The Triple AIM and the Affordable Care Act

Preparing for the Future: Alzheimer's Disease & Related Dementias

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This material was prepared by Northeast Health Care Quality Foundation (NHCQF), the Medicare Quality Improvement Organization (QIO) for Maine, New Hampshire and Vermont, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.

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Northeast Health Care Quality Foundation
The QIO for Maine, New Hampshire & Vermont

If you don't know where your going…

- Any road will take you there!
  - Lewis Carroll

A few sobering facts about healthcare……

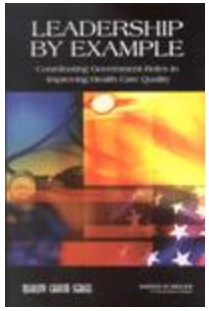
in other words… here is a clue to the destination!

Foundation of Federal Initiatives

- Three IOM Reports
  - To Err is Human-1999

  - Crossing the Quality Chasm- 2001

  - Leadership by Example- 2002



To Err is Human

- *America's wake up call about medical* errors in our healthcare system
  - 44,000 – 99,000 deaths from medical erro annually
    - (Another ~100,000 from healthcare associate infections)
  - Between $17-29 billion annually
  - Report highlighted the fact that human error is inevitable – the only way to reduce medical errors is to design a safer system

http://www.nap.edu/openbook.php?isbn=0309068371

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

The Quality of Health Care Delivered to Adults in the United States

Elizabeth A. McGlynn, Ph.D., Steven M. Asch, M.D., M.P.H., John Adams, Ph.D., Joan Keesey, B.A., Jennifer Hicks, M.P.H., Ph.D., Alison DeCristofaro, M.P.H., and Eve A. Kerr, M.D., M.P.H.

ABSTRACT

"Our results indicate that, on average, Americans receive about half of recommended medical care processes."

Northeast Health Care Quality Foundation

The QIO for Maine, New Hampshire and Vermont

N Engl J Med 2003; 348:2635-45.

U.S. scores dead last again in healthcare study

By **Maggie Fox**, Health and Science Editor
WASHINGTON | Wed Jun 23, 2010 4:48pm EDT

(Reuters) - Americans spend twice as much as residents of other developed countries on healthcare, but get lower quality, less efficiency and have the least equitable system, according to a report released on Wednesday.

Related News

Obama warns health insurers not to hike rates
Tue, Jun 22 2010

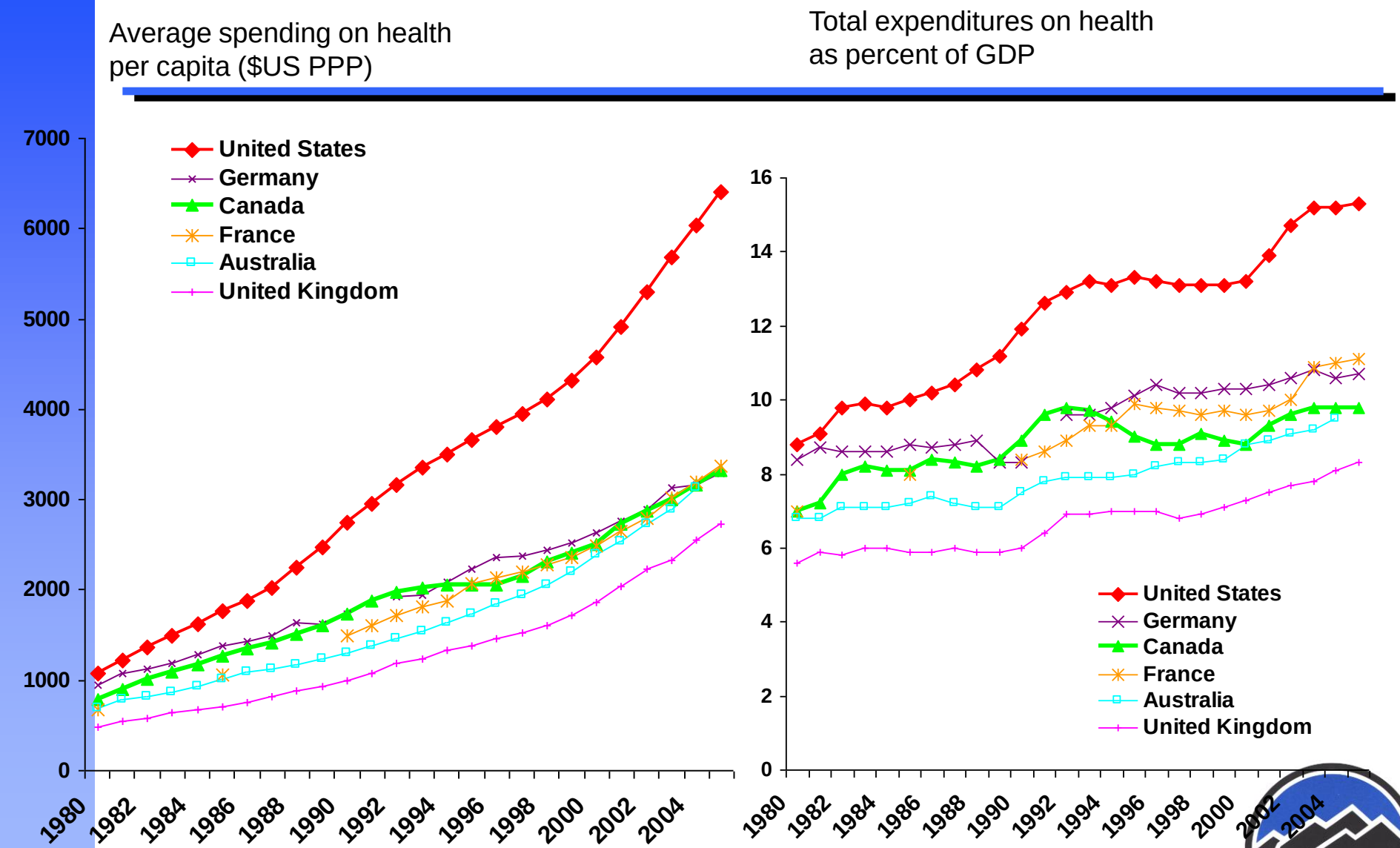
UPDATE 3-Obama warns health insurers not to hike rates
Tue, Jun 22 2010

Individuals see health insurance costs jump
Mon, Jun 21 2010

Individuals see health insurance costs jump -report
Mon, Jun 21 2010

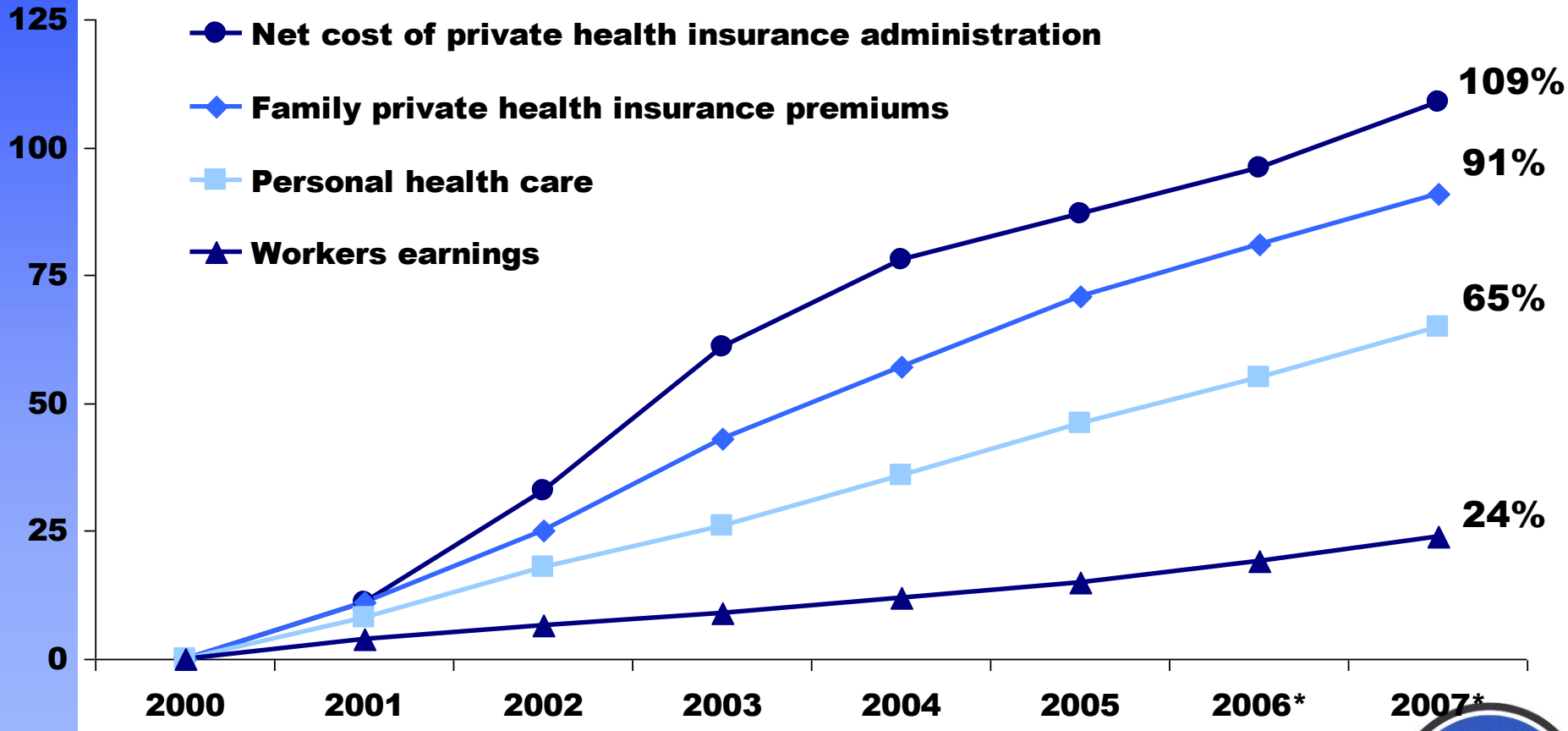
http://www.reuters.com/article/2010/06/23/us-usa-healthcare-last-idUSTRE65M05O20100623

Figure 1. International Comparison of Spending on Health, 1980–2005



Source: K. Davis, C. Schoen, S. Guterman, T. Shih, S. C. Schoenbaum, and I. Weinbaum, Slowing the Growth of U.S. Health Care Expenditures: What Are the Options?, The Commonwealth Fund, January 2007, updated with 2007 OECD data

Cumulative Changes in Annual National Health Expenditures, 2000–2007



National Health Expenditures, 2006

Total = $2.106 Trillion

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

Volume-based Payment

- Lack of accountability for the overall quality and costs of care—and for local capacity;

- A flawed payment system that rewards more care, regardless of the value (or quality) of that care.
  - In most settings a licensed physician can order any test, procedure, or treatment regardless of whether there is true patient need
    - Often times these tests or treatments result in unnecessary patient harm

Doctors Who Own Cardiac Stress Machines More Likely to Order Heart Tests.

Physicians who own and bill for nuclear cardiac stress-test technology are twice as likely to order the procedure as those who aren't paid for it, according to a study published in the *Journal of the American Medical Association*. Investigators found that physicians who owned the equipment ordered tests in 10 percent of the

Shah BR, et al. Association between physician billing and cardiac stress testing patterns following coronary revascularization. *JAMA.* 2011; 306:1993-2000.

healthgrades

American Hospital Quality Outcomes 2013:

Healthgrades Report to the Nation

Executive Summary

American consumers don't feel informed about how hospitals perform in caring for patients:

- ***45%*** are not aware that there is data available on the chance of dying at a hospital
- ***42%*** are not aware that there is data *available on a hospital's complication* rates
- ***34%*** know where to access *information about a hospital's* performance

More than 90% of Americans think that choosing a physician or hospital is at the top of the list of significant life decisions, but most of them spend more time in selecting a new car than they do in choosing a physician, specifically:

42% spend 10 or more hours researching a car

34% spend less than one hour researching a physician

Quality of Care according to Level of Medicare Spending in Hospital Referral Region of Residence.

Table 5. **Quality of Care according to Level of Medicare Spending in Hospital Referral Region of Residence***

Variable	Quintile of EOL-EI					Test for Trend†
	1 (Lowest)	2	3	4	5 (Highest)	
	← % →					
Acute MI cohort‡						
Received reperfusion within 12 hours	55.8	55.3	52.3	53.3	49.8	↓
Received aspirin in the hospital	87.7	87.0	84.8	85.3	83.9	↓
Received aspirin at discharge	83.5	82.5	79.8	78.5	74.8	↓
Received ACE inhibitors at discharge	62.7	60.0	56.6	58.3	58.5	↓
Received β-blockers in the hospital	61.5	61.0	54.3	61.5	63.9	↑
Received β-blockers at discharge	52.7	53.2	47.1	53.5	53.7	>0.05
MCBS cohort						
Preventive services						
Received influenza vaccine	60.3	56.3	54.3	50.0	48.1	↓
Received pneumonia vaccine	29.4	28.7	27.2	25.3	19.7	↓
Received Papanicolaou smear (among women without hysterectomy)	40.8	36.9	39.6	39.8	33.6	↓
Received mammography (among women age 65–69 y)	48.7	46.9	46.2	47.5	47.6	>0.05

* ACE = angiotensin-converting enzyme; EOL-EI = End-of-Life Expenditure Index; MCBS = Medicare Current Beneficiary Survey; MI = myocardial infarction.
† Arrows show the direction of any statistically significant association ($P \leq 0.05$) between the percentage of patients receiving a specified service and regional EOL-EI differences. An arrow pointing upward indicates that as spending increases across regions, the percentage of patients receiving a specified service increases. A P value greater than 0.05 was considered not significant.
‡ Values are for patients who were ideal candidates for the specific treatment, defined as having no absolute or relative contraindication.

Fisher E S et al. Ann Intern Med 2003;138:273-287

Overall Ranking

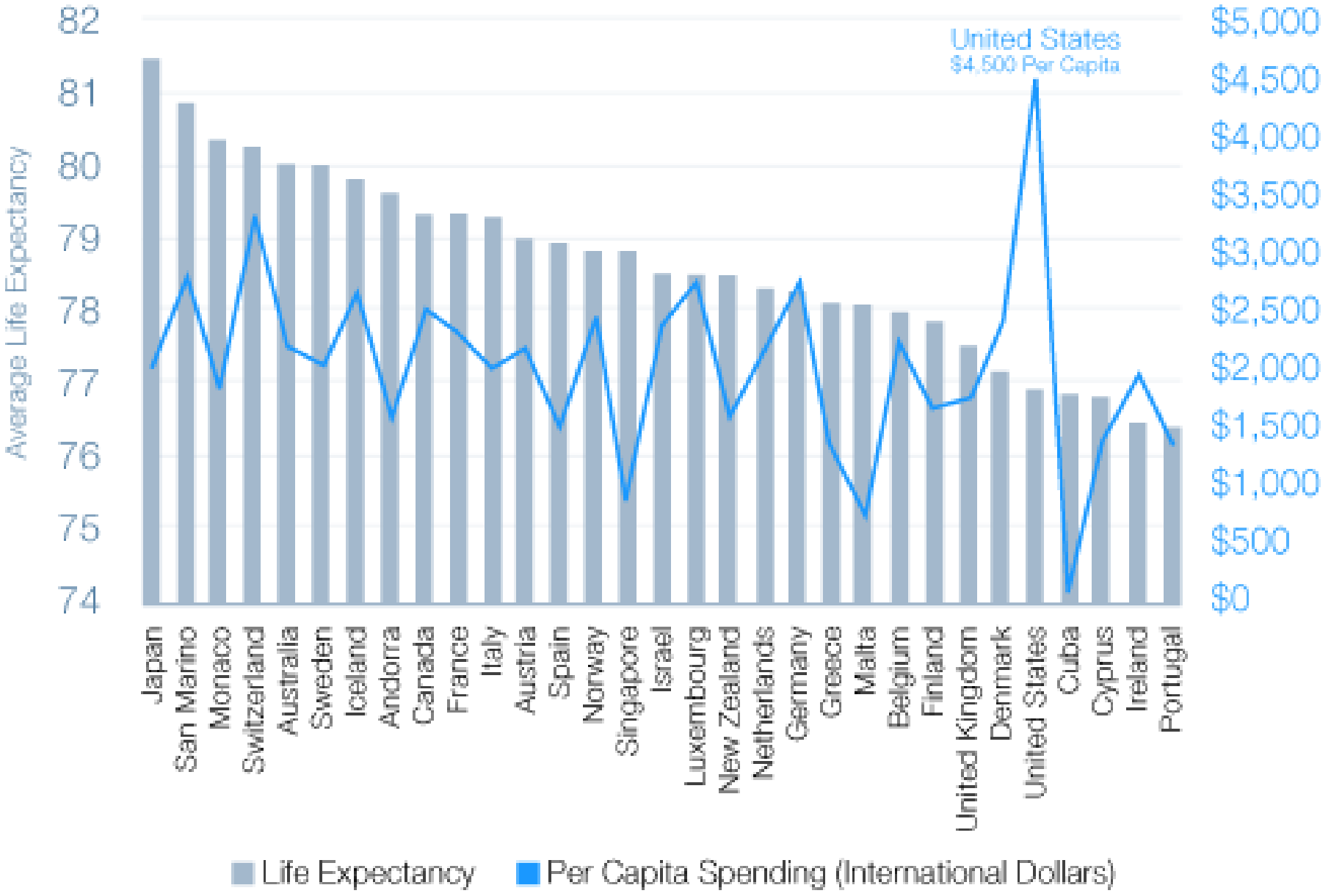
Country Rankings	
	1.00–2.33
	2.34–4.66
	4.67–7.00

	AUS	CAN	GER	NETH	NZ	UK	US
OVERALL RANKING (2010)	3	6	4	1	5	2	7
Quality Care	4	7	5	2	1	3	6
Effective Care	2	7	6	3	5	1	4
Safe Care	6	5	3	1	4	2	7
Coordinated Care	4	5	7	2	1	3	6
Patient-Centered Care	2	5	3	6	1	7	4
Access	6.5	5	3	1	4	2	6.5
Cost-Related Problem	6	3.5	3.5	2	5	1	7
Timeliness of Care	6	7	2	1	3	4	5
Efficiency	2	6	5	3	4	1	7
Equity	4	5	3	1	6	2	7
Long, Healthy, Productive Lives	1	2	3	4	5	6	7
Health Expenditures/Capita, 2007	$3,357	$3,895	$3,588	$3,837*	$2,454	$2,992	$7,290

Note: * Estimate. Expenditures shown in $US PPP (purchasing power parity).

Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for Economic Cooperation and Development, *OECD Health Data, 2009* (Paris: OECD, Nov. 2009).

The Cost of a Long Life



Challenges to our Healthcare System

- Unsustainable increase in health spending – about $2.3 trillion per year in the U.S.
  - Large geographic variations in spending
- Costs driven by technology related changes in medical practice (financial incentives)
- Large variations in clinical care when evidence is unclear
- Uncertainty about best practices involving treatments and technologies
- Overall poor quality of care compared to other developed countries

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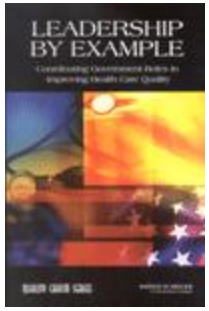


Leadership by Example- 2002

- **RECOMMENDATION 1: The federal government should assume a strong leadership position in driving the health care sector to improve the safety and quality of health care services provided to the approximately 100 million beneficiaries of the six major government health care programs. Given the leverage of the federal government, this leadership will result in improvements in the safety and quality of health care provided to all Americans.**

CMS took them at their word…

Size and Scope of CMS Responsibilities

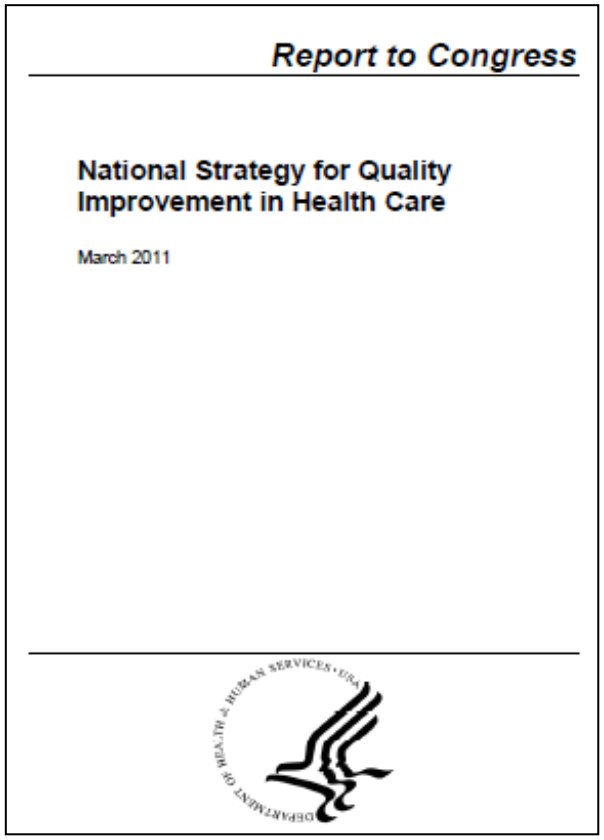
- CMS is the largest purchaser of health care in the world.
- Combined, Medicare and Medicaid pay approximately one-third of national health expenditures (approx $800B)
- CMS programs currently provide health care coverage to roughly 105 million beneficiaries in Medicare, Medicaid and CHIP; or roughly 1 in every 3 Americans.
- The Medicare program alone pays out over $1.5 billion in benefit payments per day.
- Through various contractors, CMS processes over 1.2 billion fee-for-service claims and answers about 75 million inquiries annually.
- Millions of consumers will receive health care coverage through new health insurance exchanges authorized in the Affordable Care Act.

National Quality Strategy

Overview

Northeast Health Care Quality Foundation
The QIO for Maine, New Hampshire & Vermont

National Quality Strategy promotes better health, healthcare, and lower cost



National Quality Strategy (NQS): Introduction

The **Affordable Care Act (ACA)** requires the Secretary of the Department of Health and Human Services (HHS) to establish a ***national*** strategy that will improve:

- The delivery of health care services
- Patient health outcomes
- Population health

The strategy is to concurrently pursue three aims

Better Care

Improve overall quality by making health care more patient-centered, reliable, accessible and safe.

Healthy People / Healthy Communities

Improve population health by supporting proven interventions to address behavioral, social and environmental determinants of health, in addition to delivering higher-quality care.

Affordable Care

Reduce the cost of quality health care for individuals, families, employers and government.

And focus on six priorities:

- Making care safer by reducing harm caused in the delivery of care.

- Ensuring that each person and family are engaged as partners in their care.

- Promoting effective communication and coordination of care.

- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.

- Working with communities to promote wide use of best practices to enable healthy living.

- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

Foundational Principles of the CMS Quality Strategy

Eliminate disparities

Strengthen infrastructure and data systems

Enable local innovations

Foster learning organizations

CMS Quality Strategy Six Goals

- Make care safer
- Ensure person and family engagement
- Promote effective communication and coordination of care
- Promote effective prevention and treatment
- Promote best practices for healthy living
- Make care affordable

Patient Engagement

- Refers to your *patients' and/or stakeholders'* investment in or commitment to your brand and product offerings. It is based on your ongoing ability to serve their needs and build relationships so they will continue using your products.

Patient Engagement

- Characteristics include their loyalty, their willingness to make an effort to seek health care services with your organization, and their willingness to actively advocate for and recommend your organization and health care service offerings.

Initial Implementation Activities

- Partnership for Patients (patient safety)
- Multi-payer Advanced Primary Care Practice Demonstration (care coordination)
- Million Hearts Campaign (cardiovascular disease prevention and treatment)
- Use of HCAHPS patient experience results in Value-Based Purchasing hospital payment (person-centered care)
- Community Transformation Grants (working with communities to enable healthy living)
- CMS Innovation Center 21 initiatives (development new delivery models)-ACOs being the leading canidate!
- NQS serves as the framework for the current QIO program

National Quality Strategy

Embedding the National Quality Strategy into CMS programs

Example: Quality Measurement

CMS Reporting and Payment Programs

Hospital Quality

- Medicare and Medicaid EHR Incentive Program
- PPS-Exempt Cancer Hospitals
- Inpatient Psychiatric Facilities
- Inpatient Quality Reporting
- HAC payment reduction program
- Readmission reduction program
- Outpatient Quality Reporting
- Ambulatory Surgical Centers

Physician Quality Reporting

- Medicare and Medicaid EHR Incentive Program
- PQRS
- eRx quality reporting

PAC and Other Setting Quality Reporting

- Inpatient Rehabilitation Facility
- Nursing Home Compare Measures
- LTCH Quality Reporting
- Hospice Quality Reporting
- Home Health Quality Reporting

Payment Model Reporting

- Medicare Shared Savings Program
- Hospital Value-based Purchasing
- Physician Feedback/Value-based Modifier
- ESRD QIP

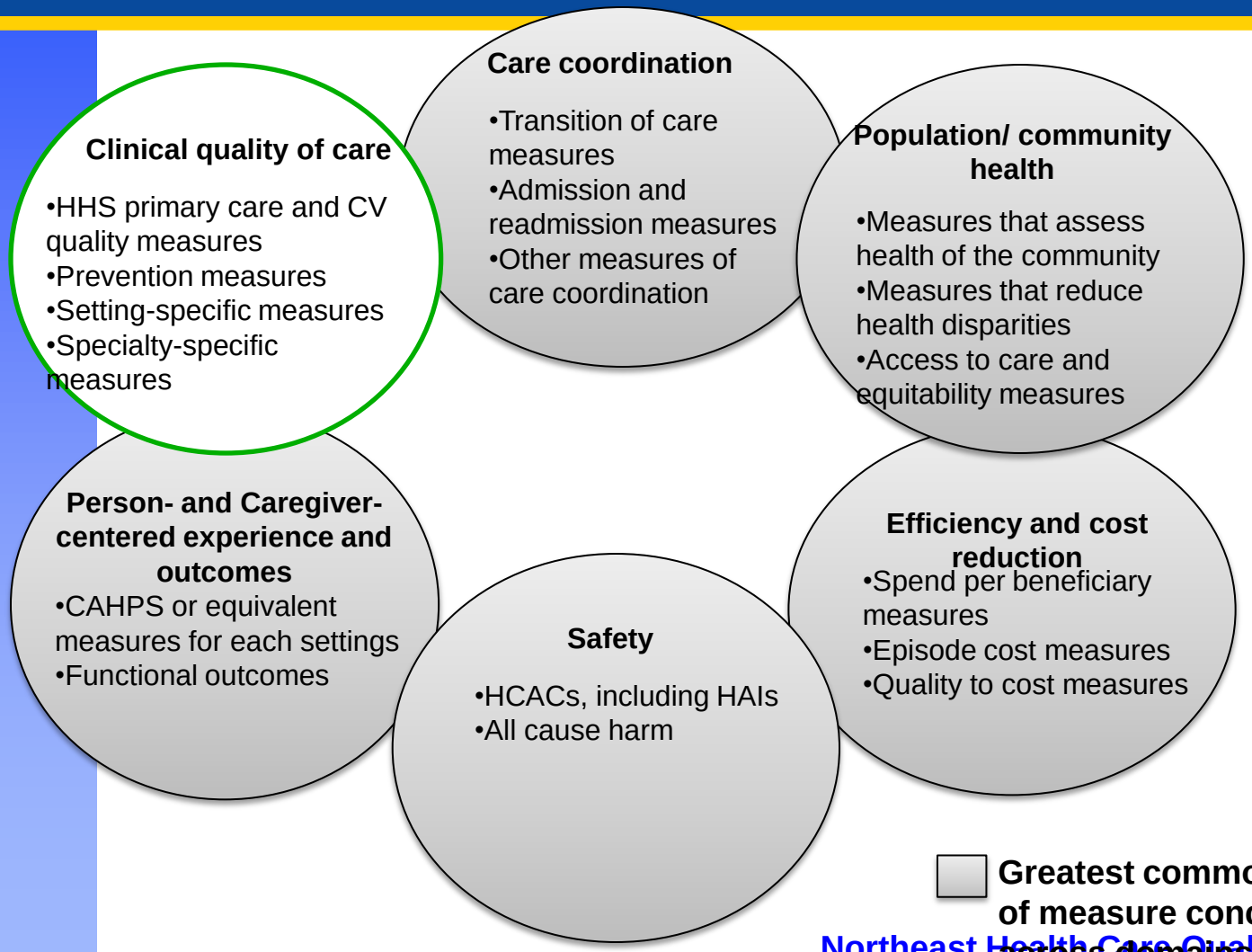
"Population" Quality Reporting

- Medicaid Adult Quality Reporting
- CHIPRA Quality Reporting
- Health Insurance Exchange Quality Reporting
- Medicare Part C
- Medicare Part D

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 where appropriate
- Focus on patient centered measures (patient outcomes and patient experience)
- Leverage opportunities to align with private sector (e.g., NQF MAP)
- Parsimonious sets of measures; core sets of measures and measure concepts
- Removal of measures that are no longer appropriate

CMS framework for measurement maps to the six national priorities



- **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**

Greatest commonality of measure concepts across domains

Cross-cutting Foundational Principles

- Eliminate disparities (includes health literacy)
- Strengthen infrastructure and data systems
- Enable local innovation
- Foster learning organizations

New Payment Models/Methods

- Value Based Purchasing
- Non-payment for unwanted outcomes
  - CAUTI, Fractures, Readmissions
- PCMH Demonstrations
- Shared Savings Models- *ACO's*

Patients with Alzheimer's Disease

- What does all this have to do with a patient with this disease
- Let us look at the intersection of the National Quality Strategy Goals and this disease vs what we have today

CMS Quality Strategy Six Goals

- Make care safer
- Ensure person and family engagement
- Promote effective communication and coordination of care
- Promote effective prevention and treatment
- Promote best practices for healthy living
- Make care affordable

Making Care Safer

- Safer care benefits this population that is particularly at risk for exposure to unsafe care for a multitude of reasons

Ensure person and family engagement

- This will drive the health system to focus on the care givers needs and the patients needs not the health system needs

Promote effective communication and coordination of care

- Minimize transitions of care
- Improve the coordination of care and the communication regarding the care

Promote effective prevention and treatment

- Focus on what works not on just trying something
- Reduction of conflicting medications

Promote best practices for healthy living

- Supporting family so they can support the patient

Make care affordable

- Health systems will be responsible for the comprehensive care of the patient- new and innovative ways to provide care will aid families in the care of the family member with this disease

Summary

- The ACA has and will change health care as we know it
- The NQS is the road map to where we are going and for once, everyone has a roadmap to follow
- CMS will drive the change through every leaver in its toolbox because it has to to survive

Summary

- Global Payment mechanisms have and will further reduce costs and have and will improve performance
- Care will shift and be supported in lower overhead environments which will, out of necessity engage families
- Patients will chronic disease will be focused on because that is where the cost is

Summary

- *Patients with Alzheimer's (as well as other dementia's) will benefit because of:*
  - improved safety
  - Increased family and patient engagement
  - a focus on over- and mis- treatment
  - Driving for affordability

Thank you

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