

AGENCY-SPECIFIC PLAN FOR THE NATIONAL QUALITY STRATEGY

Health Resources and Services Administration (HRSA)

Program	Description	NQS Priorities*						Current-Year Activities	Metrics	Future-Year Plans**	Vision/End Goals
		1	2	3	4	5	6				
Center for Integrated Health Solutions Initiative	The HRSA component of this national training and technical assistance center provides specific assistance to community behavioral health providers and HRSA-funded provider groups in developing the bidirectional integration of primary care and behavioral health services, and related workforce development.		✓	★	✓	✓		<ul style="list-style-type: none"> Provide technical assistance through Webinars, meetings, site visits, trainings, resources, and learning collaborative support to the 94 SAMHSA Primary and Behavioral Health Care Integration (PBHCI) grantee community health organizations. Serve as a national training center, distributing educational materials and toolkits that share best practices to an audience of over 35,000 people. 	Currently, quarterly patient health indicators such as BMI and blood pressure are submitted to PBHCI by grantees. In the coming years, a national evaluation of bidirectional integration within community health organizations will be conducted in conjunction with RAND.	<ul style="list-style-type: none"> Increase the number of community health organizations and trained professionals using integrated health delivery approaches (P3, Goal 3). Increase the number of consumers credentialed to provide behavioral health-related practices (P2, Goal 3). Increase the number of health providers trained in the concept of wellness and behavioral health recovery (P5, Goal 3). 	<ul style="list-style-type: none"> Prepare providers to incorporate their integrated approach of behavioral health and primary care into systems of care. Enable provider organizations to share best practices.
Healthy Weight Collaborative	The Healthy Weight Collaborative shares and spreads evidence-based, clinical and community interventions through multisector teams to prevent and treat obesity for children and families. Teams represent primary care, public health, and other relevant sectors.	1	2	3	4	5	6	<ul style="list-style-type: none"> Convene regular learning sessions where teams receive expert and peer support, and hold biannual meetings between collaborative teams and the Virtual Learning Community. Provide technical assistance and training for teams implementing selected evidence-based and promising interventions via peer networking, email, phone, site visits, and monthly data reporting and assessments. 	Each multisector team utilizes the "Breakthrough Series" methodology to determine specific target populations and goals for each program. The Collaborative also tracks traditional clinical measures (e.g., body mass index).	<ul style="list-style-type: none"> Continue tracking the progress of the team and supporting the Virtual Learning Community by sharing best practices (P5, Goal 2). 	<ul style="list-style-type: none"> Decrease percentage of overweight population. Strengthen partnerships between public health, primary care, and community organizations.

* ✓ = Priorities to which the program aligns

★ = Primary priority

** Please see Appendix A on the last page, which includes a table of the six NQS Priorities and Long-Term Goals.

Health Resources and Services Administration (HRSA) (Continued)

Program	Description	NQS Priorities*						Current-Year Activities	Metrics	Future-Year Plans**	Vision/End Goals
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Maternal and Infant Early Childhood Home Visiting Program (MIECHV)	This program supports the implementation of evidence-based home visiting models in at-risk communities by matching parents with trained professionals during or after pregnancy and through their child's first years to age 5. The program improves coordination of home visiting services, identifies and provides comprehensive health services, and integrates children into the continuum of early childhood services.	✓	✓	★			✓	<ul style="list-style-type: none"> • Provide technical assistance for new home visiting programs in program evaluation, developing and adapting data systems, and implementing quality improvement systems. • Meet with at-risk families in their homes to evaluate circumstances and connect them with available resources. • Share best practices and collect data for information sharing and targeted responses to identified needs. • Fund organizations implementing evidence-based home visiting in target communities. 	MIECHV tracks the utilization of evidence-based programs and in-home services found in the Community Resource Survey, Census data, and the Family Baseline Survey. It also monitors risk factors and health indicators periodically.	<ul style="list-style-type: none"> • Within 3 years, funded States must demonstrate improvement in at least four of the following benchmark areas: <ul style="list-style-type: none"> - Improved maternal and newborn health - Reduced child injuries, neglect, abuse, or maltreatment - Improved school readiness and achievement - Reduced crime or domestic violence - Improved family economic self-sufficiency - Improved coordination and referrals for other community resources (P3, Goals 2 and 3) • Increase receipt of appropriate services supporting optimal child and family developmental outcomes (P2, Goal 1). • Decrease gaps and duplication of home visiting services (P6, Goal 2). 	<ul style="list-style-type: none"> • By 2015, increase capacity, quality, and visibility of evidence-based home visiting (HV) programs.

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Health Resources and Services Administration (HRSA) (Continued)

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Medicare Beneficiary Quality Improvement Project (MBQIP)	This 5-year program promotes quality improvement activity within the Medicare Rural Hospital Flexibility (Flex) grant program that targets Medicare beneficiaries served by critical access hospitals (CAHs).	✓	★	✓				<ul style="list-style-type: none"> Provide grants to States with CAHs for financial and operational improvement in health system development. Collaborate with Flex coordinators to finalize and implement work plans. Facilitate Webinars, in-person meetings, and monthly updates for grantees (Flex coordinators) to disseminate information. Support data collection, aggregation, and analysis at the State and national levels to allow CAHs to track their progress and compare with companion programs. 	MBQIP collects CMS Hospital Compare and non-Hospital Compare relevant rural measures to track quality improvement activity. The program plans to phase in additional measures each year starting in 2012. ¹	<ul style="list-style-type: none"> Achieve a CAH participation rate, within quality improvement initiatives, of 75% by FY2013 and 100% by FY2014 for reporting to respective States (P2, Goal 2). 	<ul style="list-style-type: none"> By FY2014, achieve a 100% CAH participation rate in quality improvement and measurement initiatives.
Partners in Care ²	This program focuses on patient engagement in the coordination of care to help reduce the spread of HIV and improve health care outcomes. This program teaches patients self-management practices.		★					<ul style="list-style-type: none"> Present Webinars on coordination of care and patient retention to providers. Facilitate patient group meetings to increase patient engagement and sharing of resources. Support bimonthly data collection of clinical quality measures. 	Partners in Care supports the In+Care campaign ³ and its clinical quality measures (e.g., viral suppression, new patient retention, retention in care, and gaps in care).	<ul style="list-style-type: none"> Increase patient engagement and understanding of coordination of care through various activities (e.g., Webinars, patient group meetings) (P2, Goal 3). Measure impact of increased patient participation and retention on provider performance (P2, Goal 1). 	<ul style="list-style-type: none"> Reduce HIV incidence, increase access to care, optimize health outcomes, and reduce HIV-related health disparities. Continue to increase enrollment and retention of program participants to expand impact of provider performance.

1 For more information, please visit http://www.ruralcenter.org/sites/default/files/MBQIP%20Overview%20for%20Flex%20Coordinators%20Final_05112011.pdf.

2 For more information, please visit <http://incarecampaign.org/index.cfm/77453>.

3 For more information, please visit <http://incarecampaign.org/index.cfm/75089>.

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Patient-Centered Medical Home (PCMH) Initiative	PCMH aims to improve patient experience and outcomes by assisting Federally Qualified Health Centers (FQHCs) in achieving National Committee for Quality Assurance (NCQA) Level 3 recognition. This initiative utilizes a team-based clinical approach to improve maternal and child outcomes through the increased quality and coordination of care in health centers.						★	<ul style="list-style-type: none"> Facilitate the transformation of FQHCs to PCMHs to enable the delivery of advanced primary care services. Provide technical assistance and supplemental funding to FQHCs in setting governance models, regulations, and policies; and in implementing clinical and programmatic changes. Educate programs on how to share their best practices following the “train the trainer” model through educational programs, collaborative Web sites, and support networks. 	PCMH readiness scores are taken for all FQHCs at the time of application and every 6 months thereafter. Health centers are evaluated by NCQA recognition levels based on the degree of their PCMH transformation.	<ul style="list-style-type: none"> By FY2012, 13% of health centers achieve NCQA Level 3 recognition (P6, Goal 1). By FY2013, 25% of FQHCs achieve NCQA Level 3 recognition (P6, Goal 1). 	<ul style="list-style-type: none"> Transform all 500 FQHCs into PCMHs and achieve NCQA Level 3 recognition.
Patient Safety and Clinical Pharmacy Collaborative (PSPC)	PSPC integrates evidence-based clinical pharmacy services into the care and management of high-risk, high-cost, complex patients. The program works with teams of community health care providers to transform their delivery systems to effectively address patient safety and incorporate medication management services.	✓	✓	★			✓	<ul style="list-style-type: none"> Engage 244 participating teams of community health providers by incorporating new methods into health care delivery systems through Webinars, conference calls, and in-person meetings. 	PSPC tracks nine patient safety and medication management measures: diabetes, adverse drug events (ADEs), depression, human immunodeficiency virus (HIV), hypertension, antipsychotics, asthma, leukemia, and anticoagulation.	<ul style="list-style-type: none"> Reach 400 community interdisciplinary teams to transform health care delivery teams (P1, Goal 2). Achieve significant growth in scale for 50 PSPC teams through value purchasing arrangements (P6, Goal 1). 	<ul style="list-style-type: none"> Transform 3,000 communities to have an integrated delivery system that assures optimal health outcomes and patient safety.

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Appendix A. National Quality Strategy Priorities and Long-Term Goals

#	Priority	Long-Term Goals (Recommended by the National Priorities Partnership)
1	Making care safer by reducing harm caused in the delivery of care.	<ol style="list-style-type: none"> 1. Reduce preventable hospital admissions and readmissions. 2. Reduce the incidence of adverse health care-associated conditions. 3. Reduce harm from inappropriate or unnecessary care.
2	Ensuring that each person and family are engaged as partners in their care.	<ol style="list-style-type: none"> 1. Improve patient, family, and caregiver experience of care related to quality, safety, and access across settings. 2. In partnership with patients, families, and caregivers—and using a shared decisionmaking process—develop culturally sensitive and understandable care plans. 3. Enable patients and their families and caregivers to navigate, coordinate, and manage their care appropriately and effectively.
3	Promoting effective communication and coordination of care.	<ol style="list-style-type: none"> 1. Improve the quality of care transitions and communications across care settings. 2. Improve the quality of life for patients with chronic illness and disability by following a current care plan that anticipates and addresses pain and symptom management, psychosocial needs, and functional status. 3. Establish shared accountability and integration of communities and health care systems to improve quality of care and reduce health disparities.
4	Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.	<ol style="list-style-type: none"> 1. Promote cardiovascular health through community interventions that result in improvement of social, economic, and environmental factors. 2. Promote cardiovascular health through interventions that result in adoption of the most important healthy lifestyle behaviors across the lifespan. 3. Promote cardiovascular health through receipt of effective clinical preventive services across the lifespan in clinical and community settings.
5	Working with communities to promote wide use of best practices to enable healthy living.	<ol style="list-style-type: none"> 1. Promote healthy living and well-being through community interventions that result in improvement of social, economic, and environmental factors. 2. Promote healthy living and well-being through interventions that result in adoption of the most important healthy lifestyle behaviors across the lifespan. 3. Promote healthy living and well-being through receipt of effective clinical preventive services across the lifespan in clinical and community settings.
6	Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.	<ol style="list-style-type: none"> 1. Ensure affordable and accessible high-quality health care for people, families, employers, and governments. 2. Support and enable communities to ensure accessible, high-quality care while reducing waste and fraud.