Alignment with National Quality Goals
Crossing the Quality Chasm

CARE SYSTEM

Supportive payment and regulatory environment

Organizations that facilitate the work of patient-centered teams

High performing patient-centered teams

Outcomes:
- Safe
- Effective
- Efficient
- Personalized
- Timely
- Equitable

REDESIGN IMPERATIVES: SIX CHALLENGES
- Reengineered care processes
- Effective use of information technologies
- Knowledge and skills management
- Development of effective teams
- Coordination of care across patient-conditions, services, sites of care over time

Making change possible.

Source: IOM, Crossing the Quality Chasm
HHS Domains and Principles
National Quality Strategy

Strategic Domains

Better Care
Better Health
Affordable Care

Principles

» Patient-centeredness and family engagement
» Quality care for patients of all ages, populations, service locations, & sources of coverage
» Elimination of disparities
» Alignment of public and private sectors
HHS 2011 National Quality Strategy
Six National Priorities

1. SAFE - Make care safer by reducing harm caused by delivery of care
2. PATIENT-CENTERED - Ensure that individuals and families are engaged as partners in their care
3. INTEGRATED - Promote effective communication and coordination of care
4. EFFECTIVE - Promote effective prevention and treatment practices for leading causes of mortality, starting with cardiovascular disease
5. PREVENTIVE - Work with communities to promote wide use of best practices to enable healthy living
6. EFFICIENT - Make quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models
Delivery and Payment Transformation

Current State
» Producer Centered
» Unsustainable
» Fragmented Care
» FFS Payment

Future State
» People-Centered
» Outcomes driven
» Sustainable
» Coordinated Care
» Payment Systems
  • VBP
  • ACO/Shared Savings
  • Care Management Fees
  • Data Transparency
CMS framework for measurement maps to the six national priorities

- Measures should be patient-centered and outcome-oriented where possible
- Measure concepts in each of the six domains that are common across providers and settings can form a core set of measures

Clinical quality of care
- HHS primary care and CV quality measures
- Prevention measures
- Setting-specific measures
- Specialty-specific measures

Person- and Caregiver-centered experience and engagement
- CAHPS or equivalent measures for each settings
- Communication/shared decision-making

Care coordination
- Transition of care measures
- Admission and readmission measures
- Other measures of care coordination

Efficiency and cost reduction
- Spend per beneficiary measures
- Episode cost measures
- Quality to cost measures

Safety
- HAIs
- HACs
- Medication errors

Population/ community health
- Measures that assess health of the community
- Measures that reduce health disparities
- Access to care and equitability measures

Care coordination
- Transition of care measures
- Admission and readmission measures
- Other measures of care coordination
Quality: Multiple Levels of Measurement & Improvement

- Three levels of measurement critical to achieving three aims of National Quality Strategy

- Measure concepts should “roll up” to align quality improvement objectives at all levels

- Patient-centric, outcomes oriented measures preferred at all three levels

- The “six domains” can be measured at each of the three levels

Communities
- Population-based denominator
- Multiple ways to define denominator, e.g., county, HRR
- Applicable to all providers

Practice setting
- Denominator based on practice setting, e.g., hospital, group practice

Individual physician
- Denominator bound by patients cared for
- Applies to all physicians
- Greatest component of a physician’s total performance

Increasing individual accountability
Increasing commonality among providers
Crossing the Quality Chasm

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## What is the opportunity for Transforming Clinical Practice?

### Today’s Care
- Patient’s chief complaints or reasons for visit determines care.
- Care is determined by today’s problem and time available today.
- Care varies by scheduled time and memory/skill of the doctor.
- Patients are responsible for coordinating their own care.
- Clinicians know they deliver high quality care because they are well trained.
- It is up to the patient to tell us what happened to them.

### Transformed Practice
- We systematically assess all our patients’ health needs to plan care.
- Care is determined by a proactive plan to meet patient needs.
- Care is standardized according to evidence-based guidelines.
- A prepared team of professionals coordinates a patient’s care.
- Clinicians know they deliver high quality care because they measure it and make rapid changes to improve.
- You can track tests, consults, and follow-up after the ED and hospital.

Adapted from Duffy, D. (2014). School of Community Medicine, Tulsa, OK.
What are the goals of Transforming Clinical Practice?

- Support more than 150,000 clinicians in work to transform their practices by moving through 5 phases of progress.
- Reduce unnecessary hospitalizations for 5 million Medicare, Medicaid and CHIP beneficiaries.
- Position the nation to rapidly scale this work to the remaining 765,000 clinicians.
- Generate $863 million in savings to the federal government over a period of 4 years.
- Ready providers to participate in incentive programs and practice models that reward value.