



Mountain-Pacific
Quality Health

2017 Impact Report

IMPACTING HEALTH CARE DELIVERY



IMPACTING HEALTH CARE QUALITY



IMPACTING HEALTH OUTCOMES



IMPACTING HEALTH CARE COSTS



Mountain-Pacific *Quality Health*

LOCAL ROOTS • LOCAL CREDIBILITY • LOCAL SUCCESS

Our Mission: *Partnering within our communities to provide solutions for better health*
Our Vision: *Mountain-Pacific—a recognized leader for driving innovation in health care*

Mountain-Pacific Quality Health is a 501(c)(3) nonprofit corporation that strives to be the “go-to” resource for driving innovation in health care systems in the states and regions we serve. We first began partnering with providers, practitioners and patients in Montana in 1973. We now support the health care communities of Montana, Wyoming, Hawaii, Alaska, the U.S. Pacific Territories of Guam and American Samoa and the Commonwealth of the Northern Mariana Islands.

Under contract with the Centers for Medicare & Medicaid Services (CMS), we are one of 14 Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) in the nation. We partner with health care providers, practitioners, stakeholders and patients on a variety of quality improvement initiatives to achieve better care, better population health and lower health care costs. Our goal is to increase access to high quality health care that is affordable, safe and of value to the patients we serve.

Mountain-Pacific also provides Medicaid utilization and pharmacy review and management services for the Montana Department of Public Health and Human Services. Through our review and authorization process, we strive to ensure each Medicaid client gets his or her needs met in the most appropriate, cost-effective setting, using the most appropriate medical, transportation and community support services, prescription drugs, equipment and supplies.

Clinical best practices and clinical expertise are no longer enough to successfully compel quality improvement and improved outcomes. Clinical quality improvement now requires both clinical and health information technology (HIT) expertise. Our Health Transformation Services (HTS) department is a vehicle for driving data-driven practices into health care settings where both providers and patients can benefit.

Learn more by contacting Colleen Roylance, Mountain-Pacific’s chief operations officer, at croylance@mpqhf.org.

Visit our website at www.mpqhf.org or like us on Facebook.



August 2018

UNNECESSARY READMISSIONS—THE IMPACT ON QUALITY AND COST

Preventable hospital admissions and readmissions are an unnecessary cost to Medicare and puts unnecessary stress on Medicare patients, subjecting them to health risks in the form of healthcare-associated infections, medication errors and loss of function. They can also leave patients and families scrambling to prepare for adequate care and support services once the patient leaves the hospital.

Many preventable hospital admissions and readmissions can be prevented through improved communication and coordination, saving health care dollars and enhancing the patient experience. Mountain-Pacific and its partners work together to improve hospital admission and readmission rates and, in fact, were nationally recognized on several occasions for having the most improved hospital admission and readmission rates in the nation.

Unnecessary admissions and readmissions cost Medicare more than \$15 billion annually.

In 2017, Mountain-Pacific and its partners reduced avoidable 30-day readmissions by 3.19 percent, demonstrating a cost savings to tax payers of \$4.1 million.

Mountain-Pacific ensures Medicare beneficiaries receive cost-effective, quality health care by sharing best practices for facilitating communication between health care partners and providers when transitioning Medicare patients from one care setting to another. Better communication and coordination mean patients are less likely to be readmitted to the hospital because of miscommunication or a lack of support services post discharge. Reducing readmissions saves precious health care dollars, and working with our partners to build networks for sustaining improvement helps set the standard for future patient care.

Montana PBS produced and aired an episode featuring activities conducted in Kalispell to meet the needs of that city's population of superutilizers of health care.



Mountain-Pacific also works with several communities in Montana to address the needs of “superutilizers” of health care. These individuals usually have multiple emergency room visits, hospital admissions, multiple chronic conditions, mental health and/or substance abuse concerns and complex social barriers to care.

The cycle of health care delivery for these patients is often fragmented or does not meet all their needs. Mountain-Pacific works within our communities—at all levels—to wrap services around the patient to improve outcomes, eliminate duplication of services and lower costs that result in emergency room visits and unnecessary readmissions.

USING TECHNOLOGY TO IMPROVE PATIENT OUTCOMES IN RURAL AREAS

Mountain-Pacific has a deep understanding of the many challenges of delivering health care in remote, rural, frontier areas. We see firsthand the burden limited resources place on small, rural practices—particularly when it comes to meeting local health care needs. Project ECHO® (Extension for Community Healthcare Outcomes) provides the means to help frontline clinicians in small, rural areas gain the knowledge and support they need to manage patients with complex conditions. ECHO® links primary care clinicians with specialists through real-time learning made possible through videoconferencing.

To support care transitions in rural and frontier areas, Mountain-Pacific and the University of Wyoming's Center on Aging teamed up to see how Project ECHO would help bridge the gap in health care for our rural and underserved communities. Our goal was to expand capacity and provider knowledge to safely and effectively deliver best-practice care to patients with chronic, common and complex diseases in frontier and underserved areas. We recruited 13 rural and frontier communities for this project.



Results	
Savings from Decrease in Avoidable Hospital Admissions and Readmissions	\$443,219
Relative Improvement Rate (RIR) Admissions/1,000 Medicare Beneficiaries	10.38%
RIR Readmissions/1,000 Medicare Beneficiaries	9.11%
RIR Emergency Department Utilization/1,000 Medicare Beneficiaries	0.01%


The hub-and-spoke model to the right incorporates tele-education approaches to expand capacity and provider knowledge to safely and effectively deliver best-practice care to treat patients with chronic, common and complex diseases in frontier and underserved areas.



IMPROVING HEALTH OUTCOMES FOR PEOPLE WITH DIABETES

According to the American Diabetes Association, approximately 25 percent of Americans over 60 have diabetes. Diabetes and pre-diabetes cost America \$322 billion per year. In fact, one in every three Medicare dollars is spent caring for people with diabetes. Diabetes is the most common cause of blindness, kidney failure and amputations in adults and is a leading cause of heart disease and stroke. Through our contract with the Centers for Medicare & Medicaid Services (CMS), we provide Medicare beneficiaries with free diabetes education to improve clinical outcomes and save health care dollars through better chronic disease management.

The Diabetes Empowerment Education Program (DEEP)[™] is a series of fun, interactive classes that help people with diabetes or those at risk for developing it get the knowledge and skills they need to live healthier lives. The classes are meant to support, not replace, education from a health care provider or a certified diabetes educator. The classes offer supportive, informative and interactive ways to understand the benefits of making healthy lifestyle changes and choices. See what we are hearing from our participants when we ask, “What was your favorite aspect of your DEEP class?”



“The best class was the one with the doctor, nutritionist and pharmacist. I also found out about a local doctor who I subsequently went to see.”

DEEP class attendant

In Wyoming, one participant’s blood sugar was over 250. He now is running around 150 and has changed his diet.

WY DEEP class facilitator

“They listen to me, explain things clearly. I have learned way more than I even thought I would.”

DEEP class attendant

“Hearing experiences of others living with diabetes.”

DEEP class attendant

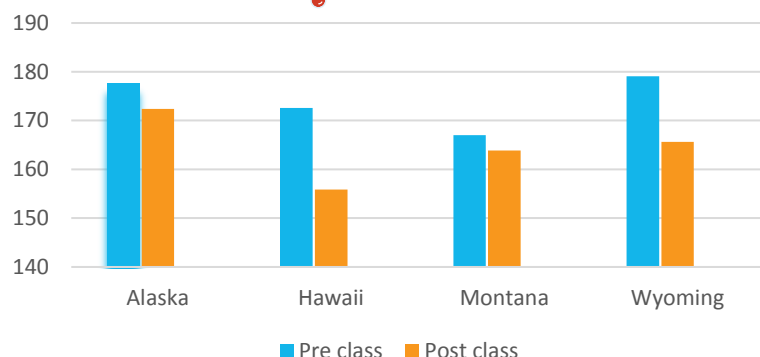
“The material we covered had many answers to questions I didn’t know I had.”

DEEP class attendant

Diabetes is about the numbers. See page 5 to learn how participants improved their numbers.



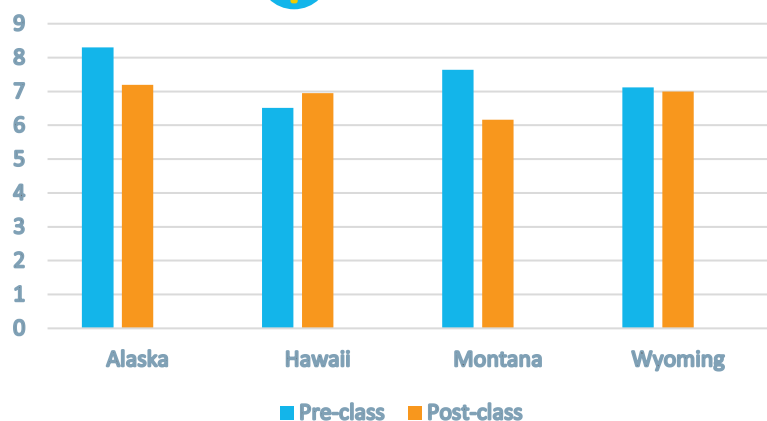
Lipids



Managing diabetic dyslipidemia, is key in preventing cardiovascular disease in people with type 2 diabetes. DEEP classes teach participants how to avoid cardiovascular disease through increased activity, diet and making sure their levels are within an acceptable range. This chart and those that follow contain pre- and post- DEEP class results in aggregate.



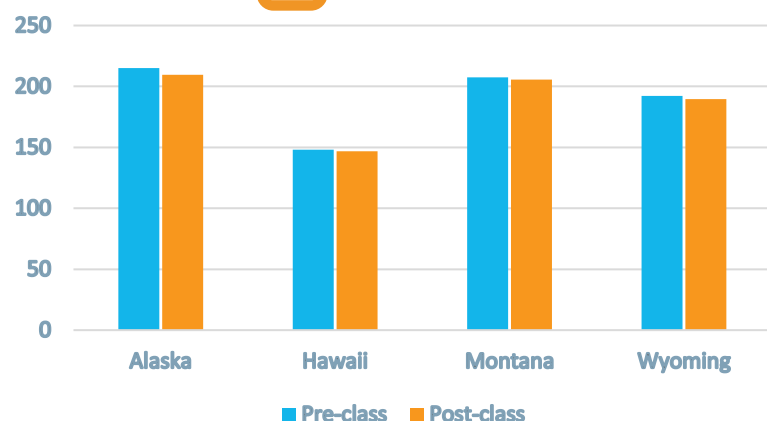
HbA1c



Hemoglobin A1c is a common blood test used to diagnose and assess how well diabetes is managed. The A1c test goes by many other names, including glycated hemoglobin, glycosylated hemoglobin, hemoglobin A1C and HbA1c.



Weight



For people with diabetes, extra weight increases the likelihood of complications. Weight loss through diet and exercise can decrease the possibility of complications and provide a leg up on diabetes control.

DECREASING USE OF ANTIPSYCHOTICS IN NURSING HOMES

More than three million Americans rely on services provided by nursing homes at some point during the year. About 1.4 million Americans reside in our nation's 15,600 nursing homes on any given day. Those individuals, along with their family members, friends and relatives, must be able to count on nursing homes to provide reliable, safe and high-quality care.

Over half of nursing home residents have some form of dementia and associated behavioral and psychological problems, which pose significant challenges for those who care for them. Unfortunately, many nursing homes cite giving residents unnecessary antipsychotics as their main means of dealing with behavioral problems due to their sedating effects, which make it easier to handle dementia patients. In the nation's 15,000+ nursing homes, one in five residents receives antipsychotic drugs they do not need.



Antipsychotic medications are not intended for use in frail and elderly residents with dementia. They are intended for patients with schizophrenia, Tourette's, Huntington's or other psychoses and not for dementia with behavior problems. These medications not only rob the resident of their independence, they also cause confusion, respiratory infections, falls and strokes. In fact, antipsychotic drugs carry a "black box" warning from the U.S. Food and Drug Administration, because they increase dementia patients' risk of death. Antipsychotics were developed to treat severe mental illness, but use of these drugs has become an acceptable alternative to providing one-on-one, compassionate and respectful care.

The Centers for Medicare & Medicaid Services (CMS) has been pushing hard to reduce the use of antipsychotics in nursing home residents with dementia. We, along with other QIN-QIOs throughout the nation, are helping nursing homes rethink the way they work with dementia patients, and instead, reconnect with residents and help restore them to a higher quality of life without use of antipsychotics.

Mountain-Pacific is spreading a Positive Approach to Care (PAC)[™] in Montana nursing homes and learning a lot about its impact on residents with dementia along the way. Our certified PAC trainer provides nursing homes with proven techniques and strategies that enable them to focus on residents' abilities and strengths and to connect with and guide them in a comforting and nonthreatening way.

Ultimately, the goal of the training is to help residents live well with dementia while reducing or eliminating the use of antipsychotic medications. This person-centered, individualized means of addressing behavioral health in nursing homes is right in line with the CMS goal to improve dementia care by using person-centered, individualized interventions that address behavioral health.

If you are interested in learning more on PAC[™], please visit our YouTube channel and tune into [Healthy Living for Life](#).

Most nursing homes working with Mountain-Pacific have seen a drop in antipsychotic medication use from the baseline period in Baseline (Q1-Q4 2013) and remeasurement (Q2 2017-Q1 2018) as seen below.

Alaska saw	an increase of four residents receiving antipsychotic medications.
Hawaii saw	a decrease of 150 residents receiving antipsychotic medications.
Montana saw	a decrease of 130 residents receiving antipsychotic medications.
Wyoming saw	a decrease of 123 residents receiving antipsychotic medications.

Decreasing the use of antipsychotic medications is only one measure organizations like ours work on with nursing homes. The National Nursing Home Quality Care Collaborative's composite score comprises 13 long-stay quality measures that are part of the long-term care setting. The score is calculated by summing the 13 numerators to obtain the composite numerator, summing the 13 denominators to obtain the composite denominator, then dividing the composite numerator by the composite denominator and multiplying by 100. The goal is to achieve a composite rate of 6.0 or less. By July 2018, 45 percent of the recruited target number (RTN) of homes had to achieve a composite score of 6.0 or less. As the table below illustrates, our four-state region exceeded this target.

The percentage of our nursing homes with a quality composite score of ≤ 6.0 as of January 2018

State	Recruited targeted number (RTN) of nursing homes* working with Mountain-Pacific	Percentage of nursing homes achieving composite score of ≤ 6.0
Alaska	13	76.9%
Hawaii	33	103.0%
Montana	60	63.3%
Wyoming	27	59.3%

*RTN (recruited target number) of nursing homes, which is 75% of the nursing homes in each state.

Pages two through 10 were developed under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. Contents presented do not necessarily reflect CMS policy.

IMPACTING CARE FOR MEDICAID MEMBERS

Montana Medicaid and other contracts: Savings in Cost, Quality and Satisfaction

In addition to the work we do under contract with CMS, Mountain-Pacific also holds Medicaid



contracts through the Montana Department of Public Health and Human Services (DPHHS). The services we provide under our Medicaid utilization review and pharmacy contracts vary, from drug utilization review and drug prior authorization to prior authorization of medical procedures and equipment and home and nursing facility screening assessments. We also provide transportation reviews, which ensure Medicaid members can get to their medical appointments using the most appropriate and cost-effective means.

Following the implementation of the DPHHS Medicaid Expansion Program (HELP) in January 2016, we primarily focused on managing the growth of our work while

maintaining the quality of services we provide. Under the expansion program, we anticipated an additional 45,000 to 70,000 lives covered over a four-year period. As of December 2017, enrollment into this program was 89,605 members, resulting in a dramatic increase in our workload.

Additionally, in January 2018, the State of Montana ended its contract with Blue Cross Blue Shield of Montana (BCBSMT) as the third-party administrator for a portion of HELP enrollees. Mountain-Pacific took over the reviews for medical, surgical, out-of-state hospital admissions and durable medical equipment (DME) for this population.

Home and Community Services (HaCS)—The HaCS contract is our largest Medicaid contract and includes six programs (Nursing Home Review related to Pre-Admission Screening, Continued Stay and Level of Care, Home Health, Personal Assistance Services and Community First Choice). Our nurses and social workers conduct reviews in person and on the telephone to assess the following:

- Level of care needs for people requesting home, community-based or nursing facility services
- Mental illness or intellectual disability for people entering a long-term care facility
- Personal assistance needs for elderly and disabled members with the goal of helping them remain in their homes rather than receiving care in an institutional setting

In FY 2018, we project completion of more than 30,500 assessments—a four percent increase from 2017.

Services under the Medicaid Utilization Program are funded in whole or in part under a contract with the Montana Department of Public Health and Human Services. The statements herein do not necessarily reflect the opinion of the Department.

Transportation Contract—We project Transportation staff will process more than 143,500 requests during FY 2018. This represents six percent more than in 2017. We estimate a cost avoidance of more than \$2.0 million.

Utilization Review (UR) Contract—Analysis of the volume of reviews received for out-of-state hospital admissions, medical and surgical services, durable medical equipment and private duty nursing care since the implementation of the HELP Act in 2016 and the addition of work previously performed by BCBSMT has shown steady and sustained growth in monthly reviews. Through data analysis and in consultation with Montana DPHHS staff, we have stabilized the volume by eliminating review of services that are no longer cost effective. For FY 2018, we are on pace to review approximately 4,700 requests and estimate a cost avoidance of approximately \$3.5 million.

URAC—In 2013, we earned our initial Health Utilization Management Accreditation from URAC, a leader in the accreditation of health and managed care organizations. Our accreditation was due to expire in December 2016. In October 2016, URAC completed comprehensive desktop and onsite audits of Mountain-Pacific's Medicaid and core programs. We achieved a perfect overall score of 100 percent to pass the audit. Effective December 1, 2016 we were reaccredited for an additional three years.

Pharmacy Programs Overview—We currently have 11 registered pharmacists and two certified pharmacy technicians on staff to support our pharmacy programs.

Montana Medicaid Drug Prior Authorization (PA)

In FY 2017 (October 1, 2016 – September 30, 2017), the call center processed more than 66,000 drug PAs. In the process, we documented **\$29 million in annualized cost savings** for the Montana DPHHS. Drug PA program activities **yielded a return on investment (ROI) of \$27 for every contract dollar spent.**

Montana Medicaid Drug Utilization Review (DUR)

Pharmacy case management staff performed more than 3,000 clinical interventions during FY 2017 (October 1, 2016 – September 30, 2017) and documented **\$23 million in annualized cost savings. The ROI comes out to \$19 to every dollar spent.**

Foster care children account for only three percent of children covered by Medicaid. However, according to a 16-state Medicaid pharmacy claims study, atypical antipsychotics are prescribed for children in foster care at almost nine times the rate of non-foster care children. Atypical antipsychotics may have significant side effects. Therefore, routine monitoring is critical to reduce the risk of metabolic side effects, movement disorders, diabetes, cardiovascular disease and joint problems.

Our DUR staff help oversee the use of psychotropic medication among these children. For example, **we have been successful in decreasing the percentage of children without appropriate lab monitoring from 75 percent of all children in the program to 22 percent of all children. Over this same period, our staff has also been successful in getting dose optimizations (typically reductions or discontinuations) for 34 percent of the foster children in the program.**

Hepatitis C drug therapy management programs have steadily grown. We now contract with the Montana Department of Corrections to help them manage their Hepatitis C inmate population.

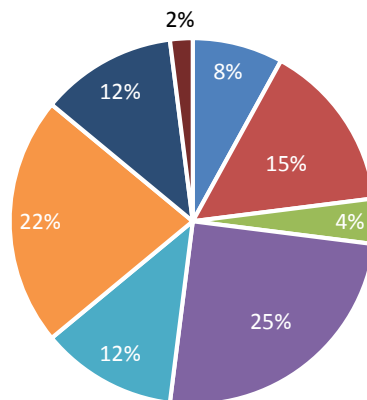
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HEALTH TRANSFORMATION SERVICES (HTS)

Our **Health Transformation Services (HTS)** department is a vehicle for directing data-driven practices into health care settings that benefit providers and patients alike. Clinical best practices and clinical expertise are no longer enough to successfully compel quality improvement and improved outcomes. Clinical quality improvement now requires both clinical and health information technology (HIT) expertise.

HTS staff uses their HIT expertise in tandem with the clinical quality improvement expertise of QIN-QIO staff to expand our services, grow our presence (especially in Montana and Wyoming) and achieve one of the department's critical goals: become self-sustaining.

- Misc. Consulting
- WY Health Dept.
- HTS Fixed Fee
- DPHHS PCMH
- Indian Health Services
- CMS/QIO
- SRA
- Indirect



HTS FY2017 Actual Revenue	
Indian Health Service (IHS)	\$121,243
CMS/QIO	\$220,075
Benefis (MT Health Care System)	\$23,336
Indirect Cost Pool	\$21,597
Montana DPHHS	\$248,000
Wyoming Department of Health	\$149,974
HTS ConsultingSRA*	\$222,067
Total	\$1,006,292

*Security risk assessment

Actual Revenue:	\$1,006,292
Actual Expenses:	\$953,614
Variance:	\$52,678

FY2017 Projected Funding Sources

Electronically Enabled Clinical Quality Improvement (eCQI)

eCQI is an approach our staff embraced, as we strive to meet the need of rural practitioners. eCQI requires a combination of expertise in clinical best practices, quality improvement, data analytics, informatics and the technical aspects of electronic health records (EHRs). Small clinics and hospitals cannot afford to employ and support all this needed expertise. ***We are able to fill this gap in resources.***

Our eCQI approach and the toolkit we developed are built on the premise that we need to optimize and leverage HIT and standardize electronic data to achieve measurable improvement in quality of care that allows for sharing of clinical best practices. Technical assistance focuses on incorporating the data and functionality of the facility's EHR into quality improvement projects. The approach works regardless the topic or condition.

eCQI has become a standard approach to quality improvement for many different HTS contracts.

Through the current Montana DPHHS contract over the last year, our contract is to utilize the HIT and eCQI expertise of our HTS staff and the clinical workflow/best practices expertise of the Montana DPHHS to provide technical assistance and education to clinics throughout Montana to help improve patient outcomes, reduce health care costs, improve patient experience of care and increase revenue/improve efficiency for participating clinics. Following are the eCQI project results so far from the FY 2018 contract:

Table 1 – eCQI Project Results in Montana

DN (Diabetes), HTN (Hypertension)

Improvement Measure	Comments
DM Foot Exams/CMS 123	Clinic 1 – Improved 52% - complete Clinic 2 – Improved 38% - complete
DM Eye Exams/CMS 131	Clinic 1 – Improved 21% - complete Clinic 2 – Improved 44% - complete
DM Urine/Protein Screening/CMS 134	Improved 78% - complete
Closing the Referral Loop/CMS 50 (care coordination)	Clinic 1 – Improved 48% - complete Clinic 2 – Improved 73% - complete
HTN Patient Education	Clinic 1 – Improved 20% - complete Clinic 2 – Improved 62% - complete
HTN Patient Follow-Up Appointments	Improved 10% - complete
Clinical Depressions/CMS 2	Clinic 1 – Improved 99% - complete Clinic 2 – Improved 19% - complete
Blood Pressure Cuff Loaner Program	Complete - implemented
Cognitive Assessments/CMS 149	Clinic 1 – Improved 58% - complete
HTN Blood Pressure Control	Clinic 1 – Improved 35% - complete Clinic 2 – Improved 8% - in process
Breast Cancer Screening/CMS 125	Clinic 1 – Improved 29% - in process Clinic 2 – Improved 63% - in process
Colon Cancer Screening/CMS 130	Clinic 1 – Improved 45% - in process Clinic 2 – Improved 53% - in process Clinic 3 – Improved 40% - in process
Cervical Cancer Screening/CMS 124	Clinic 1 – Improved 55% - in process Clinic 2 – Improved 39% - in process
Smoking Cessation – Using behavioral health integration	Clinic 1 – Improved 15% - in process
Care Plans Established for DM Patients	Clinic 1 – Improved 26% - in process
Implementation of DEEP Classes – Using existing community resources	Clinic 1 – 10 high-risk DM patients attended classes so far Clinic 2 – In initial stages
Utilization of County Health Department Healthcare Navigators to Improve Colon Cancer Screening	Clinic 1 – Establishing pilot for statewide implementation

In Montana, we are also using our eCQI quality improvement methodology, along with our designation as a Regional Health Improvement Collaborative (RHIC), to help hospitals implement antimicrobial stewardship programs and the effective policies and interventions required by the Centers for Disease Control and Prevention (CDC) Core Elements of Antibiotic Stewardship. We are working with the Montana Antibiotic Stewardship (ABS) Collaborative to develop a statewide antimicrobial stewardship implementation plan and to provide technical assistance to hospitals as needed. The stakeholders in the Montana ABS Collaborative include:

- Mountain-Pacific – HTS, QIN-QIO program and Infection Control Assessment and Response (ICAR) programs
- Montana Hospital Association – Hospital Improvement Innovation Network (HIIN) and FLEX and STRIVE Programs
- Montana Department of Public Health and Human Services
- University of Montana Skaggs School of Pharmacy
- Montana Office of Rural Health

Following are the highlights of the Montana ABS Collaborative:

- Montana ABS Collaborative mission:
 - Combine and utilize the necessary resources, expertise, skills and staff from the participating programs to create and implement a statewide ABS strategy.
 - Focus on aligning and streamlining strategy, services, education and hands-on technical assistance to eliminate duplication of effort, reduce costs and to deliver efficient, effective and high-value-added ABS services to the hospitals and clinics in Montana
- Montana ABS Collaborative Goal:
 - Implement the seven (four for outpatient) core elements, recommended by the CDC, which represent an ABS program in 85% of the recruited hospitals and clinics in Montana by the end of 2018
- Montana ABS Collaborative Activities (from Feb 2017 – May 2018):
 - Recruited 50 inpatient facilities
 - Recruited 85 outpatient facilities
 - Established baseline data for core elements and *Clostridium difficile* infection rate
 - Created Montana ABS resource webpage, consolidating ABS resources
 - Presented nine webinars with 385 participants
 - Created Montana ABS blog, which has 107 subscribers and 27 blog posts
 - Facilitated three in-person workshops with 130 attendees
 - Created new contracts and collaborative ABS deliverables for FY 2018
 - Montana ABS Collaborative members met 11 times
- Montana ABS Collaborative's 2017 Accomplishments (from Feb 2017 – December 2017):
 - 73% of recruited outpatient facilities implemented all four core elements
 - 32% of recruited inpatient facilities implemented all seven core elements
 - Inpatient facilities have shown improvement on the following core elements
 - Leadership
 - Accountability
 - Action
 - Tracking
 - Reporting

Educational Outreach to Drive Quality Reporting

As part of our QIN-QIO contract, Mountain-Pacific is expected to facilitate and support quality data reporting, as physician practices, hospitals, ambulatory surgical centers and critical access hospitals work to improve their quality and efficiency of care. We provide outreach and education, independently and in partnership with other stakeholders, about CMS hospital and physician value-based payment programs, quality reporting programs and other quality incentive payment programs.

The learning forum measure, reported previously, has been discontinued. The current measure:

"Percent of customers referred to QIN-QIOs by Quality Payment Program Service Center that are contacted by the QIN-QIO within one business day of receiving the referral."

The July 2017 target was to have 95 percent of the customers referred to QIN-QIOs by the Quality Payment Program Service Center contacted by the QIN-QIO within one business day of receiving the referral.

Mountain-Pacific achieved 100% for all states.*

To bolster our current quality reporting activities and to further support rural providers in using data to drive quality, we partnered with the Network for Regional Healthcare Improvement (NRHI) and other quality improvement agencies to write for more CMS funding, which we received.

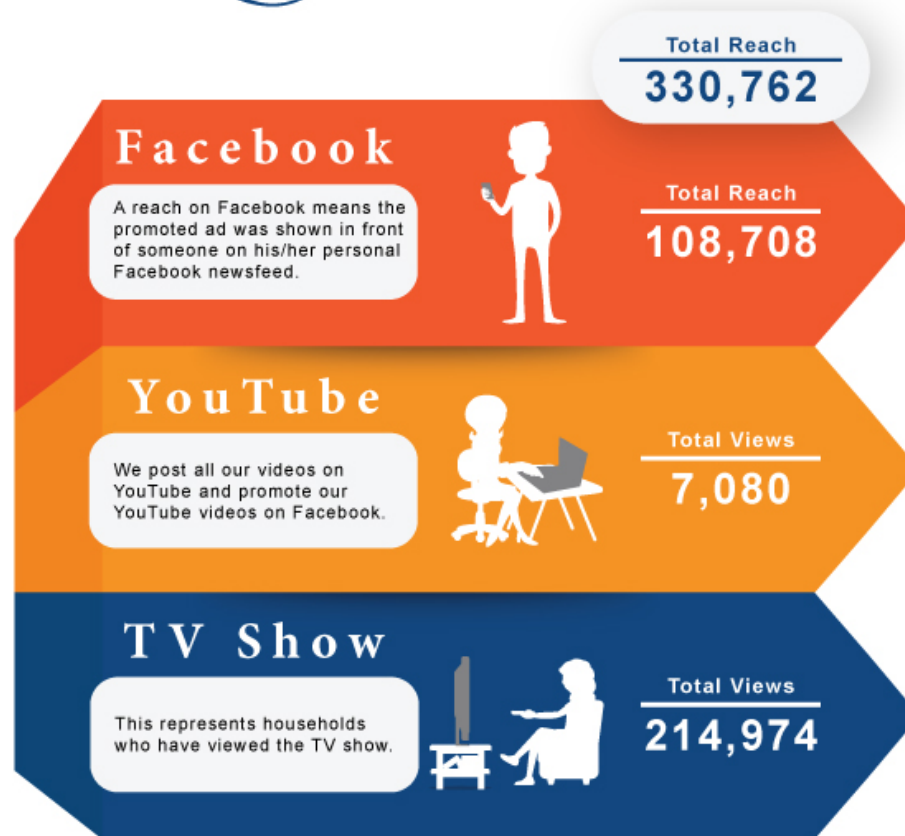
This contract allows us to provide customized technical assistance for rural and/or underserved, small or individual physician practices across our region, as they navigate the value-based payment changes associated with the Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act (MACRA).

*September 20, 2016 - July 31, 2017

HEALTHY LIVING FOR LIFE

March 2018 marks the second season of *Healthy Living for Life*. This weekly series, airing Saturdays and Sundays in Montana and northern Wyoming, is produced, written, hosted and sponsored by Mountain-Pacific. The premise of the show centers on helping seniors and their caregivers find ways to become more engaged in their health care and providing information on what they can do to live longer, healthier lives. While our main demographics are seniors and their caregivers, *Healthy Living for Life's*

wide range of topics appeal to a broader audience.



Numbers based on data from 4/1/2017 to 7/1/2018

While *Healthy Living's* broadcast area reaches Montana and northern Wyoming, our [Facebook page](#) lists topics and guests, helping "blast" our program to our entire four-state region and beyond.

In May 2018, Mountain-Pacific was chosen from over 12,000 entries from all 50 states and five continents to receive a Telly Award for *Healthy Living for Life*. Telly Awards honor excellence in video and television. This is the 39th year of the Telly Awards program and the

third Telly Award for Mountain-Pacific.

Catch all *Healthy Living for Life* episodes on our [YouTube channel](#).

We want to thank our many partners for their devotion to providing optimum patient care. We would not have achieved the impact we have seen in our region had it not been for the dedicated contributions of our stakeholders, our patients and our clinical and provider partners.

Visit us at
www.mpqhf.org

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