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Connecting America for Better Health

CMS Value Based Purchasing; Better Care, Better Health, Lower Costs, Safer More Efficient Care

CMS Initiatives to Promote Quality, Safety and Prevent HACs &HAIs

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CMS' Quality Improvement Roadmap

- Vision: The right care for every person every time

- ***Institute of Medicine: Crossing the Quality Chasm: A New Health System for the 21st Century, March, 2001.***

  - Make care:
    - Safe
    - Effective
    - Efficient: **absence of waste, overuse, misuse, and errors**
    - Patient-centered
    - Timely
    - Equitable

The Three Part Aim, Goals of CMS

Better Care
- Patient Safety
- Quality
- Patient Experience

Reduce Per Capita Cost
- Reduce unnecessary and unjustified medical cost
- Reduce administrative cost thru process simplification

Improve Population Health
- Decrease health disparities
- Improve chronic care management and outcome
- Improve community health status

What's Wrong with US Healthcare Today?

Too Costly?

Inefficient?

Disparities in Access and Quality?

Evidence Base foundation often lacking?

Lack of Prevention focus?

*Fragmentation of care, between providers and sites of care? (Silos, care transitions)*

Poor information and data sharing and transfer?

Patient safety and quality ? (Compare to aviation industry?)

A payment system that rewards providing services rather than outcomes?

Coordinated, accountable or Uncoordinated, Unaccountable care?

Performance on Medicare Quality Indicators, 2000–2001

Quartile Rank

- ☐ First
- ▨ Second
- ▨ Third
- ▨ Fourth
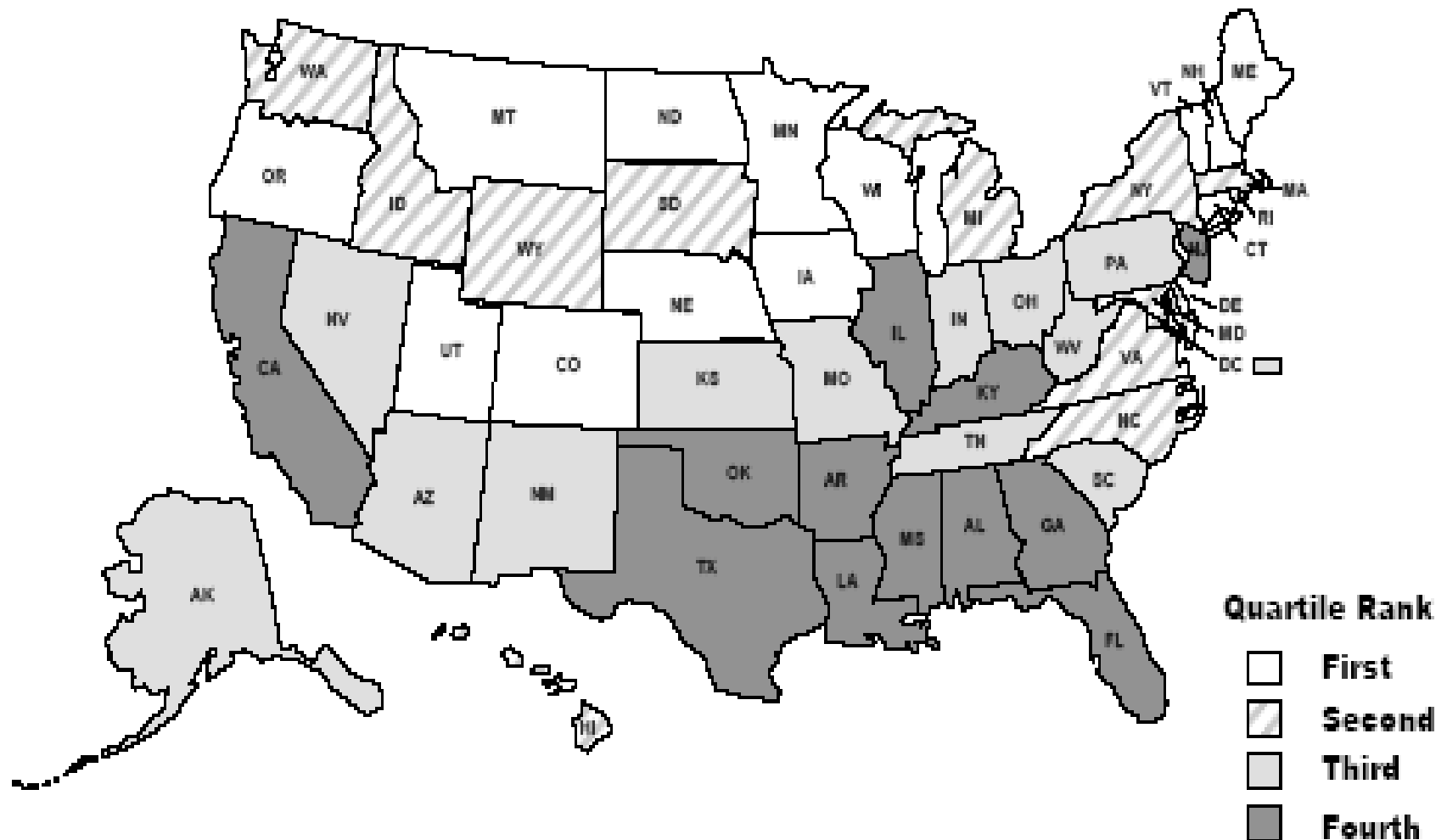
Source: S. F. Jencks, E. D. Huff, and T. Cuerdon, "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289 (Jan. 15, 2003): 305–312.

Median Pressure Sore Prevalence in U.S. Nursing Homes, 2006
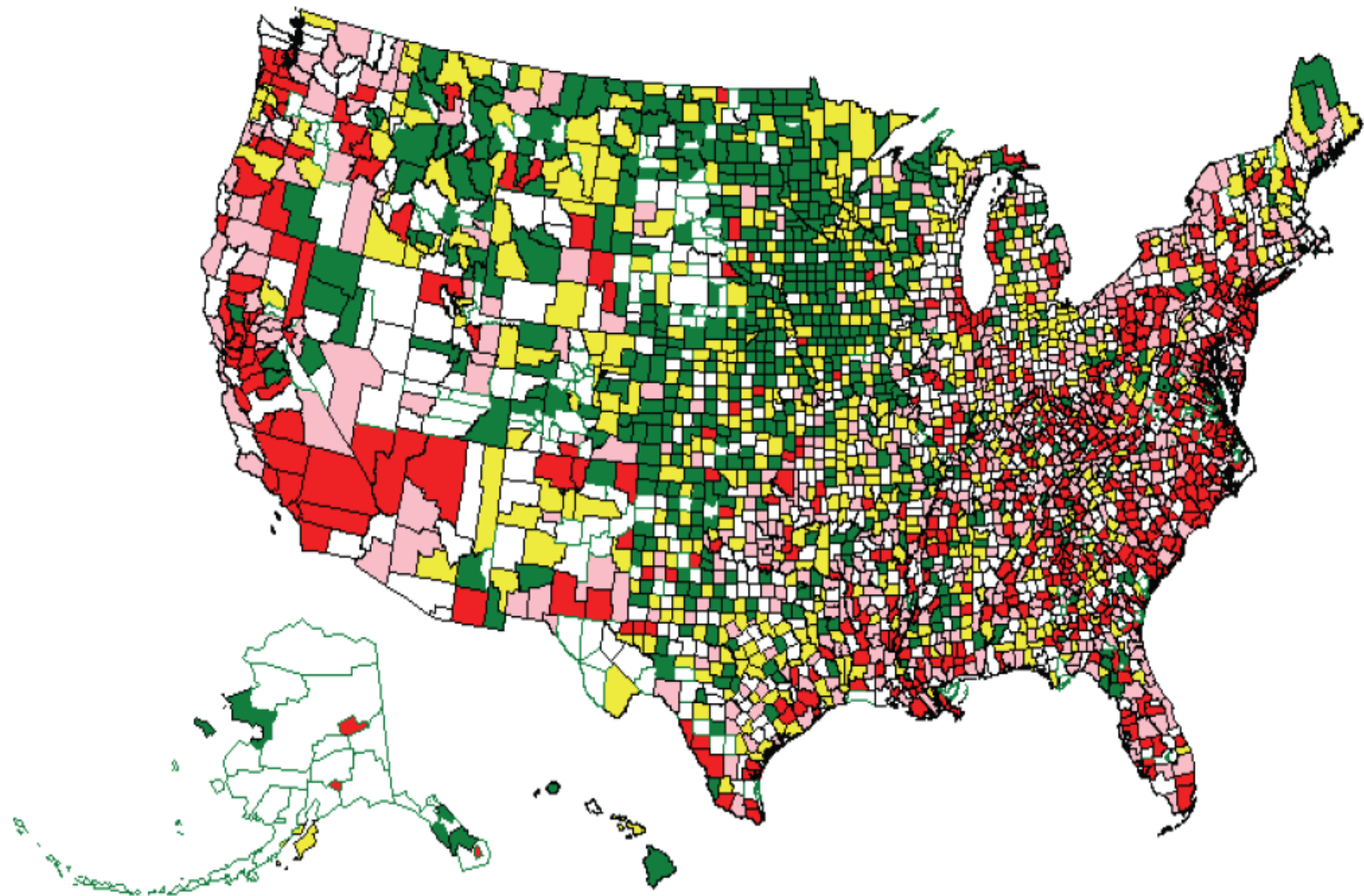
Source: MDS Data, June 2007

Legend: ■ <0.05 ■ 0.05-0.07 □ 0.08-0.08 ■ 0.09-0.10 ■ >=0.11

CMS
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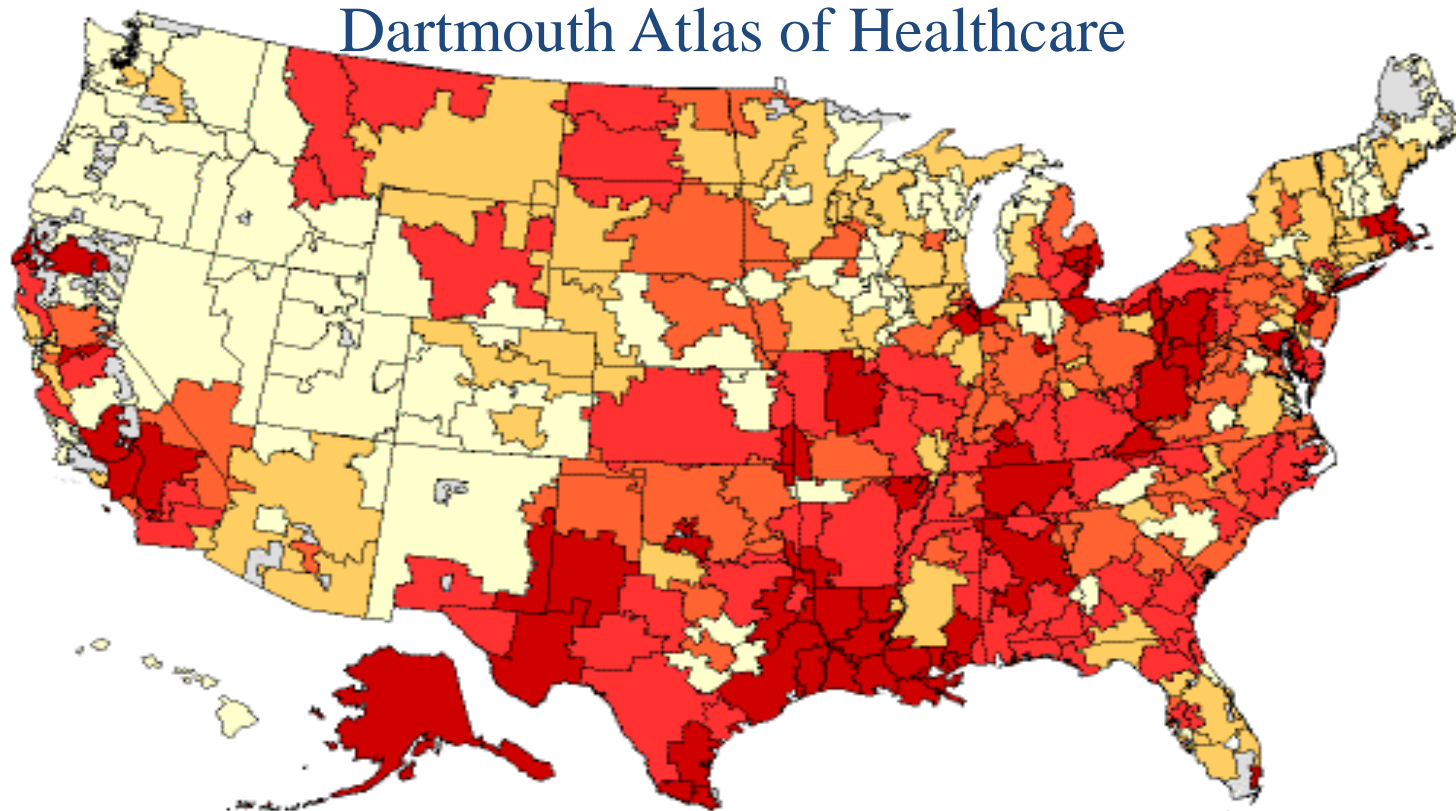
A Variation Problem

Dartmouth Atlas of Healthcare

Map 2.5. **Inpatient Hospital Services per Medicare Enrollee**
by Hospital Referral Region (1995)

- $2516 to 3723 (61)
- 2321 to < 2516 (60)
- 2117 to < 2321 (61)
- 1893 to < 2117 (62)
- 1483 to < 1893 (62)
- Not Populated
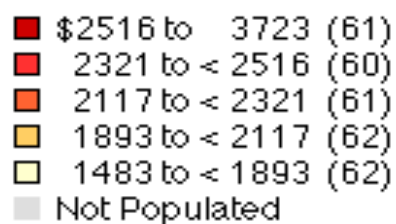
Perverse Incentives

Senator Charles E. Grassley
(R) Iowa
Senate Finance Committee

"Today, Medicare pays the same amount regardless of quality of care.

Some people would argue that in fact, the current Medicare payment system rewards poor quality," Grassley said.

This situation just doesn't make sense to me, nor should it to beneficiaries."

CQ HEALTHBEAT, JUNE 30, 2005

Value Based Purchasing Incentives

- **Incentivize the best care** and improve **transparency** for Beneficiaries

- **Transform CMS** from a **passive payer** to an **active purchaser** of care

- **Link payment to quality outcomes** and stimulate **efficiencies** in care

What Does VBP Mean to CMS?

- Transforming Medicare from a passive payer to an active purchaser of higher quality, more efficient health care

- Tools and initiatives for promoting better quality, while avoiding unnecessary costs

  - Tools: measurement, payment incentives, public reporting, conditions of participation, coverage policy, QIO program

  - Initiatives: pay for reporting, pay for performance, gain sharing, competitive bidding, bundled payment, coverage decisions, direct provider support (i.e. E.HR incentive etc)

Some Value-Based Purchasing Tools:

Performance measurement and Feedback

Payment incentives

Public reporting of performance –"Transparency"

-HAI rates CMS Hospital Compare website

National and local coverage policy decisions-no payment (or extra $) for certain HACs

Conditions of participation-survey-certification-INFECTION CONTROL

Direct support through Quality Improvement Organizations (QIOs)

Some Value-Based Purchasing Tools:

Hospital Compare

www.hospitalcompare.hhs.gov

Select the Patient Safety Measures tab during your hospital search to get information on Healthcare Associated Infections from the Centers for Disease Control and Prevention's National Healthcare Safety Network.

Some Value-Based Purchasing Tools:

EMORY UNIVERSITY HOSPITAL
1364 CLIFTON ROAD, NE
ATLANTA,GA 30322
Hospital Type:Acute Care Hospitals
Healthcare Associated Infections (HAIs)

Measure Description EMORY UNIVERSITY HOSPITAL GEORGIA Central Line Associated Blood Stream Infections (CLABSI) 0.28 Standardized infection Ratio Better than the U.S. National Benchmark 0.55

Some Value-Based Purchasing Tools:

Patients Safety Measures Graphs

Healthcare Associated Infections (HAIs)
Central Line Associated Blood Stream Infections (CLABSI)

The Central Line Associated Blood Stream Infections (CLABSI) Score is reported using a Standardized Infection Ratio (SIR). This calculation compares the number of central line infections in a hospital's intensive care unit to a national benchmark based on data reported to NHSN from 2006 – 2008. The result is adjusted based on certain factors such as the type and size of a hospital or ICU.

A score of less than 1 means that the hospital had fewer CLABSIs than hospitals of similar type and size.

Aviation or Health Care ?

We Must Make Medical Care Safer

- On any given day, 1 out of every 20 patients in American hospitals is affected by a hospital-acquired infection.

- Among chronically ill adults, 22 percent report a "serious error" in their care.

- One out of seven Medicare beneficiaries is harmed in the course of their care, costing the federal government over $4.4 billion each year.

- Medical harm is the fourth leading cause of death in the U.S. Each year, 100,000 Americans die from preventable medical errors in hospitals– more than auto accidents, AIDS, and breast cancer combined.

- Despite pockets of success -- we still see massive variation in the quality of care, and no major change in the rates of harm and preventable readmissions over the past decade.

We can do much better – and we must.

Partnership for Patients: Better Care, Lower Costs

Secretary Sebelius has launched a new nationwide public-private partnership to tackle all forms of harm to patients. Our goals are:

1. **Keep patients from getting injured or sicker. By the end of 2013**, preventable hospital-acquired conditions would **decrease by 40%** compared to 2010.

   - Achieving this goal would mean approximately 1.8 million fewer injuries to patients with more than **60,000 lives saved** over the next three years.

2. **Help patients heal without complication. By the end of 2013**, preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be **reduced by 20%** compared to 2010.

   - Achieving this goal would mean more than **1.6 million patients would recover** from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.

   - **Potential to save up to $35 billion dollars over three years.**

CMS Re-admissions

- 2009 national Medicare readmission rates
  - 19.6% within 30 days $15B in 2009 Medicare
  - 34.0% within 90 days
  - 56.1% within 365 days

- Hospital Compare website contrasts all 30 day readmission rates for every participating hospital to national average[1]

1. Hospitals that did not provide data had financial penalties in FFY 2012

Getting Started

Build on tremendous private sector enthusiasm

- Hundreds of hospitals, clinicians, employers, insurers, consumer groups and community organizations have already signed up!

Work with our partners to support the hard work of changing care delivery to make care safer

- Up to $500 million in financial support from the Innovation Center
- National-level content for anyone and everyone
- Supports for every facility to take part in cooperative learning
- An Advanced Participants Network for ambitious organizations to tackle all-cause harm
- Patient, family and professional engagement
- Improved measurement and data collection, without adding burdens to hospitals
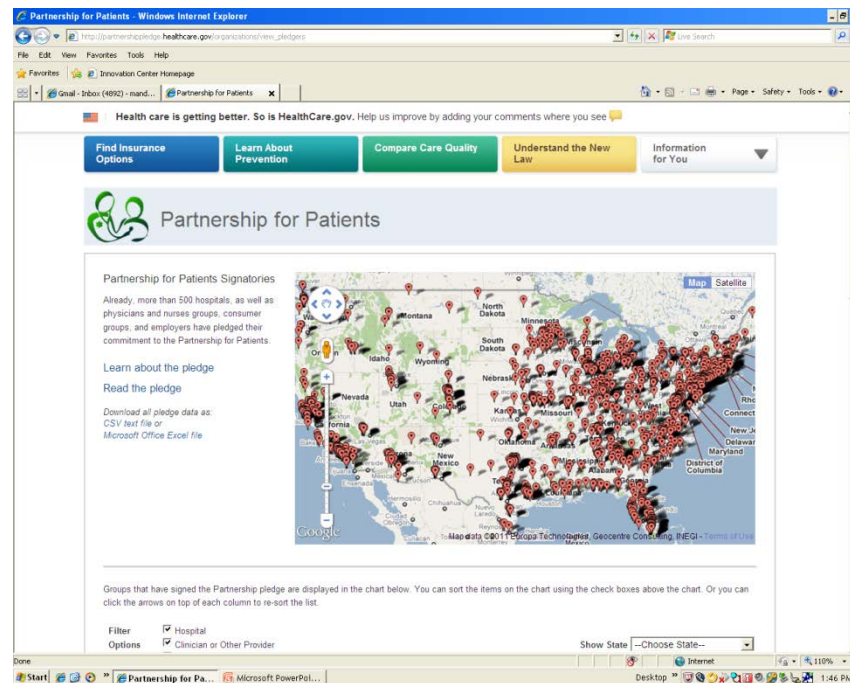
Work with communities to improve transitions between care settings:

- CMS is now accepting applications to participate in the Community-Based Care Transitions Program
- $500 million available for community-based organizations

How to Get Involved!

Join the Partnership for Patients – **Sign the Pledge!**

Go to www.healthcare.gov/center/programs/partnership

Improvement IS Possible

150 New Jersey health care facilities reduced pressure ulcers by 70%.

Rhode Island reported a 42% decrease in Central Line-Associated Bloodstream Infections (CLABSI) (2006-2007).

CLABSI rates dropped 35% in adult ICUs among the 350 hospitals participating in the *On the CUSP: Stop Blood Stream Infections* project.

More than 65 Institute for Healthcare Improvement Campaign **hospitals** reported going **more than a year without** a ventilator-associated pneumonia in at least one unit.

Ascension Health sites participating in a 2007 peri-natal safety initiative achieved birth trauma rates that were at or near zero.

And much more…

Why E-Prescribing?

98,000 die from medical errors annually

- More than breast cancer, AIDS, or motor vehicle accidents

1.5 million preventable adverse drug events annually

- Hospitals, long-term care, outpatient encounters
- 530,000 among Medicare beneficiaries
- $877 million per year for Medicare beneficiaries

Source Institute of Medicine 1999, 2000, 2003, 2006

A Current VBP Initiative

No payment for Hospital-Acquired Conditions

(POA indicator)

The HAC Problem

The IOM estimated in 1999 that as many as 98,000 Americans die each year as a result of medical errors

Total national costs of these errors estimated at $17-29 billion

IOM: To Err is Human: Building a Safer Health System, November 1999.
Available at: http://www.iom.edu/Object.File/Master/4/117/ToErr-8pager.pdf.

Statute: CMS must select conditions that are:

High cost, high volume, or both

Assigned to a higher paying DRG when present as a secondary diagnosis (unless POA-present on admission)

Reasonably preventable through the application of evidence-based guidelines

Hospital Acquired Conditions (1 of 3)

1. Foreign object retained after surgery
2. Air embolism
3. Blood incompatibility
4. Pressure ulcers
   - Stages III & IV
5. Falls
   - Fracture
   - Dislocation
   - Intracranial injury
   - Crushing injury
   - Burn
   - Electric shock

Hospital Acquired Conditions (2 of 3)

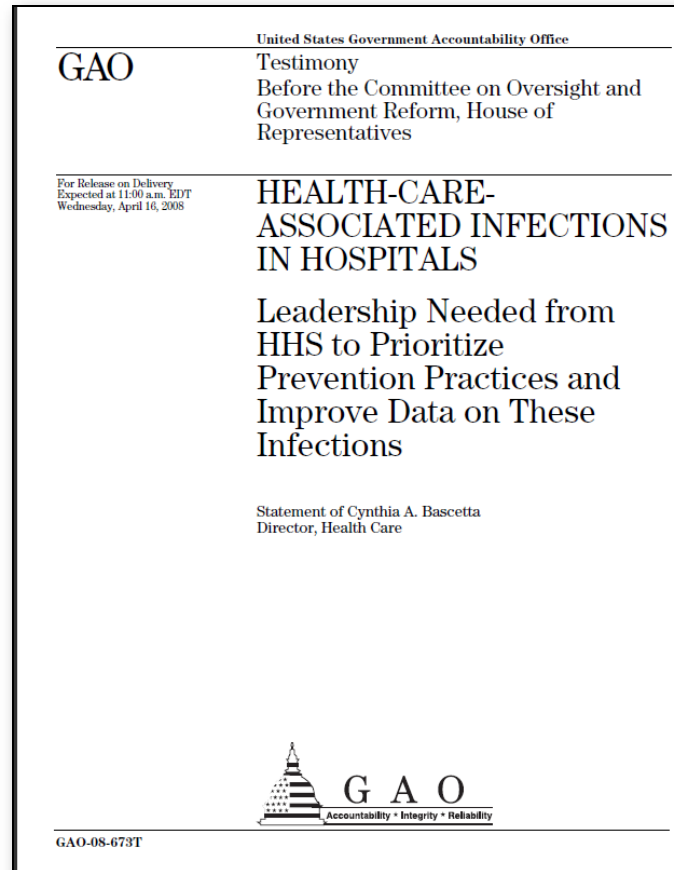6. Manifestations of poor glycemic control
   - Hypoglycemic coma
   - Diabetic ketoacidosis
   - Nonketotic hyperosmolar coma
   - Secondary diabetes with ketoacidosis
   - Secondary diabetes with hyperosmolarity

7. Catheter-associated urinary tract infection

8. Vascular catheter-associated infection

9. Deep vein thrombosis (DVT)/pulmonary embolism (PE)
   - Total knee replacement
   - Hip replacement

Hospital Acquired Conditions (3 of 3)

10. **Surgical site infection**
    - Mediastinitis after coronary artery bypass graft (CABG)
    - Certain orthopedic procedures
        - Spine
        - Neck
        - Shoulder
        - Elbow
    - Bariatric surgery for obesity
        - Laprascopic gastric bypass
        - Gastroenterostomy
        - Laparoscopic gastric restrictive surgery

HAI's: A National Problem

United States Government Accountability Office

GAO

Testimony
Before the Committee on Oversight and Government Reform, House of Representatives

For Release on Delivery
Expected at 11:00 a.m. EDT
Wednesday, April 16, 2008

HEALTH-CARE-ASSOCIATED INFECTIONS IN HOSPITALS

Leadership Needed from HHS to Prioritize Prevention Practices and Improve Data on These Infections

Statement of Cynthia A. Bascetta
Director, Health Care

GAO
Accountability * Integrity * Reliability

GAO-08-673T

The HAC/HAI Problem

In 2000, CDC estimated that hospital-acquired infections add nearly $5 billion to U.S. health care costs annually

Centers for Disease Control and Prevention: Press Release, March 2000. Available at: http://www.cdc.gov/od/oc/media/pressrel/r2k0306b.htm.

A 2007 study found that, in 2002, 1.7 million hospital-acquired infections were associated with 99,000 deaths

Klevens et al. Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002. *Public Health Reports*. March-April 2007. Volume 122.

The HAC/HAI Problem

A 2007 Leapfrog Group survey of 1,256 hospitals found that 87% of those hospitals do not consistently follow recommendations to prevent many of the most common hospital-acquired infections

2007 Leapfrog Group Hospital Survey. The Leapfrog Group 2007. Available at: http://www.leapfroggroup.org/media/file/Leapfrog_hospital_acquired_infections_release.pdf

HHS Action Plan

HHS Action Plan to Prevent Healthcare-Associated Infections 06222009
Section 2: Executive Summary

HHS Action Plan to Prevent Healthcare-Associated Infections:
EXECUTIVE SUMMARY

Background on Healthcare-Associated Infections

The Department of Health and Human Services (HHS) "Action Plan to Prevent Healthcare-Associated Infections" represents a culmination of several months of research, deliberation, and public comment to identify the key actions needed to achieve and sustain progress in protecting patients from the transmission of serious, and in some cases, deadly infections.

Healthcare-associated infections (HAIs) are infections that patients acquire while receiving treatment for medical or surgical conditions. HAIs occur in all settings of care, including acute care within hospitals and same day surgical centers, ambulatory outpatient care in healthcare clinics, and in long-term care facilities, such as nursing homes and rehabilitation facilities. HAIs are associated with a variety of causes, including (but not limited to) the use of medical devices, such as catheters and ventilators, complications following a surgical procedure, transmission between patients and healthcare workers, or the result of antibiotic overuse.

Healthcare-associated infections exact a significant toll on human life. They are among the leading causes of death in the United States, accounting for an estimated 1.7 million

HAI's: A National Priority

WHITE PAPER

Moving toward Elimination of Healthcare-Associated Infections: A Call to Action

Denise Cardo, MD; Penelope H. Dennehy, MD; Paul Halverson, DrPH, MHSA, FACHE; Neil Fishman, MD; Mel Kohn, MD, MPH; Cathryn L. Murphy, RN, PhD, CIC; Richard J. Whitley, MD, FIDSA; HAI Elimination White Paper Writing Group

INTRODUCTION

Jointly, the Association for Professionals in Infection Control and Epidemiology (APIC), the Society for Healthcare Epidemiology of America (SHEA), the Infectious Diseases Society of America (IDSA), the Association of State and Territorial Health Officials (ASTHO), the Council of State and Territorial Epidemiologists (CSTE), Pediatric Infectious Diseases Society (PIDS), and the Centers for Disease Control and Prevention (CDC) propose a call to action to move toward the elimination of healthcare-associated infections (HAIs) by adapting the concept and plans used for the elimination of other diseases, including infections. Elimination, as defined for other infectious diseases, is the maximal reduction of "the incidence of infection caused by a specific

clinicians attending the Fifth Decennial International Conference on Healthcare-Associated Infections 2010 is that now is the time to advance the cause of HAI elimination.[4] In this white paper, we embrace the goal of HAI elimination and we identify steps to achieve this goal. We are committed to working together to eliminate HAIs, recognizing that further work is needed to implement the steps identified in this call to action.

HAIs are an increasingly recognized problem. The number of people who are sickened or die and the financial impact from HAIs are unacceptably high.[5] Intrinsic to the problem is the inconsistent implementation of proven preventive measures. Furthermore, we know little about the burden of infections outside hospitals, particularly in long-term care fa-

Hospital Inpatient Quality Reporting Program (Pay for Reporting) - 1

CMS Hospital Quality Initiative

Voluntary

Tied to annual payment update since 2003

99% of hospital participate

- 96% received full Annual Payment Update in FY 2010

2% payment reduction if do not participate

Hospital Inpatient Quality Reporting Program (Pay for Reporting) - 2

10 quality measures in 2004

46 current quality measures

- 27 chart-abstracted
- 15 claims-based
- 1 survey-based
- 3 structural

Hospital Inpatient Quality Reporting Program
Changes for FY2011

Adding the following 10 measures:

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Pressure ulcer stages III & IV
- Falls & trauma
- **Vascular catheter-associated infection**
- **Catheter-associated UTI**
- Manifestations of poor glycemic control
- Post-operative respiratory failure
- Post-operative pulmonary embolism or DVT

Hospital Inpatient Quality Reporting Program
Additional Changes for FY 2011

Measures for FY2011 reporting:

- **AMI – Statin at discharge**
- **Catheter-associated blood stream infection (CABSI)**

Measures for FY2012 reporting:

- **2 measures of ED throughput**
- **2 global immunization measures**
- **Surgical site infection (SSI)**

Reporting to National Healthcare Safety Network:

- **Central line-associated blood stream infection (CLABSI) in 2011**
- **Surgical site infection (SSI) in 2012**
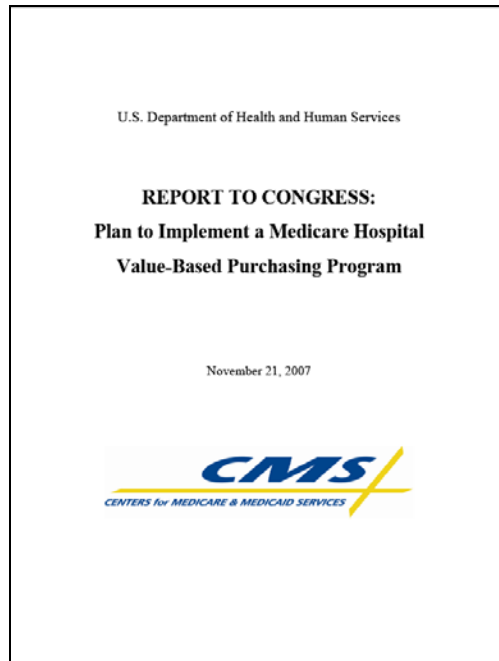
National Healthcare Safety Network
How Data Are Used

Improving patient safety at the local and national levels.

In aggregate, CDC analyzes and publishes surveillance data to estimate and characterize the national burden of healthcare-associated infections.
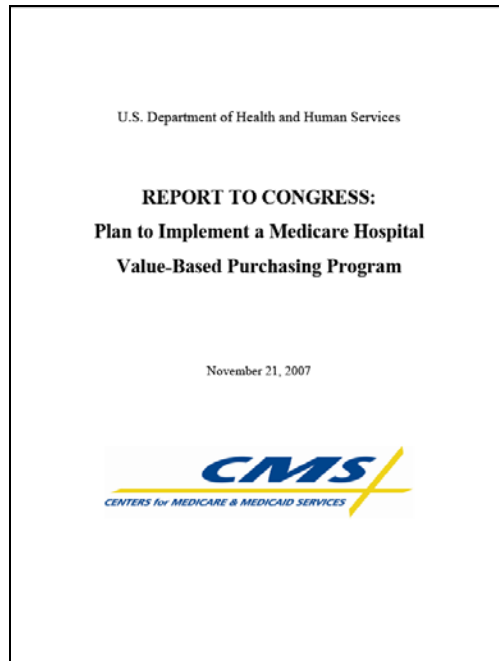
At the local level, the data analysis features of NHSN that are available to participating facilities range from rate tables and graphs to statistical analysis that compares the healthcare facility's rates with the national aggregate metrics.

Hospital Value-Based Purchasing Plan

U.S. Department of Health and Human Services

REPORT TO CONGRESS:

Plan to Implement a Medicare Hospital Value-Based Purchasing Program

November 21, 2007

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

- **Phased transition from Pay for Reporting to payment incentive (Pay for Performance)**

- **Translate performance score to incentive payment**

- **Reward achievement and/or improvement**

- **Affordable Care Act (ACA):**
  - **Begin FY 2013 (Oct 2012 et seq)**
  - **Incentive**
    - **1% in FY 2013**
    - **gradual increase to 2% FY 2017**

Hospital Value-Based Purchasing Plan

U.S. Department of Health and Human Services

REPORT TO CONGRESS:

Plan to Implement a Medicare Hospital Value-Based Purchasing Program

November 21, 2007

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

- **Included after FY 2014 are Hospital Acquired Conditions (HACs)**
- **To include CLABSIs and CAUTIs**

- Incentive- Pay for Performance
    - 1% in FY 2013
    - gradual increase to 2% FY 2017

Additional ACA Provisions

Sec 3008:
Affordable Care Act (ACA)
For hospital discharges beginning in FY 2015, acute care hospital in the top quartile of national risk adjusted rates for hospital acquired conditions (HACs) (i.e. bottom quartile performance) will receive a 1% reduction in payment.

Partnership for Patients. CMS will provide $1 billion in support to improve care within hospitals, and to improve care transitions

Beginning 2013, hospitals will receive payment reduction if excess 30 day readmission for MI, CHF, pneumonia

Beginning 2015, hospitals with high rates of HACs will receive further payment reductions

By 2015, most hospitals will face payment reductions if they do not meaningfully use health information technology

Medicare Hospital Value Payments 2011-2017

Policy	2011	2012	2013	2014	2015	2016	2017
Hospital Inpatient Quality Reporting Program /a	-2.0%	-2.0%	-2.0%	-2.0%	-1.0%	-1.0%	-1.0%
Meaningful Use + Incentive Payments /b -	.5%	1.7%	1.7%	1.3%	1.4% -1.0%	-2.0%	-3.0%
Hospital Acquired Conditions (Current) /c	-.02%	-.02%	-.02%	-.02%	-.02%	-.02%	-.02%
Hospital Acquired Conditions (ACA) /d					-1.0%	-1.0%	-1.0%
Readmissions /e			-1.0%	-2.0%	-3.0%	-3.0%	-3.0%
Hospital Value-Based +			1.0% - 1.0%	1.25% - 1.25%	1.5% - 1.5%	1.75% - 1.75%	2.0% - 2.0%

Parting Thoughts

Old thinking: "Make me the business case"- for quality.

New thinking: "Quality is the business"

(If you are not putting quality first, perhaps you are in the wrong business.)

Parting Thoughts

Old thinking- **Volume** and **product line margin** determines **income** –The CFO was responsible for profitability. ("no margin, no mission")

New thinking- The Chief Quality Officer will be equally important in your profitability.

("No outcome, no income")

Parting Thoughts

Old thinking-"many HAIs or HACs are inevitable but <u>some</u> may be preventable"

New thinking-"Each infection (HAI) or HAC is potentially preventable unless evidence shows otherwise".

Parting Thoughts

Culture change takes Leadership beginning with the governing board and CEO and continuing on down through every level of the organization. From the C-suite, the medical and nursing staffs to housekeeping. All have important responsibility for patient safety and quality.

Any member of the team should be empowered to say "time out" to prevent a potential harmful event.

Parting Thoughts

The delivery of health care is a <u>TEAM</u> sport.

We need more team players in healthcare and fewer "lone rangers".

Must <u>change culture</u> from "name and blame" to total systems improvement for patient safety.

"Any system is perfectly designed to deliver the results it delivers".

More information:

- **http://www.cms.gov**

- **www.hospitalcompare.hhs.gov**

- **http://www.cms.gov/HospitalAcqCond/**

- **http://www.cms.gov/Hospital-Value-Based-Purchasing/**

- http://www.innovations.cms.gov/

- www.healthcare.gov/center/programs/partnership
- www.healthcare.gov/partnershipforpatients

Questions?

THANK YOU