Partnership for Patients

Dennis Wagner & Paul McGann, M.D.
Co-Directors, Partnership for Patients
U.S. Department of Health & Human Services
CMS Center for Medicare & Medicaid Innovation

Third Innovative Communities Summit
Long-Term Quality Alliance
June 5, 2012

Partnership for Patients
-- Questions to Run On--

1. ***What is happening at CMS and the Innovation Center?***

2. ***What is the Partnership for Patients?***

3. ***How can long-term care providers benefit from and align with the Partnership for Patients?***

4. ***What actions can we take to improve better health, better care, and lower costs?***

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Innovation to Impact: The Old Way

New Idea or Innovation

Seek Legislative Authority & Demo Funding (1-3 years)

Field the Demo (3 years)

Evaluate the Demo (1-2 years)

Seek statutory authority for new model based on demo (1-3 years)

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Innovation to Impact: The CMS Innovation Center Way

Field Innovative Models

Test Them at Scale

Certification by Actuary

Implement Change via Innovation Infrastructure “Pipeline”

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Innovation Center Portfolio
Long-Term Care Involvement in Many Areas

Primary Care Transformation

- Comprehensive Primary Care Initiative (CPC)
- Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration
- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration
- Independence at Home Demonstration
- Graduate Nursing Education Demonstration

ACOs

- Medicare Shared Savings Program
- Pioneer ACO Model
- Advance Payment ACO Model
- PGP Transition Demonstration

Bundled Payment for Care Improvement

- Model1: Retrospective Acute Care
- Model 2: Retrospective Acute Care Episode & Post Acute
- Model 3: Retrospective Post Acute Care
- Model 4: Prospective Acute Care

Capacity to Spread Innovation

- **Partnership for Patients**
- **Community-Based Care Transitions**
- Million Hearts
- Innovation Advisors Program
- **Health Care Innovation Challenge**

Initiatives Focused on the Medicaid Population

- Medicaid Emergency Psychiatric Demonstration
- Medicaid Incentives for Prevention of Chronic Diseases
- Strong Start Initiative

Dual Eligible Beneficiaries

- State Demonstration to Integrate Care for Dual Eligible Individuals
- Financial Models to Support State Efforts to Integrate Care
- **Demonstration to Reduce Avoidable Hospitalizations of Nursing Facility Residents**

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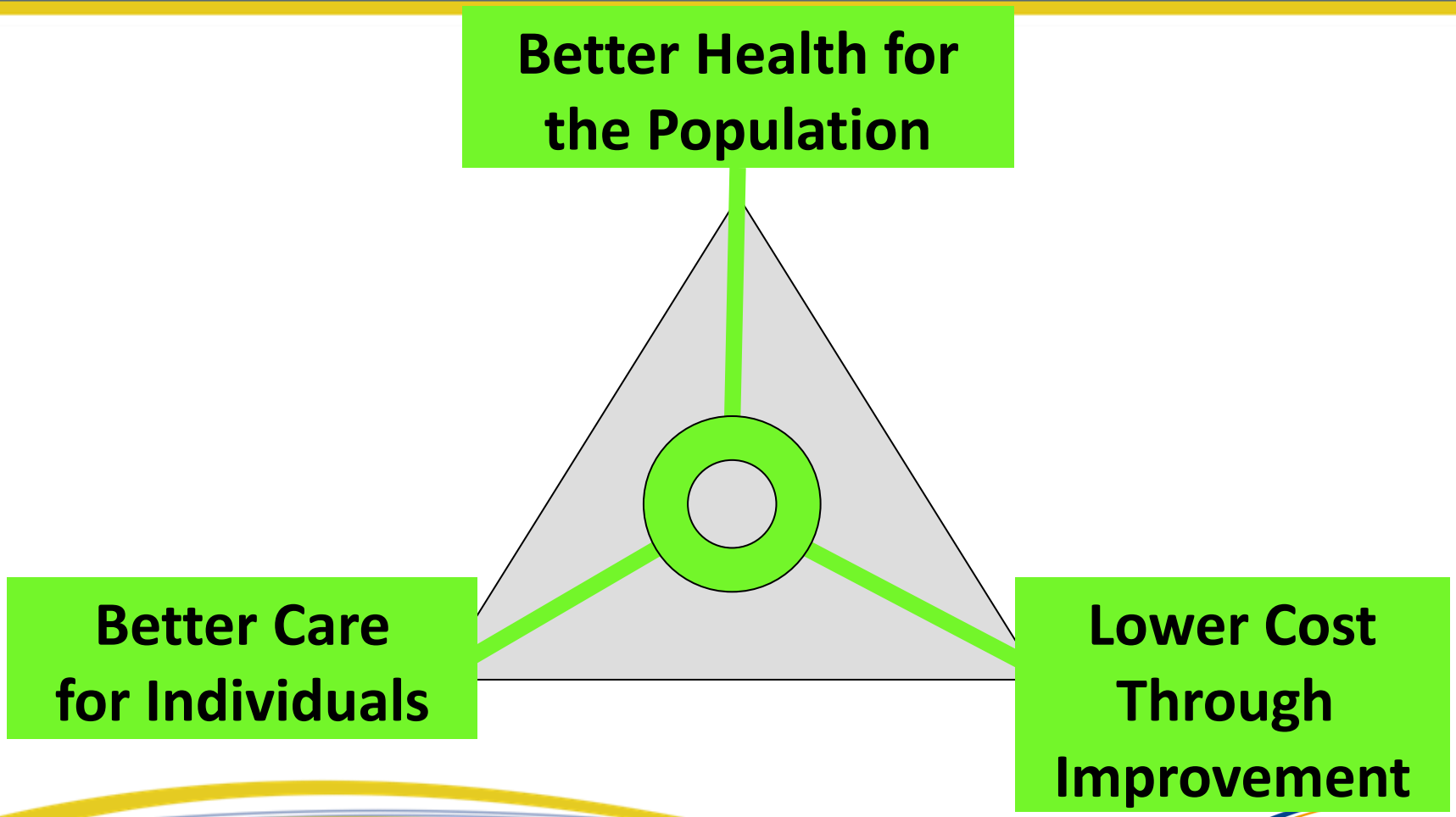
Accountability for Achieving Simultaneous Results on 3 Levels



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Breakthrough Aims of the Partnership for Patients

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

Up to $35 Billion Dollars Saved

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Ten Priority Areas of Focus

Hospital Engagement Networks are required to address ten areas of focus:

1. Adverse Drug Events
2. Catheter-Associated Urinary Tract Infections
3. Central Line Associated Blood Stream Infections
4. Injuries from Falls and Immobility
5. Obstetrical Adverse Events
6. Pressure Ulcers
7. Surgical Site Infections
8. Venous Thromboembolism
9. Ventilator-Associated Pneumonia
10. **Reducing Readmissions**

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Our Operating Values

How shall we work together and with others?

- Boundarilessness
- Speed and Agility
- Unconditional Teamwork
- Valuing Innovation
- Customer Focus
- Servant Leadership
- Constant Testing and Iteration
- Bias for Action
- Celebrating and Focusing on Success
- Including the Patients We Serve

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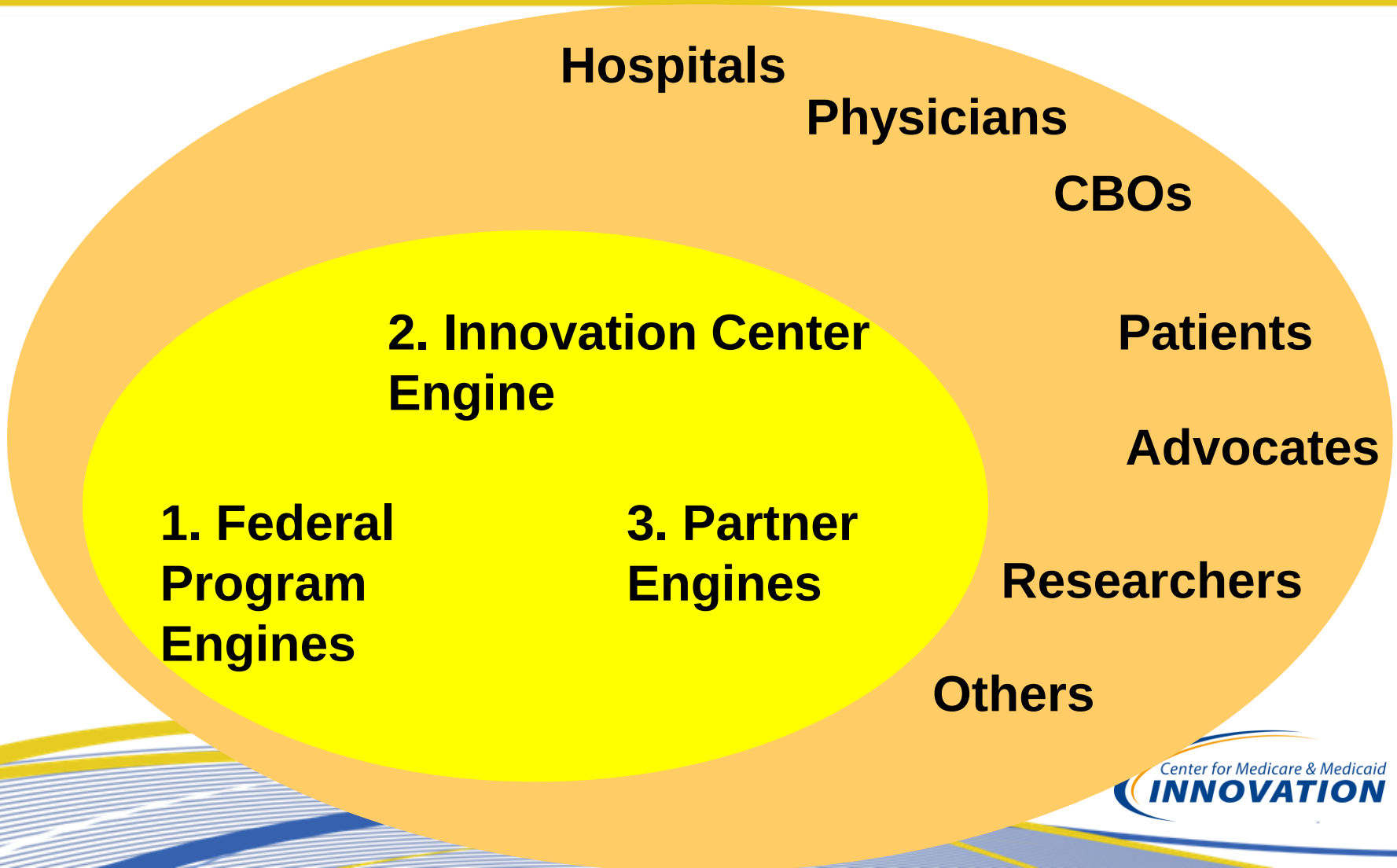
Three Engines for Achieving the Partnership for Patients Aims



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Victoria Limone, a Mom with terminal Congestive Heart Failure, was constantly being readmitted to the hospital -- at great financial cost to her and her daughter, and at great cost to her quality of life. Then, she enrolled into a QIO–supported hospice program designed for the CHF population in her area.

Her daughter Judy got married.

Better Care, Lower Costs
…this is what it looks like.

Questions for Discussion and Action

1. *What excites you about this material?*
2. *What actions or initial results on the Partnership for Patients (PfP) 20/40 Aims are you most proud of?*
3. *What are your best ideas for ramping up further partnering and collaboration on the PfP Aims?*

What are the ways the Partnership for Patients gets Results?

1. CMMI Investments
   - Technical Assistance to Hospitals
   - Community Based Care Transitions Program

2. Programs and platforms of the Department of Health & Human Services: AHRQ, CDC, AoA, HRSA, CMS, ONC, others

3. Programs and platforms of Partners: AMA, ABMS, AFL-CIO, AHA, NAPH, ANA, many more

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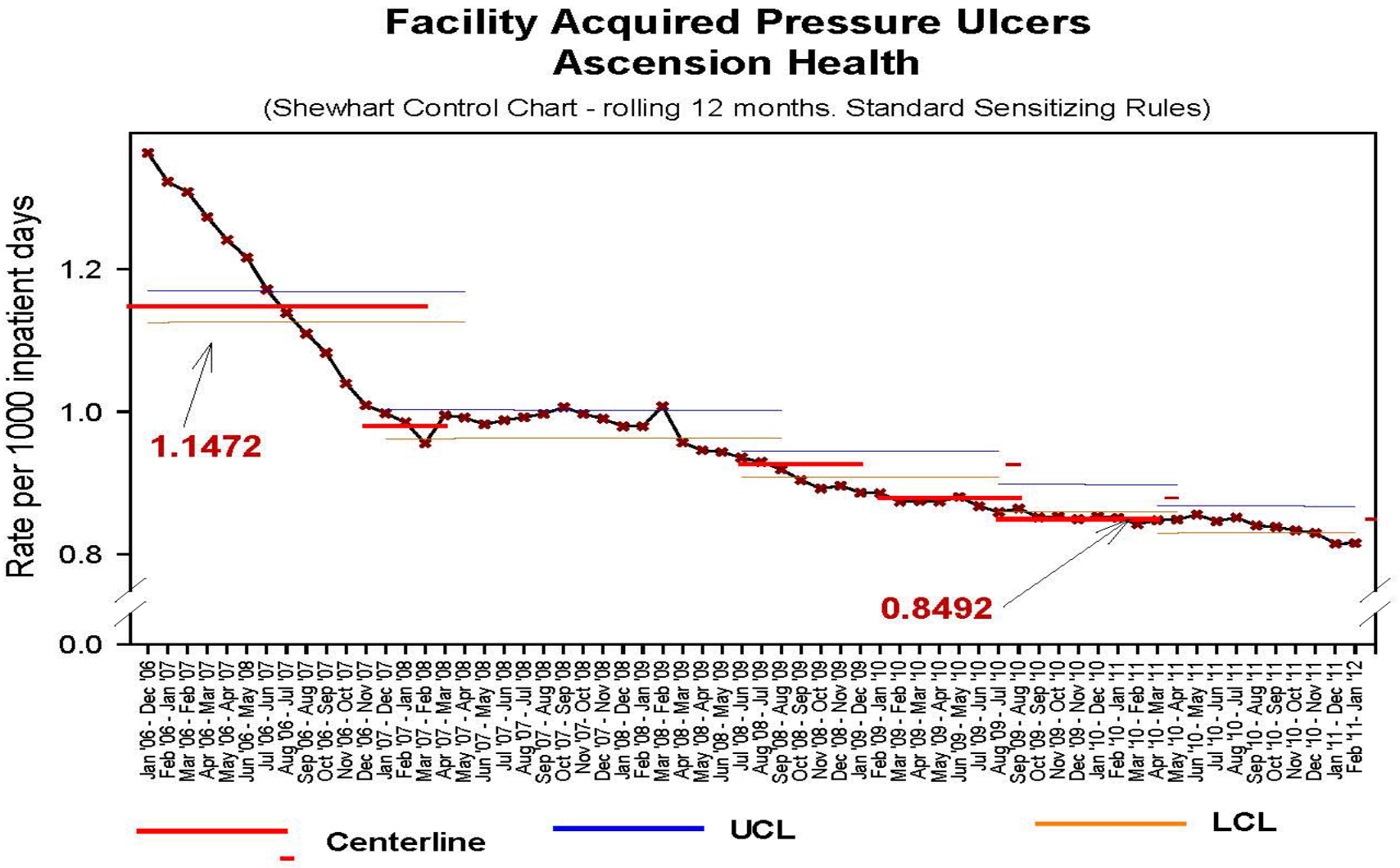
26 Hospital Engagement Networks Achieving Results through ~4,000 Hospitals

- American Hospital Association
- Premier Healthcare Alliance
- VHA
- NC Hospital Assoc
- Intermountain HealthCare
- GA Hospital Assoc
- TX Hospital Assoc
- MN Hospital Assoc
- Healthcare Assoc of NY State
- IA Healthcare Collaborative
- PA Hospital Assoc
- WA Hospital Assoc
- DFWHC Foundation
- OH Hospital Assoc
- NJ Hospital Assoc
- Ascension Health
- TN Hospital Assoc
- MI Health & Hospital Assoc
- National Public Hospital & Health Institute
- LifePoint Hospitals, Inc
- Joint Commission Resources
- OCHSPS National Children's Network
- Dignity Healthcare
- NV Hospital Assoc
- Carolinas Health Care
- UHC

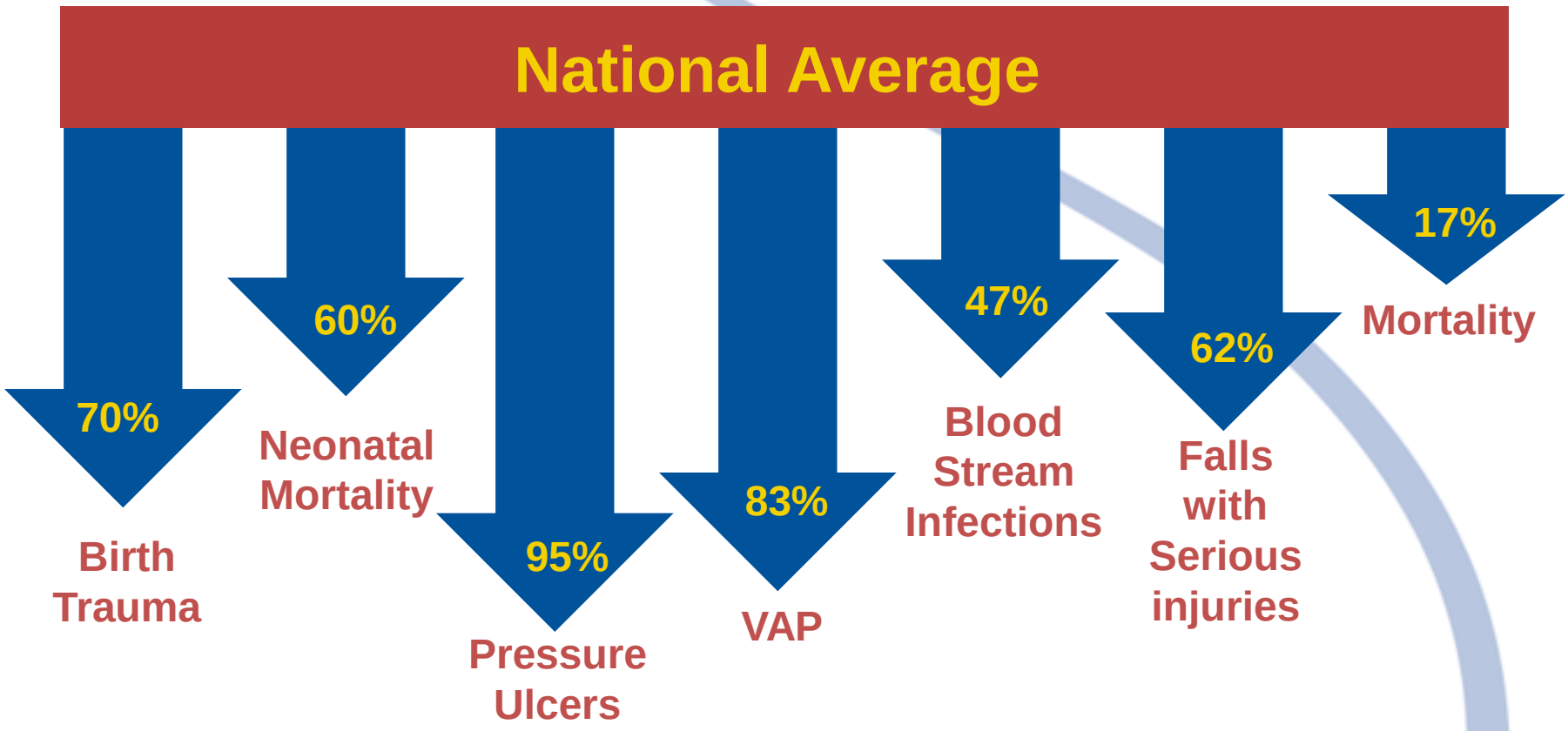
Operational and Program Results Are Starting to Flow In

- 26 Hospital Engagement Networks (HENs) launched in December 2011
- Some HENs and their hospitals are already reporting initial outcomes because of early commitment to PfP aims
- 39 communities in action in the Community-based Care Transitions Program (CCTP)…with more coming
- Robust work by HENs, QIO Program, Private Partners and others complement the larger effort to reduce 30-day readmissions
- Alignment and Action across HHS

Ascension Health System on Pressure Ulcers Incidence Rates Declined 26% Over Last 6 Years



Ascension Health
Our Journey to Zero -CY2011 Results



ASCENSION HEALTH

Measurement of Ascension Health Performance 01/01/2011 - 12/31/11. National estimates are the latest available in the literature and other sources of data (data collection methodologies may not be identical). Birth Trauma & Neonatal Mortality -2008 Facility-Acquired Pressure Ulcers – 2004 data; Falls with Serious Injury 1985 – 1999 data; Central Line Blood Stream Infection & Ventilator-Associated Pneumonia – 2006 -2008 data, Mortality 2011data.

Federal Partners and Programs Are Aligned & Generating Results on Partnership for Patients

CMS Office of Clinical Standards and Quality Programs & Policies in Alignment with PfP

- **QIO 10th Scope of Work**
  - **ICPC Aim: Improve Care Transitions/Reduce Readmissions, Assist applicants to CCTP**
  - **IIPC Aim: Reduce HAIs, ADEs**
- **Medicare Hospital Inpatient Value-Based Purchasing Program**
- **Reform of Hospital and CAH Conditions of Participation for Medicare & Medicaid**
- **Measures for HAC and Readmission Penalties**
- **Multi-Stakeholder Involvement in Measure Endorsement**

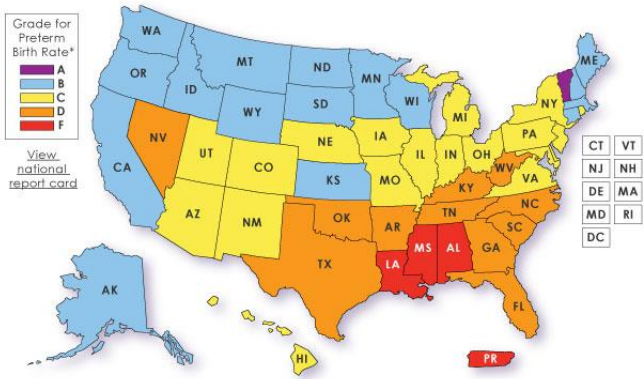
Federal Employees Health Benefits Program: Harmonizing Across 91 Insurance Carriers

FEHBP Annual Call Letter sets strategic objectives

- Plans respond in their rate/benefit proposals
  - March 29, 2012 annual call letter available at http://www.opm.gov/carrier/carrier_letters/2012/2012-09.pdf
  - Technical Guidance and Carrier Letters amplify deliverables

- Supporting the goals of CMS Partnership for Patients
  - Reducing readmissions
  - Reducing harm
  - Reducing early elective delivery

Carriers report 2010 baseline, 2011 trend



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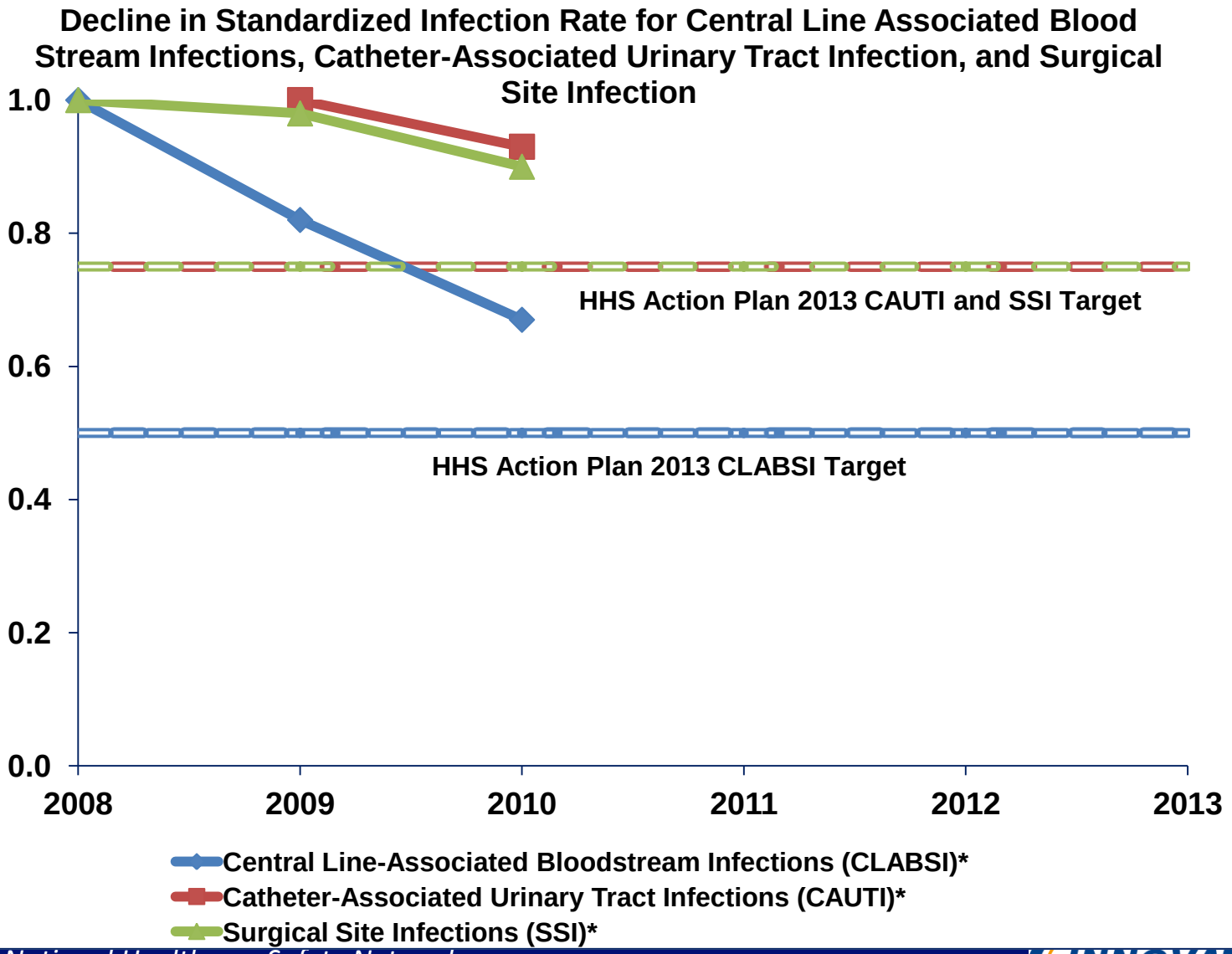
HAIs Decreasing Nationally



Source: CDC's National Healthcare Safety Network

**Hospital setting*

Teaming with the Private Sector: By the Numbers

More than 8,400 partners have pledged their commitment to the aims of the Partnership for Patients, including over 4,100 hospitals participating in the Hospital Engagement Networks.

Private Sector Commitments in Action

- Blue Cross Blue Shield Association sets goal of having all plans engaged – at present 70% of the plans are in action now
- National Business Group on Health has aligned large national employers to expect participation from Plans
- National Priorities Partnership has teamed with HHS to organize 100+ partners in June 2011-present, and secured 150+ commitments for action on the Campaign. Partners are implementing these actions now.
- National Association of Area Agencies on Aging has mobilized AAA's to become ACA 3026 community-based organizations. 21 of the 38 program agreements are now led by AAAs.
- American Nurses Association is mobilizing the nation's nurses to reduce falls and pressure ulcers and is contributing data at national scale (1,800 hospitals). This work began in 2009 and continues.
- In April 2012, Johnson & Johnson launched "CareConnect" program that provides financial incentives to patients who take steps to prevent 30-day readmissions while in the hospital.

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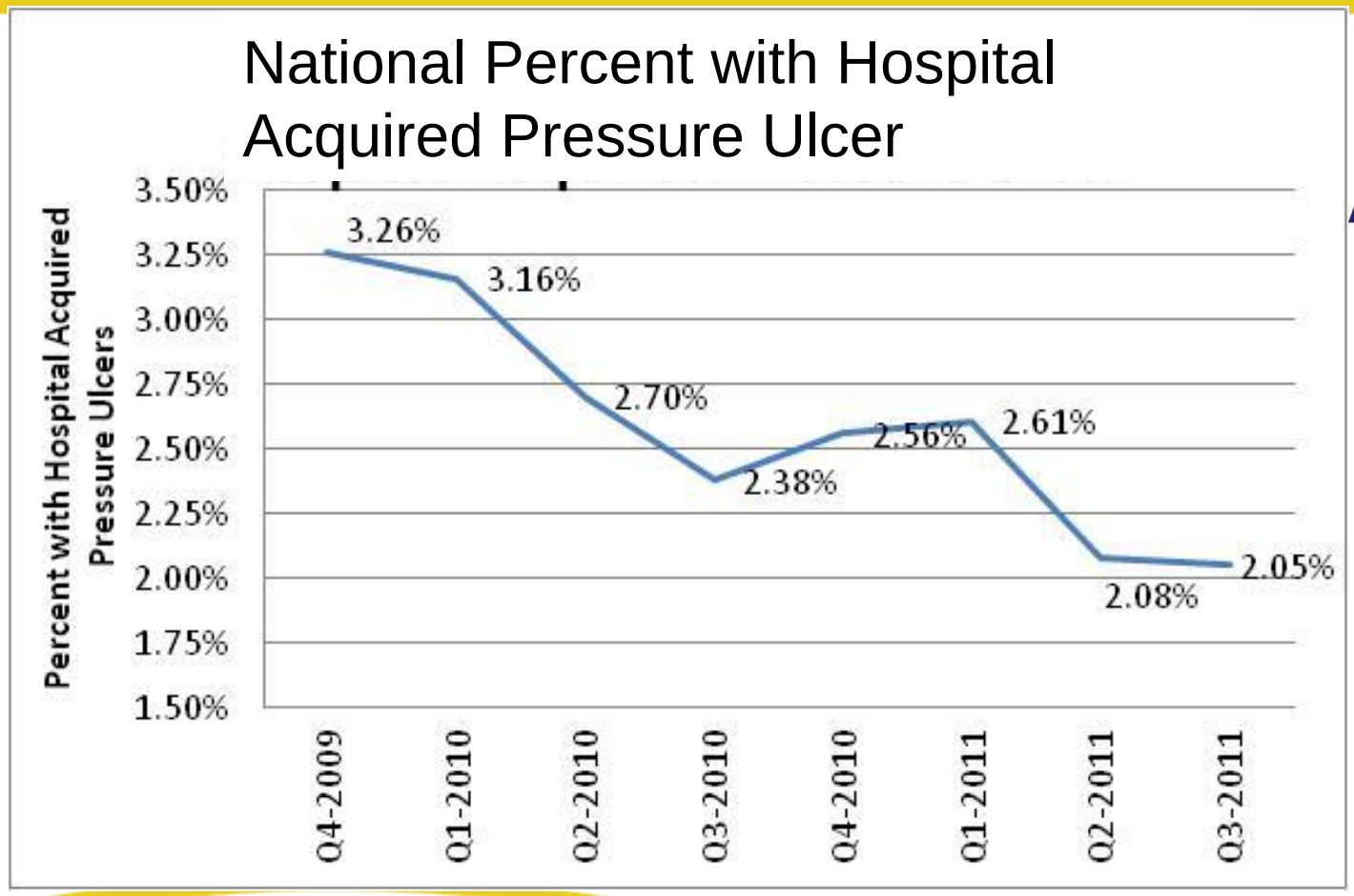
National Results Run Chart Pressure Ulcers



AMERICAN NURSES ASSOCIATION

Source – ANA National Database of Nursing Quality Indicators (NDNQI)
36,000 Units in 1,800 Hospitals

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Scope of the National Readmissions Aim

Payer	Payer-specific Rate	Total Index Admissions (2009 for Medicaid; 2010 for all others)	Total Readmissions	Number of Readmissions to prevent to reach 20% reduction (annual), *based on 32.85 million admissions*
Medicare	18.7%	14,672,303	2,742,187	548,437
Medicaid	14.0%	6,004,407	838,412	167,682
Private Insurers	8.6%	8,527,941	731,101	146,220
Uninsured Population	10.3%	1,650,410	170,518	34,104
All Other	12.7%	1,996,018	253,315	50,663
TOTAL	14.4%	32,851,079	4,735,532	947,106

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Community Care Transition Program (CCTP)

- Improve transitions of Medicare FFS beneficiaries from the inpatient hospital setting to home or other settings
- Improve quality of care
- Reduce readmissions for high risk beneficiaries
- Document measurable savings to the Medicare program to expand program beyond the initial 5 years
- Rolling Application Process
- $500M Investment

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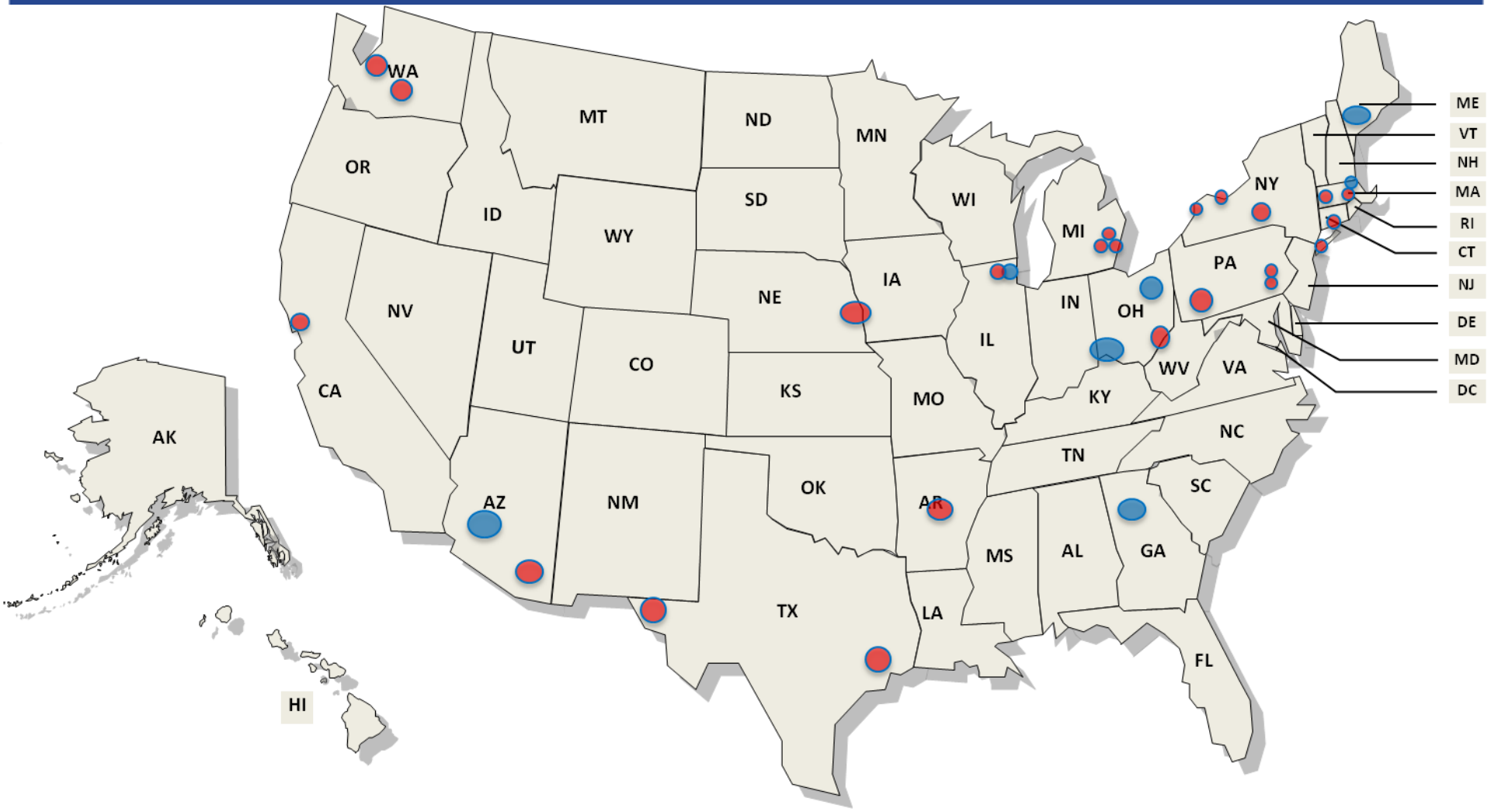
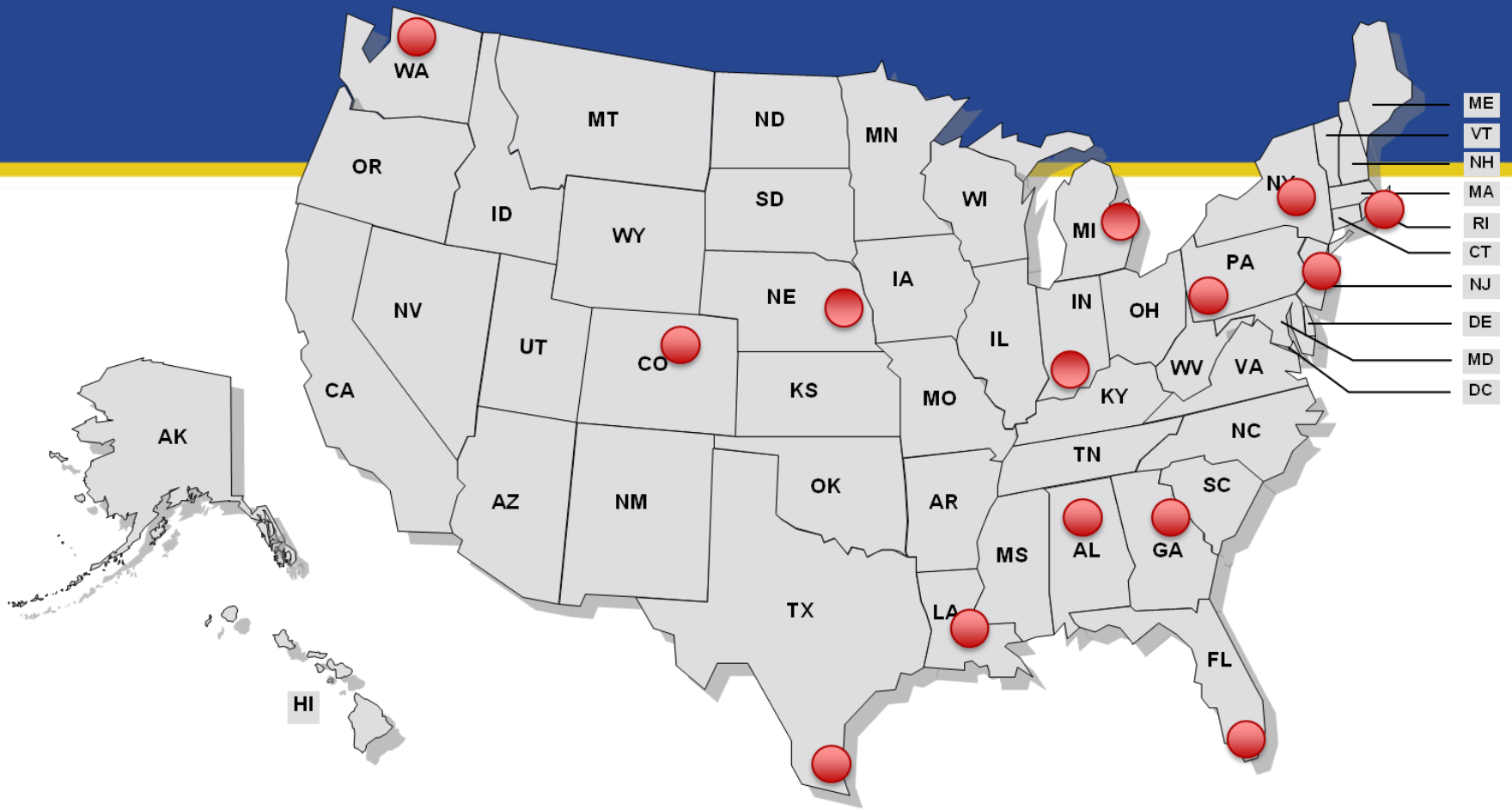
39 CCTP Participants Selected So Far!



CCTP Participants (11/29/11 announcement)

CCTP Participants (3/14/12 announcement)

Building Community Capacity, Improving Care Transitions



QIO 9th Scope of Work Care Transitions Theme, 2008-2010

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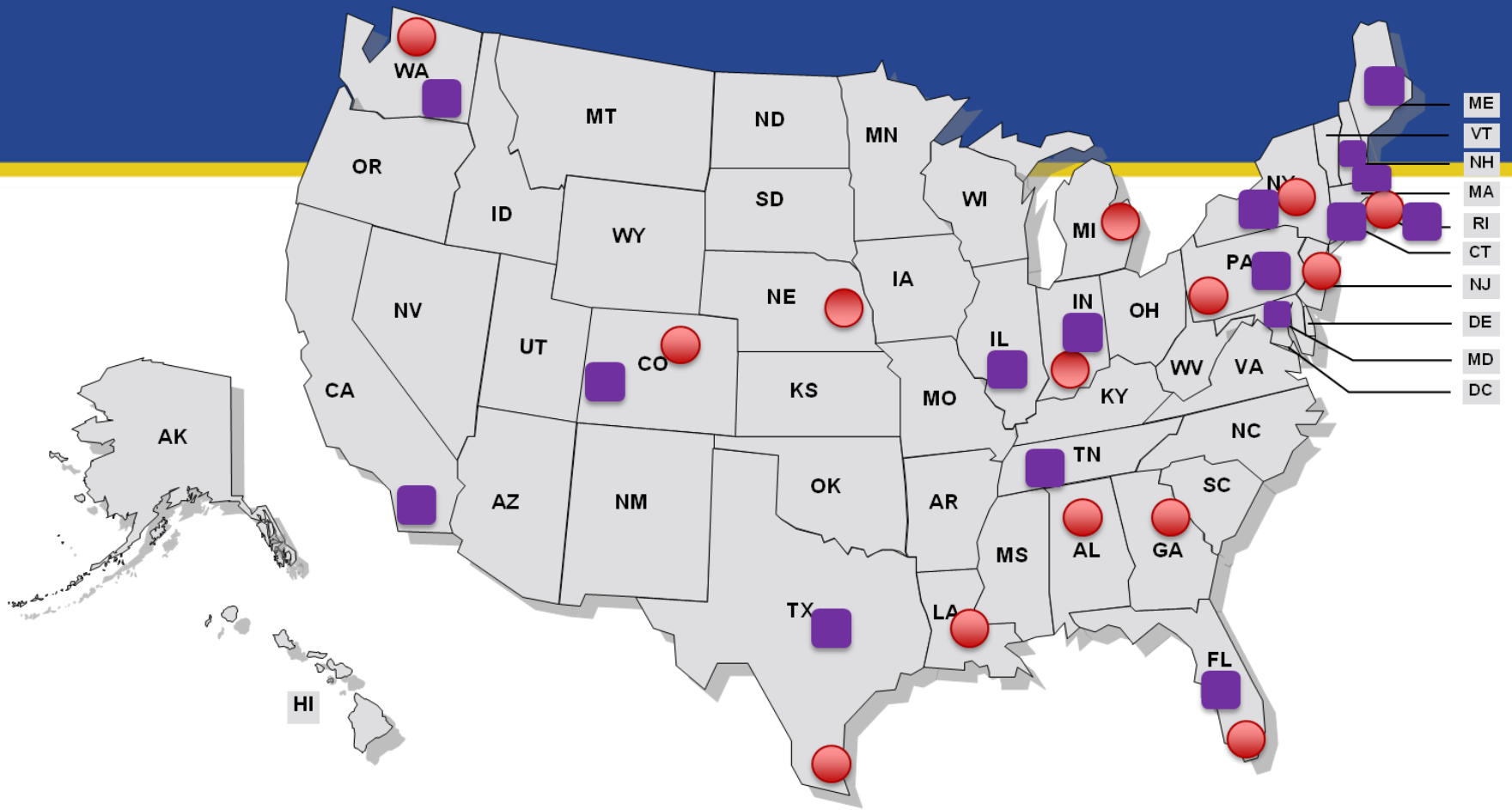
Building Community Capacity, Improving Care Transitions



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- ADRC Evidence Based Care Transitions Grantee, 2010

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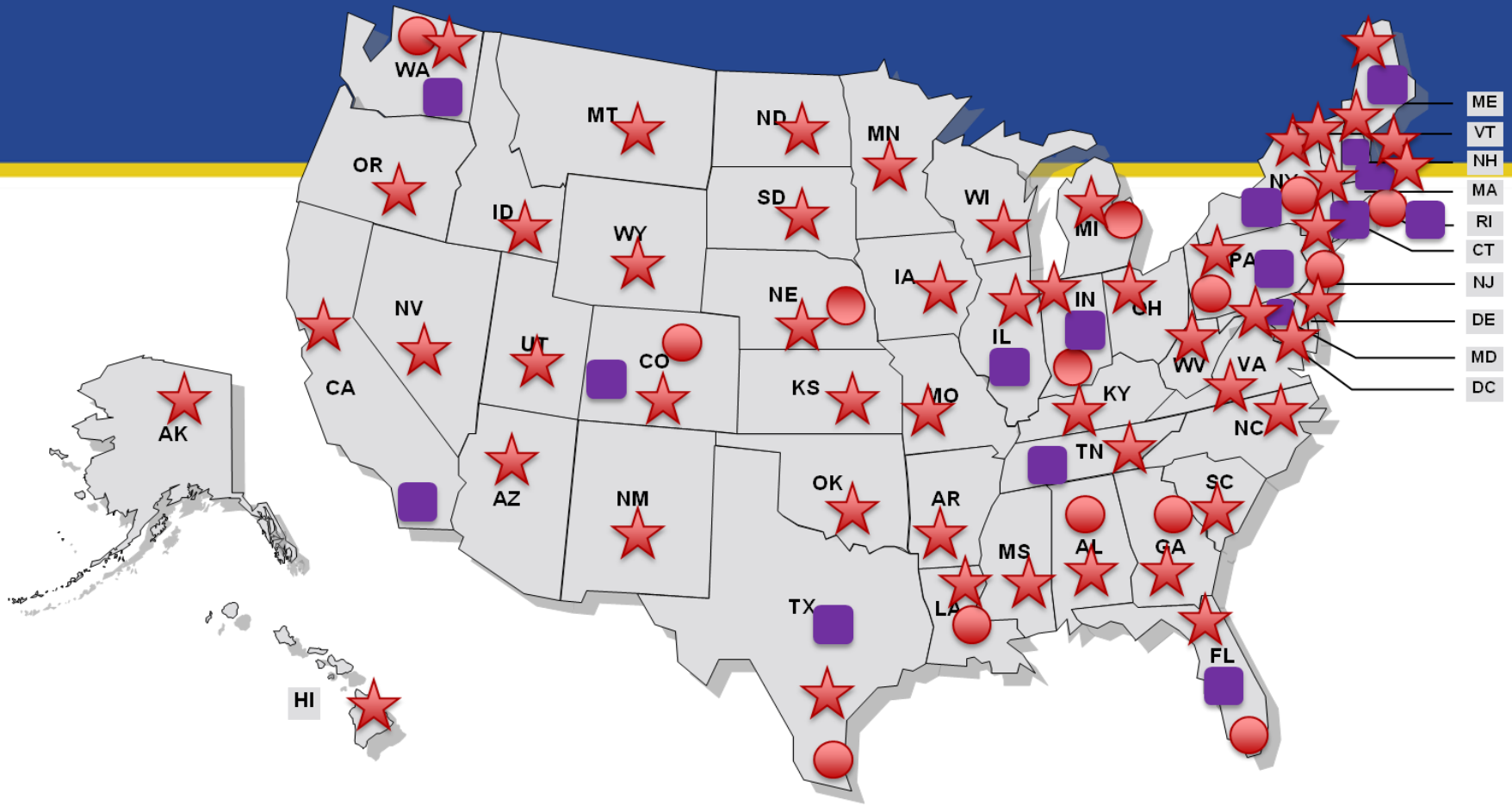
Building Community Capacity, Improving Care Transitions



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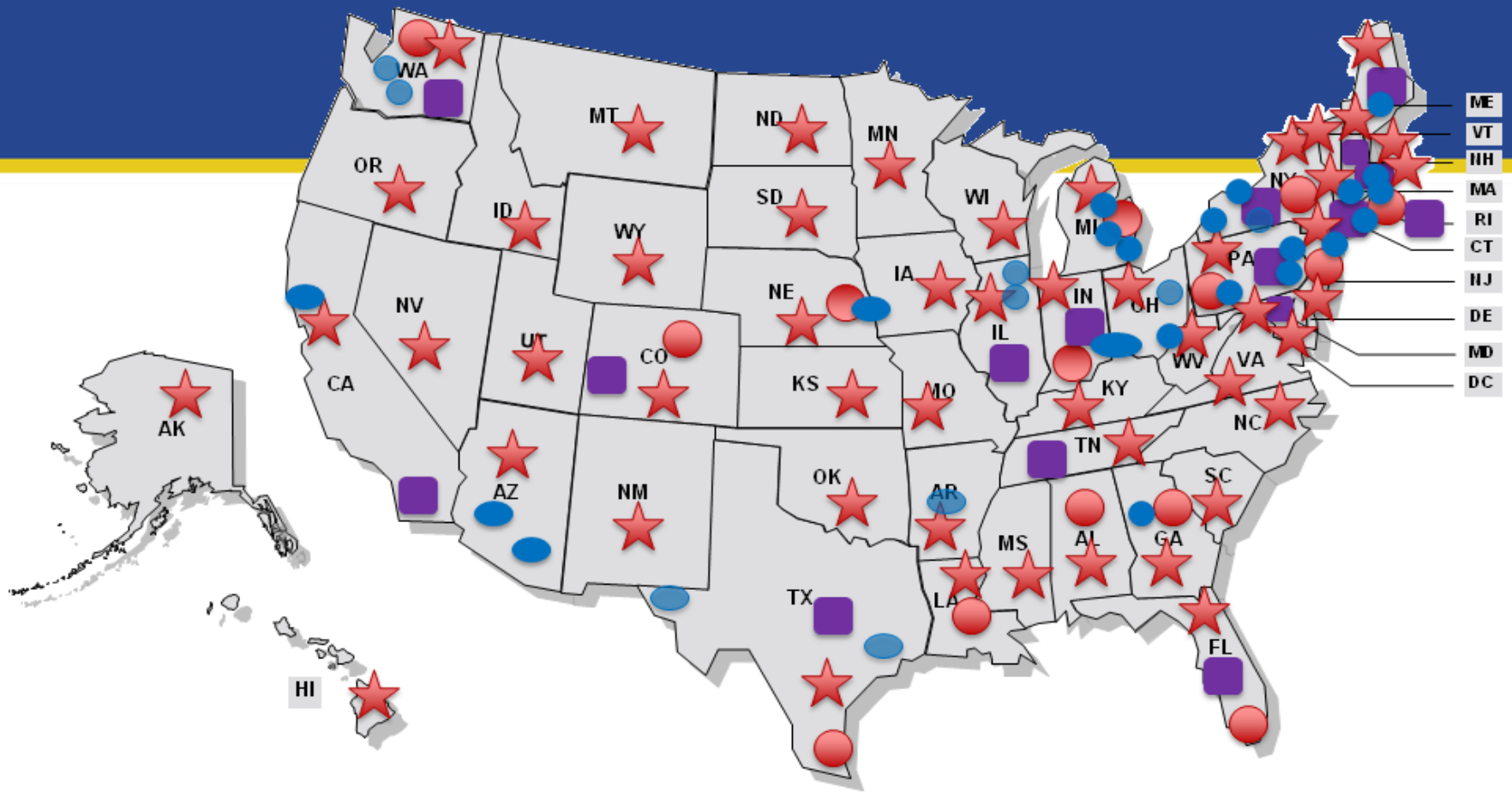

- QIO 9th Scope of Work Care Transitions Theme, 2008-2010
- ADRC Evidence Based Care Transitions Grantee, 2010
- QIO 10th Scope of Work ICPC Aim, 2011-2013
- CCTP Participants, First 30 Sites Selected, 2011-2015 (based on success)

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Community-Based Care Transitions - Your QIO Can Help!

- Community Coalition Formation
- Community-specific Root Cause Analysis
- Intervention Selection and Implementation
- Assist with an Application for a Formal Care Transitions Program

For assistance please locate your QIO care transitions contact at: http://cfmc.org/integratingcare under “Contact Us”

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QIO Work & Results on Partnership for Patients

- 176 Communities Recruited
- 141 Community Coalition Charters Signed
- 89 Communities Submitting Applications to Care Transitions Funded Programs
- 17 Communities Accepted into Funded Care Transitions Programs

- Recruited communities across the country include 585 hospitals, 972 Skilled Nursing Homes, 532 Home Health Associations, 83 Dialysis Facilities, and 188 Hospice Programs

Avoidable Hospitalization of Nursing Facility Residents

- Two-thirds of nursing facility residents are dual eligible beneficiaries enrolled in Medicaid and Medicare
- Nursing facility residents are frequently subject to avoidable readmissions and inpatient hospitalizations
- Nursing facility residents are vulnerable to risks that accompany expensive and disruptive hospital stays and transitions between nursing facilities and hospitals
- Avoidable hospitalizations among nursing facility residents stem from multiple system failures

Initiative to Reduce Avoidable Hospitalizations in Nursing Facility Residents

Joint Initiative of the Center for Medicare and Medicaid Innovation (Innovation Center) and the Medicare-Medicaid Coordination Office (MMCO)

- Primary objectives:
  - Reduce frequency of avoidable hospital admissions and readmissions
  - Improve resident health outcomes
  - Improve transition process between inpatient hospitals and nursing facilities
  - Reduce overall health care spending without restricting access to care or provider choice

More Information:
http://www.innovations.cms.gov/initiatives/rahnfr/index.html

About the Initiative

Target Population

- fee-for-service, long-stay Medicare-Medicaid enrollees in nursing facilities
- Clinical interventions will focus on long-stay residents
- Applicants will describe a plan to target their proposed intervention to long-stay beneficiaries

Funding

- $128 million plus $6.4 million in supplemental funds over a 4-year period
- Will award approx 7 cooperative agreements in approx 150 nursing facilities
- Awards expected to range from $5 million - $30 million over a 4-year period

Implementation Timeline

- May 7, 2012: Non-binding Notice of Intent to Apply (NOIA) due by 3:00 PM ET
- June 14, 2012: Full applications due by 3:00 PM
- August 24: Awards anticipated
- August 2012 to August 2016: Anticipated period of performance

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Sharing Insight, Possibility and Action
Third Innovative Communities Summit on June 5

My biggest insight from this session is: _____

_____.

The possibilities I see for how my organization can take action to ramp up Partnership for Patients work to improve patient care through quality improvement strategies in long-term care communities:

1.

2.

3.

My main advice to CMS/HHS about what resources or help on the Partnership that would be most helpful to our organization is:_____

_____.

Name, Organization, Email:_____

Ramping Up Action & Results with Long-Term Care Provider Involvement

For All

- Send success stories about engaging partners & achieving results to Traci, Dennis & Paul

For QIOs

1. How many additional communities could you recruit by October 1?
2. Would you work to exceed the 2% statewide and 7% coalition reductions in readmissions? If so, by how much?
3. Send in monthly data on intervention effectiveness

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Contact Information

Traci Archibald, OTR/L, MBA
Centers for Medicare and Medicaid Services
Office of Clinical Standards and Quality
traci.archibald@cms.hhs.gov

Paul McGann, MD
Co-Director, Partnership for Patients
CMS Innovation Center
Paul.mcgann@cms.hhs.gov

Dennis Wagner, MPA
Co-Director, Partnership for Patients
CMS Innovation Center
Dennis.wagner2@cms.hhs.gov

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