CMS –Better, Smarter, Healthier

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Centers for Medicare and Medicaid Services (CMS)
Center for Clinical Standards and Quality
Better Care, Smarter Spending, Healthier People

- In three words, our vision for improving health delivery is about **better, smarter, healthier**.

- If we find better ways to **deliver care, pay providers, and distribute information**, we can receive better care, spend our dollars more wisely, and have healthier communities, a healthier economy, and a healthier country.

- We understand that it’s **our role and responsibility to help lead ... and we will**.

- What we won’t do – and can’t do – is go it alone. Patients, physicians, government, and business all stand to benefit if we get this right, and this **shared purpose calls out for deeper partnership**.

- So we will continue to work across sectors and across the aisle for the goals we share: **better care, smarter spending, and healthier people**.
CMS support of Health Care Delivery System Reform (DSR) will result in better care, smarter spending, and healthier people

### Historical state

**Key characteristics**
- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented Care

**Systems and Policies**
- Fee-For-Service Payment Systems

### Evolving future state

**Key characteristics**
- Patient-centered
- Incentives for outcomes
- Sustainable
- Coordinated care

**Systems and Policies**
- Value-based purchasing
- Accountable Care Organizations
- Episode-based payments
- Medical Homes
- Quality/cost transparency
Delivery System Reform requires focusing on the way we pay providers, deliver care, and distribute information

<table>
<thead>
<tr>
<th>Focus Areas</th>
<th>Description</th>
</tr>
</thead>
</table>
| Pay Providers        | ▪ Promote value-based payment systems  
                        - Test new alternative payment models  
                        - Increase linkage of Medicaid, Medicare FFS, and other payments to value  
                        ▪ Bring proven payment models to scale |
| Deliver Care         | ▪ Encourage the integration and coordination of clinical care services  
                        ▪ Improve population health  
                        ▪ Promote patient engagement through shared decision making |
| Distribute Information| ▪ Create transparency on cost and quality information  
                            ▪ Bring electronic health information to the point of care for meaningful use |

Source: Burwell SM. Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care. NEJM 2015 Jan 26; published online first.
CMS Quality Strategy

**Goals**

- Make care safer
- Strengthen person and family centered care
- Promote effective communications and care coordination
- Promote effective prevention and treatment
- Promote best practices for healthy living
- Make care affordable

**Foundational Principles**

- Enable Innovation
- Foster learning organizations
- Eliminate disparities
- Strengthen infrastructure and data systems
January 2015 Announcement
• HHS Secretary Sylvia M. Burwell announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they give patients
• First time in the history of the program that explicit goals for alternative payment models and value-based payments set for Medicare
• Creation of national Health Care Payment Learning & Action Network to accelerate the transition and foster collaboration between private payers, employers, providers, consumers, and state/federal partners

Goals
1. Alternative Payment Models:
   1. 30% of Medicare payments are tied to quality or value through alternative payment models by the end of 2016
   2. 50% by the end of 2018
2. Linking FFS Payments to Quality/Value:
   1. 85% of all Medicare fee-for-service payments are tied to quality or value by 2016
   2. 90% by the end of 2018
## Payment Taxonomy Framework

<table>
<thead>
<tr>
<th>Category 1: Fee for Service - No Link to Quality</th>
<th>Category 2: Fee for Service - Link to Quality</th>
<th>Category 3: Alternative Payment Models Built on Fee-for-Service Architecture</th>
<th>Category 4: Population-Based Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Limited in Medicare fee-for-service</td>
<td>▪ Hospital value-based purchasing</td>
<td>▪ Accountable care organizations</td>
<td>▪ Eligible Pioneer accountable care organizations in years 3-5</td>
</tr>
<tr>
<td>▪ Majority of Medicare payments now are linked to quality</td>
<td>▪ Physician Value-Based Modifier</td>
<td>▪ Medical homes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Readmissions/Hospital Acquired Condition Reduction Program</td>
<td>▪ Bundled payments</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Comprehensive primary care initiative</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Comprehensive ESRD</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model</td>
<td></td>
</tr>
</tbody>
</table>

- Medicare FFS
- Medicare fee-for-service
- Majority of Medicare payments now are linked to quality
Target percentage of payments in ‘FFS linked to quality’ and ‘alternative payment models’ by 2016 and 2018

- **Alternative payment models (Categories 3-4)**
- **FFS linked to quality (Categories 2-4)**
- **All Medicare FFS (Categories 1-4)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Historical Performance</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>0% 68%</td>
<td>0% 68%</td>
</tr>
<tr>
<td>2014</td>
<td>22% 85%</td>
<td>30% 85%</td>
</tr>
<tr>
<td>2016</td>
<td>85% 85%</td>
<td>50% 90%</td>
</tr>
<tr>
<td>2018</td>
<td>50% 90%</td>
<td></td>
</tr>
</tbody>
</table>
CMS will reach Goal 2 through more linkage of FFS payments to quality or value

### Hospitals, % of FFS payment at risk

<table>
<thead>
<tr>
<th>Program</th>
<th>Performance period 2014 (payment FY16)</th>
<th>Performance period 2015 (FY17)</th>
<th>Performance period 2016 (FY18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAC (Hospital-Acquired Conditions)</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>IQR/MU (Inpatient Quality Reporting / Meaningful Use)</td>
<td>1.75</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>HVBP (Hospital Value-based Purchasing)</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Readmissions Reduction Program</td>
<td>6.75</td>
<td>8</td>
<td>8</td>
</tr>
</tbody>
</table>

### Physician / Clinician, % of FFS payment at risk

<table>
<thead>
<tr>
<th>Program</th>
<th>2014 Performance period (payment FY16)</th>
<th>2015 Performance period (payment FY17)</th>
<th>2016 Performance period (payment FY18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician VBM (Value-Based modifier)</td>
<td>2</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>MU (Electronic Health Record Meaningful Use)</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>PQRS (Physician Quality Reporting System)</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
CMS has a variety of quality reporting and performance programs

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

* Denotes that the program did not meet the statutory inclusion criteria for pre-rulemaking, but was included to foster alignment of program measures.
CMS framework for measurement maps to the six National Quality Strategy priorities

Care coordination
- Transition of care measures
- Admission and readmission measures
- Other measures of care coordination

Population/ community health
- Measures that assess health of the community
- Measures that reduce health disparities
- Access to care and equitability measures

Efficiency and cost reduction
- Spend per beneficiary measures
- Episode cost measures
- Quality to cost measures

Safety
- HCACs, including HAIs
- All cause harm

Person- and Caregiver-centered experience and outcomes
- CAHPS or equivalent measures for each setting
- Functional outcomes

Clinical quality of care
- HHS primary care and CV quality measures
- Prevention measures
- Setting-specific measures
- Specialty-specific measures

Greatest commonality of measure concepts across domains

- 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 six domains can be measured at each of the three levels

1. Community
   - Population-based denominator
   - Multiple ways to define denominator, e.g., county, HRR
   - Applicable to all providers

2. Practice setting
   - Denominator based on practice setting, e.g., hospital, group practice

3. Individual physician/EP
   - Denominator bound by patients cared for
   - Applies to all physicians/EPs

Increasing individual accountability

Increasing commonality among providers
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)
- Report once and receive credit for multiple programs
Hospital Inpatient Quality Reporting (IQR) Program

• Provides hospitals with financial incentive to report on quality of care delivery
• Provides Medicare beneficiaries with data to make informed decisions about their care
• Data used for CMS Hospital Value-Based Purchasing
• Applies to hospitals paid under the Inpatient Prospective Payment System (IPPS). Hospitals that meet data reporting requirements during a given calendar year receive their full IPPS annual payment update (APU); those hospitals that do not participate or fail to meet requirements receive a 2% percentage point reduction of their APU.

Includes 59 quality measures in several domains

Clinical Processes of Care -- Patient experience
Healthcare-Associated Infections (HAI) -- Structural Measures
Mortality and Readmissions -- Cost Efficiency
Over 5-years, Our Value-Based Purchasing Programs will increasingly help HHS achieve the three-part aim.

Vision for VBP programs

**Longer-term VBP program objectives (FY2017+)**
- Better care
- Better Health
- Lower Costs

**VBP program objectives over time**

**Initial programs years (FY2012-2013)**
- Limited to hospitals (HVBP) and dialysis facilities (QIP)
- Existing measures providers recognize and understand
- Focus on provider awareness, participation, and engagement

**Proposed and near-term programs (FY2014-2016)**
- Expand to include physicians
- New measures to address HHS priorities
- Increasing emphasis on patient experience, cost, and clinical outcomes
- Increasing provider engagement to drive quality improvements, e.g., learning and action networks

**Longer-term VBP program objectives (FY2017+)**
- VBP measures and incentives aligned across multiple settings of care and at various levels of aggregation (individual physician, facility, health system)
- Measures are patient-centered and outcome oriented
- Measure set addresses all 6 national priorities well
- Rapid cycle measure development and implementation
- Continued support of QI and engagement of clinical community and patients
- Greater share of payment linked to quality

**VBP measures and incentives**
- VBP measures and incentives aligned across multiple settings of care and at various levels of aggregation (individual physician, facility, health system)
- Measures are patient-centered and outcome oriented
- Measure set addresses all 6 national priorities well
- Rapid cycle measure development and implementation
- Continued support of QI and engagement of clinical community and patients
- Greater share of payment linked to quality
Introduction: Hospital VBP Program

- Required by the Affordable Care Act, which added Section 1886(o) in the Social Security Act
- Quality incentive program built on the Hospital Inpatient Quality Reporting (IQR) measure reporting infrastructure
- Next step in promoting higher quality care for Medicare beneficiaries
- Pays for care that rewards better value, patient outcomes, and innovations, instead of just volume of services
- Funded by the program year reduction from participating hospitals’ base-operating Diagnosis-Related Group (DRG) payments
  - 1.25% for FY 2014 and 1.50% for FY 2015
Hospital VBP Program

• For the first time, about 3,000 hospitals across the country will have payment more closely aligned with quality.

• In FY 2013, an estimated $850 million was redistributed to hospitals based on their overall performance on a set of quality measures that have been shown to improve clinical processes of care and patient satisfaction.

• This funding will be taken from what Medicare otherwise would have spent, and the size of the fund will gradually increase over time, resulting in a shift from payments based on volume to payments based on performance.

• We added outcomes, healthcare associated infection, and cost measures to the program for FY 2014 and FY 2015
  • FY 2014, 3 30-day mortality measures (AMI, HF, and PN)
  • FY 2015, CLABSI, AHRQ Patient Safety Indicator Composite, and Medicare Spending per Beneficiary measures
Fiscal Year (FY) 2017 Hospital Value-Based Purchasing Program

Patient and Caregiver Centered Experience of Care/Care Coordination

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Dimensions:
1. Communication with Nurses
2. Communication with Doctors
3. Responsiveness of Hospital Staff
4. Pain Management
5. Communication about Medicines
6. Cleanliness and Quietness of Hospital Environment
7. Discharge Information
8. Overall Rating of Hospital

Safety
1. AHRQ PSI-90: Complication/patient safety for selected indicators (composite)
2. CDI*: Clostridium difficile Infection
3. CAUTI: Catheter-Associated Urinary Tract Infection
4. CLABSI: Central Line-Associated Blood Stream Infection
5. MRSA*: Methicillin-Resistant Staphylococcus aureus Bacteremia
6. SSI: Surgical Site Infection Colon Surgery & Abdominal Hysterectomy

Clinical Care Outcomes
1. MORT-30-AMI: Acute Myocardial Infarction (AMI) 30-Day Mortality Rate
2. MORT-30-HF: Heart Failure (HF) 30-Day Mortality Rate
3. MORT-30-PN: Pneumonia (PN) 30-Day Mortality Rate

Clinical Care Process
1. AMI-7a: Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
2. PC-01*: Elective Delivery Prior to 39 Completed Weeks Gestation
3. IMM-2: Influenza Immunization

Efficiency and Cost Reduction
1. MSPB-1: Medicare Spending per Beneficiary (MSPB)
The ESRD QIP is the first Federal Value-Based Purchasing (VBP) Program. CMS views value-based purchasing (VBP) as an important step in redesigning how healthcare and healthcare services are paid for, moving increasingly toward rewarding better value, outcomes, and innovations—instead of merely volume.

Complements other CMS Quality Improvement initiatives for ESRD.

ESRD QIP is mandated by the Medicare Improvements for Patients and Providers of 2008 (MIPPA):

- §153(b) expands the payment bundle to include expensive items that were previously separately billable, and may create incentives for providers to “cherry-pick”
- §153(c) establishes a mandate for payment reductions up to 2% for dialysis providers that do not meet or exceed ESRD QIP performance standards.

ESRD QIP is intended to incentivize quality improvement.
Hospital Outpatient Quality Reporting (OQR) Program

- Provides outpatient hospitals paid under the Outpatient Prospective Payment System (OPPS) with financial incentive to report on quality of care delivery.
- Provides Medicare beneficiaries with data to make informed decisions about their care.
- Hospitals that meet data reporting requirements during a given calendar year receive their full OPPS annual payment update (APU); those hospitals that do not participate or fail to meet requirements receive a 2% percentage point reduction of their APU.

Includes 24 quality measures in several domains:

<table>
<thead>
<tr>
<th>Cardiac Care</th>
<th>Surgical Care Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td>Pain Management</td>
</tr>
<tr>
<td>Emergency Department Throughput</td>
<td>Imaging Efficiency Measures</td>
</tr>
<tr>
<td>Structural Measures</td>
<td></td>
</tr>
</tbody>
</table>
Hospitals Want You to Know...

- From April 2012 to March 2013:
  - Jackson Hospital’s (Marianna, FL) Median Time to Transfer to Another Facility for Acute Coronary Intervention decreased from 161 minutes to 120 minutes
  - Palo Verde Hospital’s (Blythe, CA) Aspirin at Arrival rate increased from 52.6% to 82.9%
  - Hahnemann University Hospital’s (Philadelphia, PA) Patient Door to Diagnostic Evaluation by a Qualified Medical Professional decreased from 40 minutes to 32 minutes

OQR Measures OP-3b, OP-4, and OP-20, respectively
The IPFQR program awards reimbursement under Medicare’s IPF Prospective Payment System (PPS) to eligible facilities reporting quality measure data.

CMS has adopted six National Quality Forum (NQF)-endorsed measures measuring important quality components applicable to inpatient psychiatric care. These measures are:

- Hours of Physical Restraint Use
- Hours of Seclusion Use
- Patients Discharged on Multiple Antipsychotic Medications
- Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification
- Post Discharge Continuing Care Plan Created
- Post Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge
The Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR) Program requires 11 PPS exempt cancer hospitals to submit data for specific cancer clinical process of care measures.

PCHQR encourages hospitals and clinicians to improve the quality of inpatient care provided to Medicare beneficiaries by ensuring that providers are aware of and reporting on best practices for their respective facilities and type of care.

CMS has identified three National Quality Forum–endorsed quality of cancer care measures that will be reported on the Hospital Compare website:

| Measures Finalized in the FY 2013 IPPS/LTCH PPS Final Rule Beginning with FY 2014 |
| Safety and Healthcare Acquired Infections—HAI |
| • (NQF #0139) NHSN Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure |
| • (NQF #0138) NHSN Catheter-Associated Urinary Tract Infections (CAUTI) Outcome Measure |

| Clinical Process/Cancer-Specific Treatments |
| • (NQF #0223) Adjuvant Chemotherapy is considered or administered within 4 months (120 days) of surgery to patients under the age of 80 with AJCC III (lymph node positive) colon cancer |
| • (NQF #0559) Combination Chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1c, or Stage II or III hormone receptor negative breast cancer |
| • (NQF #0220) Adjuvant Hormonal Therapy |
Ambulatory Surgical Center Quality Reporting Program (ASCQR)

- Provides ASC’s paid under the ASC Prospective Payment System (ASC-PPS) with financial incentive to report on quality of care delivery.
- Provides Medicare beneficiaries with data to make informed decisions about their care.
- Hospitals that meet data reporting requirements during a given calendar year receive their full ASC-PPS annual payment update (APU); those hospitals that do not participate or fail to meet requirements will receive a 2% percentage point reduction of their applicable annual APU starting with CY 2014.

**ASC Quality Measures**

ASC-1: Patient Burn
ASC-2: Patient Fall
ASC-3: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant
ASC-4: Hospital Transfer/Admission
ASC-5: Prophylactic Intravenous IV Antibiotic Timing
ASC-6: Safe Surgery Checklist Use
ASC-7: ASC Facility Volume Data on Selected ASC Surgical Procedures
CMS At Work Engaging Patients and Families

Policy, Programs and Quality Improvement
- Focused Groups/Patients in the Room for Program Development
- Incorporating Public Comments
- Learning and Action Networks with Patients
- Measures Development and Patient Reported Outcomes
- Patient’s Experience of Care Data
- Partnership for Patients
- QIOs/ESRD Networks Improvement Activities and Technical Assistance

Benefit Design, Value and Incentives
- Weighting of Patient Experience and Patient Reported outcomes in VBP Programs
- Innovations Models (e.g. Medicare Care Choice Models for Palliative Care; Premium design and co-pay innovations)
- Money Follows the Person
- Promoting Patient Adherence
- “From Coverage to Care” Activities

Engagement in Decision-making, Care Coordination, Prevention and Treatment
- CMS Compare Sites
- Early Elective Delivery Reduction Initiative
- Every person with Diabetes Counts
- Transforming Clinical Practice Initiative
- Use of Decisions Support Tools in HIT
- MU requirements for providing info to patients
- Advanced Directives
- Promoting respect for Patient Values, Cultures and Traditions

Family and Caregiver Support and Engagement
- Families in the Room opportunities
- Learning and Action Network Participation
- Respite Programs
- Medicaid Family Counseling Programs
- Caregiver resources on Medicare.gov
Quality Improvement Efforts
Learning and Action Network Approach to Learning Organizations

Support for Learning and Action Networks With Presetablished Targets and Goals

- Using QI Tools/PDSA for improvement
- Collaborations with Partners and Sharing Best Practices
- Hands on Technical Assistance
- Sharing of Best Practice at Local and National Level
- Process Reengineering and Lean
- CMS, Payor, Beneficiary and other Data for analysis
Quality Innovation Network (QIN-QIO) Work

**QIN NCC**

**A. Excellence in Operations**
- B. Better Health
  - B1. Improving cardiac health & reducing cardiac disparities
  - B2. Reducing disparities in diabetes care
  - B3. Coordinating care through Immunization IS
  - B4. Coordinating prevention through HIT meaningful use

**Essential Functions**
1. Results-Oriented Quality Improvement Activities
2. Community Learning and Action Networks
3. Technical Assistance (i.e., QI Experts)
4. Integrated Communications

**C. Better Care**
- C1. Reducing care-associated infections
- C2. Reducing care-acquired conditions
- C3. Coordinating care to reduce readmits & adverse drug events

**D. Lower Costs**
- D1. TA provided to for Physician Value Modifier
- D2. Local QIO Projects

**E. Technical Assistance**
- BFCC
- VBP

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Reduced Potential for Adverse Drug Events

2,629 more beneficiaries have **INRs within Therapeutic Range**
Improving the lives of Diabetics…

5,371 diabetics now in control of A1c levels

More diabetics informed & self-managing their health.
Safer Injections. Less infection.

53% relative improvement in reduced Central Line Associated Blood Stream Infections (CLABSI)

Approximately 198 less central-line associated blood-stream infections for beneficiaries
# of Instances | Baseline | Re-measurement | Difference
--- | --- | --- | ---
10,784 | 7,818 | 2,966

# of Residents | Baseline | Re-measurement | Difference
--- | --- | --- | ---
6,794 | 4,717 | 2,077
5,840 beneficiaries

FREE

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Re-measurement</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Instances</td>
<td>15,263</td>
<td>4,613</td>
<td>10,650</td>
</tr>
<tr>
<td># of Residents</td>
<td>8,259</td>
<td>2,419</td>
<td>5,840</td>
</tr>
</tbody>
</table>
Partnering to Rapidly Improve Care…
The Nursing Home Collaborative

# of Nursing Homes with CCNs Participating in the National Collaborative

6,500 Nursing Homes recruited!
## NNHQCC Project Participation

<table>
<thead>
<tr>
<th>Topic</th>
<th># Homes</th>
<th>% Homes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antipsychotic Med</td>
<td>4,566</td>
<td>91.45</td>
</tr>
<tr>
<td>Falls</td>
<td>2,236</td>
<td>44.78</td>
</tr>
<tr>
<td>Pressure Ulcer</td>
<td>1,487</td>
<td>29.78</td>
</tr>
<tr>
<td>UTI</td>
<td>1,252</td>
<td>25.08</td>
</tr>
<tr>
<td>Staff Turnover/Stability</td>
<td>1,246</td>
<td>24.95</td>
</tr>
<tr>
<td>Hospitalizations, Care Transitions</td>
<td>1,183</td>
<td>23.69</td>
</tr>
<tr>
<td>Consistent Assignment</td>
<td>896</td>
<td>17.95</td>
</tr>
</tbody>
</table>
Nursing Homes Composite Scores* by Recruitment Status
*(The lower the score, the better!)

1st full time period after NNHQCC launch

NNHQCC begins
QIOs are working with **over 400 communities** nationally to improve transitions of care.
By working with QIOs, communities across the country have collectively saved **over 27,000 people** from being readmitted and **over 95,000 people** from being admitted to the hospital. This implies **nearly 1 billion in cost savings**.

$912,000,000 in cost savings
### QIO Accomplishments

<table>
<thead>
<tr>
<th># of Engaged Communities</th>
<th>410</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Beneficiaries Living there</td>
<td>14,607,292</td>
</tr>
<tr>
<td># Communities with Signed Coalition Charter</td>
<td>230</td>
</tr>
<tr>
<td># Communities Receiving Formal Funding</td>
<td>83</td>
</tr>
<tr>
<td># Recruited Hospitals</td>
<td>884</td>
</tr>
<tr>
<td># Recruited Nursing Homes</td>
<td>1,619</td>
</tr>
<tr>
<td># Recruited Home Health Agencies</td>
<td>965</td>
</tr>
<tr>
<td># Recruited Hospice Facilities</td>
<td>367</td>
</tr>
<tr>
<td># Recruited Dialysis Facilities</td>
<td>92</td>
</tr>
<tr>
<td># Recruited Outpatient Physicians</td>
<td>&gt; 1,975</td>
</tr>
</tbody>
</table>
Seasonally-adjusted Admission Rates per 1,000 benes

Relative Improvement
Baseline to Remeasurement
Nation 8.17
Coalition A 8.38
Seasonally-adjusted Readmission Rates per 1,000 benes

Coalition A
Relative Improvement
Baseline to Remeasurement
Nation: 12.65
Coalition A: 13.25
How will we get there?

- **Eliminate** patient harm
- **Focus** on better health, better care, and lower costs for the patient population you serve
- **Engage** in accountable care and other alternative contracts that move away from fee-for-service to model based on achieving better outcomes at lower cost
- **Invest** in the quality infrastructure necessary to improve
- **Focus** on data and performance transparency
- **Develop** specialty physician payment and service delivery models
- **Test** new innovations and scale successes rapidly
- **Relentlessly pursue** improved health outcomes
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