Leading Change: Using Quality Improvement Strategies, Data, and Culture to Drive Practice Transformation: The Power of Learning Networks

Annual Summer Institute hosted by Arizona State University
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Chief Medical Officer for Quality Improvement

Quality Improvement Innovation Group
Centers for Clinical Standards & Quality
Centers for Medicare and Medicaid Services
Thank You!

- For your **hard work & commitment**
- For your **leadership and contributions to innovation**
- For improving the **quality, safety, and delivery of care** to our beneficiaries
What to Listen for Today

- How the evolution to a more results-oriented system, and ambitious aims is setting the stage for a new era of quality improvement in health systems in the US;

- How the power of aligned clinical, physician, and patient perspectives create meaningful transformation; and

- How the power of professional resilience in times of change, leadership towards optimizing quality, and finding joy in the work allow us to practice medicine in the ways we first imagined at the start of our training.
A Quote from a Wise “Improver”

“There is only one way out of the health care system we have now....

....We have to learn our way out of it.”
Study and Learn from your Peers: Learning Networks

- **Examine the many real life examples** of quality improvement leading to practice transformation from our TCPI program

- **Compare the experiences** of the >100,000 physicians in this national quality improvement project to your own projects

- **Consistently leverage your quality improvement data to identify gaps, and adjust your approach** accordingly in order to achieve the commitments you’ve made and aims you’ve created.
Some of Our Key Methods for Achieving Results in Learning Networks

- **Bold, Clear Aims -- Implemented at Scale**
- Do More of What Works
- Transparency of Data & Performance
- Real-time Sharing, Learning, Improvement
- Make Best-In-Class Performance, Common Performance
- Tight About the “What” Outcome; Flexible on the “How”
Transformation of Health Care at the Front Line

At least six components:

- Quality measurement
- Aligned payment incentives
- Comparative effectiveness and evidence available
- Health information technology
- Quality improvement collaboratives and learning networks
- Training of clinicians and multi-disciplinary teams

Source: P.H. Conway and Clancy C. Transformation of Health Care at the Front Line. JAMA 2009 Feb 18; 301(7): 763-5
WE NEED TO LEARN OUR WAY INTO A BETTER SYSTEM, TOGETHER.
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**
- 100,000 Clinicians & growing

**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
“I believe that this nation should commit itself to achieving the goal, before this decade is out, of landing a man on the moon and returning him safely to the earth.”

--- President John F. Kennedy, Delivered in person before a joint session of Congress May 25, 1961
Aims Create Systems...

Medicare Fee-for-Service

GOAL 1: 
Medicare payments are tied to quality or value through alternative payment models (categories 3-4) by the end of 2016, and 50% by the end of 2018

GOAL 2: 
Medicare fee-for-service payments are tied to quality or value (categories 2-4) by the end of 2016, and 90% by the end of 2018

STAKEHOLDERS:
Consumers | Businesses | Payers | Providers | State Partners

Set Internal goals for HHS
Invite private sector payers to match or exceed HHS goals

NEXT STEPS:
Testing of new models and expansion of existing models will be critical to reaching incentive goals
Creation of a Health Care Payment Learning and Action Network to align incentives for payers

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

20% Overall Reduction in Hospital Acquired Conditions

90% of Eligible Clinicians Participate in the Quality Payment Program

12% Reduction in 30-Day Readmissions
Aims Create Systems; Systems Create Results.
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

- 2010: 145
- 2011: 142
- 2012: 132
- 2013: 121
- 2014: 121
- 2015: 115

Number of Harms per 1,000 Discharges
Medicare FFS 30-Day All-Cause Readmissions (Medicare Claims)

- FFS Rate decreased 5.56 percent between calendar year 2010 and Q4 2014.
- AHRQ All-Payer All-Cause 30-Day Readmissions declined 2.6 percent from 2010 to 2013.

Source: Medicare claims data provided by the Health Policy and Data Analysis Group in the Office of Enterprise Management at CMS. The Evaluation Contractor processed and ran regression-adjusted analysis to control for changing demographics independently, with similar findings.

Note: Center line and control limits (U chart) for the first phase were calculated with data between January 2009 and March 2010. Center line and control limits (U chart) for the second phase were calculated with data between January 2012 and March 2013. The dashed green line is the center line, the dashed red lines are the upper and lower control limits, the closest dotted lines above and below the center line are the one-sigma limits, and the dotted lines just inside the control limits are the two-sigma limits. Data include between 981,065 and 754,486 discharges per month.
Transforming Clinical Practice Initiative is designed to help clinicians achieve large-scale health transformation.

The model will support over 140,000 clinicians to improve on quality and enter alternative payment models (APMs).

- **Current Enrollment:** 110,000 clinicians

Two network systems have been created:

1. **Practice Transformation Networks:**
   Peer-based learning networks designed to coach, mentor, and assist

2. **Support and Alignment Networks:**
   Provides a system for workforce development utilizing professional associations and public-private partnerships

**Phases of Transformation**

- Set Aims
- Use Data to Drive Care
- Achieve Progress on Aims
- Achieve Benchmark Status
- Thrive as a Business via Pay-for-Value Approaches
# Transforming Clinical Practice Initiative (TCPI) Goals

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
### Clinical Practice Leaders Have Already Charted the Pathway to Practice Transformation

<table>
<thead>
<tr>
<th>Traditional Approach</th>
<th>Transformed Practice</th>
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<tbody>
<tr>
<td>Patient’s chief complaints or reasons for visit determines care.</td>
<td>We systematically assess all our patients’ health needs to plan care.</td>
</tr>
<tr>
<td>Care is determined by today’s problem and time available today.</td>
<td>Care is determined by a proactive plan to meet patient needs.</td>
</tr>
<tr>
<td>Care varies by scheduled time and memory/skill of the doctor.</td>
<td>Care is standardized according to evidence-based guidelines.</td>
</tr>
<tr>
<td>Patients are responsible for coordinating their own care.</td>
<td>A prepared team of professionals coordinates a patient’s care.</td>
</tr>
<tr>
<td>Clinicians know they deliver high-quality care because they are well trained.</td>
<td>Clinicians know they deliver high-quality care because they measure it and make rapid changes to improve.</td>
</tr>
<tr>
<td>It is up to the patient to tell us what happened to them.</td>
<td>You can track tests, consults, and follow-up after the emergency department and hospital.</td>
</tr>
</tbody>
</table>

Adapted from Duffy, D. (2014). School of Community Medicine, Tulsa, OK.
What are the 5 phases of TCPI?

Set Aims
Use Data to Drive Care
Achieve Progress on Aims
Achieve Benchmark Status
Thrive as a Business via Pay for Value Approaches
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.”
Questions for Group Reflection, Discussion and Action

➤ What are you most proud of at this juncture of the TCPI model test?

➤ What things have you identified that you could be doing differently in order to meet your goals?
The Practice Innovation Institute (Pii) is a statewide Practice Transformation Network (PTN).

Pii is a collaboration of Health Current (AzHeC), Mercy Care Plan and Mercy Maricopa Integrated Care and supports health care providers in the Transforming Clinical Practice Initiative (TCPI) program.

The Pii currently has enrolled over 2,500 clinicians and 467 practice locations across Arizona.
Vision & Mission

Our Vision:

The vision of the Practice Innovation Institute is to help clinicians transform their practices into entities that make meaningful improvements in patients’ health and wellbeing. We do this by driving continuous improvement within the clinical, operational and financial areas needed to thrive in the new world of healthcare.

Our Mission:

Our mission is to support clinician efforts to transform their practices bringing meaningful improvement in their patients’ health and wellbeing. We do this through engagement and collaboration, by providing them with:

- Coaching
- Education
- Training
- Data and data analytics

We believe that high functioning and innovative ideas bring joy in practice, improved patient care, and a better patient experience.
NUMBER OF CHILDREN:
- 27,000 Medicaid Children

INTERVENTION:
- Asthma Action Plan and check-ins

RESULTS:
- 18% Reduction in ED Use
- 1,762 Fewer visits in 6 months
- $1.05 million full year savings projected based on 6 month claims data
Quality Improvement Example #2

ASTHMA BREATHMOBILE GLOBAL PAYMENT
INPATIENT STAYS: “PDSA” AT WORK

Inpatient Cost Comparison
Pre vs. Post Program Entry

Pre-Entry Inpt. Cost
9-1-2014 thru 9-30-2015

Post-Entry Inpt. Cost
10-1-2015 thru 6-30-2016

N=178 enrollees—highest risk children

$56,000.00
27 bed days for 11 children

$0
no bed days for 178 children
Optimal Blood Pressure Management

Baseline 3 months 6 months 10 months

- 6 months: 41%, 46%, 57%, 64%
- 10 months: 47%, 64%, 80%

Target: 80%

6,199 patients

14,366 patients

Optimal BP---BP <140/90; < 60 years, BP<150/90, >= 60 years
Hypertension Control

65% of Patients with HTN Controlled as of 2016 Q4 (target 75% by 2019 Q4)

Interventions Used:
• Risk assessment tools
• “Population Health” digital dashboard
Quality Improvement Example #4 (cont.)

Initial Quality Impacts

% Patients Aged 18-64 Years with Controlled Hypertension (NQF 0018)

20,000 more people now with BP in control than at baseline!
Quality Improvement Example #5

Appropriate CT and MRI Imaging Utilization for Headache

- Claims data source
- All 234 practices
- Total PTN capitated population of 230,000 children
- 8313 children with headache
- 79.5% year over year reduction in imaging use

Full population projection:
- 60,000 children impacted
- $2.0 million potential savings
Reduction in inappropriate CT scans for suspected pulmonary embolus
Baylor College of Medicine, TX

ED-Radiology collaborative effort

Ensure D-dimer testing by ED physicians in suspected patients

50% reduction in CT scans
Quality Payment Program

- Committed to providing technical assistance to 100% of eligible providers.
Medicare Payment Prior to MACRA

Fee-for-service (FFS) payment system, where clinicians are paid based on volume of services, not value.

The Sustainable Growth Rate (SGR) formula

- Established in 1997 to control the cost of Medicare payments to physicians

IF

Overall physician costs > Target Medicare expenditures

Physician payments cut across the board

Each year, Congress passed temporary “doc fixes” to avert cuts (no fix in 2015 would have meant a 21% cut in Medicare payments to clinicians)
The Quality Payment Program policy will:
- Reform Medicare Part B payments for more than 600,000 clinicians
- Improve care across the entire health care delivery system

Clinicians have two tracks to choose from:

**MIPS**

The Merit-based Incentive Payment System (MIPS)

*If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.*

**Advanced APMs**

Advanced Alternative Payment Models (APMs)

*If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.*
What is the Merit-based Incentive Payment System?

Performance Categories Weights for 2017 Transition Year

- **Quality**: 60%
- **Cost**: 0%
- **Improvement Activities**: 15%
- **Advancing Care Information**: 25%

- Comprised of four performance categories
- Provides MIPS eligible clinicians included in the 2017 Transition Year with the flexibility to choose the activities and measures that are most meaningful to their practice.
Pick Your Pace for Participation for the Transition Year

Participate in an Advanced Alternative Payment Model

- Some practices may choose to participate in an Advanced Alternative Payment Model in 2017
- Submit some data after January 1, 2017
- Neutral payment adjustment

MIPS

Test

- Submit Something
- 0

Partial Year

- Submit a Partial Year
- Report for 90-day period after January 1, 2017
- Neutral or positive payment adjustment

Full Year

- Submit a Full Year
- +%
- Fully participate starting January 1, 2017
- Positive payment adjustment

Note: Clinicians do not need to tell CMS which option they intend to pursue.

Not participating in the Quality Payment Program for the Transition Year will result in a negative 4% payment adjustment.
MIPS Performance Category: Improvement Activities

• Attest to participation in activities that improve clinical practice
  - Examples: Shared decision making, patient safety, coordinating care, increasing access

• Clinicians choose from 90+ activities under 9 subcategories:

1. Expanded Practice Access
2. Population Management
3. Care Coordination
4. Beneficiary Engagement
5. Patient Safety and Practice Assessment
6. Participation in an APM
7. Achieving Health Equity
8. Integrating Behavioral and Mental Health
9. Emergency Preparedness and Response
Proposed Rule for Year 2 of the Quality Payment Program

• Proposed changes for Year 2 of the Quality Payment Program (2018) are open for public comment.

• See the proposed rule for information on submitting these comments by the close of the 60-day comment period on **August 21, 2017**. When commenting refer to file code CMS 5522-P.

• Instructions for submitting comments can be found in the proposed rule; FAX transmissions will not be accepted. You must officially submit your comments in one of the following ways: electronically through
  - [Regulations.gov](https://www.regulations.gov)
  - by regular mail
  - by express or overnight mail
  - by hand or courier

• For additional information, please go to: [qpp.cms.gov](https://qpp.cms.gov)

• For additional support, please call **1-866-288-8292** or email [qpp@cms.hhs.gov](mailto:qpp@cms.hhs.gov)
# Advanced APMs

The list of Advanced APMs is posted at QPP.CMS.GOV and will be updated with new announcements as needed.

**Keep in mind:** The Physician-Focused Payment Model Technical Advisory Committee (PTAC) will review and assess proposals for Physician-Focused Payment Models based on proposals submitted by stakeholders to the committee.

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<td>Comprehensive End Stage Renal Disease Care Model (Two-Sided Risk Arrangements)</td>
<td>Acute Myocardial Infarction (AMI) Track 1 CEHRT</td>
</tr>
<tr>
<td>Comprehensive Primary Care Plus (CPC+)</td>
<td>Coronary Artery Bypass Graft (CABG) Track 1 CEHRT</td>
</tr>
<tr>
<td>Next Generation ACO Model</td>
<td>Surgical Hip/Femur Fracture Treatment (SHFFT) Track 1 CEHRT</td>
</tr>
<tr>
<td>Oncology Care Model (Two-Sided Risk Arrangement)</td>
<td>Medicare-Medicaid ACO Model (for participants in SSP Tracks 2 and 3)</td>
</tr>
<tr>
<td></td>
<td>Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)</td>
</tr>
<tr>
<td></td>
<td>Medicare Accountable Care Organization (ACO) Track 1+ Model</td>
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Atrius Health a Low Cost-High Quality “Value” Pioneer ACO

Where can I go to learn more?
Technical Assistance

CMS has free resources and organizations to provide help to clinicians who are participating in the Quality Payment Program:

To learn more, view the Technical Assistance Resource Guide: [https://qpp.cms.gov/resources/education](https://qpp.cms.gov/resources/education)
Technical Assistance

• The available forms of technical assistance depend on how clinicians participate in the Quality Payment Program.

• Clinicians participating in an Advanced APM and considered Qualifying APM Participants (QPs) receive support through the APM Learning Systems.

• Clinicians participating in MIPS may receive support as a part of the Transforming Clinical Practice Initiative (TCPI) through their Practice Transformation Network (PTN).

• Alternatively, there are two other options for MIPS assistance for clinicians not enrolled in a PTN or not interested in TCPI. These include:
  o Through a Quality Innovation Network – Quality Improvement Organization (QIN-QIO) if they are in a large practice (more than 15 clinicians); or
  o Through Small, Underserved, and Rural Support (SURS) if they are in a small practice (15 or fewer clinicians), with priority given to those in rural locations, health professional shortage areas, or medically underserved areas.

• Finally, clinicians who are a part of an APM and are required to participate in MIPS are eligible to receive technical assistance through either the QIN-QIOs or Small, Underserved, and Rural Support, depending on practice size.
CMS has organizations on the ground to provide help to clinicians who are eligible for the Quality Payment Program:

**Quality Payment Program Portal**
- Learn about the Quality Payment Program, explore the measures, and find educational tools and resources.

**Transforming Clinical Practice Initiative (TCPI):**
- Designed to support more than 140,000 clinician practices over the next 4 years in sharing, adapting, and further developing their comprehensive quality improvement strategies.

**Quality Innovation Network (QIN)-Quality Improvement Organizations (QIOs):**
- Includes 14 QIN-QIOs
- Promotes data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality.

The **Innovation Center’s** Learning Systems provides specialized information on:
- Successful Advanced APM participation
- The benefits of APM participation under MIPS
CMS has organizations on the ground to provide help to clinicians who are eligible for the Quality Payment Program:

**Transforming Clinical Practice Initiative (TCPI):** TCPI is designed to support more than 140,000 clinician practices over the next 4 years in sharing, adapting, and further developing their comprehensive quality improvement strategies. Clinicians participating in TCPI will have the advantage of learning about MIPS and how to move toward participating in Advanced APMs. Click [here](#) to find help in your area.

**Quality Innovation Network (QIN)-Quality Improvement Organizations (QIOs):** The QIO Program’s 14 QIN-QIOs bring Medicare beneficiaries, providers, and communities together in data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality. More information about QIN-QIOs can be found [here](#).

**If you’re in an APM:** The Innovation Center’s Learning Systems can help you find specialized information about what you need to do to be successful in the Advanced APM track. If you’re in an APM that is not an Advanced APM, then the Learning Systems can help you understand the special benefits you have through your APM that will help you be successful in MIPS. More information about the Learning Systems is available through your model’s support inbox.
The Malizzo Family

Bob and Barb Malizzo, along with daughter Kristina Chavez and her son Adrian, visit their daughter Michelle Ballog's grave at Graceland Cemetery in Valparaiso, Ind. She died after a medical error was made during surgery. (Heather Charles/Chicago Tribune)
PFE Metrics: Measuring Hospital Successes

Governance

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

Policy and Protocol

- Shift Change Huddles/Bedside Reporting
- PFE Leader or Functional Area

Point of Care

Planning Checklist
Person & Family Engagement Cycle

- Promote Informed Decision Making
- Encourage Engagement & Self Management
- Promote PFE Best Practices
- Co-Create Goals
- Share Preferences and Values

Improving Healthcare Experiences & Outcomes
Key Sources of Personal & Organizational Resilience

- Purpose
- Partners
A Wholehearted Commitment to Clear Purpose is a Powerful Source of Resilience

- 125,000 lives saved
- $28B in cost savings
- 3.1M fewer harms

- Support more than 140,000 clinicians in their practice transformation work
- Improve health outcomes for millions of Medicare, Medicaid and CHIP beneficiaries and other patients
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Some Partners on Our Team at the CMS Quality Improvement and Innovation Group (QIIG)
Key CMS Partners Provide Tremendous Resilience in Times of Change

Jean Moody-Williams, Dennis Wagner & Paul McGann
What Are the Sources of Resilience?

- Partners
- Purpose
- Perspective
- Embracing Change
- Leading Change
- Choice
Our Requests to Each of You

- Set aims for all the work that you do—“Aims create systems, and systems generate results”;
- Invest in the quality infrastructure necessary to improve and engage in collaborative Quality Improvement and learning networks;
- Test models to better coordinate care for patients with multiple chronic conditions;
- Actively mine and constantly use your real-time, quality improvement data to identify areas of opportunity, and rapidly adjust your course to achieve the goals you set for your organization and your patients.
Contact Information

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