Kansas Healthcare Collaborative
Summit on Quality 2019

Jade Perdue, Director
Division of Quality Improvement
Innovations Model Testing
Centers for Medicare and Medicaid Services

May 10, 2019
Wichita, Kansas
Thank You…

• For the hard work you are doing to improve and transform our nation’s healthcare system

• For your steadfast commitment to improving patient safety

• For your leadership, partnership, participation and results to reduce patient harm & readmissions
Our Time Together Today

- HHS/CMS Strategic Vision
- Ensuring Safety and Quality
- Hospital Improvement Innovation Network—Getting to the 20/12 X 2019 goal or BEYOND!
- Patient Safety- Where we are going
How to Be

• Interactive
• Focused on what’s working WELL
• Telling the good story for replication purposes
• Listening for insight and action
• Celebrating one another
My Request…

More Positives Than Negatives
Centers for Medicare and Medicaid Strategic Priorities
### Secretary of Health and Human Services, Alex Azar

**Key Priorities**

<table>
<thead>
<tr>
<th>Priority</th>
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<tbody>
<tr>
<td>1. Opioids</td>
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<tr>
<td>2. Health Insurance Affordability &amp; Availability</td>
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<tr>
<td>3. Drug Pricing</td>
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<tr>
<td>4. Improved Health Outcomes &amp; Value</td>
</tr>
</tbody>
</table>
CMS Strategic Priorities for 2019
CMS Goals

- Empower patients and doctors to make decisions about their health care
- Usher in a new era of state flexibility and local leadership
- Support innovative approaches to improve quality, accessibility, and affordability
- Improve the CMS customer experience
How do these priorities and goals resonate with your healthcare experience or the work that you do?
“We are moving away from fee-for-service.”

“When there are too many measures, or measures are too complex, then we actually create roadblocks to quality care. This is why we announced the Meaningful Measures initiative.”

-- Administrator Seema Verma
CMS Quality Conference, 2018
Weaknesses of Fee for Service Payment

- Excessive use of low-value services
- Insufficient incentives to improve quality of care
- Poor coordination of care
1. **Paying for value** in FFS and through Innovation Center models
2. **Quality Improvement networks** to spread best practices and help health systems transform how they deliver care;
3. **Health and safety regulations**, which hold providers accountable for outcomes;
4. **Enforcement of regulations** with a focus on consistency and standardization; and
5. **Quality Measurement** as a foundational component of an outcomes-focused value driven system.
Meaningful Measures
Meaningful Measures Objectives

Meaningful Measures focus everyone’s efforts on the same quality areas and lend specificity, which can help identify measures that:

- Address high-impact measure areas that safeguard public health
- Are patient-centered and meaningful to patients, clinicians and providers
- Are outcome-based where possible
- Fulfill requirements in programs’ statutes
- Minimize level of burden for providers
- Identify significant opportunity for improvement
- Address measure needs for population based payment through alternative payment models
- Align across programs and/or with other payers
Meaningful Measures: Progress to Date

• Removed 79 measures overall (nearly 20%); in MIPS we removed 26 measures immediately while adding new outcome and appropriate use measures
• CMS Measure Inventory:
  • 180 outcome
  • 43 patient-reported outcome
  • 96 able to be submitted through electronic means
• Measure alignment internally
  • MA, Medicaid, Exchanges
  • Across Post Acute settings
• Measure alignment with states, MA plans and commercial payers
  • Core Quality Measures Collaborative
Transparency
Putting Data in the Hands of Patients

What this means for CMS

• **Blue Button 2.0**
  • Developer-friendly, standards-based API
  • Developer preview program – open now (over 1200 developers so far)
  • Data security is of the utmost importance
• **Overhaul of Meaningful Use and Advancing Care Information in QPP**
  • Program alignment
  • Strong emphasis on interoperability and privacy/security
  • Flexibility
  • Lower burden
• **2015 edition Certified EHR Technology**
• **Prevention of Information Blocking**
• **Working with Commercial Payers in MA and Exchanges**
• **Star Ratings**
## Comparison of Current and Future Promoting Interoperability Requirements

<table>
<thead>
<tr>
<th>Current Stage 3 Requirements</th>
<th>Future Requirements</th>
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<tbody>
<tr>
<td>• Report 11 measures from 6 objectives and meet required measure thresholds</td>
<td>• Report 6 measures from 4 objectives (Query of PDMP and Verify Opioid Treatment Agreement are optional in 2019)</td>
</tr>
<tr>
<td>• Scoring is pass/fail</td>
<td>• Scoring based on performance (Public Health and Clinical Data Exchange measures are reported using yes/no responses)</td>
</tr>
<tr>
<td>• All-or-nothing; report every single measure and meet all requirements or be subject to a payment adjustment</td>
<td>• Score of 50 points or more would satisfy the reporting requirement.</td>
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<tr>
<td></td>
<td>• Flexibility; allows hospitals to focus on the measures that are more appropriate for the ways in which they deliver care to patients and types of services that they provide.</td>
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</table>
Quality Payment Program
Overview
Combined legacy programs into a single, improved program.

- Physician Quality Reporting System (PQRS)
- Value-Based Payment Modifier (VM)
- Medicare EHR Incentive Program (EHR) for Eligible Professionals
Considerations

- Improve beneficiary outcomes
- Increase adoption of Advanced APMs
- Improve data and information sharing
- Reduce burden on clinicians
- Maximize participation
- Ensure operational excellence in program implementation

Quick Tip: For additional information on the Quality Payment Program, please visit qpp.cms.gov
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to implement an incentive program, referred to as the Quality Payment Program:

- **MIPS** (Merit-based Incentive Payment System)
  - If you are a MIPS eligible clinician, you will be subject to a performance-based payment adjustment through MIPS.

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

There are two ways to take part in the Quality Payment Program:
Comprised of four performance categories

So what? *The points from each performance category are added together to give you a MIPS Final Score*

The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a **positive**, **negative**, or **neutral payment adjustment**
Performance period opens January 1, 2019
Closes December 31, 2019
Clinicians care for patients and record data during the year

Deadline for submitting data is March 31, 2020
Clinicians are encouraged to submit data early

CMS provides performance feedback after the data is submitted
Clinicians will receive feedback before the start of the payment year

MIPS payment adjustments are prospectively applied to each claim beginning January 1, 2021
11 uniquely experienced organizations to provide national coverage to MIPS clinicians in small and rural practices.
Health Equity
CMS Health Equity Framework

- Increasing understanding and awareness of disparities
- Developing and disseminating solutions
- Implementing sustainable actions
Improving Data Collection, Analysis and Reporting of Health Disparities

• Mapping Medicare Disparities Tool
  - Includes Hospital Quality Data

• Partnered with NQF’s Disparities Steering Committee

• Social Risk Factors/Social Determinants of Health
Embedding A Focus on Health Equity in CMS Programs

- CMS Equity Plan for Improving Quality in Medicare
- Accountable Health Communities Model
- Transforming Clinical Practice Initiative
- Quality Payment Program – Merit-Based Incentive Program
- Everyone with Diabetes Counts
- End Stage Renal Disease Quality Improvement Program
- Hospital Innovation Initiative Network
# Health Equity Organizational Assessment (HEOA)

## 7 Assessment Categories

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Data Collection</strong></td>
<td>Hospital uses a self-reporting methodology to collect demographic data from the patient and/or caregiver.</td>
</tr>
<tr>
<td><strong>Data Collection Training</strong></td>
<td>Hospital provides workforce training regarding the collection of self-reported patient demographic data.</td>
</tr>
<tr>
<td><strong>Data Validation</strong></td>
<td>Hospital verifies the accuracy and completeness of patient self-reported demographic data.</td>
</tr>
<tr>
<td><strong>Data Stratification</strong></td>
<td>Hospital stratifies patient safety, quality and/or outcome measures using patient demographic data.</td>
</tr>
<tr>
<td><strong>Communicate Findings</strong></td>
<td>Hospital uses a reporting mechanism (e.g., equity dashboard) to communicate outcomes for various patient populations.</td>
</tr>
<tr>
<td><strong>Address &amp; Resolve Gaps in Care</strong></td>
<td>Hospital implements interventions to resolve difference in patient outcomes.</td>
</tr>
<tr>
<td><strong>Infrastructure &amp; Culture</strong></td>
<td>Hospital has organizational culture and infrastructure to support the delivery of care that is equitable for all patient populations.</td>
</tr>
</tbody>
</table>
## Health Equity Organizational Assessment (HEOA)

### Assessment Category

<table>
<thead>
<tr>
<th>Category</th>
<th>Level of Hospital Implementation</th>
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<tbody>
<tr>
<td>Data Collection</td>
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<td>Data Collection Training</td>
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<tr>
<td>Data Validation</td>
<td></td>
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<tr>
<td>Data Stratification</td>
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<tr>
<td>Communicate Findings</td>
<td></td>
</tr>
<tr>
<td>Address &amp; Resolve Gaps in Care</td>
<td></td>
</tr>
<tr>
<td>Infrastructure &amp; Culture</td>
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</tbody>
</table>

The level of hospital implementation ranges from Basic/Fundamental to Advanced.
HIINs have each chosen 4 acute care harm areas to impact health disparities.

HIINs are using a quality improvement framework tool called a Disparities Impact Statement (DIS) to:

- Use data to identify vulnerable populations and differences between populations (outcomes, prevalence, etc.)
- Engage stakeholders/communities
- Set SMART aims and develop action plans, with targeted interventions, that close identified disparate gaps between populations
- Monitoring and PDSA interventions and outcomes
HIIN Examples: Disparities Impact Statements with Opioids

- Developed interactive hospital performance dashboards that allows hospitals to stratify opioid related data (i.e. opioid daily average dose) by race, ethnicity, age, payor and other socioeconomic factors.

- Identifying areas with lack of access to Medication Assisted Therapy (MAT) providers (MAT deserts) and increasing provider training and use of MAT with ECHO Model hubs.

- Utilizing the Area of Deprivation Index (ADI) to identify and then target interventions at hospitals where the majority of the opioid incidences are occurring (i.e. 80% of opioid events happen at 20 hospital in the state).

- Examining racial-ethnic disparities with opioid prescriptions given in ED vs. opioid prescriptions given at discharge for both non-definitive conditions (i.e. tooth ache, abdominal pain, back pain) and definitive conditions (i.e. long bone fractures, kidney stones).
Rural Health
In 2018, CMS released the agency's first Rural Health Strategy intended to provide a proactive, but preliminary step in our efforts ensure that individuals who live in rural America have access to high quality, affordable healthcare.

We continue to expand upon our efforts within rural America to promote policies across our programs to better serve individuals in rural areas and avoid unintended consequences of policy and program implementation.
Rural Healthcare and HIINs: By the Numbers

- **1224 Very Small Rural Hospitals (VSRHs) & Critical Access Hospitals (CAHs)**
- Represents approximately 30% of the HIIN supported hospitals

<table>
<thead>
<tr>
<th>HIIN</th>
<th>Total No. VSRHs &amp; CAHs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carolinas</td>
<td>3</td>
</tr>
<tr>
<td>Dignity Health</td>
<td>2</td>
</tr>
<tr>
<td>HealthInsight</td>
<td>36</td>
</tr>
<tr>
<td>HRET</td>
<td>574</td>
</tr>
<tr>
<td>HSAG</td>
<td>34</td>
</tr>
<tr>
<td>Iowa</td>
<td>125</td>
</tr>
<tr>
<td>Michigan</td>
<td>114</td>
</tr>
<tr>
<td>Minnesota</td>
<td>72</td>
</tr>
<tr>
<td>New Jersey</td>
<td>0</td>
</tr>
<tr>
<td>New York</td>
<td>52</td>
</tr>
<tr>
<td>Ohio</td>
<td>17</td>
</tr>
<tr>
<td>Ohio Children's</td>
<td>51</td>
</tr>
<tr>
<td>Premier</td>
<td>57</td>
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<tr>
<td>Pennsylvania</td>
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<tr>
<td>Vizient</td>
<td>20</td>
</tr>
<tr>
<td>Washington</td>
<td>55</td>
</tr>
</tbody>
</table>

Source: Program Evaluation Contractor (November 2018)
# VSRH/CAH with zero harm over previous 12 months

- Catheter-associated Urinary Tract Infection (CAUTI): 804
- Pressure Injury: 753
- Catheter-associate Blood Stream Infection (CLABSI): 743
- *Clostridium difficile (C. diff):* 588
- Venous Thromboembolism (VTE): 352
- Falls: 217

Source: Program Evaluation Contractor Formative Feedback Report (February 2019)
Opioids
The Problem

3 Waves of the Rise in Opioid Overdose Deaths

- Wave 1: Rise in Prescription Opioid Overdose Deaths
- Wave 2: Rise in Heroin Overdose Deaths
- Wave 3: Rise in Synthetic Opioid Overdose Deaths

As one of the largest payers of healthcare services, CMS has a key role in addressing the opioid epidemic and is focused on three key areas:

**PREVENTION**
Manage pain using a safe and effective range of treatment options that rely less on prescription opioids

**TREATMENT**
Expand access to treatment for opioid use disorder

**DATA**
Use data to target prevention and treatment efforts and to identify fraud and abuse
Early Successes

**COVERAGE**
CMS coverage policies now ensure some form of medication-assisted treatment across all CMS programs—Medicare, Medicaid, and Exchanges.

**AWARENESS**
CMS sent 24,000 letters in 2017 and 2018 to Medicare physicians to highlight that they were prescribing higher levels of opioids than their peers to incentivize safe prescribing practices.

**DATA**
CMS released data in 2017 and 2018 to show where Medicare opioid prescribing is high to help identify areas for additional interventions.

**TRACKING**
Due to safe prescribing policies, the number of Medicare beneficiaries receiving higher than recommended doses from multiple doctors declined by 40% in 2017.

**BEST PRACTICES**
CMS activated over 4,000 hospitals, 120,000 clinicians, and 5,000 outpatient settings through national quality improvement networks to rapidly generate results in reducing opioid-related events.

**ACCESS**
As of June 2018, CMS approved 12 state Medicaid 1115 demonstrations to improve access to opioid use disorder treatment, including new flexibility to cover inpatient and residential treatment while ensuring quality of care.
Future of our Health System

• Alternative Payment Models – all payers
  o Population based payments
  o Bundled Payments
  o Comprehensive Primary Care
  o Physician-focused APMs

• Private payer and CMS collaboration critical – alignment of incentives, payment models and measures

• States and Communities driving innovation and delivery system reform

• Patient-centered, team-based coordinated care is the norm

• System re-design through Lean, continuous improvement is widespread

• **Focus on quality and outcomes**
Action-focused Networks to Support State and Local Quality Improvement for Patients

Hospital Improvement and Innovation Networks
4,042 Hospitals

Transforming Clinical Practices Initiative
140,000+ Clinicians

End Stage Renal Disease Networks
7,000+ Dialysis Facilities

Beneficiary and Family Centered Care (BFCC) Quality Improvement Organizations
~800,000 Reviews Performed

Quality Innovation Networks – Quality Improvement Organizations
250+ Communities
12,000+ 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
Hospital Improvement Innovation Network

Latest Available Results
All Cause Harm Aim

20% Reduction in All-Cause Patient Harm

12% Reduction in 30-Day Readmissions
16 Hospital Improvement Innovation Networks

- American Hospital Association, HRET
- Carolinas HealthCare System
- Dignity Healthcare
- Healthcare Association of NY State
- HealthInsight
- Hospital & Healthsystem Association of Pennsylvania
- HSAG
- Iowa Healthcare Collaborative

- Michigan Health & Hospital Association
- Minnesota Hospital Association
- New Jersey Hospital Association, HRET
- Ohio Children’s Hospital Solutions for Patient Safety
- Ohio Hospital Association
- Premier
- Vizient
- Washington State Hospital Association
### Core Harm Areas

<table>
<thead>
<tr>
<th>Across 11 Harm Event Areas</th>
<th>Other Topic Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Adverse Drug Events (ADE)</td>
<td>• All Cause Harm</td>
</tr>
<tr>
<td>• Catheter-Associated Urinary Tract Infections (CAUTI)</td>
<td>• Airway Safety</td>
</tr>
<tr>
<td>• Central Line Associated Blood Stream Infections (CLABSI)</td>
<td>• Methicillin-Resistant Staphylococcus aureus (MRSA)</td>
</tr>
<tr>
<td>• <em>Clostridium difficile</em> Infections (CDI) and Antibiotic Stewardship</td>
<td>• Person and Family Engagement (PFE)</td>
</tr>
<tr>
<td>• Injury from Falls</td>
<td>• Health Disparities</td>
</tr>
<tr>
<td>• Pressure Ulcers</td>
<td>• Leadership and Safety Culture</td>
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<tr>
<td>• Preventable Readmissions</td>
<td></td>
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<tr>
<td>• Sepsis and Septic Shock</td>
<td></td>
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<tr>
<td>• Surgical Site Infections (SSI)</td>
<td></td>
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<tr>
<td>• Venous Thromboembolism (VTE)</td>
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<tr>
<td>• Ventilator-Associated Events (VAE)</td>
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</table>
20,500 lives saved

$7.7B in cost savings

910,000 fewer harms

Think about what these means for so many patients and families

Data Points: CMS' quality improvement organizations had far reach in 2017

By Modern Healthcare | September 15, 2018

**ANTIBIOTIC STEWARDSHIP**
- More than 7,600 outpatient facilities have been involved in an effort to reduce antibiotic-resistant bacteria.
- 48.7% of the outpatient settings have implemented the CDC's Core Elements of Outpatient Antibiotic Stewardship.

**BEHAVIORAL HEALTH**
- More than 5,050 practices were recruited to increase the number of alcohol and depression screenings.
- More than 306,600 alcohol screenings were conducted during primary-care visits.
- 837,800 depression screenings were conducted during primary-care visits.

**MEDICATION SAFETY**
- More than 7,450 facilities, clinicians, and practices are working with quality improvement organizations tolocal medication safety and prevent adverse drug events.
- More than 2.3 million beneficiaries are at high risk for an adverse drug event were screened.

**DIABETES CARE**
- More than 47,800 beneficiaries completed a diabetes self-management education and support program.
- More than 5,300 diabetes educators were trained.

**NURSING HOME CARE**
- There was a 26% reduction in anti-psychotic medication use among nursing homes across the nation.
- About 54,500 fewer nursing home patients received unnecessary anti-psychotic medications.

**DIABETES**
- Diabetes management programs were taught in different languages.

**NURSING HOME**
- More than 12,200 nursing homes were recruited for an effort to reduce healthcare-acquired conditions and improve patient care.
What are YOU most proud of?
Measuring National Progress
Leading Indicators
Getting to 20/12X 2019 or BEYOND!
Person & Family Engagement Metrics

**Governance**
- Patient and Family Advisor on Board
- PFAC or Representative on Quality Improvement Team

**Policy and Protocol**
- Planning Checklist
- Shift Change Huddles/Bedside Reporting
- PFE Leader or Functional Area

**Point of Care**
# Patient & Family Engagement Metrics

<table>
<thead>
<tr>
<th>Percentage of Hospitals</th>
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<tbody>
<tr>
<td>0%</td>
<td>47%</td>
<td>78%</td>
<td>53%</td>
<td>47%</td>
<td>38%</td>
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<tr>
<td>N=1,890</td>
<td>N=3,069</td>
<td>N=2,160</td>
<td>N=1,902</td>
<td>N=2,428</td>
<td>N=1,557</td>
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<td>PFE 1: Planning Checklist</td>
<td>PFE 2: Shift Change Huddles/Bedside Reporting</td>
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<td>N=2,428</td>
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### Source CMS

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<thead>
<tr>
<th>Metric</th>
<th>Description</th>
<th>Percent</th>
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<tbody>
<tr>
<td>Medicare FFS 30-Day All-Cause Readmission Rate per 100 admissions</td>
<td></td>
<td>-38.8%</td>
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<tr>
<td>Medicare FFS 30-Day All-Cause Readmission Rate per 1,000 beneficiaries</td>
<td></td>
<td>1.0%</td>
</tr>
<tr>
<td>PrU (Stage 3+) per 1,000 Discharges, Medicare FFS</td>
<td></td>
<td>7.8%</td>
</tr>
<tr>
<td>Postoperative PE or DVT Rate (PSI-12) per 1,000 Surgical Discharges, Medicare FFS</td>
<td></td>
<td>7.6%</td>
</tr>
<tr>
<td>Post-operative Sepsis per 1,000 Discharges (PSI-13), Medicare FFS</td>
<td></td>
<td>9.7%</td>
</tr>
<tr>
<td>Sepsis Mortality Rate for Medicare FFS Beneficiaries with Septicemia in U.S. Short-Term Acute Care Hospitals</td>
<td></td>
<td>12.7%</td>
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<tr>
<td>Septicemia with Death per 10,000 Medicare FFS Beneficiaries in U.S. Short-Term Acute Care Hospitals</td>
<td></td>
<td>3.8%</td>
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### National Healthcare Safety Network (NHSN) Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>SIR</th>
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<tbody>
<tr>
<td>CLABSI</td>
<td>24.3%</td>
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<tr>
<td>CAUTI SIR in ICUs</td>
<td>21.7%</td>
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<tr>
<td>SSI-Colon Surgery SIR</td>
<td>9.4%</td>
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<tr>
<td>SSI-Abdominal Hysterectomy SIR</td>
<td>1.0%</td>
</tr>
<tr>
<td>C. difficile SIR</td>
<td>31.3%</td>
</tr>
<tr>
<td>MRSA SIR</td>
<td>15.8%</td>
</tr>
<tr>
<td></td>
<td>Falls with Injury (NQF 0202) per 1,000 Patient Days</td>
</tr>
<tr>
<td>--------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>Falls</td>
<td>8.1%</td>
</tr>
<tr>
<td>VAE</td>
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</tr>
</tbody>
</table>
Medicare FFS 30-Day All-Cause Readmission Rate per 1,000 Medicare Beneficiaries

Baseline: 3.71 (Jan - Dec 2014)
Current: 3.42 (Oct 2018 – Dec 2018)

7.8% decrease from baseline

Source: Office of Enterprise Data & Analytics at CMS. March 2018 – December 2018 readmission rates were adjusted by a completion factor model to compensate for claims maturity lag. Includes U.S. short-term acute care hospitals.

Note: Phase shifts for the center line (dashed-green) and control limits (upper and lower) dashed lines were determined using guidelines consistent with the consensus of research on calculating U’ chart phase shifts.
What is your #1 insight from these national trends?

How do the results resonate with your experience?
2019 and Beyond

What does the future of the QIO Program & Patient Safety look like?
1. Improve Behavioral Health Outcomes, focusing on Decreased Opioid Misuse
2. Increase Patient Safety
3. Increase Chronic Disease Self-Management
4. Increase Quality of Care Transitions
5. Improve Long-Term Care Quality
NQIIC Task Orders

TASK ORDER 1
QIN-QIO Focused 12th Scope of Work

TASK ORDER 2
Clinician Quality Improvement Contractor (CQIC) Focused

TASK ORDER 3
Hospital Improvement & Innovation (HIIN) Focused

TASK ORDER 4
End-stage Renal Disease (ESRD) Networks Focused
NOTE: NQIICs can compete for any or all task orders with the potential to win one or more task orders. There will be individual task order competitions with multiple awardees for these task orders.
<table>
<thead>
<tr>
<th>Aims</th>
<th>National Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Improve Behavioral Health Outcomes, focusing on Decreased Opioid Misuse</td>
<td>Engage 414 communities and 6.8 million Medicare beneficiaries to improve access to behavioral care and improve behavioral health outcomes. <strong>Decrease opioid related adverse events</strong>, including deaths by 7%, with a focus on Medicare beneficiaries using opioids.</td>
</tr>
<tr>
<td>2. Increase Patient Safety</td>
<td>Reduce all cause harm in hospitals, community-based facilities, and long-term care settings by 2024, including: <strong>reduce by 10% or higher all cause harm in hospitals</strong> and reducing adverse drug events across all of these settings.</td>
</tr>
</tbody>
</table>
### National Targets for Five Aims

<table>
<thead>
<tr>
<th>Aims</th>
<th>National Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Increase Chronic Disease Self-Management</td>
<td>By 2024, help millions of people with the prevention and management of chronic diseases by: 1) supporting the Million Hearts Initiative to <strong>prevent 1 million cardiovascular events</strong> by improving aspirin use, blood pressure control, cholesterol management, smoking cessation and cardiac rehabilitation, 2) <strong>supporting 69,000 Medicare beneficiaries</strong> to quit smoking, 3) preventing <strong>25,171 Medicare beneficiaries</strong> from developing diabetes, 4) screen for, diagnose, and manage <strong>238,464 individuals with CKD</strong> to prevent progression of CKD or to ESRD; and 5) improving diabetes management in <strong>at least 238,464 Medicare beneficiaries</strong>.</td>
</tr>
<tr>
<td>4. Increase Quality of Care Transitions</td>
<td>Improve community-based care transitions to reduce hospital admissions by <strong>4.1% nationally</strong> and reduce hospital readmissions by <strong>5.4% nationally</strong>.</td>
</tr>
<tr>
<td>5. Improve Long-Term Care Quality</td>
<td>Improve quality and patient safety in long-term care settings by 2024, including: <strong>improve by 11%</strong> the mean total quality score for all nursing homes, <strong>reduce by 41%</strong> the percentage of nursing homes with a <strong>total quality score less than or equal to 1258</strong> (homes with a two-star or lower rating on the “quality measures” domain).</td>
</tr>
</tbody>
</table>
Thank you
Jade Perdue, MPA

Director, Quality Improvement Innovations Model Testing

Quality Improvement Innovations Group
Center for Clinical Standards & Quality
Centers for Medicare & Medicaid Services

Jade.perdue@cms.hhs.gov
Pressure Ulcers (Stage 3+) per 1,000 Discharges (PSI-03), Medicare FFS, HIIN-Aligned Hospitals

Baseline: 0.446 (Q4 2015-Q3 2016)

Year after baseline: 0.654 (Q4 2016-Q3 2017)

Current: 0.619 (Q4 2017–Q3 2018)

38.8% increase from baseline
5.4% decrease from year after baseline

Source: Office of Enterprise Data & Analytics at CMS.