Creating a Culture of Quality 2013:
The Critical Role of Communication in Improving ESRD Patient Safety
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Summary of the Keynote Presentation (prepared by Andrew Howard, MD, FACP)

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1. Fundamentally different care delivery system for Medicare beneficiaries
2. VBP – higher value with lower cost
    a. Mentions OP dialysis care beginning in 2011 with the PPS and QIP
    b. Seeing an altered trajectory for costs in Medicare
        i. 0 per capita increase for beneficiaries compared to general costs for health care
        ii. JB believes that this is not due to changes in the economy but rather different and better care
            1. Part A (hospital) – decrease in spending due to decreased LOS and 30 day readmissions
            2. Part B – increase in spending (would have seen a decrease in this spending as well if changes in the economy were the driving force)
            3. Part D – decrease in spending due the increased utilization of generics
3. Hospital Readmissions (30 day)
    a. After a 5 year plateau at 19% now down to 17-18%
    b. Possible explanations: technical assistance, payment incentives, improvement in quality, ACOs, care coordination
    c. Is this the result of shifting of care to the increase in designation as observation status or LTAC? **NO**
    d. Still seeing high variability across different regions of the U.S.
4. Quality
    a. 1/3 beneficiaries receive care through Medicare Advantage (KP, Aetna, United)
    b. Payment tied to # stars (1-worst, 5-best)
        i. 2010: 16% 4-5 star plans
        ii. 2013: 37% 4-5 star plans
    c. Beneficiaries seeking 4-5 star plans
    d. Changing payment incentives alters the behavior of providers and beneficiaries
    e. Continue to focus on cost, quality and beneficiary experience of care
5. ESRD PPS/QIP
    a. CMS committed to monitor unintended changes in the delivery of care to insure that beneficiaries do not go without needed care
        i. ESA: 92% receiving in 1/2010 vs 82% in 5/2013

ii. Track usage carefully
iii. Usage trends changing prior to the implementation of the PPS – labeling
iv. Increase in transfusions noted – up to 2.6%/month following label change, maximum of 3.5%/month end of 2012 – contacted CMOs of DOs and now back to 2.6%/month as of the June 2013
v. Decrease in stroke and MI

b. Home Dialysis - increase noted
   i. 8 to 9.8%
c. Sensipar – increase in usage
   i. 10 to 13%
   ii. Will migrate to the PPS
d. Data seen to date suggests that it is possible to change reimbursement by modifying the payment model and cost can improve
   i. Tie incentives to quality seeing lower cost and improved care
   ii. **Congress by statutory authority had mandated CMS to consider changes in payment**
      1. **Conversation should be not about good vs bad but rather about exploring hypotheses giving confidence to communities**
      2. **We can do all these things at the same time**
      3. **Watch, listen, calibrate when necessary**
      4. **Must continue to improve benefits, improve care and lower cost**

6. Q&A – additional comments by JB
   a. Evolving from using claims based care
   b. Pursuing multiple payment systems to focus on several domains simultaneously
   c. Incorporate the patient experience
   d. Hold accountable all parts of the healthcare system
   e. Set high aspirations for quality
   f. For the dialysis community – what if we were to say over time that hospital readmissions would be an element of responsibility and tied to payment?