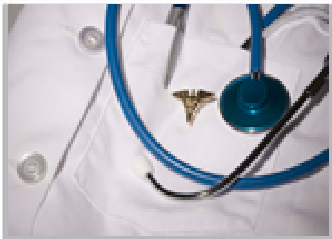
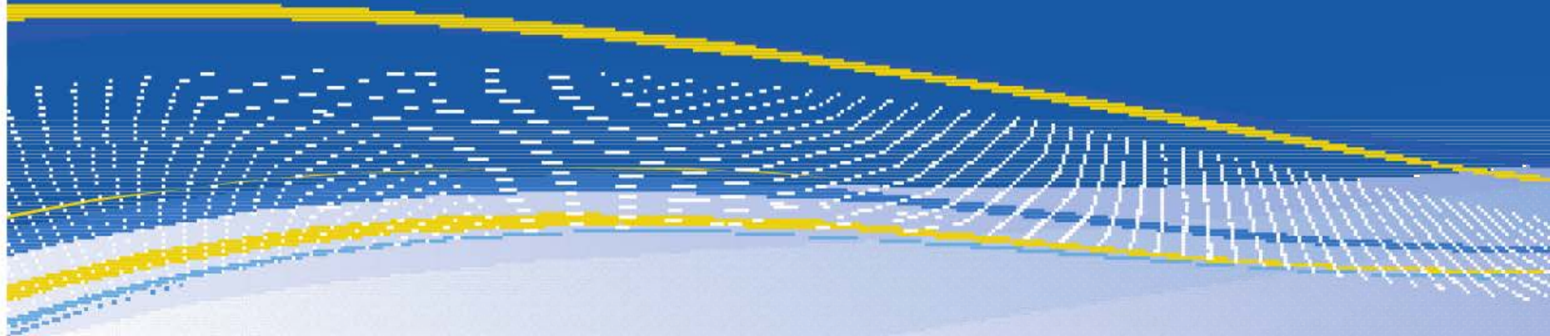
Creating a Culture of Quality: Pursuing Excellence in Care Transitions; Enhancing Safety in Kidney Patient Care



Patrick Conway, M.D., MSc
CMS Chief Medical Officer and
Director, Center for Clinical Standards and Quality

September 12, 2012



Objectives

- Outline methods to transform and improve patient quality and safety while delivering high value health care
- Discuss CMS efforts related to quality end stage renal disease (ESRD) within the ESRD Networks and Quality Incentive Program

Size and Scope of CMS Responsibilities

- CMS is the largest purchaser of health care in the world.
- Combined, Medicare and Medicaid pay approximately one-third of national health expenditures (approx $800B.
- CMS programs provides health care coverage to roughly 105 million beneficiaries in Medicare, Medicaid and CHIP; or roughly 1 in every 3 Americans.
- The Medicare program alone pays out over $1.5 billion in benefit payments per day.
- CMS answers about 75 million inquiries annually.
- Millions of consumers will receive health care coverage through new health insurance programs authorized in the Affordable Care Act.

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Our Aims

Better Health for the Population

Better Care for Individuals

Lower Cost Through Improvement

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CCSQ Vision

- To optimize health outcomes by leading clinical quality improvement and health system transformation

CCSQ Logo

SPARKING INNOVATION
IGNITING ACTION
BETTER CARE, BETTER HEALTH, REDUCED COSTS

CCSQ Mission Statement

- We serve CMS, HHS, and the public as a trusted partner with steadfast focus on improving outcomes, beneficiary experience of care, and population health and reducing health care costs through improvement. We will:

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CCSQ Mission Statement

We will:

- Lead quality measurement alignment, prioritization, and implementation and the development of new innovative measures
- Guide quality improvement across the nation and foster learning networks that generate results
- Lead an evidence based culture to inform coverage policy and incent the continuous development of better evidence
- Establish clear and effective clinical standards
- Systematically link quality to payment
- Collaborate across CMS, HHS, and with external stakeholders
- Listen to the voices of beneficiaries and patients as well as those who provide health care

Be a model of effective business operations, customer support, and innovative information systems that excel in making meaningful information available.

We develop individuals, create high functioning teams, foster pride and joy in work at all levels, continuously learn, and strive to improve.

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Desired Approach and Culture

- Seek input and actively listen
- Collaboration and partnership with stakeholders outside CMS
- Responsive
- Learn from others and foster learning networks
- Catalyst for health system improvement
- Strategic vision, coupled with execution
- Relentless focus on what is best for patients

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Center for Clinical Standards and Quality Levers for Safety, Quality & Value

- **Over 425 federal FTE's, $1.5 billion in budget, and approximately 10K contractors focused on improving quality across the nation**
- ***Contemporary Quality Improvement:*** **Quality Improvement Organizations**
- ***Quality Measurement and Public Reporting:*** **Hospital Inpatient Quality Reporting Program**
- ***Incentives:*** **Hospital Value Based Purchasing, ESRD, physician value modifier**
- ***Regulation:*** **Conditions of Participation (Hospitals, 15 other provider types) and** ***Survey and Certification***
- ***Coverage Decisions*****: Coverage with evidence development, coverage for Preventative Services**

Examples of Recent Work

- Revised hospital conditions of participation, estimated savings >$1B per year and improved quality and safety standards
- New quality improvement organization funding directed toward learning networks, care transitions, safety, and patient/family engagement
- Aligning quality measures across programs and selecting parsimonious sets of measures
- Launched value-based purchasing programs for ESRD and hospital and working on other settings, including physician
- Coverage: FDA-CMS parallel review and coverage to support quality and evidence development

National Quality Strategy promotes better health, better healthcare, and lower costs

Report to Congress

National Strategy for Quality Improvement in Health Care

March 2011

Six priorities:

- Making care safer by reducing harm caused in the delivery of care.
- Ensuring that each person and family are engaged as partners in their care.
- Promoting effective communication and coordination of care.
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
- Working with communities to promote wide use of best practices to enable healthy living.
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

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CCSQ has a wide variety of tools to achieve the three-part aim of the National Quality Strategy

CCSQ tool kit

- National coverage determinations
- Setting clinical standard for providers
- Survey and certification
- Technical assistance for quality improvement
- Public reporting of providers' quality performance
- Value-based purchasing

These tools allow CCSQ to define the kind of care CMS pays for and to ensure it furthers the national quality strategy

CMS has a variety of quality reporting and performance programs, many led by CCSQ

Hospital Quality	Physician Quality Reporting	PAC and Other Setting Quality Reporting	Payment Model Reporting	“Population” Quality Reporting
•Medicare and Medicaid EHR Incentive Program •PPS-Exempt Cancer Hospitals •Inpatient Psychiatric Facilities •Inpatient Quality Reporting •HAC payment reduction program •Readmission reduction program •Outpatient Quality Reporting •Ambulatory Surgical Centers	•Medicare and Medicaid EHR Incentive Program •PQRS •eRx quality reporting	•Inpatient Rehabilitation Facility •Nursing Home Compare Measures •LTCH Quality Reporting •ESRD QIP •Hospice Quality Reporting •Home Health Quality Reporting	•Medicare Shared Savings Program •Hospital Value-based Purchasing •Physician Feedback/Value-based Modifier*	•Medicaid Adult Quality Reporting* •CHIPRA Quality Reporting* •Health Insurance Exchange Quality Reporting* •Medicare Part C* •Medicare Part D*

* **Denotes that the program did not meet the statutory inclusion criteria for pre-rulemaking, but was included to foster alignment of program measures.**

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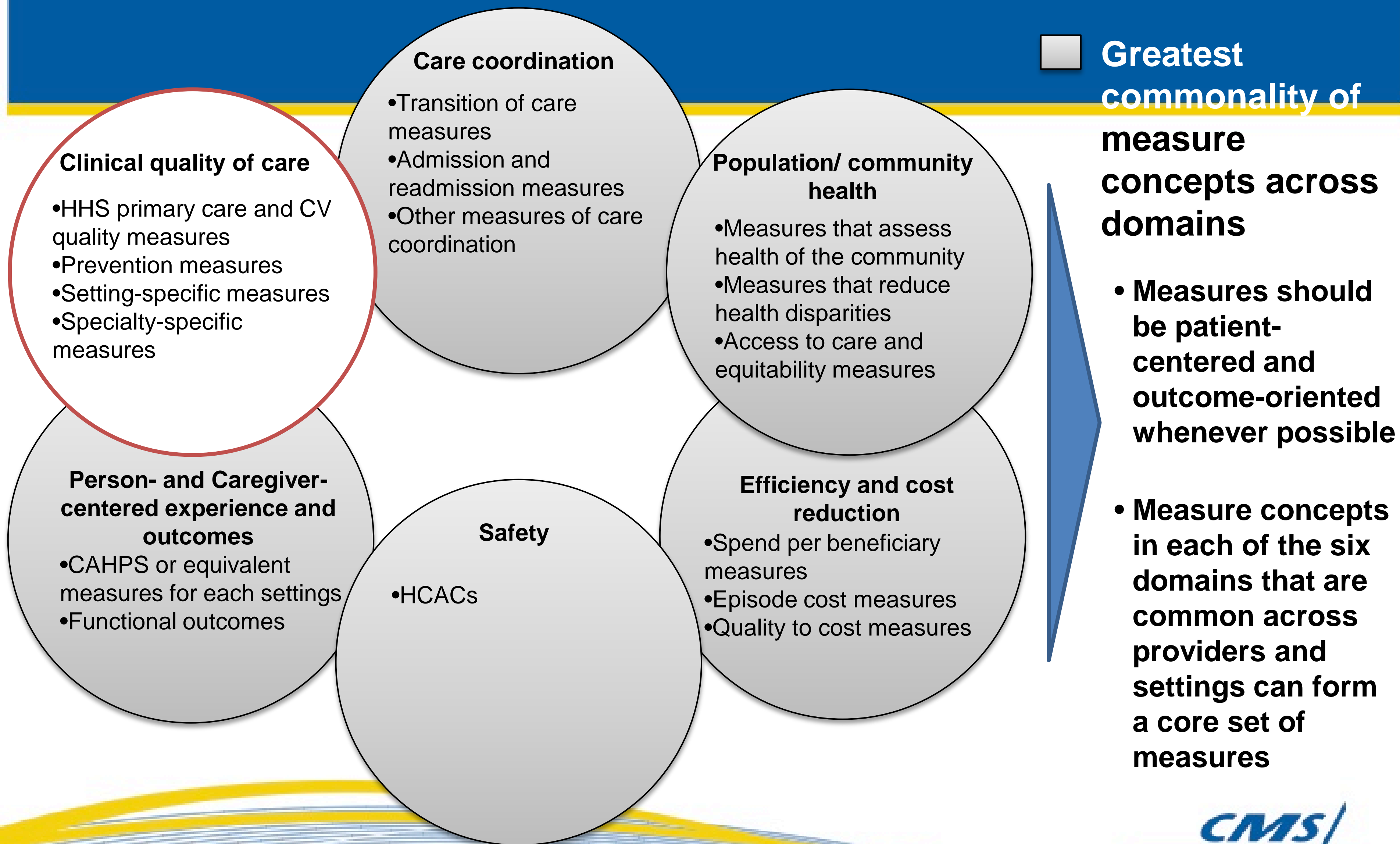
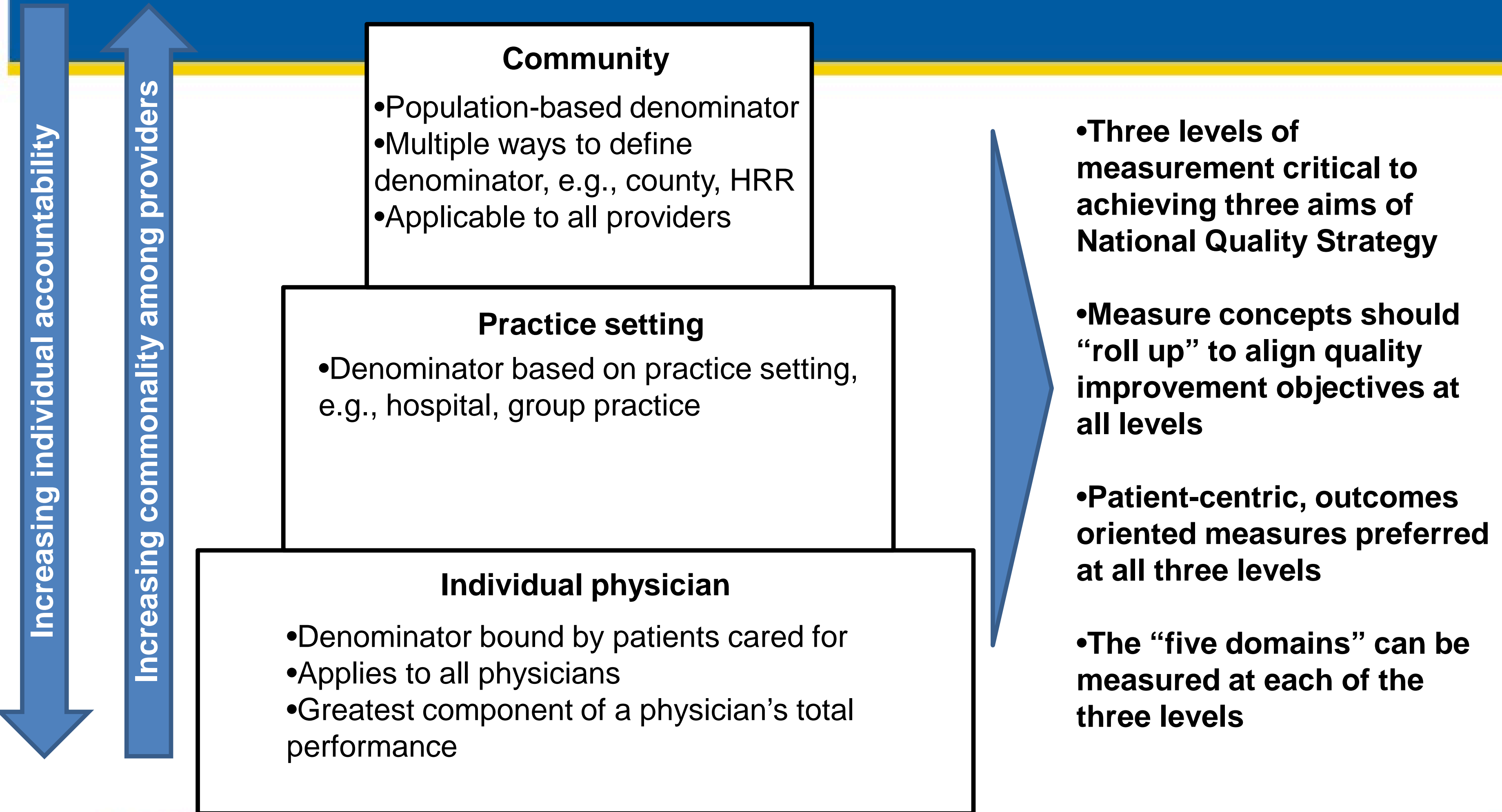
CCSQ framework for measurement maps to the six national priorities



- Measures should be patient-centered and outcome-oriented whenever possible
- Measure concepts in each of the six domains that are common across providers and settings can form a core set of measures

Quality can be measured and improved at multiple levels



- **Three levels of measurement critical to achieving three aims of National Quality Strategy**
- **Measure concepts should "roll up" to align quality improvement objectives at all levels**
- **Patient-centric, outcomes oriented measures preferred at all three levels**
- **The "five domains" can be measured at each of the three levels**

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CMS Vision for Quality Measurement

- Align measures with the National Quality Strategy and Six Measure Domains
- Implement measures that fill critical gaps within the 6 domains
- Align measures across programs whenever appropriate
- Focus on patient centered outcome measures
- Parsimonious sets of measures; core sets of measures
- Removal of measures that are no longer appropriate (e.g., topped out)

How do we make quality better?

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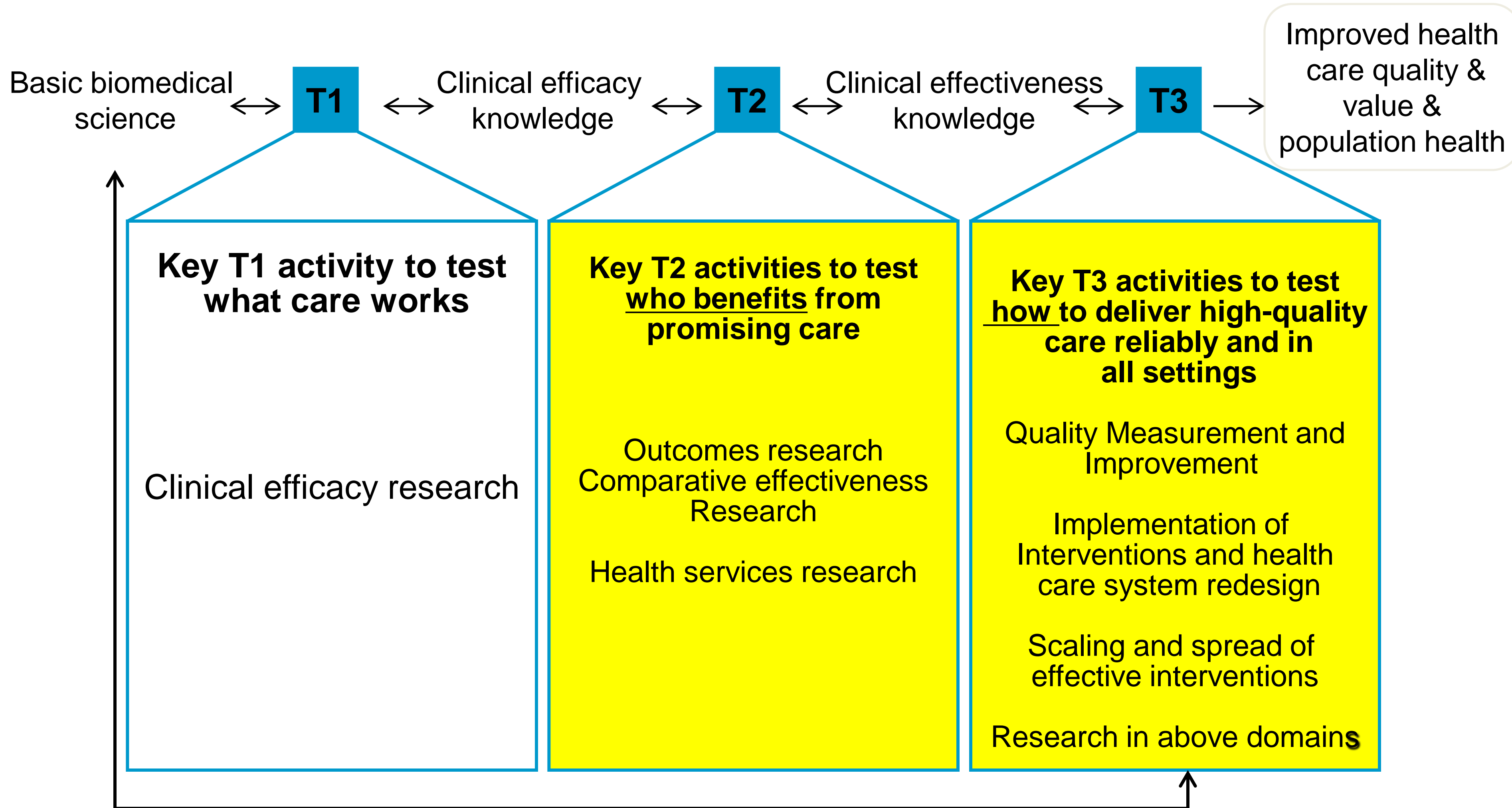
How Will Change Actually Happen?

- There is no “silver bullet”
- We must apply many incentives
- We must show successful alternatives
- We must offer intensive supports
  - Help providers with the painstaking work of improvement
- We must learn how to scale and spread successful interventions

The "3T's" Road Map to Transforming U.S. Health Care



Source: JAMA, May 21, 2008: D. Dougherty and P.H. Conway, pp. 2319-2321. The "3T's Roadmap to Transform U.S. Health Care: The 'How' of High-Quality Care."

Transformation of Health Care at the Front Line

- At least six components
  - Quality measurement
  - Aligned payment incentives
  - Comparative effectiveness and evidence available
  - Health information technology
  - Quality improvement collaboratives and learning networks
  - Training of clinicians and multi-disciplinary teams

Source: P.H. Conway and Clancy C. Transformation of Health Care at the Front Line. JAMA 2009 Feb 18; 301(7): 763-5

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ESRD Networks and the Quality Incentive Program A Framework for Quality Outcomes

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Aligned for Action – For Patient Safety

HAI/HAC Learning and Action Networks and Hands on Technical Assistance

HAI/HAC Hospital Inpatient Quality Reporting Assistance

HAI/HAC Hospital Value Based Purchasing Assistance

Partner Benefits

Active Learning and Improvement

Reduce patient harm

Shaping system requirements with partners (e.g. NHSN development with CDC)

High Performance leading to Incentive Payments

Quality Improvement Organizations

Sharing Knowledge. Improving Health Care.

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Poised to Achieve Success Across Multiple Areas of the Care Transitions

Technical Assistance with Completion of a Quality Application for Community Based Organization Work (3026)

Care Transitions and Reduction in Readmission Community Formation, Data Analysis, Technical Assistance and Coaching

Partner Benefits

Active Learning and Teaching

Reduction in Readmissions

Connecting with Community Partners

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
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QUALITY IMPROVEMENT AND TECHNICAL ASSISTANCE

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Background of the ESRD Network Program

- ESRD Network SOW has been operating under the same general provisions since 2003 and requires redesign. Several events will drive the redesign
  - Medicare Improvements for Patients and Providers Act (MIPPA) July 15, 2008
  - Patient Protection and Affordable Care Act (ACA) March 23, 2010
  - CMS Strategic Areas of Focus 2010 – The “Three Part Aim”
  - Partnership for Patients Campaign and HHS HAI Action Plan
  - Support the HHS Disparities Reduction Action Plan

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Approach to Writing the SOW Redesign Contract

- Employed a Collaborative Multi-Disciplinary Approach to Create a New Baseline for ESRD Network Program
  - Design process representation included
    - Patients
    - Advocacy Groups
    - ESRD Networks
    - CMS ESRD COTRs/GTLs
    - Nephrologists
    - DQIPCAC Staff
    - CM Staff
    - ESRD Network Forum
    - CMCS Staff Survey and Certification
    - Centers for Disease Control & Prevention
    - Health Resources and Services Administration
    - National Institutes of Health

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Maximizing Impact

- For success, the ESRD Networks will lead transformation by…
  - Convening, organizing, and motivating
  - Leveraging technology
  - Serving as a partner
  - Securing commitments
  - Achieving and measuring changes
  - Disseminating and spreading best practices
  - Participating in CMS national framework

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ESRD NW Strategic AIMS and Drivers

Strategic Aims

"What will be done"

AIM 1: Better Care for the Individual through Beneficiary and Family-Centered Care

- Beneficiary and family engagement
- Patient Experience of Care
- Promote Appropriate Access to Outpatient Dialysis Care
- Vascular Access Management
- Patient Safety: Reduction of Healthcare Acquired Infections (HAIs)

AIM 2: Better Health for the ESRD Population

Community Focused Learning and Action Networks/Innovation Pilot Projects

- Increasing Immunization Rates
- Transplant Coordination with a Focus on Reduction of Disparities
- Cardiac Health
- Care Coordination
- Exploring Treatment Modalities
- Quality of Life
- Hospitalization

AIM 3: Lower Costs of ESRD Care through Improvement of Care

- Support of the ESRD QIP for Performance Improvement
- Support facility data submission

Other Rapid Cycle Projects

- **Hospitalization in ESRD Patient**

Drivers of Change

"How the work will be done"

Learning and Action Networks

- Breakthrough Collaboratives
- Patient Engagement and Stories
- Campaigns
- Technical Assistance
- Learning Laboratories

Focused Technical Assistance

- On-site Visits
- Intensive Consultation
- Distribution of Resources

Care Reinvention through Innovation Spread

- Identification of stakeholders
- Spread Strategies
- Multi-media management

Strategic Aims -“What will be done”

AIM 1: Better Care for the Individual through Beneficiary and Family-Centered Care

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Strategic Aims -"What will be done"

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- **Strategic Aims -“What will be done”**

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- **Support of the ESRD QIP for Performance Improvement**
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- **Other Rapid Cycle Projects**

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VALUE-BASED PURCHASING

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Purpose statement for Value-Based Purchasing

Value-based purchasing is a tool that allows CMS to link the National Quality Strategy, and the work of ESRD community with payments at a national scale. It is an important driver in revamping how services are paid for, moving increasingly toward rewarding providers and health systems that deliver better outcomes in health and health care at lower cost to the beneficiaries and communities they serve.

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Value Based Purchasing Cycle

Measure development and selection

Data collection

Data analysis and validation

Incentive calculation and disbursement

Monitoring and evaluation of process, measures, and quality improvement

- Supportive policy and rule-making
- Integrated IT infrastructure
- Seamless communication with providers
- Public engagement and input
- Support of quality improvement
- Person-centeredness

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Background on the Payment Year 2012 ESRD QIP

- **Section 153(c) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) mandates the establishment of a QIP, which requires CMS to:**
  - Assess the quality of dialysis care by selecting quality measures, establishing performance standards and a performance period, and evaluating performance with respect to the standards.
  - Starting January 1, 2012, apply payment reductions of up to 2% for providers that do not meet standards (*based on scoring methodology published in the ESRD QIP Final Rule on January 5, 2011*).
  - Publicly report provider performance through a website and provide a Performance Score Certificate for each facility to post in their patient area.
- **The ESRD QIP is intended to complement the Prospective Payment System (PPS) by establishing a financial incentive for providing high-quality dialysis care.**

2012 QIP Results

- For the PY 2012 ESRD QIP, 4,939 facilities received a Total Performance Score. Of these facilities:
  - 69.1 percent will receive no payment reduction as a result of meeting or exceeding the performance expectations.
  - The payment reductions for the remaining facilities are as follows:
    - 16.6 percent will receive a 0.5 percent reduction
    - 6.0 percent will receive a 1.0 percent reduction
    - 7.7 percent will receive a 1.5 percent reduction
    - 0.6 percent will receive a 2.0 percent reduction

PY 2014: Overview

- **The PY 2014 Final Rule broadens the scope of the ESRD QIP measures:**
  - Total of three clinical measures:
    - **Addition of one new clinical measure**
    - Clinical measures comprise 90% of the Total Performance Score
  - Total of three reporting measures:
    - **All reporting measures are new**
    - Reporting measures comprise 10% of the Total Performance Score
- **Scoring on clinical measures is based upon a facility's achievement or improvement on a measure**
- **The facility receives the higher of its achievement score or improvement score for each clinical measure**

PY 2014: Three Clinical Measures: Summary

- **Continued from PY 2013:**
  - Anemia Management
    - Assess percentage of patients with hemoglobin greater than 12g/dL
    - Lower percentage indicates better care
  - Hemodialysis Adequacy
    - Assess percentage of hemodialysis patients with a URR of at least 65%
    - Higher percentage indicates better care
- **New for PY 2014:**
  - Vascular Access Type (VAT)
  - Comprised of two submeasures
    - Arteriovenous Fistula

PY 2014:
Three Reporting Measures: Summary

- Dialysis event data submission to the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) system
- Patients' experience of care survey administration
  - In-center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) survey
- Monthly mineral metabolism monitoring (serum calcium and serum phosphorus)

Future Potential Measures

- Kt/V
- Standardized Hospitalization Ratio for Admissions
- Anemia management
- Others?

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Ongoing Policy Considerations

- **How will policy decisions impact the patient, family and caregivers?**
- **How will practice patterns change as a result of the model?**
- **Are we disproportionately impacting facilities based on it characteristics?**
- **How do we allow for the greatest level of participation and what are the trade offs?**
- **Are the measurements of performance accurate, fair, feasible and reflective of systematic difference?**

Why do we do this work?

- As a practicing physician – I see the need for system changes
- Left a hospital medicine and quality improvement position I loved to help foster a broader system enabling others to drive improvement
- Almost all of us have family members in the populations we serve
- The nation needs our service
- We have seen success; now the question is how do we scale and spread?

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Call to Collective Action

- Historic moment in health care
- ESRD networks and providers can and should be major factor on whether our system transforms to achieve better results
- Must focus on all 3 parts of aims: Better Care, Better Health, and Lower Costs
- We need YOU; We cannot accomplish the three part aim from Baltimore/DC
- Think of the patients that inspire you to keep striving to do better

Contact Information

Dr. Patrick Conway, M.D., M.Sc.
CMS Chief Medical Officer and
Director, Centers for Clinical Standards and Quality
410-786-6841
patrick.conway@cms.hhs.gov

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Questions or Comments

- Questions for you
  - How can I and CMS serve you better?
  - What are some ways that we can collaborate?
  - How can CMS and CCSQ improve?
  - What should we collectively do to achieve better outcomes for patients on dialysis?
  - What should I know that I might not?

- Questions or comments for me

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