Creating a Win-Win Future:

Patients, Providers, and Health Plans Working Together

Illinois Association for Healthcare Quality Annual Meeting

April 29, 2016

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Telligen

Objectives

- ✓ Alignment, Integration, Collaboration, Coordination
- ✓ Expanding engagement of patients, families, consumers in health care
- ✓ Current requirements; those in development
- ✓ Future of healthcare
- ✓ Start now

Alignment, Integration, Collaboration, Coordination

- Performance measurements and incentives aligning
- To be successful, integration of performance efforts must occur
- Collaboration with all stakeholders is key to advancing care and leveraging resources
- Coordination within and outside of care settings is essential for providers and patients

Changing Environment

- Hospitals undergoing change – major focus on:
  - Readmissions
    - Targeted and all cause
  - Hospital acquired infections
    - CLABSI, CAUTI, MRSA, C-Diff
  - Hospital acquired conditions
    - Avoidable complications
    - Sepsis

Readmissions

- How best to address
- Understand patient and family discharge needs and support systems
- Using best practice methods – teach back, warm hand-offs, motivational approaches
- Understanding community needs and resources
- Engaging patients, families, and consumers in targeted advisory groups and ongoing advice and guidance

Avoidable Infections and Complications

- CDC and CMS Goal of Getting to Zero
- Engagement of patients and families in solutions
  - Are they part of the discussion
  - How do we engage them when a complication or infection occurs?
  - How do we engage the family?
  - What type of follow up do we undertake?
  - What do we learn from a RCA and how do we spread the lessons learned?
  - Do we engage the patient or family in the solution making process?

HAC Proposal for 2017

- Shift to a Winsorized Z Score Method

Z Score = (Hospital's Measure Performance – Mean Performance for All Hospitals)

Standard Deviation for All Hospitals

Change modeled from 2016 data expects to shift 114 hospitals into penalty and 103 into no penalty

Nursing Homes

- Required by law to have resident or resident and family councils
- Information on Nursing Home Compare – www.medicare.gov/nursinghomecompare
  - 746 nursing homes in Illinois; 36% Star 1 or 2 Ratings
  - Specialized Mental Health Rehabilitation Facilities (SMHRFs) removed from CMS Nursing Home listing
- CMS suggests asking why there is not a resident and family council; speak to the president of the council
- Engagement occurs at various levels
- Some actively engaged in leading the nursing home

Nursing Home Rankings for Dementia Care

- Illinois ranked 50 out of 51 in administration of antipsychotic medications to dementia residents
- 21.71 of dementia residents are on antipsychotic medications
- National Institute of Health and National Institute of Mental Health recent reports in March and April 2016:
  - Antipsychotic medications for dementia patients advances ‘early death’
  - Antipsychotic medications for dementia patients with chronic diseases complicates care and outcomes

Dialysis Facilities

- No requirements for patient or family councils
- Overall and readmission ratings on Dialysis Facility Compare – www.medicare.gov/dialysisfacilitycompare
- Detailed information on ESRD facilities
  - http://www.hfsrb.illinois.gov/ESRD%20Profiles.htm
- Highest rates of readmission for any segmented group of patients
- Network 10 ESRD QIO serves Illinois
  - Located in Indianapolis
  - Board and councils with some patient and provider engagement

Home Health Reporting and Value Based Purchasing – IMPACT Legislation

- Patient Rights
- Effective communication
- Standardize Patient Assessment Tools
- 2015 – 2017 – Home Health Compliance Reporting of OASIS – 2% penalty for failure to meet thresholds
  - 2015 70%; 2016 80%; 2017 90%
- Home Health Agency VBP to be announced with 2016 rules based upon pilot with 5% to 8% of payments at risk

Medicare Access and CHIP Reauthorization Act of 2015 MACRA

- Patient-centered to promote highest quality and most coordinated care for beneficiaries
- Second, to be practice-driven, so physicians can select among measures that are right for their practices
- Third, consistent with the goals of the legislation to make it as simple as possible for physicians

Medicare Access and CHIP Reauthorization Act of 2015 MACRA

- Result of Sustainable Growth Rate compromise
- Focus on:
  - Moving providers to Alternative Payment Models (APM)
    - APMs include models with both risk and reward for providing coordinated, high-quality care
      - Comprehensive ESRD Care Model (Large Dialysis Organization arrangement)
      - Comprehensive Primary Care Plus (CPC+)
      - Medicare Shared Savings Program – Track 2
      - Medicare Shared Savings Program – Track 3
      - Next Generation ACO Model
      - Oncology Care Model Two-Sided Risk Arrangement (available in 2018)
  - Merit-based Incentive Payment System (MIPS)

MIPS

- First year – January 1, 2017 – December 31, 2017
- The maximum negative adjustments for each year are:
- 2019 –4 percent
- 2020 –5 percent
- 2021 –7 percent
- 2022 and after –9 percent

MIPS

- **Quality** – 50% of a total score in year one
  - Clinicians would choose to report six measures from among a range of options that accommodate differences among specialties and practices.
- **Cost** - 10 % of total score in year one based on Medicare claims
  - Category includes 40 episode-specific measures to account for differences among specialties.
- **Advancing Care Information** - 25 % of total score in year one
  - Clinicians choose to report customizable measures reflecting their use of technology in day-to-day practice with emphasis on interoperability and information exchange. This is not an all or nothing level of participation
- **Clinical Practice Improvement Activities** – 15% of total score in year one
  - Rewarding clinical practice improvements, such as activities focused on care coordination, beneficiary engagement, and patient safety – clinicians will be able to submit from a list of more than 90 options

MACRA

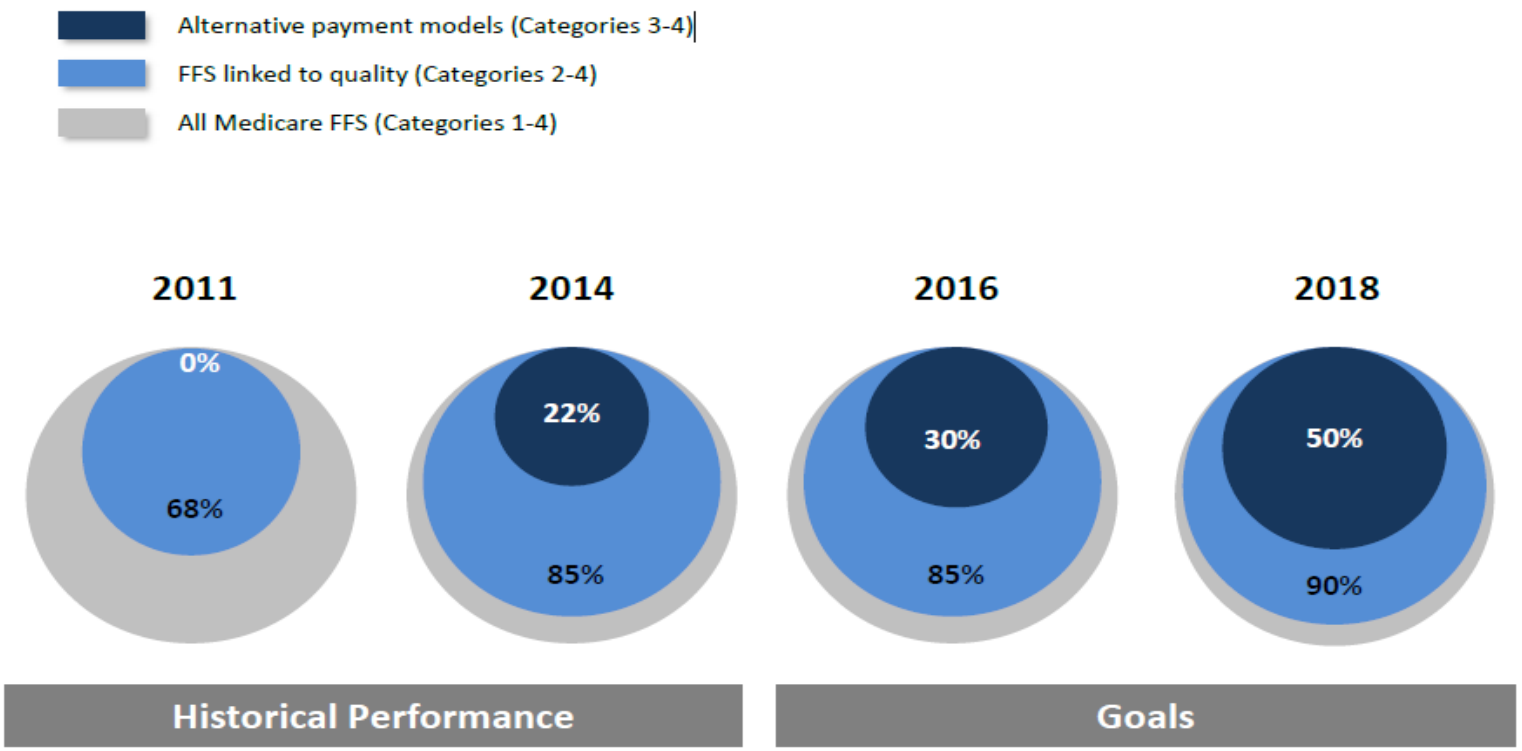
- To be successful, need person, family, and community engagement
- ACOs
  - Preventive care
  - Disease management
  - Care management
  - Goals of care

MIPS Success – Engaging Persons, Families, and Consumers

- Quality
  - Process and outcome measurements
- Cost:
  - efficiency measurements; avoidable hospitalizations and readmissions
- Advancing Care Improvement:
  - Protect Patient Health Information (yes/no)
  - Electronic Prescribing (numerator/denominator)
  - Patient Electronic Access (numerator/denominator)
  - Coordination of Care Through Patient Engagement (numerator/denominator)
  - Health Information Exchange (numerator/denominator)
  - Public Health and Clinical Data Registry Reporting (yes/no)
- Clinical Practice Improvement:
  - Expanded Practice Access
  - Population Management
  - Care Coordination
  - Beneficiary Engagement
  - Patient Safety and Practice Assessment
  - Participation in a medical home model
  - Achieving Health Equity
  - Emergency Preparedness and Response
  - Integrated Behavioral and Mental Health

CMS Transition to APMs

Target percentage of payments in 'FFS linked to quality' and 'alternative payment models' by 2016 and 2018



Social Determinant Research and Reports

- Institute of Medicine – 3 Reports Series
- Required under IMPACT (Improving Medicare Post-Acute Care Transformation) Act of 2014
  - Impact of Socioeconomic Status (SES) on quality and resource use
  - The first report released January 12, 2016 entitled "Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors."
  - The second report released April 7, 2016 entitled "Systems Practices for the Care of Socially At-Risk Populations."
  - The third report provides suggestions for risk adjustment in quality measurement and payment methodologies

http://nationalacademies.org/hmd/Activities/Quality/Accounting-SES-in-Medicare-Payment-Programs.aspx

2014 PFEC and Work to Reduce Readmissions

- ✓ Understood relationship between low rates of immunization and higher rates of readmissions
- ✓ PFEC aimed at identifying barriers to seniors using preventive services
- ✓ 4 Chicago communities selected: largely black and Hispanic
  - Englewood, Washington Heights, Lawndale, and Little Village experienced greatest violence and lowest health indicators – low rate of immunizations; high incidence of diabetes, amputations, hypertension; high rates of readmissions; high rates of Years Potential Lives Lost
  - Negative socio-economic factors – high poverty rates; high unemployment rates; low rates of high school graduation; health professional shortage area; pharmacy desert.

Developing Rapport with Seniors

- Established trusting relationships with community and faith based groups; opened up doors to seniors
- Conducted focused group sessions with seniors – over 800 seniors reached in a few months
- Key Findings:
  - Lack of Access to Services – distance, weather, and violence
  - Hispanics did not understand Medicare programs – especially Part D
  - HRSA Health Professional Shortage Areas existed in study areas
  - Mapping helpful to understanding social determinant relationships
  - While not a focus group discussion topic, every group session the issue of fraud was brought up
  - Several myths and concerns around immunizations persisted – not covered by Medicare, live virus causing flu; and concerns among black men over the Tuskegee syphilis experiment and other vaccines tests on Africans

Immunization Interventions

- Developed brochures in English and Spanish based upon their concerns and information they requested
  - Information included facts on key Medicare coverage issues; immunizations; free transportation; and fraud and civil rights contacts
- Conducted reachout campaigns in senior housing centers and nursing homes to increase seasonal flu and pneumonia rates
  - Senior and assisted living facilities partnered with pharmacies
  - Nursing homes in the areas needed education on how best to immunize on ongoing basis rather than just one immunization day

Immunizations

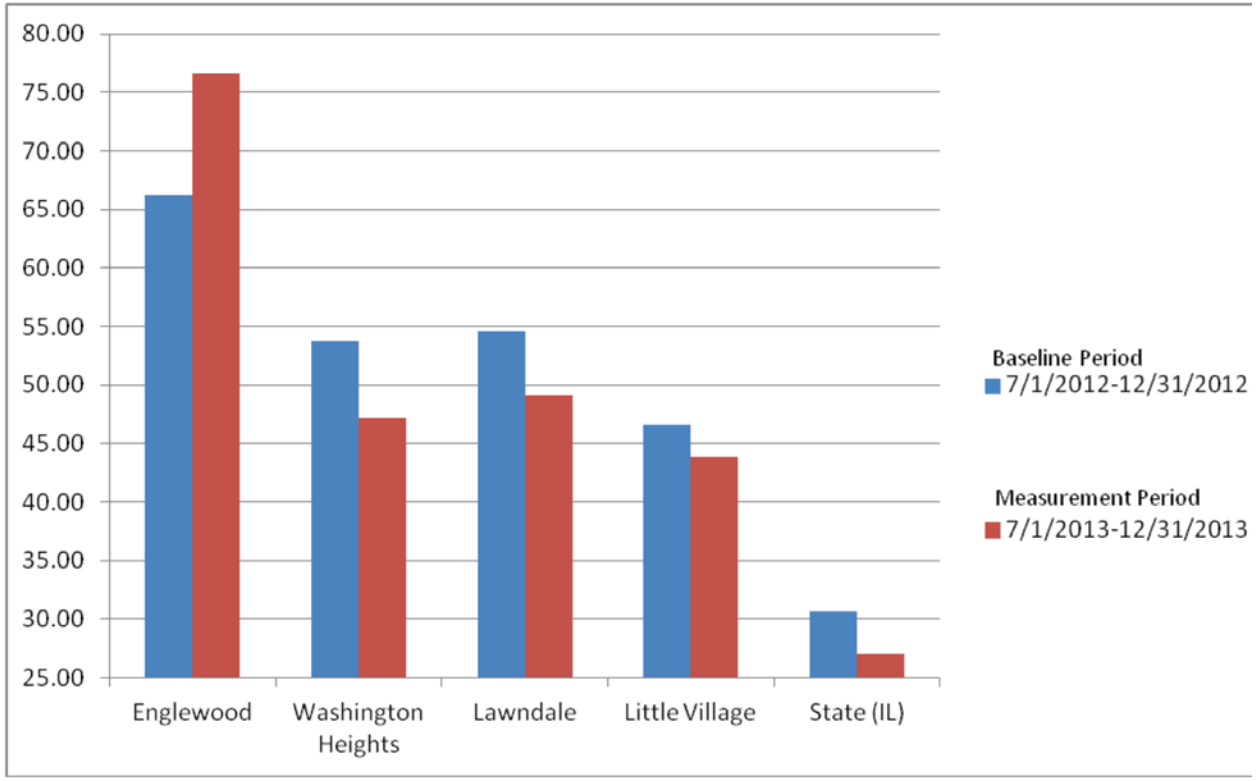
- Telligen and Flu Fighters NAIIS Award on May 11
- Flu Fighters
  - Chicago Housing Authority
  - Telligen
  - Chicago Department of Public Health
  - Blue Cross Blue Shield of Illinois
  - Walgreens
  - Ever Thrive Illinois

PFEC Community Study Areas

3 of 4 Decreased Readmissions; Still Above State and National Averages

Readmissions Per 1,000 Medicare Beneficiaries in SIP Communities and State of Illinois

Baseline Period Compared to Measurement Period



Data source: CMS ASAT Database

Joining in Partnership To Save Lives and Reduce Health Harm Through Immunizations

- All parties appreciate Seniors and dual beneficiaries need to be inside by Noon
- Community and faith based organizations are safe havens
- Focus on community assisted living and senior housing centers
- Joining in partnership with large pharmacies, nursing homes, home health, and health plans
- Involved in First Ladies, Health Fairs, Radio Shows, community centers, peace initiatives
- Focus on increasing immunizations by holidays to reduce deaths and ICU admissions

NAIIS Community – Neighborhood Award
Telligen and the *Flu Fighters!*

- Focus on community
- Working in collaboration
- Immunizations in 40 Senior Chicago Housing Authority Buildings
- Collaboration with CHA staff and residents
  - Community building meetings lead by President of building
  - President Meeting
  - President Leadership

Additional Information

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