Leading Change: Creating Systems that Lead to Momentum and Results

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Thank You!

- For your **hard work & commitment**
- For your **leadership and contributions**
- For improving the **quality, safety, and delivery of care** to our beneficiaries
Patient and Family Engagement at CMS
Strengthen Persons and Families as Partners in their Care

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

Improving Healthcare Experiences & Outcomes

- Promote Informed Decision Making
- Share Preferences and Values
- Co-Create Goals
- Promote PFE Best Practices
- Encourage Engagement & Self Management
CMS established large-scale, action-oriented networks to **spread quality improvement** and safety activities on a national scale

**Partnership for Patients**
- 4,000 Hospitals

**Transforming Clinical Practices Initiative**
- 140,000 Clinicians

**End Stage Renal Disease Networks**
- 6,000 Dialysis Facilities

**Quality Innovation Networks – Quality Improvement Organizations**
- 250+ Communities
- 11,000+ Nursing Homes
- 3,800 Home Health Organizations
- 300 Hospice
- 1,700 Pharmacies

**MACRA and Quality Payment Program - Small, Underserved, Rural Support (SURS)**
- Up to 200,000 Clinicians
Aims & Results: a choice we make every day

Value

What will the future be?

Time

Today
A leadership choice – breakthrough Aims

“I want to see something much better.”

Value

Time

Today

Current Drift

Practical
Emergent Strategy: Stand For Them, Enroll Others, Persist, Learn, Evolve...Fast
Our Key Methods for Achieving Results

- Bold, Clear Aims -- Implemented at Scale
- Focus on Results
- Do More of What Works
- Make Best-In-Class Performance, Common Performance
- Tight About the “What” Outcome; Flexible on the “How”
- Foster and Foment Joy in Work
Hospital Safety Project
Focused on Two Breakthrough Aims
(2011 – 2016)

Aims Create Systems; Systems Create Results.

**GOALS:**

- **40% Reduction in Preventable Hospital-Acquired Conditions**
  - 1.8 Million Fewer Injuries | 60,000 Lives Saved

- **20% Reduction in 30-Day Readmissions**
  - 1.6 Million Patients Recover without Readmission
National Results on Patient Safety
Substantial progress thru 2015, compared to 2010 baseline

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

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

Number of Harms per 1,000 Discharges

New Goal: 97
Success on Partnership for Patients has resulted in new bold aims

**AIMS for 2019**

- **20%** Overall Reduction in Hospital-Acquired Conditions
- **12%** Reduction in 30-Day Readmissions
Authentically engage patients in our work; model engagement in our own work

Identify organizations that reflect best practices

Replicate and spread effective practices

Track progress on PFE across hospitals and increase transparency

Team with and support others involved in leading this work
PFE Metrics: Measuring Hospital Successes

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
**Transforming Clinical Practice Initiative (TCPI)**

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

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

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

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

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

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

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

Aim 7
“We purchased a software program to let all of our clinicians have access to their quality data, all day every day.”
REDUCTION in ASTHMA-RELATED ED Visits
Example: SW PEDIATRICS PTN
15 PEDIATRICIAN PRACTICE

NUMBER OF CHILDREN:
• 27,000 Medicaid Children

INTERVENTION:
• Asthma Action Plan and check-ins

RESULTS:
• 18% Reduction in ED Use
• 1762 Fewer visits in 6 months
• $1.05 million full year savings projected based 6 month claims data
In Action on Person & Family Engagement (PFE) in the Transforming Clinical Practice Initiative (TCPI)

PFE Program Co-Produced by Patients, Providers, Improvement Leaders & Measurement Experts

**Six Metrics** -- Does the physician practice:

1. Train staff on *shared decision-making*?
2. Assess *patient activation*?
3. Use a patient *health literacy* survey?
4. Have a *portal or other e-tool* to share test results, med lists, etc.?
5. Engage patients in practice design or strategies through a structure such as a *Patient/Family Advisory Council*?
6. Monitor and support patient *medication use*?

**Strategies & Early Results**

- Patient & family caregivers serve as *national faculty* shaping strategy, coaching practices
- **263 physician practices** committed to implementing all 6 PFE Program metrics by April 30, 2017
- Demonstration project engaging *native Hawaiians in rural communities* to improve diabetes & heart disease management
- PFE Affinity Group in action developing *curricula, resources & success stories*
- Collaboration with Rural, Medication Management, Business Case and Behavioral Health Affinity Groups to avoid “PFE in a silo.”
- Call for practice performance stories showing *PFE business case*, e.g. impact on clinical outcomes, patient-reported outcomes, patient satisfaction, provider joy/meaning & success in the QPP program.
14 QIN-QIOs work with providers and the community to advance patient safety, reduce harm, engage patients and families, and improve clinical care locally and regionally.
Some High-Level Results from Current 11th Scope of Work

- QIO program work by Hospital Improvement Innovation Networks and others through CY 2015 compared to CY 2010 baseline has contributed to major national improvements in hospital safety, resulting in:
  - More than 3 million fewer patient harms;
  - 125,000 lives saved; and
  - More than $28 billion in cost savings.

- 12,000 of the nation’s 15,000 nursing homes have been recruited by the Quality Innovation Network – Quality Improvement Organizations (QIN-QIOs) to work on improving care for the nation’s nursing home residents
  - QIN work is showing improvements across a number of targeted quality indicators, including for example, significant reductions in the rate of inappropriate antipsychotic medication use:
    - 10,601 nursing homes are working on reducing the use of antipsychotic medications
    - Recent report cites Antipsychotic Medication Use (nationally) at 16% and as of September 30, 2016 all QINs and 47 states have met and/or exceeded the July 2017 relative improvement rate performance criterion of a 9% reduction.

- QIN-QIO care coordination work in 294 communities has resulted in preventing more than 24,000 readmissions and approximately $230 million in cost savings

- QIN-QIO work to reduce disparities in diabetes care and improve outcomes in the United States included education of providers at 2,173 practice sites and 27,894 Medicare beneficiaries completing diabetes self-management education (DSME). The efforts completed to date for the DSME component alone are projected to yield $57 million in savings for health care utilization over 5 years.
QIO Program Person and Family Engagement Efforts

QIO PFE activities:

- Participating in the Gateways Program to establish Patient and Family Advisory Councils (PFACs)
- Engaging beneficiaries in Learning and Action Networks (LANs)
- Supporting the work of Everyone with Diabetes Counts (EDC)

QIN-QIOs are working alongside beneficiaries wherever possible to co-design work products and learning system content
Puerto Rico and Virgin Islands are part of Network 3
Hawaii, Guam, American Samoa are part of Network 17
End-Stage Renal Disease (ESRD) Network Activities

- ESRD Networks have a 5 Year Contract with 3 AIMS
  1. Better Care for the Individual through Patient and Family Centered Care
  2. Better Health for the ESRD Population
  3. Reduce Costs of ESRD Care by Improving Care

- Responsible for Performance-Based Outcome Driven Quality Improvement Activities

- Use of Patient Subject Matter Experts in the Development and Execution of Quality Improvement Activities

- Focus on Person, Family and Caregiver Centered Care and Rapid Cycle Improvement
End Stage Renal Disease (ESRD)

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

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

ESRD National Coordinating Center

4 Affinity Groups – Patient Driven Goals

Annual Quality Conference – ESRD Patient Track
ESRD Challenge to Consider

Improving Healthcare Experiences & Outcomes

- Promote Informed Decision Making
- Share Preferences and Values
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Transplantation Patient Survival is Much Better than Dialysis

Considerable Variation in Kidney Discard Rates by Donation Service Area
High Performers Can “Show the Way” to Other DSAs

Percentage of Kidneys Recovered Then Discarded
58 US OPOs (2012-2014)

Source: OPTN DSA Dashboard
U.S. Recovered Kidney Growth Rate

Annual Growth Rate in Recovered Kidneys
2010-2015
58 U.S. Donation Service Areas
Two Opportunities for Quality Improvement to Improve Care & Reduce Costs

Opportunity to reduce known variations, and achieve significant improvements in both health care quality and cost savings:

1. **Reduce Kidney Discord Rate**
   - 19 Percent of Kidneys Procured Are Discarded

2. *Increase annual rate of growth in kidney donation and recovery from 2.6% to 8.0%.*
Our Requests to Each of You

1. Foster the use of rapid-cycle improvement, real-time quality improvement data, and “living in the red” to drive results.

2. Choose to focus on the mission: Stand for better care, smarter spending, and healthier people...for our patients, for your profession, and for our nation.

3. Nurture your own resilience and that of others on our teams.

4. Team with your networks, and with one another, intentionally and wholeheartedly.

5. Intentionally choose and model the behaviors you want to see more of in others.

Lead in our ESRD NWs and Communities of Practice on these ways of being.
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