Leading Change: Creating Systems that Lead to Momentum and Results

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

Thank You!

- For your **hard work & commitment**
- For your **leadership and contributions**
- For improving the **quality**, **safety**, **and delivery of care** to our beneficiaries

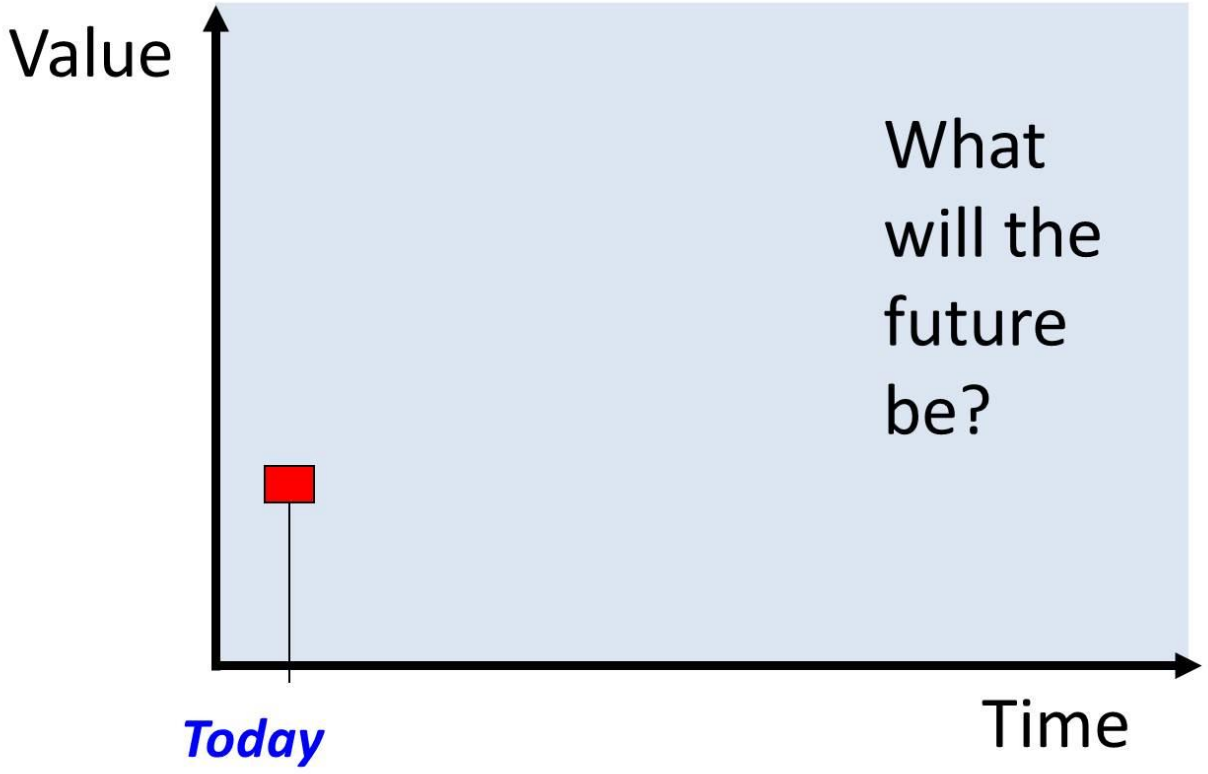
How Do We Approach the Work?

- Foster an ethos of **aspiration** among ourselves and our partners;
- Collaboratively manage the work by **empowering** our networks to lead;
- Hold ourselves **accountable** for supporting, managing, and responding quickly to emerging lessons learned;
- Actively surface the **joy in the work**, and strive to make this the **best experience** of everyone's professional lives.

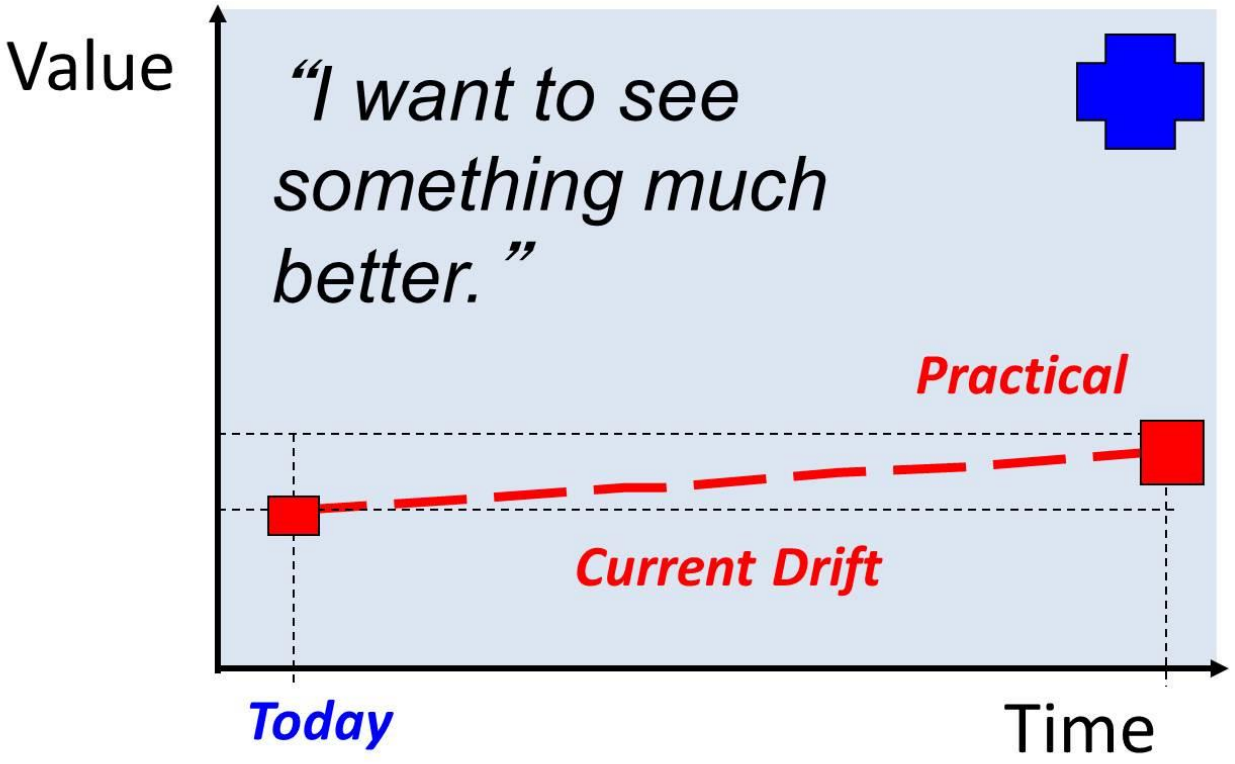
Our Key Methods for Achieving Results

- Bold, Clear Aims -- Implemented at Scale
- Focus on Results
- Do More of What Works
- Make Best-In-Class Performance, Common Performance
- Tight About the "What" Outcome; Flexible on the "How"
- Foster and Foment Joy in Work

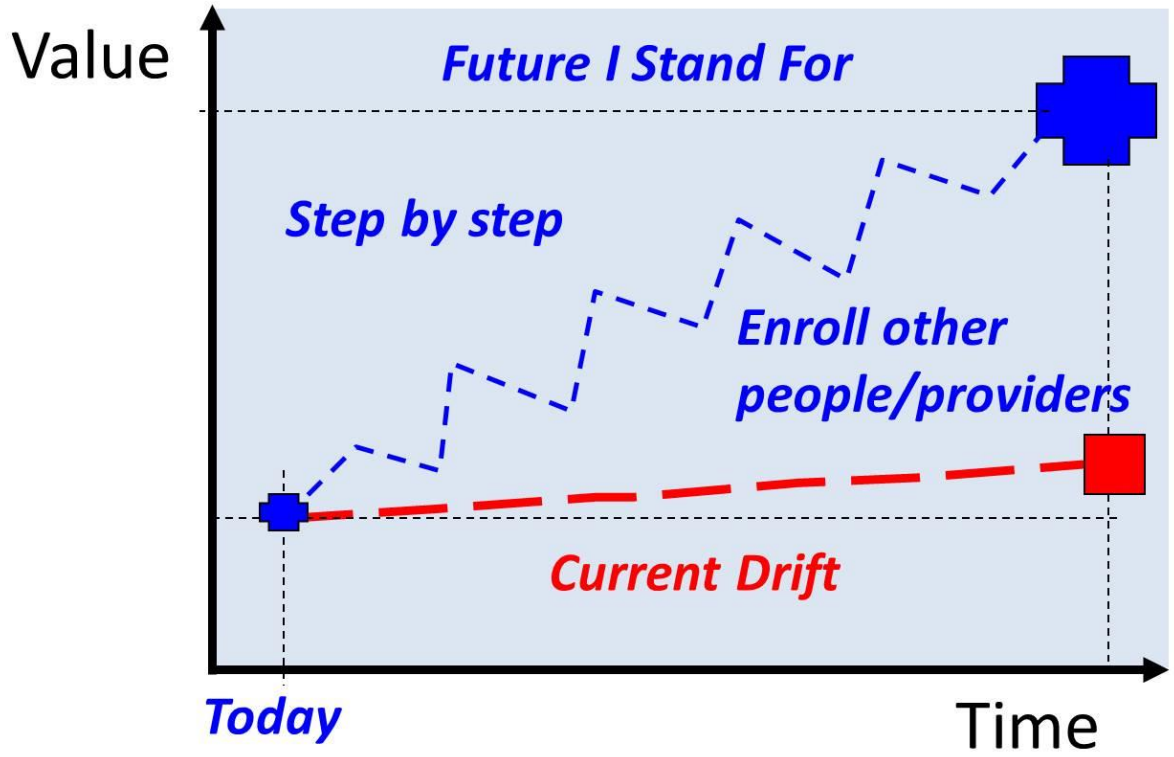
Aims & Results: a choice we make every day



A leadership choice – breakthrough Aims



Emergent Strategy: Stand For Them, Enroll Others, Persist, Learn, Evolve...Fast



CMS established large-scale, action-oriented networks to **spread quality improvement** and **safety activities on a national scale**

Partnership for Patients

- 4,000 Hospitals

Transforming Clinical Practices Initiative

- 140,000 Clinicians

End Stage Renal Disease Networks

- 6,000 Dialysis Facilities

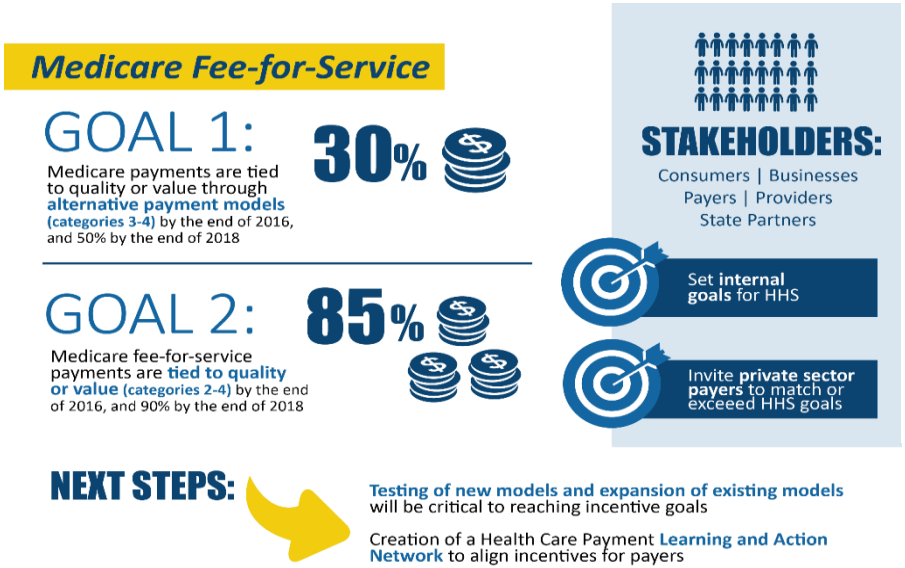
Quality Innovation Networks – Quality Improvement Organizations

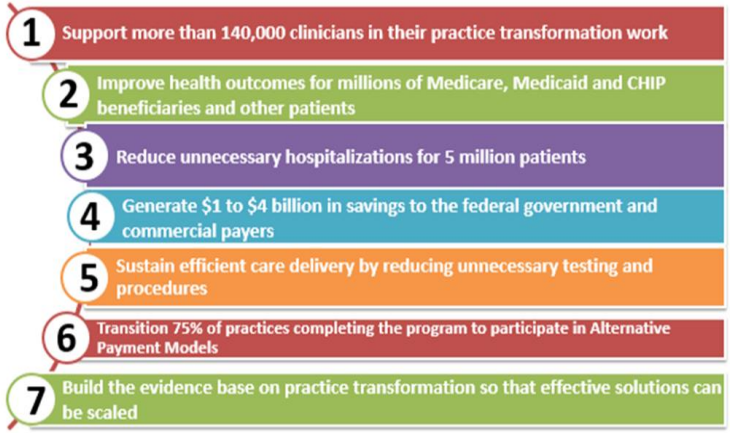
- 250+ Communities
- 11,000+ Nursing Homes
- 3,800 Home Health Organizations
- 300 Hospice
- 1,700 Pharmacies

MACRA and Quality Payment Program - Small, Underserved, Rural Support (SURS)

- Up to 200,000 Clinicians

Aims Create Systems…





90% of Eligible Clinicians Participate in the Quality Payment Program

20% **Overall Reduction in Hospital Acquired Conditions**

12% **Reduction in 30-Day Readmissions**

Hospital Safety Project
Focused on Two Breakthrough Aims
(2011 – 2016)

G O A L S :

40% **Reduction in Preventable Hospital-Acquired Conditions**

1.8 Million Fewer Injuries | 60,000 Lives Saved

20% **Reduction in 30-Day Readmissions**

1.6 Million Patients Recover without Readmission

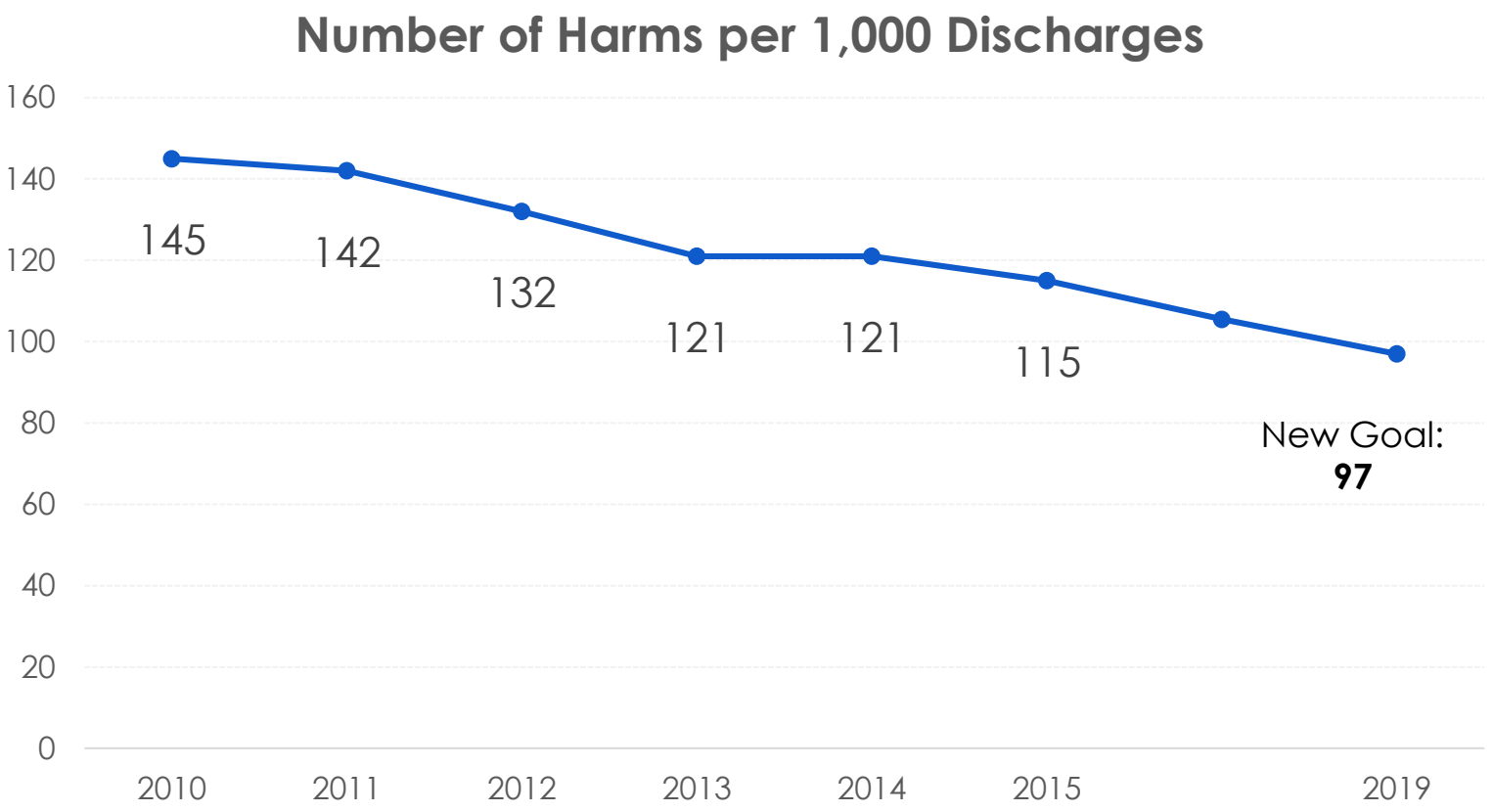
Aims Create Systems; Systems Create Results.

National Results on Patient Safety
Substantial progress thru 2015, compared to 2010 baseline

- **21 percent decline in overall harm**
- **125,000 lives saved**
- **$28B in cost savings from harms avoided**
- **3.1M fewer harms over 5 years**

Source: Agency for Healthcare Research & Quality. "Saving Lives and Saving Money: Hospital-Acquired Conditions Update. Interim Data From National Efforts To Make Care Safer, 2010-2014." December 1, 2015.

Sustaining and Accelerating Major Reductions in Harm: AHRQ 2010 Baseline & Progress



Success on Partnership for Patients has resulted in **new bold aims**

AIMS for 2019

- **20%** Overall Reduction in Hospital-Acquired Conditions
- **12%** Reduction in 30-Day Readmissions

Transforming Clinical Practice Initiative (TCPI)

1. Support more than 140,000 clinicians in their practice transformation work
2. Improve health outcomes for millions of Medicare, Medicaid and CHIP beneficiaries and other patients
3. Reduce unnecessary hospitalizations for 5 million patients
4. Generate $1 to $4 billion in savings to the federal government and commercial payers
5. Sustain efficient care delivery by reducing unnecessary testing and procedures
6. Transition 75% of practices completing the program to participate in Alternative Payment Models
7. Build the evidence base on practice transformation so that effective solutions can be scaled

Transforming Clinical Practice Initiative is designed to help clinicians achieve large-scale health transformation

The model will support over **140,000 clinicians** to **improve on quality and enter alternative payment models (APMs).**

- **Current Enrollment: 110,000 clinicians**

Two network systems have been created:

1. **Practice Transformation Networks:** Peer-based learning networks designed to coach, mentor, and assist
2. **Support and Alignment Networks:** Provides a system for workforce development utilizing professional associations and public-private partnerships

Phases of Transformation

Transforming Clinical Practice Initiative: Practice Transformation Networks (PTNs)

- Arizona Health-e Connection
- Baptist Health System, Inc.
- Children's Hospital of Orange County
- Colorado Department of Health Care Policy & Financing,
- Community Care of North Carolina, Inc.
- Community Health Center Association of Connecticut, Inc.
- Consortium for Southeastern Hypertension Control
- Health Partners Delmarva, LLC
- Iowa Healthcare Collaborative
- Local Initiative Health Authority of Los Angeles County
- Maine Quality Counts
- Mayo Clinic
- National Council for Behavioral Health
- National Rural Accountable Care Consortium
- New Jersey Innovation Institute
- New Jersey Medical & Health Associates dba CarePoint Health
- New York eHealth Collaborative
- New York University School of Medicine
- Pacific Business Group on Health
- PeaceHealth Ketchikan Medical Center
- Rhode Island Quality Institute
- The Trustees of Indiana University
- VHA/UHC Alliance Newco, Inc.
- University of Massachusetts Medical School
- University of Washington
- Vanderbilt University Medical Center
- VHQC
- VHS Valley Health Systems, LLC
- Washington State Department of Health

Transforming Clinical Practice Initiative: Support & Alignment Networks (SANs)

- American College of Emergency Physicians
- American College of Physicians, Inc.
- HCD International, Inc.
- Patient Centered Primary Care Foundation
- The American Board of Family Medicine, Inc.
- Network for Regional Healthcare Improvement
- American College of Radiology
- American Psychiatric Association
- American Medical Association
- National Nursing Centers Consortium

Examples of How TCPI Promises are Fulfilled at the Practice Level

Aim 1
"We have implemented strategies that have impacted all 19,556 of our diabetic patients in 12 months."

Aim 2
"We have controlled blood pressure for 80% of our 14,366 patients in 10 months."

Aim 3
"We kept 1762 kids of the expected 2,800 out of the ER in just 6 months."

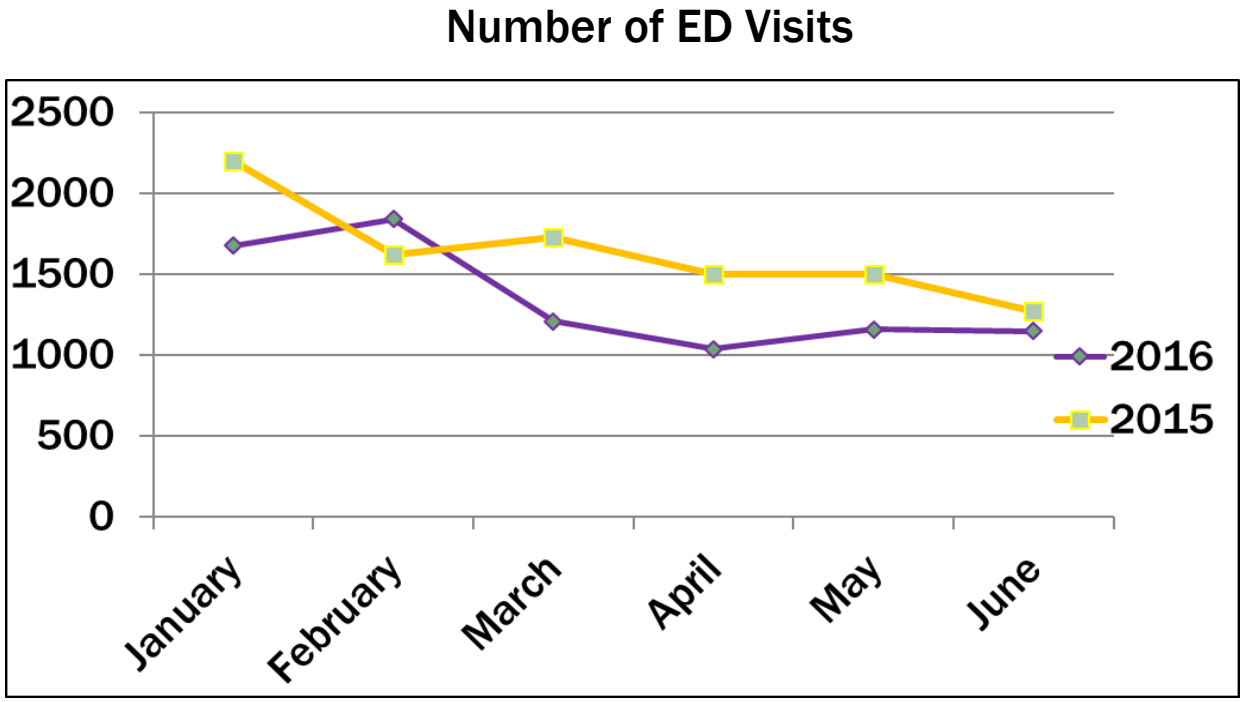
Aim 4
"We decreased ER spending from $22,000 to $3,000 by using transformation principles for 197 high risk patients."

Aim 5
"We decreased the number of CT scans for 8313 patients with headaches from 165 (2%) to 33 (0.4%) by standardizing the guidelines."

Aim 6
"We received a set $ on the front end to care for a group of asthmatics and were given the freedom to provide care at the right time, the right way. We improved their care for less cost."

Aim 7
"We purchased a software program to let all of our clinicians have access to their quality data, all day every day."

REDUCTION in ASTHMA-RELATED ED Visits
Example: SW PEDIATRICS PTN
15 PEDIATRICIAN PRACTICE



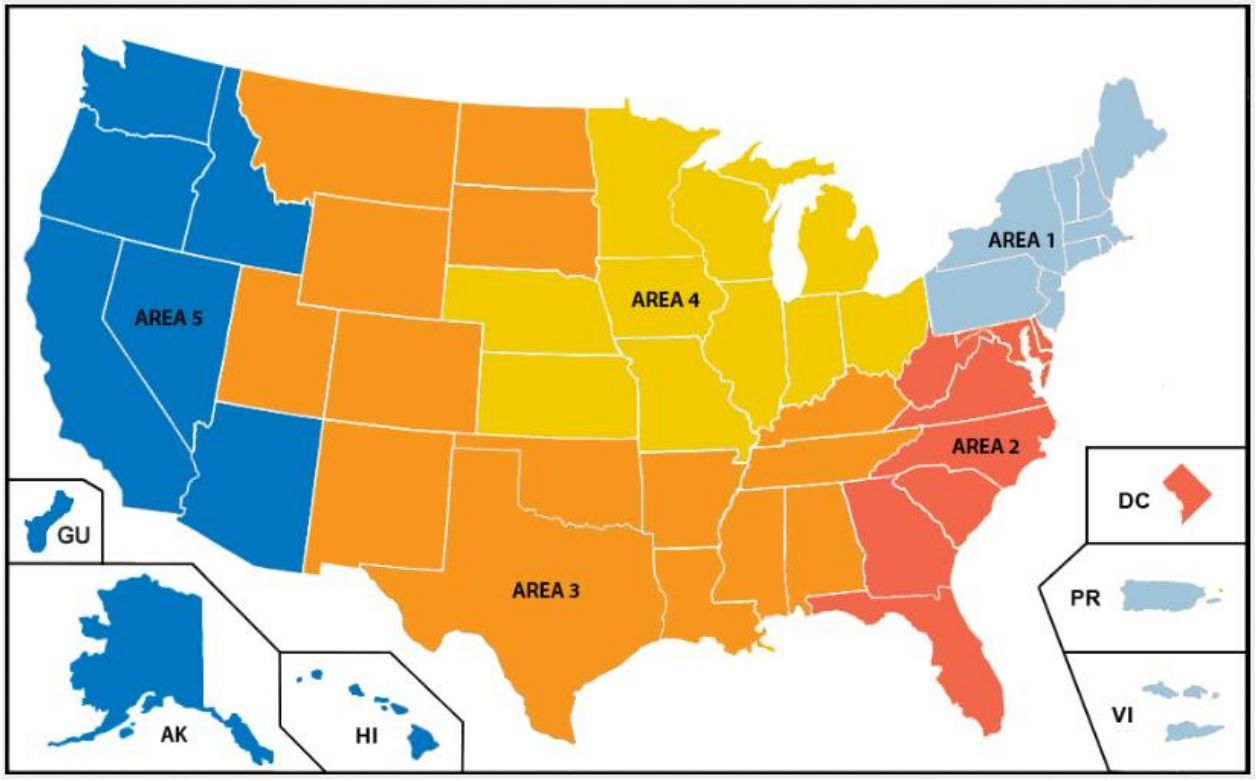
NUMBER OF CHILDREN:
- 27,000 Medicaid Children

INTERVENTION:
- Asthma Action Plan and check-ins

RESULTS:
- 18% Reduction in ED Use
- 1762 Fewer visits in 6 months
- $1.05 million full year savings projected based 6 month claims data

Beneficiary & Family Centered Care (BFCC) Quality Improvement Organizations

- Five CMS defined areas
- Operating during business hours 7 days a week
- Ohio-based **KEPRO** for 33 states, and the District of Columbia; and
- Maryland-based **LIVANTA** for 17 states, the USVI and Puerto Rico



Area	QIO
1	LIVANTA
2	KEPRO
3	KEPRO
4	KEPRO
5	LIVANTA

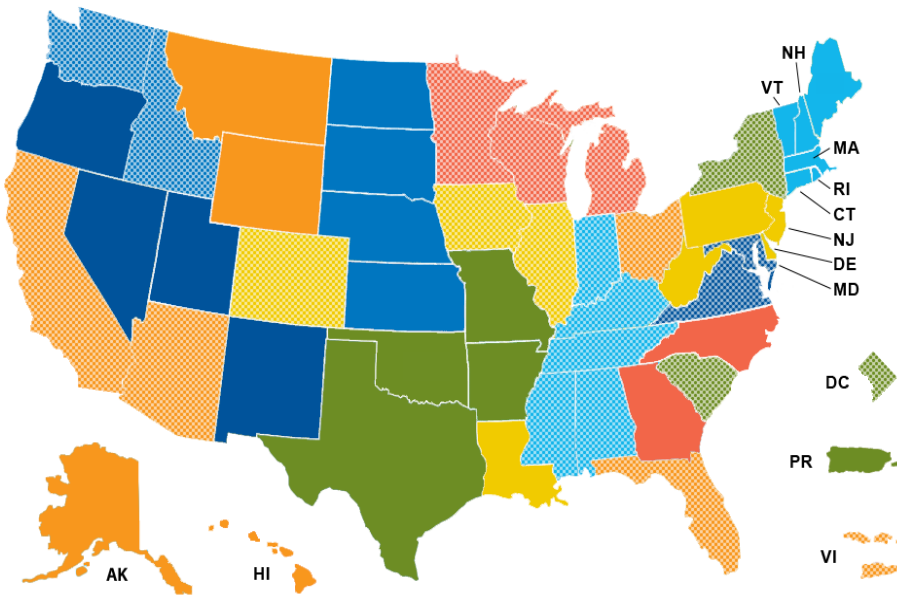
Beneficiary and Family Centered (BFCC) QIO Contract Results

- National Case Review Volume* of approximately 450,000 since August 1, 2014
- 2-midnight Review Volume of over 26,000 as of February 2017
- Higher-weighted diagnosis related group payments (HWDRGs) Return on Investment of over $26.3M as of March 2017
- National Review Timeliness Rate of 97.84% as of February 2017

**National Volume count here excludes 2-midnight reviews*

Quality Innovation Network- Quality Improvement Organizations (QIN-QIOs)

14 QIN-QIOs work with providers and the community to advance patient safety, reduce harm, engage patients and families, and improve clinical care locally and regionally



- Alliant-Georgia Medical Care Foundation
- Atlantic Quality Improvement Network
- atom Alliance
- Great Plains Quality Innovation Network
- New England QIN
- HealthInsight
- Health Services Advisory Group
- Lake Superior Quality Innovation Network
- Mountain Pacific Quality Health Foundation
- Qualis Health
- Quality Insights Quality Innovation Network
- Telligen
- TMF
- HQI

11th SoW Current Quality Improvement Tasks

Quality Innovation Network (QIN)

B.1	Cardiac Health	B.2	Diabetes Care *Everyone with Diabetes Counts*	C.2	Nursing Home Care
C.3	Care Coordination *Reduction of Admissions/ Readmissions*	C.3.6	Medication Safety	C.3.10	Antibiotic Stewardship
D.1	Quality Reporting/ Quality Payment Program	E.1	Quality Improvement Initiatives (QII)	F.1	Immunizations
G.1	Behavioral Health *Screening*	H.1	Transforming Clinical Practice Initiative		

Note: Patient and Family Engagement is a cross-cutting requirement for all QIN tasks.

QIO Impact on Nursing Home Quality Improvement

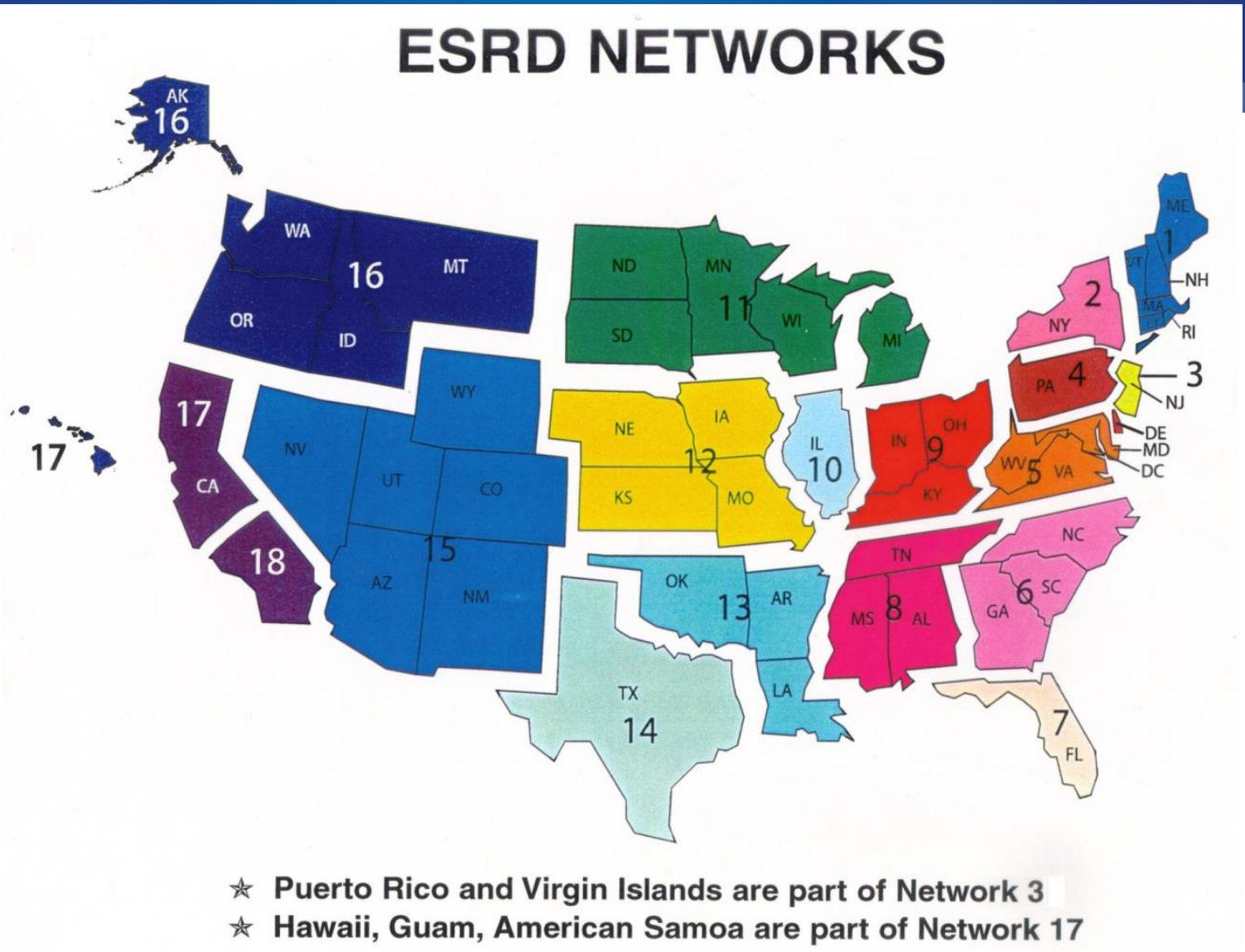
- As of March 31, 2017:
  - 12,217 nursing homes are participating in the QIN-QIO National Nursing Home Quality Care Collaborative (approximately 79% of all the nursing homes in the country)
  - 2,630 1-star nursing homes are recruited for the QIN-QIO project
- NHSN enrollment:
  - Nationally, **2,337** nursing homes are fully enrolled in NHSN, approximately 15% of the nation's nursing homes.
  - This achievement would not have been possible without the collaboration and commitment of nursing home staff across the country.

Examples of QIOs having National Impact

1. QIN-QIOs have avoided 24,383 readmissions in Cohort A,B, and C communities, nearly doubling the program target of 12,824.
2. Residents Living in Safer Nursing Homes (quarterly: July 1, 2016-Sep 30, 2016): Program Progress - 442, 482
3. PPV and Influenza vaccinations Provided by QIN-QIO Practices (cumulative through Sep. 30, 2016): Program Progress – 544,291
4. Beneficiaries completing Diabetes Self-Management Education (DSME) (cumulative through Jan 31. 2017): Program Progress – 27, 894

- Readmissions avoided over the time period 1/1/15-9/30/16. Target represents the number of readmissions avoided if QIN-QIOs exactly met all QIN-QIO contract targets.

ESRD Network Map



ESRD Performance-Based Outcome Driven Quality Improvement Activities

- Addressing Patient Grievances and Care Issues
- Reducing Long Term Catheter Use
- Reducing Blood Stream Infections
- Increasing Pneumococcal and Hepatitis B Vaccination
- Reduction of Hospitalizations
- Improving Transplant Referrals
- Promoting Home Dialysis

End-Stage Renal Disease (ESRD) Network Activities

- ESRD Networks have a 5 Year Contract with 3 AIMS
  1. Better Care for the Individual through Patient and Family Centered Care
  2. Better Health for the ESRD Population
  3. Reduce Costs of ESRD Care by Improving Care
- Responsible for Performance-Based Outcome Driven Quality Improvement Activities
- Use of Patient Subject Matter Experts in the Development and Execution of Quality Improvement Activities
- Focus on Person, Family and Caregiver Centered Care and Rapid Cycle Improvement

End Stage Renal Disease (ESRD)

- 18 ESRD Networks (6,000 dialysis facilities) improve access to care and quality of care
- 661,648 ESRD Patients on Dialysis
- Number of ESRD Patients Increases Every Year by 21,000
- ESRD population remains at less than 1% of the total Medicare population, it has accounted for about 7% of Medicare fee for service spending in recent years.
- Medicare Funds Dialysis at an Annual Cost of $30.9 Billion

Quality Payment Program

Medicare Payment Prior to MACRA

Fee-for-service (FFS) payment system, where clinicians are paid based on **volume** of services, not **value.**

The Sustainable Growth Rate (SGR)

- Established in 1997 to **control the cost of Medicare payments** to physicians

Each year, Congress passed temporary **"doc fixes"** to avert cuts (no fix in 2015 would have meant a **21% cut** in Medicare payments to clinicians)

The Quality Payment Program

- The Quality Payment Program policy will reform Medicare Part B payments for more than 600,000 clinicians across the country, and is a major step in improving care across the entire health care delivery system.
- Clinicians can choose how they want to participate in the Quality Payment Program based on their practice size, specialty, location, or patient population.

Two tracks to choose from:

Advanced Alternative Payment Models (APMs)
If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.

or

The Merit-based Incentive Payment System (MIPS)
If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.

Technical Assistance General

CMS has **free** resources and organizations on the ground to provide help to clinicians who are eligible for the Quality Payment Program:

PRIMARY CARE & SPECIALIST PHYSICIANS

Transforming Clinical Practice Initiative

- Supports more than 140,000 clinician practices through active, collaborative and peer-based learning networks over 4 years.
- **Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs)** are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.
- Contact TCPI.ISC@TruvenHealth.com for extra assistance.

Locate the PTN(s) and SAN(s) in your state

SMALL & SOLO PRACTICES

Small, Underserved, and Rural Support (SURS)

- Provides outreach, guidance, and direct technical assistance to clinicians in **solo or small practices (15 or fewer), particularly those in rural and underserved areas**, to promote successful health IT adoption, optimization, and delivery system reform activities.
  - Assistance will be tailored to the needs of the clinicians.
  - There are 11 SURS organizations providing assistance to small practices in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.
  - For more information or for assistance getting connected, contact QPPSURS@IMPAQINT.COM.

LARGE PRACTICES

Quality Innovation Networks-Quality Improvement Organizations (QIN-QIO)

- Supports clinicians in **large practices (more than 15 clinicians)** in meeting Merit- Based Incentive Payment System requirements through customized technical assistance.
- Includes one-on-one assistance when needed.
- There are 14 QIN-QIOs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.

Locate the QIN-QIO that serves your state

Quality Innovation Network (QIN) Directory

TECHNICAL SUPPORT

All Eligible Clinicians Are Supported By:

Quality Payment Program Website: qpp.cms.gov
Serves as a starting point for information on the Quality Payment Program.

Quality Payment Program Service Center
Assists with all Quality Payment Program questions.
1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov

Center for Medicare & Medicaid Innovation (CMMI) Learning Systems
Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs. More information about the Learning Systems is available through your model's support inbox.

Help Is Available

qpp.cms.gov

CMS has organizations on the ground to provide help to clinicians who are eligible for the Quality Payment Program:

TCPI

Transforming Clinical Practice Initiative (TCPI): TCPI is designed to support more than 140,000 clinician practices over the next 4 years in sharing, adapting, and further developing their comprehensive quality improvement strategies. Clinicians participating in TCPI will have the advantage of learning about MIPS and how to move toward participating in Advanced APMs. Click here to find help in your area.

QIN-QIOs

Quality Innovation Network (QIN)-Quality Improvement Organizations (QIOs): The QIO Program's 14 QIN-QIOs bring Medicare beneficiaries, providers, and communities together in data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality. More information about QIN-QIOs can be found here.

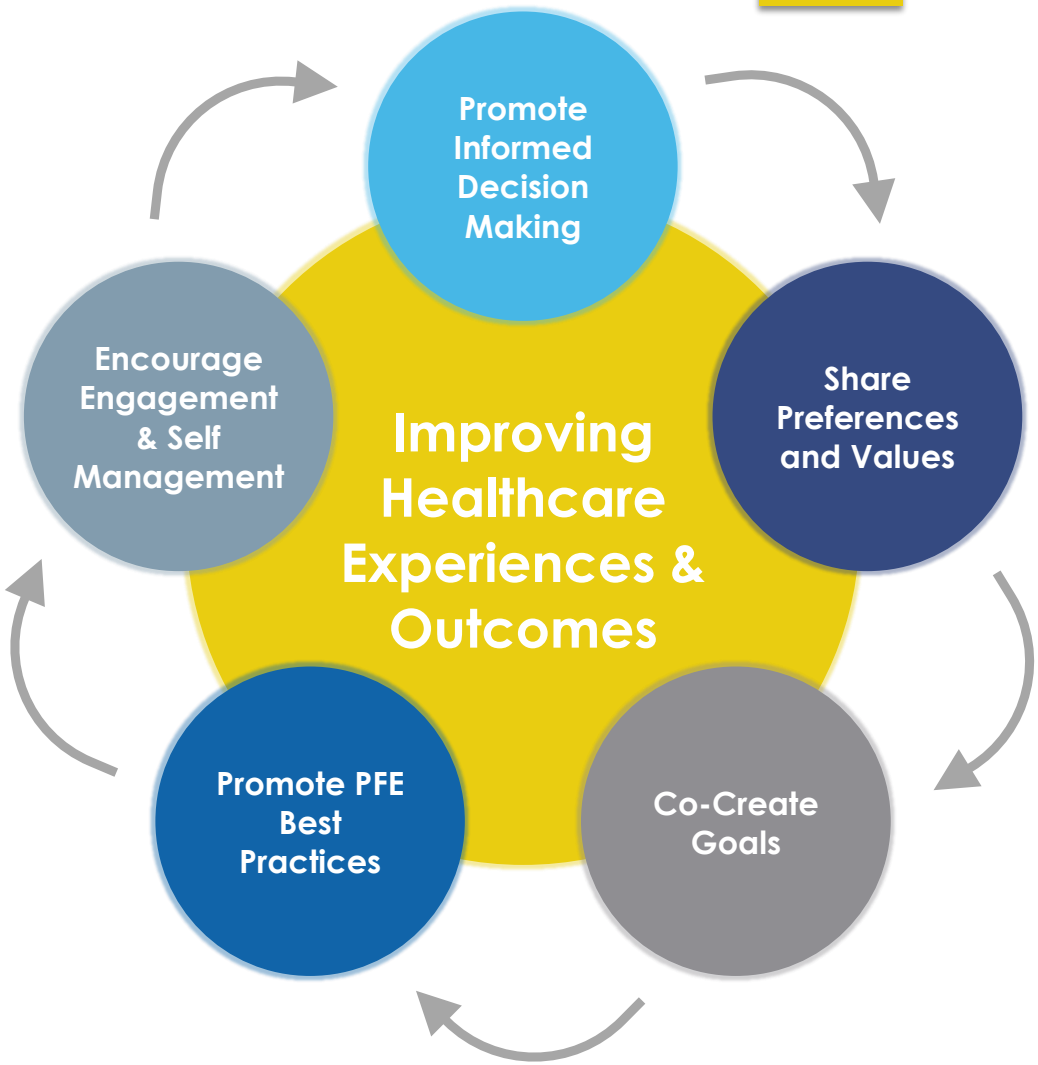
APM Learning Systems

If you're in an APM: The Innovation Center's Learning Systems can help you find specialized information about what you need to do to be successful in the Advanced APM track. If you're in an APM that is not an Advanced APM, then the Learning Systems can help you understand the special benefits you have through your APM that will help you be successful in MIPS. More information about the Learning Systems is available through your model's support inbox.

Strengthen Persons and Families as Partners in their Care

- CMS Person and Family Engagement (PFE) Strategy
  - **Vision**: A transformed healthcare system that **proactively engages persons and caregivers** in the definition, design, and delivery of their care.
  - **Mission**: To create an inclusive, collaborative and aligned national PFE framework that is guided by person-centered values and **drives genuine transformation in attitudes, behavior, and practice**.
  - **Values**:
    - Person-centered
    - Health Literacy
    - Accountability
    - Respect

Person & Family Engagement Cycle



Partnership for Patients Work on Patient & Family Engagement (PFE)

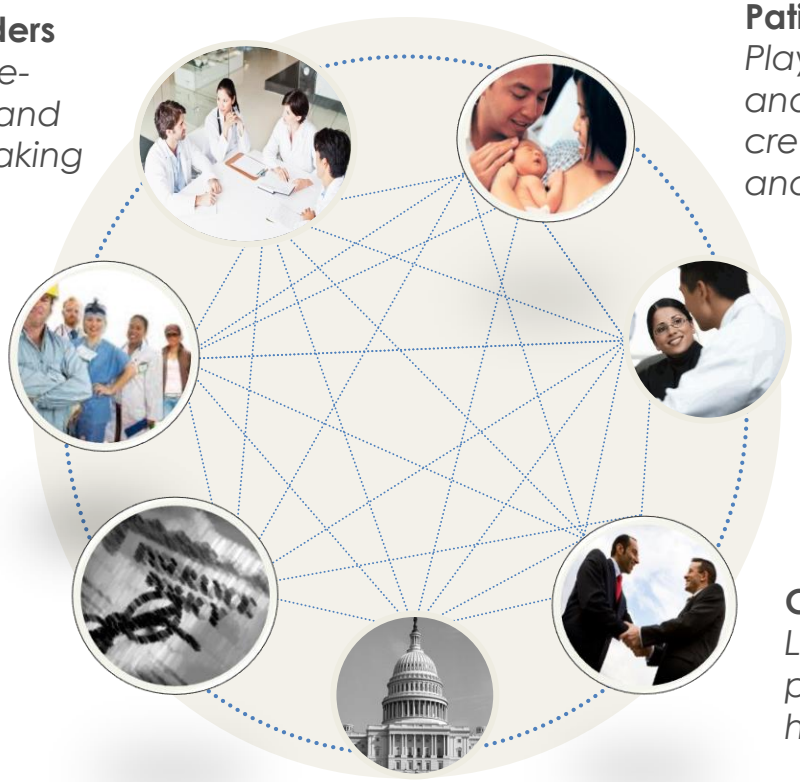
- **Authentically engage** patients in our work; model engagement in our own work
- **Identify** organizations that reflect best practices
- **Replicate** and spread effective practices
- **Track** progress on PFE across hospitals and increase transparency
- **Team** with and support others involved in leading this work

Mobilizing a Diverse Network on PFE

Healthcare Providers
Practice evidence-based medicine and rely on data in making patient decisions

Patients and Families
Play the most vital role in Patient and Family Engagement, creating a path to better care and conversation

HENs and Hospitals
Are on the front lines of patient care and patient engagement



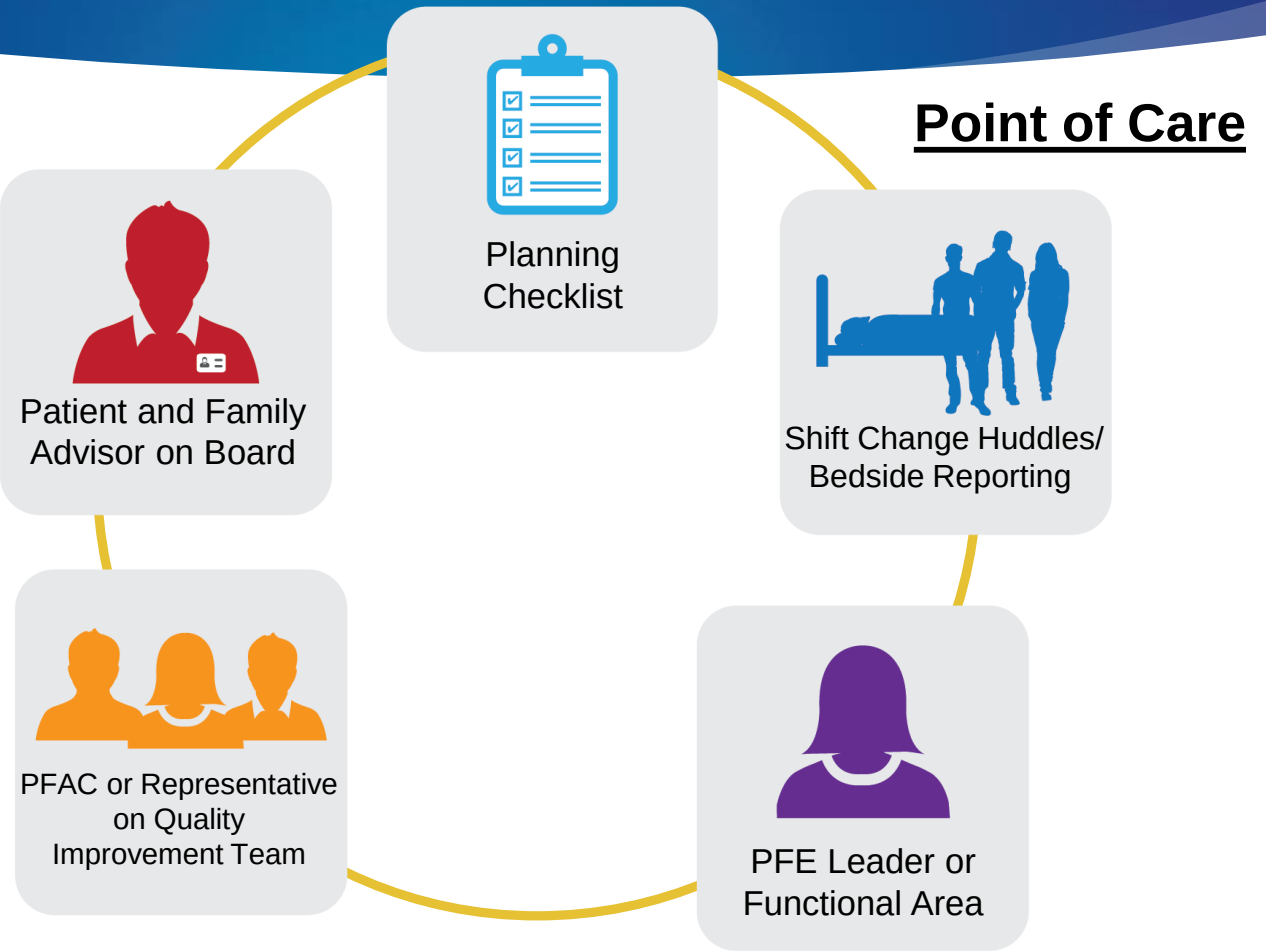
Non-profit and Advocacy Organizations
Provide ongoing support for key programs, activities for patients and families

Quality Leaders
Set the standard for how patients and families receive care

C-suite Leadership
Leaders in adoption of best practices at HENs and hospitals

Federal Government and Agencies
Have the power to influence large audiences and extend reach and frequency of messages

PFE Metrics:
Measuring Hospital Successes



Our Requests to Each of You

1. Foster the use of **rapid-cycle improvement, real-time quality improvement data, and "living in the red"** to drive results.
2. **Choose to focus on the mission:** Stand for better care, smarter spending, and healthier people…for our patients, for your profession, and for our nation.
3. **Nurture your own resilience** and that of others on our teams.
4. **Team with your networks, and with one another, intentionally and wholeheartedly**.
5. **Intentionally choose and model the behaviors** you want to see more of in others.

Lead in our QIO, ESRD, HIIN, TCPI, SURS Communities of Practice on these ways of being.

Questions to Run On

- ***How do we do the work of our networks better, faster, and by being more efficient with our resources?***

- ***How can we leverage the answer to #1 in the upcoming QIO 12th SoW?***

Contact Information

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