency standards and proven strategies and interventions. All of the programs above depend on the input of patients and involve family and friends. IPRO partners with providers, AARP, senior centers and other community groups, as well as New York City aging and housing agencies, in order to engage and educate seniors.

Questions & Answers

Mr. Wisniewski moderated a question and answer session.

Question: Are we improving health disparities with our programs?

Ms. Butterfield: We will see improvement. We are encouraging providers to address disparities as part of our work with them, and we are focusing on racial/ethnic disparities as well as socioeconomic factors in the design of our programs.

Jean Stone, Volunteer, Senior Medicare Patrol: Is there a hotline that addresses inadequate care that isn't fraud related when seniors are readmitted?

Mr. Coss: We handle quality complaints in all settings as long as they are Medicare-related. Our lines are answered 365 days a year and 24 hours a day.

Michelle Berney, Outreach Coordinator, New York City Dept. for the Aging HIICAP program: How do patients

know who to reach out to when they have chronic diseases?

Ms. Hidalgo: We go to where seniors are and have an extensive network in the community we work with, including senior centers and the New York City Department for the Aging.

Question: What if someone has a complaint and they are not a Medicare beneficiary?

Jeneen Iwugo, MPA, Deputy Director, Quality Improvement and Innovation Group, Center for Clinical Standards & Quality, CMS: I suggest they call 1-800-MEDICARE, and they will be pointed in the right direction.

Quality Improvement Panel

Anthony C. Wisniewski, Esq., Moderator

PANELISTS

Anne Myrka, BS Pharm, MAT, Director, Drug Safety, IPRO

Steve Stein, MD, Medical Director, Livanta

Jed A. Levine, Executive Vice President, Director of Programs & Services, CaringKind-The Heart of Alzheimer's Caring

Anderson Torres, PhD, President and CEO of Regional Aid for Interim Needs (R.A.I.N.), Total Care Inc.

Carol Levine, Director, Families and Health Care Project, United Hospital Fund

Nilsa Gutierrez, MD, MPH, FACP, Chief Medical Officer, Region 2, CMS

Ms. Myrka: IPRO focuses on reducing adverse drug events primarily from high-risk medications such as anticoagulants, opioids and diabetes drugs. Our drug safety team has convened coalitions including patients, advocates, expert physicians, pharmacists and other healthcare professionals to focus on each class of drugs and come to a consensus about what to communicate about these medications when patients are transferred between care settings. The coalitions have developed medication checklists, for example, that should be reviewed during care transitions in order to ensure drug safety.

IPRO has received SIP funding to integrate its mobile app – Management of Anticoagulation in the Peri-Procedural Period (MAPPP) into electronic health records as active clinical decision support to help prescribers determine when to stop anticoagulants before surgery and when to resume again. The project also includes patient education materials.

IPRO has also just received SIP funding to train pharmacists to counsel patients when they receive opioid prescriptions, and identify high-risk patients who would benefit from receiving naloxone from the pharmacy to ensure patient, family and caregiver access in case of overdose. Family members and caregivers are trained on how to administer naloxone. The primary goals are to reduce overdose risk and increase patient safety by reducing opioid-related emergency department visits. Another goal is to create an intervention for when benzodiazepines and opioids – a potentially dangerous combination -- are prescribed together.

Dr. Stein: Livanta has a program that expedites quality complaint resolution – the Immediate Advocacy Program. This program increases beneficiary and provider satisfaction. If someone calls Livanta’s hotline with a quality-of-care complaint, a nurse will actually get on the phone right away and call someone at the institution. In some cases, patients call Livanta from their hospital or nursing home beds and our nurses and social workers call the patient’s nursing station or case manager. This program can also be put into action in home care settings.

This saves the time required to go through the case review process and immediately engages the patient, caregiver and provider. Livanta’s calls to physician offices can help prevent ER visits. When a doctor’s office fails to call back with test results, the Livanta team can intervene and advocate for the patient. With home care, if the situation is urgent the Livanta nurse calls right away to resolve the problem.

Mr. Levine: There is a lot you can do to improve quality of life for Alzheimer’s patients and their caregivers. CaringKind provides a wide range of support and resources for New York City families affected by Alzheimer’s or another dementia. When they need help, family caregivers usually don’t know where to start. They call CaringKind’s **24 hour helpline**. CaringKind helps them understand how to use the system and create a roadmap of care. When a family member is diagnosed with dementia, caregivers need to know where to turn and where to seek help. Our programs and materials are in multiple languages.

CaringKind has 90 support groups for family caregivers. A lot of education takes place at these meetings. CaringKind also has programs for nursing home residents and an innovative palliative care program. People with dementia are very likely to wander, and we have a Wandering Safety program that includes alert bracelets. CaringKind works very closely with the NYPD on this

program.

Dr. Torres: R.A.I.N. has just brought a number of programs to Puerto Rico. R.A.I.N. has 12 senior centers in the Bronx and Manhattan, and a total of 20 programs. Ms. Hidalgo’s team did many of IPRO’s diabetes self-management education programs at R.A.I.N.’s centers. Health literacy is an important focus. R.A.I.N. is about to launch an intergenerational program in which millennials will work with seniors, focused on Alzheimer’s disease. This program will be part of Millennium High School’s curriculum. Students will visit seniors in long-term care facilities, and the seniors will visit them at the school twice a month.

One way R.A.I.N. engages the community is through outreach to houses of worship. R.A.I.N. also has joint internship programs with social work and nursing schools at Lehman College, Hunter College and Concordia College. We have also recently started partnerships with managed long-term care companies.

Ms. Levine: The United Hospital Fund has family caregiver guides that explain the CARE Act and the next step in care. These guides are in four languages.

What does patient and family engagement mean? Not just getting a patient to do what you want them to do. I am encouraged that the presentations this morning have focused on how providers can engage. Disrespect for patients and their families is still a major issue. I have experienced it myself as a family caregiver. Things have improved, but only to some extent. Vigilance is important.

Dr. Gutierrez: Despite the fact that CMS has pushed the healthcare community to respect and take patient and caregiver preferences into account, there are many places where this hasn’t happened.

The U.S. Department of Health & Human Services Office of Minority Health (<https://minorityhealth.hhs.gov>) has data on disparities for Medicare beneficiaries for common chronic conditions. The site has a tool that can be used to map Medicare disparities and differences in outcomes for ethnic and racial minorities, which can even look at the neighborhood level. These differences are significant, and they show us where work needs to be directed.

We know that communication outside of the physician practice doesn’t always work effectively. The burden is placed on the caregiver, because providers don’t provide enough staff to help. If you don’t address caregiver and provider roles and responsibilities, then you miss the story. We also have an obligation to assure that providers offer treatments that address family needs.

Question and Answer Session for Panel

Mr. Wisniewski moderated a question and answer session.

Mr. Wisniewski: What's being done for Puerto Ricans who have come to the mainland because of the hurricane?

Dr. Gutierrez: CMS has been involved in response and recovery, working with HHS-deployed teams, FEMA, local emergency management teams and others to provide a range of medical and support services. We have also been helping people from the Virgin Islands and have airlifted patients from there because both of the island's hospitals were damaged. CMS has also been working with relocation states to get Medicare waivers to make sure people can enroll in Medicare in the states where they have gone. Service centers have been set up at airports and elsewhere.

Dr. Torres: R.A.I.N. Puerto Rico established collaborations with local organizations. R.A.I.N. and the local groups have provided a number of direct healthcare service programs, including "meals on wheels" and case management services in Puerto Rico and New York City. We've also provided services to schools and nursing homes.

Mr. Wisniewski: How do you incorporate person and family engagement into your initiatives?

Mr. Levine: This is integral to our organization. We work through providers to encourage doctors, nurse practitioners and social workers about referring family caregivers to our programs. It is very personalized. People really need support, a care plan, and help with navigating. We provide special assistance to Puerto Rican migrants.

Ms. Levine: United Hospital Fund doesn't provide direct services because it is a policy organization, but it does provide educational materials. We stress the family caregiver voice in everything we do. We collaborate with groups like AARP. UHF also does research on care transitions and other issues, including focus groups.

Mr. Wisniewski: What do you see as the biggest challenges and opportunities in engaging families?

Ms. Myrka: As a practicing pharmacist, I was actively engaged with patients, helping them understand the medical terminology and basics of the drugs they were taking. Now we have the opportunity to open conversations on opioids. Our opportunity is to create tools to bridge that gap, such as training in pharmacy school that involves patients. We often say we teach back, but we don't assess patient understanding of the education provided in an objective manner. There's a need to document this type of objective assessment within the

medical record and communicate gaps in understanding to the next provider.

Dr. Stein: Teaching communication to physicians is key. Get patients to repeat your instructions back to you. It's very simple to do, but providers need to make sure patients really understand. This is both a challenge and an opportunity.

Ms. Myrka: Teach back isn't often done. It needs to be assessed and documented.

Mr. Levine: The challenges are that we don't acknowledge enough that patients aren't always cognitively intact and that neither are caregivers, because they are dealing with so much over so many years. The opportunity is to provide a place for family members to process this. On the provider side, there is a challenge to know where to refer. For families, it's a challenge to find resources because they are overwhelmed.

Dr. Torres: The challenge is addressing dismissiveness of family concerns during discharge.

Ms. Levine: The emphasis to provide care in the community and not the hospital is good, but the way it is done places a burden on families. Another challenge is to recognize that patients and their caregivers and other family members are different people and they don't always agree. Not overriding the patient's wishes can be challenging.

Dr. Gutierrez: The healthcare community needs to be much more literate about resources and what happens after discharge. The patient needs to become more literate about healthcare. The family also needs more education: What is the role they will be playing in patient care? We need to break down the walls and make sure healthcare providers understand how they fit in as part of a larger community.

Summation of Panel Discussion

Clare B. Bradley, MD, MPH, Chief Medical Officer and Senior Vice President, IPRO

All of our speakers are working to improve outcomes and make care more patient- and family-centered. Two foundational principles drive our work. We used to look at healthcare that was provided, retrospectively, whether it was appropriate, and then created quality improvement programs based on what we learned and on issues identified by CMS. Then CMS decided that we needed to look at care as it was being provided. CMS is now encouraging a patient-centered approach. The patient's

voice should drive our communications and socioeconomic issues need to continue to be a focus.

Patients need to help inform and evaluate interventions. The healthcare system is very complicated and we need to support patients in navigating through the system. Disparities are also still very much alive and well and need to be addressed. Using youth to reach seniors is a promising approach. There is a strong need to support family caregivers and focus on each patient's unique needs.

Community care is critical to reaching patients, and helps us be patient-centered, as we've seen with the Care Transitions coalitions.

No two patients are the same. We can't reach our goals without the involvement of patients. Eighty percent of sepsis cases occur in the community, so patients need to be educated in the community. The MAPPP app shows that no two patients are the same. We need to focus on the individual needs of patients.

Self-management of chronic diseases is important, so that patients understand how they can engage in managing their illness beyond taking medications. Immediate advocacy is important as well. Involving youth in working with seniors is a promising idea.

Challenges include how to promote immediate advocacy. People don't know they can call, or who to call. Healthcare navigation is very complex. We need providers willing to engage with patients and their families in order to achieve the best outcomes.

Opportunities include continuing to get the word out about challenges, disparities and promising approaches. Training professionals while they're still in school is critical. The professional schools need to be at the table with our Learning and Action Networks. Family caregivers are a wonderful resource, but we don't always treat them appropriately as valued members of the care team.

We will create a one-pager on how to get in touch with Livanta and IPRO, and listing resources, and send it to everyone in attendance.

Dr. Gutierrez suggested holding these meetings every six months to discuss where things stand. We can map and pace our progress and identify barriers and impediments.

Suggestion: We should also share resources with Medicaid caregivers.

Suggestion: The cultural component of quality improvement is missing. We need research in this area and people need to be trained. We need to do more focus groups with Latinos and their families.

CMS Keynote Presentation

Jeneen Iwugo, MPA, Deputy Director, Quality Improvement and Innovation Group, Center for Clinical Standards & Quality, CMS

Ms. Iwugo spoke about her multiple roles at CMS. One role includes pairing needs with resources. Her group runs five quality improvement networks, as well as a range of other programs such as the End-Stage Renal Disease Network (ESRD) Program. Ms. Iwugo leads the CMS person and family engagement strategy effort. Her group leads person and family engagement affinity groups. They also work with 200,000 clinicians on the Quality Payment project.

Ms. Iwugo complimented IPRO for its work bringing providers, partners and beneficiaries together for innovative programs. IPRO and other QIN-QIOs have done great work in helping patients manage their own diseases.

She discussed the BFCC-QIOs, which have daily contact with beneficiaries. BFCC-QIOS do medical record review, claim validation and person and family engagement. The BFCC-QIOs have seen 600,000 complaints and appeals over the last four years.

CMS wants to support innovative approaches. These include Livanta's Immediate Advocacy program, which is critical and has been made a national program, and the Beneficiary Navigation program discussed by Livanta, which has been designed to help patients with complex needs. It also includes Beneficiary BFCC-QIO Satisfaction Surveys and the Beneficiary & Family Advisory Councils (BFACs).

Many types of patient complaints would never be captured in a medical record, yet are very important to patients. That's why immediate advocacy is so important – QIO staff get directly involved with the patient.

BFCC-QIOs have been very involved in patient and family engagement. There's a need to evaluate.

Livanta's Immediate Advocacy Program has had great results. When someone calls and complains, there's the need to understand that the issue is much larger than the complaint. Beneficiaries often have complex issues that need to be addressed.

Miscommunication happens all the time. Many seniors will say they understand what the doctor told them, even if they didn't. They don't often question their doctors. Immediate Advocacy is perfect for dealing with these situations. We've learned that complaints aren't always for narrow reasons; you need to talk about what are typically multiple underlying issues.

Patient and Family Engagement is a growing and evolving area of work. QIN-QIO programs like IPRO's Community Based Sepsis project and chronic disease self-management projects are also part of this strategy as they provide patients with vital, actionable information.

QIN-QIOs have Patient and Family Advisory Councils to give feedback to the QIOs. It's critical that this feedback is integrated into QIO programs.

Putting Patients First is an Administration priority, and is growing. CMS wants to make sure that patients' healthcare is improving. Providers need to check back with patients, then adjust and modify based on feedback. Patients should be armed with data – everyone has the right to know what's in their medical record.

A well-rounded strategy also gets providers to understand how to better communicate with patients and with each other. There's a need for providers to help beneficiaries understand that they share their values and preferences.

QIOs have the ability to innovate with CMS-funded Special Innovation Projects. If these projects are successful, they may be made national or regional.

The next QIO Scope of Work starts in 2019. CMS has been holding listening sessions and is interested in hearing ideas for new programs. Initiatives that address the opioid crisis are a top priority for the Administration, and there are other programs that are already in the planning stage. But CMS is interested in hearing what those in this symposium think needs to be done next to address putting patients and caregivers first.

Ms. Iwugo asked: What is the greatest opportunity for engaging patients? What do we need to do next? What are the needs?

SUGGESTIONS:

- Educate patients that they need to have a caregiver BEFORE they get sick. Make sure that primary care physicians recognize they need to go over basic issues with patients and that their caregivers, so they also understand.
- Need research on how to reach the Hispanic community about the opioid crisis and design programs that are focused on them. Not enough is being done to address the needs of this community.
- Emphasize a dementia care coordination model: start with screening and embed principles of palliative care early on.
- Need a way to get Parts C and D data, because they are important to addressing readmissions.
- Advocate for reimbursement opportunities for primary care to develop care plans that include the family caregivers. This will be important for care transitions.
- Duplicate some of these innovative programs for Medicaid patients.

CLOSING REMARKS – MR. WISNIEWSKI

Mr. Wisniewski thanked Ms. Iwugo. He also acknowledged IPRO and its great work on the symposium. In addition, he accepted Dr. Gutierrez's challenge to "keep this going."

He closed with mentions of some other Livanta initiatives. In their work with the Puerto Rican community, Livanta uses the Puerto Rican dialect, not Castilian Spanish. Livanta also has an Arrow program, which enables family members and friends to electronically track a case hour by hour, without violating HIPAA rules. And the new LivantaCares Medicare Helpline app provides real time engagement with patients in the hospital.

APPENDIX

SPEAKER BIOGRAPHIES

Introductions/Greetings

Anthony C. Wisniewski, Esq., Chairman of the Board, Chief of Government & External Affairs, Livanta LLC

Mr. Wisniewski, Esq. is the Chief of External & Government Affairs for Livanta LLC. Wisniewski's responsibilities at Livanta, as well as previously as Executive Director and Counsel of sister company, AGS, have included oversight for operations and strategic initiatives. This includes legal and government affairs, compliance, new business development, and project management on federal and state government contracts within specific areas of expertise such as quality reporting.

Previously, Wisniewski served as a senior vice president at the health care accreditor, URAC, leading operations, legal affairs, and strategic development. He led the drafting and successfully lobbying into law, landmark health reform legislation: Section 1311 of PPACA on accreditation of health insurance exchanges. He likewise spearheaded development and ongoing execution of federal and state advocacy plans to incorporate URAC accreditation into mandated health insurance exchanges. Prior to URAC, Wisniewski served as executive director for health policy at the U.S. Chamber of Commerce, developing Chamber policy on hospital and physician quality improvement measures, comparative effectiveness, life sciences and advocating those policies before Congress and the federal agencies. In this role, Wisniewski served as principal to the Hospital Quality Alliance and Quality Alliance Steering Committee, functioning as a nationally recognized employer stakeholder on the development and reporting of hospital and physician quality reporting measures, as well as health care reform payment incentives. Just prior to joining AGS full time, Wisniewski served as the president and chief executive officer of CAHME, the accreditor of graduate-level health care management education. While at CAHME, he led the rollout of competency-based criteria for accreditation that factored in health care quality improvement measures for the next generation of hospital administrators, supply chain and other health care executives.

Wisniewski was appointed by the President of the United States to the Christopher Columbus Fellowship Foundation Board of Trustees. He was also appointed by U.S. Secretary of Health and Human Services to the Agency for Healthcare Research and Quality (AHRQ) National Advisory Council, serving as a key employer voice on national

quality measures reporting in areas such as disparities of care for minority populations, hospital associated infections, and overall patient safety. Further, Wisniewski was also appointed by the Director of AHRQ to serve on its Effective Health Care Stakeholder Group, focusing primarily upon development and reporting of quality measures associated with comparative effectiveness research of designated chronic diseases.

Within the State of Maryland, Wisniewski has served on the University of Maryland Biotechnology Institute Board of Visitors and is a former gubernatorial appointee to the board of the venture capital Maryland Technology Development Corporation. Wisniewski is admitted to the bars of both Maryland and Washington, D.C. He received his Juris Doctorate from the University of Notre Dame and a Bachelor of Arts from the Catholic University of America, majoring in politics, with minors in philosophy and history.

Theodore O. Will, MPA, Chief Executive Officer, IPRO

Theodore O. Will serves as the Chief Executive Officer of IPRO, one of the largest healthcare evaluation organizations in the country. Mr. Will has been involved in the management of healthcare evaluation operations and establishing quality improvement initiatives for more than 30 years.

Providing leadership in a number of national and state healthcare organizations, Mr. Will is a Fellow of both the American College of Healthcare Executives (ACHE) and the New York Academy of Medicine; a member of the American Board of Quality Assurance and Utilization Review, and has served on the ACHE Regents Advisory Council. Currently serving as a member of the Board of Directors of the American Health Quality Association (AHQA), Mr. Will previously held the office of Treasurer of the AHQA Board of Directors and was a member of the Chief Executive Officers' Section of AHQA. Mr. Will was awarded the first Annual Healthcare Quality Improvement Distinguished Executive Leadership Award. The award, which is sponsored by the James Q. Cannon Memorial Endowment, was presented at the 1999 American Health Quality Association Annual Session. In 2007, he was honored with a Leon J. Warshaw Leadership in Health Care Award, presented by the Board of Directors of the Northeast Business Group on Health.

Mr. Will received a Master's Degree in Public Administration, Health Policy, Planning and Administration from New York University.

Gilbert Kunken, DMD, MPH, Deputy Regional Administrator, Centers for Medicare & Medicaid Services, Region 2

Dr. Gilbert Kunken is the Deputy Regional Administrator (DRA) for the New York Regional Office of the Centers for Medicare and Medicaid Services (CMS). He shares in the oversight of the Regional Office's internal management and business functions throughout New Jersey, New York, Puerto Rico and the U.S. Virgin Islands and provides direct support to the Consortium Administrator for Medicare Health Plans Operations nationwide.

Prior to assuming the role of DRA in November 2001, Dr. Kunken served as a commissioned officer in the United States Public Health Service (USPHS) where he was detailed to the United States Coast Guard. While serving with the U.S. Coast Guard, he held several senior program management positions including Chief Dental Officer, Chief of Operational Medicine, and Chief of Health Services, Safety and Environmental Health and Food Service. Dr. Kunken led a Senate Appropriations Committee mandated Health Care Task Force to evaluate and make recommendations for the future of Coast Guard health care and played a major field role in integrating the Coast Guard health care program into TRICARE, the DoD managed health care program. During his Coast Guard detail, he also practiced clinical dentistry and mentored more than 300 senior dental students.

Dr. Kunken received his baccalaureate degree from Temple University, his Master in Public Health from Columbia University and Doctor of Dental Medicine from Temple University. He is a Fellow of both the American and International Colleges of Dentistry and has held several faculty appointments at dental schools nationwide.

Livanta Initiatives

Lance N. Coss, MS, MEd, CGC, BFCC-QIO Program Director, Livanta LLC

Mr. Coss brings 22 years of QIO experience with CMS to his leadership role at Livanta. As the Program Director, Mr. Coss maintains direct responsibility for all aspects of the BFCC-QIO Program for Areas 1 and 5. He earned a Master of Science degree in Human Genetics and a Masters of Educations degree in Educational Psychology from the University of Pittsburgh. He is certified by the American Board of Genetic Counseling and is an active member of the American College of Healthcare Executives.

Previously, Mr. Coss was Vice President of the Quality Assurance Division at HealthInsight, where he oversaw all Medicare assurance-related activities for Nevada, New

Mexico, and Utah. Mr. Coss previously served as the Chair of the CMS Case Review Workgroup (2002-2003) and the Chair of the American Health Quality Association (AHQA) Beneficiary Protection Network (2000-2002; 2008). Mr. Coss actively represented the QIO community by serving as an invited subject-matter expert on multiple CMS task forces, generally focused on designing and implementing new information technologies and process improvements throughout the Medicare program. In 2010 and 2018, CMS formally recognized Mr. Coss for his continuing contributions to improving the Medicare program with Special Service Awards.

IPRO Initiatives

Patricia Gagliano, MD, Vice President for Quality Improvement, IPRO

Dr. Gagliano is a New York-licensed physician and serves on IPRO's senior leadership team. In her role as Vice President of IPRO's Healthcare Quality Improvement Department, she is responsible for leading IPRO's efforts to improve the quality of care provided in hospitals, nursing homes, home health agencies, clinics, and physician offices. She also serves as the State Program Director for New York on IPRO's five-year Quality Innovation Network-Quality Improvement Organization contract with the Centers for Medicare & Medicaid Services.

Formerly, she served as a Medical Officer supporting IPRO's External Quality Review quality improvement activities, across multiple states. In this capacity, she reviewed performance improvement projects focusing on prenatal care, reducing avoidable emergency department visits, hospital admissions and readmissions, improving postpartum care, preventive dental care, preventive health screenings, falls reduction and coordination between physical and behavioral health providers. She also developed data abstraction tools and instructions for clinical focus studies and validation studies.

Dr. Gagliano earned her Doctor of Medicine degree from Albany Medical College and her Bachelor of Arts degree in Biology from Siena College.

Janice Hidalgo, Director, Center for Healthcare Consumer Engagement Programs, IPRO

Janice Hidalgo serves the Director of the IPRO Center for Healthcare Consumer Engagement. Her responsibilities include strategic planning for all activities related to patient and family outreach and engagement programs under the rubric of the Center, including the development of community-based health education programs, curriculum development, consumer-friendly publications

and sustainability models. She has also established evaluation methodologies for patient behavior change measurement and cultural competency training for clinical staff.

Ms. Hidalgo leads the IPRO's New York Everyone with Diabetes Counts program since 2008, leading her team to graduate close to 8,000 Medicare beneficiaries with diabetes and pre-diabetes. To date, the program has resulted in improvements in patient knowledge and behavior, as well as reductions in hemoglobin A1c and blood pressure measures for patients who completed the program during the last two years.

Ms. Hidalgo earned her Bachelor of Science degree in Health Communications from Universidad Interamericana de Puerto Rico and is a T-Trainer in the Stanford University Chronic Disease Self-Management Program, Diabetes Self-Management Program and Gateway Diabetes and Cardiovascular Self-Management Program in both English and Spanish.

Prior to her employment at IPRO, Ms. Hidalgo served as the communications director for QIPRO, the Medicare QIO for Puerto Rico, where she directed beneficiary outreach, communications, marketing, and provider relation activities.

Sara Butterfield, RN, BSN, Senior Director for Quality Improvement, IPRO

Sara Butterfield is IPRO's Senior Director of Health Care Quality Improvement and serves as Project Lead for the Centers for Medicare & Medicaid Services' (CMS) Coordination of Care initiative and the Transforming End of Life Care and the Community Based Sepsis CMS Special Innovation Projects. Ms. Butterfield is responsible for facilitating and managing quality improvement initiatives addressing the National Quality Improvement Priorities for Medicare beneficiaries, as identified by CMS.

Since joining IPRO in July 1998, Ms. Butterfield has coordinated collaborative partnerships with acute care hospitals, home health, Hospice, skilled nursing facility and private physician practices on a cross-setting, multidisciplinary level to facilitate performance improvement initiatives in support of CMS' project objectives.

Ms. Butterfield holds a Bachelor's of Science Degree in Nursing from Russell Sage College, Troy, NY. She received the Certified Case Manager credential from the Commission for Case Manager Certification and is a Certified Professional in Healthcare Quality, through the national Healthcare Quality Certification Board.

Quality Improvement Panel

Anne Myrka, BS Pharm, MAT, Director, Drug Safety, IPRO

Anne Myrka is a practicing licensed pharmacist with 25 years of experience in the states of New York and Vermont who is currently employed by IPRO as Director of Drug Safety. In this role, Ms. Myrka leads the Preventing and Reducing Adverse Drug Events task in NYS along with Special Innovation Projects that focus on reducing opioid related adverse events through a community pharmacy intervention and reducing anticoagulant related adverse events in chronically anticoagulated patients who are undergoing invasive procedures.

Prior to joining IPRO she was a Clinical Instructor at Albany College of Pharmacy and Health Sciences in Albany, NY and Assistant Professor and Chair of the Science and Technology Division at Southern Vermont College in Bennington, VT. Her professional experience includes health care quality improvement, teaching and course design, long term care consulting, hospital, home healthcare and community pharmacy practice and she continues as an adjunct faculty member at Albany College of Pharmacy and is a faculty member of the Institute for Healthcare Improvement. She earned her Bachelors of Science in Pharmacy degree from Albany College of Pharmacy and her Masters of Arts in Teaching Science from The State University of New York at New Paltz.

Steve Stein, MD, Medical Director, Livanta

Dr. Stein is the Chief Medical Director of Livanta's BFCC-QIO program. He provides clinical oversight and leadership, manages the consultant physician panel, and monitors the quality of reviews for Appeals, Quality of Care Complaints, Sanctions, EMTALA, and Utilization Review activities. He is a Fellow of the American College of Emergency Physicians and has served many roles in local and national medical organizations (prior positions include ACEP Council member, President Vermont ACEP, county and state medical society positions, section chief of Emergency Medicine Rutland Regional Medical Center, etc.). He is a graduate of the Massachusetts Institute of Technology and University of Connecticut School of Medicine, has over 20 years' experience as a reviewer in the QIO program, and has practiced EM for over 35 years in University, community, and trauma center settings. He continues to practice Emergency Medicine in a busy regional emergency department.

Jed A. Levine, Executive Vice President, Director of Programs & Services, CaringKind

Jed A. Levine is Executive Vice President and Director of Programs at Caring Kind, The Heart of Alzheimer's Caregiving, formerly known as the Alzheimer's Association, New York City Chapter, where he has been on staff since 1990. He is the author of numerous articles on Alzheimer's and Alzheimer's care and the co-author of a chapter on Hospital Care for Persons with Dementia, and co-author of a chapter on Disaster Preparedness for Persons with Dementia. Mr. Levine holds a Master's degree in Applied Human Development with a specialization in Gerontology and Community Recreation Services from Columbia University's Teachers College. He has post-graduate training in group process from the Center for the Advancement of Group Studies, and is currently pursuing Certification in a psychoanalytic training program at the Center for Human Development.

He has taught at Columbia Mailman School of Public Health and Hunter College, School of the Health Professions. He was appointed by the Governor to the New York State Coordinating Council for Services Related to Alzheimer's and Other Dementias, serves on Senator Gillibrand's Working Group on Aging and was appointed by the Mayor to the Age-Friendly New York Commission at the New York Academy of Medicine.

He is the principal investigator for CaringKind's Palliative Care for Advanced Dementia: Training and Implementation project.

Mr. Levine has presented nationally and internationally on dementia including the Japan-US Conference on Dementia Strategy in Tokyo, Japan.

Anderson Torres, PhD, President and CEO of R.A.I.N. Total Care Inc.

Born in Ponce Puerto Rico and raised in the Bronx, Dr. Torres is currently the President of the Regional Aid for Interim Needs (R.A.I.N.) Total Care, Inc. R.A.I.N. services include: 12 Full-Service Senior Centers, Home Delivered Meals, Home Care Services serving Homebound Persons of all ages, Integrated Care Coordination, Housing, Case Management, Advocacy, Support Groups for the Elderly and their Caregivers, Alzheimer's initiatives, Transportation and Intergenerational programs.

Dr. Torres secured his Masters in Social Work from the Silberman School of Social Work at Hunter College, and his Doctorate in Behavioral Psychology with a focus on environmental design for Latinos and individuals with Alzheimer's. He has been in the field of healthcare for 30

years in mental health, senior care, academia, government, and administration. Dr. Torres serves on the NYS Public Health and Health Planning Council and lectures on the topic of Alzheimer's disease and related disparities. He also Co-founder of the Latino Alzheimer's Coalition of NY, Inc.

Carol Levine, Director, Families and Health Care Project, United Hospital Fund

Carol Levine directs the United Hospital Fund's Families and Health Care Project, which focuses on developing partnerships between health care professionals and family caregivers, especially during transitions in health care settings (www.nextstepincare.org). Before joining the Fund in 1996, she directed the Citizens Commission on AIDS in New York City from 1987 to 1991, and The Orphan Project, which she founded, from 1991 to 1996. As a senior staff associate of The Hastings Center, she edited the Hastings Center Report.

Ms. Levine is the editor of *Always on Call: When Illness Turns Families into Caregivers* (2nd ed., Vanderbilt University Press, 2004); co-editor, with Thomas H. Murray, of *The Cultures of Caregiving: Conflict and Common Ground Among Families, Health Professionals and Policy Makers* (Johns Hopkins University Press, 2004); and editor of *Living in the Land of Limbo: Fiction and Poetry about Family Caregiving* (Vanderbilt University Press, 2014).

In 1993, Ms. Levine was awarded a MacArthur Foundation Fellowship for her work in AIDS policy and ethics. She was named a WebMD Health Hero in 2007.

In 2009, Ms. Levine was named a Purpose Prize fellow, an honor for social entrepreneurs over 60 who are using their experience and passion to take on society's biggest challenges.

In 2016, Ms. Levine was named one of the Top 50 "2016 Influencers in Aging" by Next Avenue, a digital publication dedicated to covering issues for people 50 and older.

Nilsa Gutierrez, MD, MPH, FACP, Chief Medical Officer, Region 2, CMS

Dr. Gutierrez is the Chief Medical Officer (CMO) of the Centers for Medicare & Medicaid Services in Region II, which includes New York State, New Jersey, Puerto Rico and the US Virgin Islands.

She serves in a clinical advisory role to the Medicare, Medicaid, and Children's Health Insurance programs as well as Survey and Certification activities in the Region. In that role, she is responsible for assessing their impact on the twelve million beneficiaries and diverse communities throughout the region, with a focus on quality of care and

access to care and services. In addition, her expertise in Medicare and Medicaid program policy differences in the US Territories has been critical to assessing the underlying disparities and their impact on health and disease in Puerto Rico and the US Virgin Islands. As such, she has authored multiple policy papers submitted to the President's Task Force on Puerto Rico's Status.

As chief medical officer, she is the liaison to the medical community and health professional associations on Medicare program policy, CMS quality initiatives, and the Medicare Quality Payment Program (QPP). She also plays a lead role in Region II HHS interagency activities, provides clinical expertise to the Region II HHS Office of General Counsel and the Office of the Inspector General and has a lead role in the All Hazards Emergency Preparedness and Response activities for CMS Operations within the region. She is the CMS CMO lead on the CMS Zika Health Services Program grant, which is part of a larger HHS award of \$66.1 million to address the Zika virus public health emergency in the Caribbean and continental US. She also serves as co-chair of the Regional Advisory Council Subgroups on Hurricane Irma and Maria response and recovery activities.

Prior to working at CMS, Dr. Gutierrez was director of the New York State AIDS Institute responsible for advising the Governor, state health commissioner and legislature on HIV/AIDS policy and funding. In 1997 she was appointed by President William Jefferson Clinton to serve as a member of the Presidential Advisory Council on HIV/AIDS. She is a graduate of the SUNY at Stony Brook School of Medicine, a primary care internist with a Master of Public Health from Columbia University, and Fellow of the American College of Physicians.

Panel Summation

Clare B. Bradley, MD, MPH, Chief Medical Officer & Senior Vice President, IPRO

Dr. Bradley serves as IPRO's Senior Vice President/Chief Medical Officer. Her responsibilities include leadership of the Health Care Quality Improvement Program and the Managed Care Department. She is also responsible for managing and coordinating the medical operations and policies of the corporation.

Dr. Bradley is the former Commissioner of the Suffolk County Department of Health Services in New York. A graduate of the University of Maryland School of Medicine and Columbia University School of Public Health, Dr. Bradley is an advocate for public health services and tobacco control initiatives.

Dr. Bradley is board certified in Internal Medicine. She is an Associate Professor in the Department of Preventive Medicine in the School of Medicine at the State University of New York, Stony Brook.

CMS Presentation and Q&A

Jeneen Iwugo, MPA, Deputy Director, Quality Improvement and Innovation Group, Center for Clinical Standards & Quality, CMS

Jeneen Iwugo is the Deputy Director of the Quality Improvement & Innovation Group in the Center for Clinical Standards and Quality at the Centers for Medicare & Medicaid Services. With a formal education in Speech Communication and Public Policy, she has concentrated her QIO work in the Beneficiary and Family Centered Care tasks of the Quality Improvement Organization program. Since joining QIIG in 2008, she has served as a subject matter expert, GTL, QIO confidentiality regulation lead, Special Assistant and Division Director. Jeneen led the revision of the QIO regulations to expand eligibility for QIO contracts beyond the previous state based structure. She also led the transition of the 10th Scope of Work QIO case review task into the now separate BFCC task in the QIO 11th Scope of Work.

Prior to her various roles within CCSQ, Jeneen worked in the Center for Medicaid and CHIP Services on Medicaid managed care policy, state plan amendments, demonstrations and waivers. Jeneen has also served as Adjunct Faculty for the Community College of Baltimore County teaching Speech Communication.

