Improving Care, Controlling Costs: Inside New CMS Quality Initiatives

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Disclosures
• Melinda C. Joyce: “declare(s) no conflicts of interest, real or apparent, and no financial interests in any company, product, or service mentioned in this program, including grants, employment, gifts, stock holdings, and honoraria.”

Learning Objectives
• Outline initiatives by the Centers for Medicare and Medicaid (CMS) that are designed to encourage healthcare quality, focusing on those that can be impacted by health-system pharmacists.
• Describe CMS Conditions of Participation including survey readiness.
• Describe bundled payment care initiatives in which pharmacists can participate.
• Discuss the impact of clinical pharmacy services on bundled payment care initiatives.

1. Which of the following statements is true regarding the Centers for Medicare and Medicaid (CMS)?
A. CMS is the single largest payor for health care in the United States.
B. Each state has a CMS regional office.
C. Although responsible for the creation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), CMS has no other activities with the administrative actions of HIPAA.
D. CMS defers quality standards for various healthcare entities, such as hospitals to other accrediting organizations.
2. Which of the following is not included in the Healthcare Delivery System Reform by CMS?
A. Provider payment reform
B. Care delivery reform
C. Enhanced patient engagement
D. Limiting services that are paid for by Medicare

3. Which of the following statements are true regarding the readmission penalty?
A. The readmission penalty takes into account all readmissions in a 30 day period of time.
B. There are only certain disease states, such as heart failure, acute myocardial infarction, and COPD that are part of the penalty.
C. The readmission penalty gives some allowances to those hospitals located in poorer states or states with higher percentages of patients with chronic conditions.
D. The vast majority of hospitals in the United States are not impacted by the readmission penalty.

4. There are many important functions that a pharmacist may have to positively impact quality. Which of the following has not been demonstrated to be beneficial?
A. Pharmacist involvement in Accountable Care Organizations (ACOs).
B. Pharmacist development and review of standing orders.
C. Pharmacist not providing any education to the patient/family regarding medications.
D. Pharmacist responsibility for medication reconciliation.

5. Which of the following has been identified as a “hot topic” during CMS surveys?
A. Pharmacist involvement in critical care rounds
B. Medication storage
C. Safe injection practices involving multi-dose vials (MDV)
D. Safe use of benzodiazepines

What is CMS?
- The Centers for Medicare and Medicaid (CMS) is a federal agency within the United States Department of Health and Human Services (HHS)
  - Previously known as the Health Care Financing Administration (HCFA)
- Administers the Medicare program
- Works in conjunction with states to administer Medicaid, the State Children’s Health Insurance Program (SCHIP), and health insurance portability standards
- Administrative standards for the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Quality standards for healthcare facilities, including long-term care facilities and clinical laboratories
Brief CMS History

- President Lyndon B Johnson signed the Social Security Amendments on July 30, 1965, establishing Medicare and Medicaid
- Initially, the Social Security Administration (SSA) was responsible for Medicare and the Social and Rehabilitation Service (SRS) was responsible for Medicaid
- Eventually, both agencies were brought under the same organization
- CMS headquarters is in Maryland, but there are 10 regional offices located throughout the United States

CMS Overview

- CMS is the single largest payor for health care in the United States.
- Nearly 90 million Americans rely on health care benefits through either Medicare, Medicaid, or SCHIP
- As the steward for health care services for these individuals, CMS must ensure that these individuals have access to high quality care
- As health care costs continue to increase at alarming rates, this high quality care must become more affordable

The Triple Aim

- Lower Costs
- Improved Health for Populations
- Better Patient Experience

The Affordable Care Act

Six Goals of the CMS Quality Strategy

- Make care safer by reducing harm caused in the delivery of care
- Strengthen person and family engagement as partners in their care
- Promote effective communication and coordination of care
- Promote effective prevention and treatment of chronic disease
- Work with communities to promote healthy living
- Make care affordable

CMS Comprehensive Approach

- Overall goal is to improve healthcare
- Better
  - Better ways to deliver care
  - Better ways to pay providers
- Smarter
  - Smarter ways to distribute information
- Healthier
  - Lead healthcare transformation for healthier individuals and healthier communities

Current System to Future System

Unsustainable
Provider-Centric
Fragmented
Transaction-Based

Sustainable
Patient-Centric
Coordinated
Value-Based
Shifting from Volume to Value-Based Payment

Healthcare Delivery System Reform
- Provider Payment Reform
  - Creating value-based payment systems models
  - Providers accountable for quality and costs
  - Incentives to align private and public payment models and measures
- Care Delivery Reform
  - Encouraging the integration and coordination of clinical and support services
  - Increased efficiency and cost transparency
- Patient Engagement
  - Shared accountability
  - Improving population health
  - Increased consumerism

Three Primary Goals for Healthcare Delivery Transformation
- Increase Access
  - Significantly increase access to care in rural and urban underserved areas
  - Prioritize investments in primary care and preventive services
- Increase Integrated & Coordinated Care
  - Maximize use of local resources to help individuals entering and navigating the health care system
  - Assess workforce needs strategically by leveraging existing state-level, multi-stakeholder efforts
  - Craft delivery options from a consumer service and convenience perspective

Three Primary Goals for Healthcare Delivery Transformation
- Increase Integrated & Coordinated Care
  - Leverage effective models that are currently in place
  - Identify regulatory measures and economic incentive structures
  - Explore how workforce measures can support these goals
  - Determine impact of consolidation in delivery system
  - Emphasize prevention and wellness

CMS Systems and Policies
- Value-Based Purchasing (VBP)
- Accountable Care Organizations (ACOs)
- Clinically Integrated Networks (CINs)
- Bundled Payment Care Initiative (BPCI)
- Patient-Centered Medical Homes (PCMH)
- Transparency of Quality
  - Public reporting of quality and cost data
  - Surveys
PAYMENT REFORM

Value-Based Purchasing (VBP)
- This rule went into effect on October 1, 2012 (FY 2013)
- Each hospital receives a value-based purchasing score, which determines how the hospital will be reimbursed for care provided for Medicare patients
  - The score is then applied to the reimbursement for each Medicare patient
  - Rewards for achievement or improvement
  - Does not apply to critical access hospitals
  - Hospitals that have too few patient cases of the applicable measures are also excluded
- There are several domains that comprise the VBP score
  - The percentages and the specific measures change annually

VBP Payment Strategies
- Reduce base operating payments for each Medicare discharge by:
  - 1% in FY 2013
  - 1.25% in FY 2014
  - 1.5% in FY 2015
  - 1.75% in FY 2016
  - 2% in FY 2017
- Will be based on performance of quality measures
  - Different baseline and performance time frames
- All hospitals have been working to improve their quality scores, which means that there is a continually changing target for hospitals to reach
VBP for FY 2017

- Clinical Care – 30%
  - Clinical Process – 5%
  - Influenza Immunization (IMM-2)
  - Early Elective Delivery (PC-01)
- Outcomes – 25%
  - 30 Day Mortality – AMI
  - 30 Day Mortality – HF
  - 30 Day Mortality – PN
- Patient and Caregiver Experience – 25%
  - HCAHPS including Care Coordination Questions
- Efficiency and Cost Reduction -25%
  - Medicare Spending per Beneficiary

VBP for FY 2018

- Clinical Care – 25%
  - Outcomes
  - 30 Day Mortality – AMI
  - 30 Day Mortality – HF
  - 30 Day Mortality – PN
- Patient and Caregiver Experience – 25%
  - HCAHPS including Care Coordination Questions
- Safety – 25%
  - CLABSI
  - CAUTI
  - SSI
  - AHRQ PSI-90
  - MRSA Bacteremia
  - C. Diff
- Efficiency and Cost Reduction -25%
  - Medicare Spending per Beneficiary

Clinical Care

- Outcomes measures that are claims-based
- All-cause mortality within 30 days of discharge for certain disease states
  - There are some limited exclusions, such as documentation and coding of palliative care
- In the past, this domain was where the clinical core measures would reside
  - Most hospitals have “topped out” and the core measures have been retired
- Still important to track those core measures as adherence to the core measures should lead to a decrease in mortality

Patient and Caregiver Experience

- The patient’s perception of the care that they received while hospitalized is still very important
- For VBP, the “top box” or “always” answer to the survey questions is used to compute the score
- For public reporting purposes, CMS has moved to the “star ratings”, which calculates a score based on all of the answers to the questions.
  - Very few hospitals have been able to achieve a Five Star Rating for patient and caregiver experience

Safety Measures

- All of these measures are claims-based
- Healthcare-Associated Infections
  - CLABSI: Central line-associated blood stream infections among adult, pediatric, and neonatal ICU patients
  - CAUTI: Catheter-associated urinary tract infections among adult and pediatric ICU patients
  - SSI: Surgical site infections specific to abdominal hysterectomy and colon surgeries
  - Clostridium difficile infections
  - MRSA bacteremias
- PSI-90
  - AHRQ Patient Safety for Selected Indicators (composite score of five indicators)

PSI-90 Safety Score (ARHQ)

<table>
<thead>
<tr>
<th>PSI Number</th>
<th>Description</th>
<th>National Rate per 1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSI 04</td>
<td>Death Among Surgical Inpatients with Serious Treatable Complications</td>
<td>117.75</td>
</tr>
<tr>
<td>PSI 06</td>
<td>Iatrogenic Pneumothorax Rate</td>
<td>0.39</td>
</tr>
<tr>
<td>PSI 12</td>
<td>Post-Operative Pulmonary Embolism or Deep Vein Thrombosis Rate</td>
<td>4.35</td>
</tr>
<tr>
<td>PSI 14</td>
<td>Post-Operative Wound Dehiscence Rate</td>
<td>1.70</td>
</tr>
<tr>
<td>PSI 15</td>
<td>Accidental Puncture or Laceration Rate</td>
<td>1.81</td>
</tr>
<tr>
<td>PSI-90</td>
<td>Complication/ Patient Safety Composite</td>
<td>0.81</td>
</tr>
</tbody>
</table>

Data from Medicare claims submitted from July 1, 2012 – June 30, 2014
**Efficiency Measure: Medicare Spending Per Beneficiary (MSPB)**

- Total risk-adjusted spending per beneficiary between 3 prior to inpatient admission and 30 days post discharge

Hospital's Medicare spending per beneficiary = National Median Medicare spending per beneficiary

**Implication:** Hospitals must use their leverage to reduce spending outside of the hospital.

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**Readmission Penalty Summary**

- Maximum penalty for readmission is 3%
- All cause 30 day readmissions for:
  - AMI
  - HF
  - PN
  - COPD
  - Elective Hip/Knee Arthroplasty
  - CABG will be added for FY 2017
- No confirmed additional conditions at this time
- Does not take into account any socio-economic issues
- Nationally, only 799 out of 3464 hospitals did not face a readmission penalty for FY 2016
- 38 hospitals will be subject to the maximum 3% reduction

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**Readmissions Penalty for FY 2016**

- 38 hospitals (1.1%) received the maximum 3% penalty for readmissions. Six were in Kentucky.

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**Hospital-Acquired Condition (HAC) Reduction Program**

- HAC Reduction program reduces total Medicare payments by 1% for worst performing quartile of hospitals
  - Began in FY 2015
  - All or none reduction
- Two domains
  - Agency for Healthcare Research and Quality (ARHQ) measures
  - Centers for Disease Control (CDC) and Prevention National Healthcare Safety Network (NHSN) measures
- It is possible to have multiple penalties for the same measure

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**Overlapping HAC and VBP Measures**

<table>
<thead>
<tr>
<th>Hospital-Acquired Condition (HAC)</th>
<th>Not Eligible for Higher Payment</th>
<th>VBP</th>
<th>HAC Reduction Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catheter-associated UTI</td>
<td>X</td>
<td></td>
<td>FY 2016</td>
</tr>
<tr>
<td>Surgical site infections</td>
<td>X</td>
<td></td>
<td>FY 2016</td>
</tr>
<tr>
<td>Vascular catheter-associated infections</td>
<td>X</td>
<td></td>
<td>PSI-90/CLABSI</td>
</tr>
<tr>
<td>Foreign object retained after surgery</td>
<td>X</td>
<td></td>
<td>PSI-90/CLABSI</td>
</tr>
<tr>
<td>Air embolism</td>
<td>X</td>
<td></td>
<td>PSI-90/CLABSI</td>
</tr>
<tr>
<td>Blood incompatibility</td>
<td>X</td>
<td></td>
<td>PSI-90/CLABSI</td>
</tr>
<tr>
<td>Pressure ulcer stage III or IV</td>
<td>X</td>
<td></td>
<td>PSI-90 FY 2015</td>
</tr>
<tr>
<td>Falls and trauma</td>
<td>X</td>
<td></td>
<td>PSI-90 FY 2015</td>
</tr>
<tr>
<td>DVT/PE after hip/knee replacement</td>
<td>X</td>
<td></td>
<td>PSI-90 FY 2015</td>
</tr>
<tr>
<td>Manifestations of poor glycemic control</td>
<td>X</td>
<td></td>
<td>PSI-90 FY 2015</td>
</tr>
<tr>
<td>Infections pneumonitis</td>
<td>X</td>
<td></td>
<td>PSI-90 FY 2015</td>
</tr>
<tr>
<td>Methicillin-resistant Staph aureus (MRSA)</td>
<td>FY 2017</td>
<td></td>
<td>PSI-90 FY 2015</td>
</tr>
<tr>
<td>Clostridium difficile</td>
<td>FY 2017</td>
<td></td>
<td>PSI-90 FY 2015</td>
</tr>
</tbody>
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**Pharmacist Impact**

- Pharmacists have been able to make a huge impact on these quality initiatives!
- Activities include:
  - Critical role in the care redesign process
  - Hospital action plans
  - Standing orders
  - Pharmacist education
  - Medication Reconciliation
  - Don't forget technicians as a possible resource
  - Medication Therapy Management
Pharmacist Impact

- Standing orders
  - Continuation of documentation of core measures is not optional
  - Impact on harm/safety measures, such as VTE prophylaxis
  - Electronic prescribing and documentation can help
- Identification of patients at high risk for non-compliance and possible readmission
- Standardize the discharge process
  - Discharge checklists may be helpful
  - Discharge planning begins at admission
  - Assess for post-discharge needs

Pharmacist Impact

- Education must occur during the entire hospital stay
  - Do not wait until day of discharge to start education
- Engage families, patients, and caregivers
  - Use of Teach-Back
  - Other visual aids
- Good communication between providers, patient, and family
- Assist the patient in managing their medication
  - Medication reconciliation
- Develop community connections to help eliminate barriers to successful transition

Identifying the “High Risk” Patient

- A “high risk” patient is a patient that may be at risk for readmission
- No accepted approach for determining those patients that may be at risk
- Some approaches are specific to a disease state, such as the LACE tool for heart failure
- If the patient is identified as “high risk” additional interventions may be done during hospitalization
  - Additional education
  - Complete medication review
  - Providing a supply of medications at discharge
  - Coordination with other providers
- The pharmacist documentation can be a critical component

Accountable Care Organizations (ACOs)

- ACOs create incentives for healthcare providers to work together to treat an individual patient across care settings (across the continuum)
  - Physician practice
  - Hospital
  - Long-term care facility
- Some hospitals are opting for the development of a clinically integrated network
- If care is better coordinated, then patients should receive the care that they need, decrease duplicative services, and much less likely to suffer medical errors or adverse events that can lead to hospitalizations

Defining Accountable Care

- An entity that directly influences the provision of care and bears financial risk for the measured health outcomes of a defined population
- There are three main components

How Do ACOs Reduce Expenditures?

- Appropriate Workforce
- Informed Patient Choices
- Health Information Technology
- Reduces Waste
Pharmacists and ACOs

- ACOs and Medication Therapy Management (MTM) services with a local pharmacist is a great fit!
- Medications should not be viewed as a “siloed expense”
  - Medication costs and quality benefits resulting from medication use can be calculated in a shared savings plan
  - Medications must be individualized and closely monitored
- Pharmacist involvement with an ACO can allow interventions to be more accurate and more timely
- Those high-risk patients that are more likely to be readmitted may be the patient population where pharmacist involvement is necessary
- Successful ACOs understand the importance of pharmacist involvement

Pharmacist Service Delivery Models in the ACO

- Pharmacist “onsite”
  - Physician office
  - Community health center
  - Health-system
- Contracted network of pharmacists
  - Variety of practice settings
- Virtual member of the team
  - Community pharmacy
  - Managed care
  - Consultant

Bundled Payment Care Initiative (BPCI)

- Pilot project from CMS to encourage providers to work together to manage disease episodes across the continuum of care
- Brings together the hospital, the physicians, and the post-acute care providers
- Targets 48 conditions with a single payment for an episode of care
- It incentivizes providers to take accountability for both the cost and quality of care
- Goal is to achieve the “Triple Aim”
- Four models
  - Model 1: Retrospective acute care hospital stay only
  - Model 2: Retrospective acute care hospital stay plus post-acute care (90 days)
  - Model 3: Retrospective post-acute care only
  - Model 4: Acute care hospital stay only
- Many hospitals are involved in BPCI using Model 2

BPCI – Model 2 Example

- The hospital acts as the “convener” and agrees to take a 2% discount for a particular episode
- Looks at the costs of the anchor stay (the patient’s inpatient admission) and then the next 90 days
- The cost is the amount of expense incurred by Medicare
- “Average” cost is compared to the costs incurred during the bundle
- Savings that are achieved are returned to the “convener” or the group that initiates the bundle
- Medicare Part D is not included in the bundle
- Appropriate medication use is still a critical factor
- Providers need to know how care is currently being provided across the continuum for the 90 days, the costs and how that care can be improved

Pharmacists in Bundled Payment

- Pharmacists are uniquely qualified to positively impact the care of the patient involved in the bundle
  - Care redesign
  - Medication reconciliation
  - Confirmation of and education about the medication plan
  - Post-discharge telephone calls
  - Spanning the continuum through communications with other post-acute care pharmacy providers
    - Community pharmacists
    - Long-term care pharmacists
    - Home care pharmacists
  - All phases of transitions of care

What Are Some of the “Episodes”

- Acute myocardial infarction (DRG 280, 281, 282)
- Heart failure (DRG 291, 292, 293)
- Cardiac arrhythmia (DRG 308, 309, 310)
- COPD (DRG 190, 191, 192, 202, 203)
- Diabetes (DRG 637, 638, 639)
- Simple pneumonia and respirator infections (DRG 177, 178, 179, 193, 194, 195)
- Stroke (DRG 61, 62, 63, 64, 65, 66)
- Double joint replacement of the lower extremity (DRG 469, 470)
- Fractures femur and hip/pelvis (DRG 533, 534, 535, 536)
- Hip and femur procedures except major joint (DRG 485, 486, 487, 488, 489)
- Major joint replacement of the lower extremity (DRG 489, 490)
- Knee procedures (DRG 485, 486, 487, 488, 489)
- Removal of orthopedic devices (DRG 495, 496, 497, 498)
- Revision of the hip or knee (DRG 496, 497, 498)

Not a complete list
Comprehensive Care for Joint Replacement Model (CJR) - 2015

- The Comprehensive Care for Joint Replacement (CJR) model aims to support better and more efficient care for Medicare beneficiaries undergoing some common inpatient surgeries
  - Hip and knee replacements
  - Model 2 is the approach with hospitals as the conveners
- Hip and knee replacements are the most common inpatient surgery for Medicare beneficiaries and can require lengthy recovery and rehabilitation periods
- Despite the high volume of these surgeries, quality and costs of care vary greatly among providers
- Not all hospitals are required to participate at this point

Physicians and Hospitals Collaborating in Population Health

- $100+ billion of Medicare payment cuts
- ACA, sequestration, 2MN. Pay for Performance
- Alternative payment models
- Fee-for-service linked to quality

CMS Goals for Payment

<table>
<thead>
<tr>
<th>Year</th>
<th>Alternative payment models</th>
<th>Fee-for-service linked to quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>68%</td>
<td>32%</td>
</tr>
<tr>
<td>2014</td>
<td>&gt;80%</td>
<td>20%</td>
</tr>
<tr>
<td>2016</td>
<td>85%</td>
<td>15%</td>
</tr>
<tr>
<td>2018</td>
<td>90%</td>
<td>10%</td>
</tr>
</tbody>
</table>

Work with Communities to Promote Best Practice of Healthy Living

- Partner with and support federal, state, and local public health improvement efforts
- Improve access within communities to best practices of healthy living
- Promote evidence-based community interventions to prevent and treat chronic disease
- Increase use of community-based social supports

Preventive Services Offered by Pharmacists

- Immunizations
  - Authorized to provide immunizations in all 50 states
  - Nearly 1 in 4 adults received a vaccination in a community pharmacy in 2013
- Screenings
  - Cholesterol, HbA1c, bone density scans, screening for depression
  - Based on the results, pharmacist can either provide education or a referral
- Educational and Behavioral Counseling
  - Smoking Cessation
  - Lifestyle modifications

Pharmacist Run Chronic Care Programs

- Multidisciplinary program that is often an off-shoot of a robust MTM program
- Typically targets those disease states with the most complex drug regimens
- Structure is similar to many outpatient anticoagulation clinics
- Disease management protocols are often utilized and can help with buy-in from the medical staff
<table>
<thead>
<tr>
<th>Pharmacist Run Chronic Care Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medication evaluation</td>
</tr>
<tr>
<td>– Review of patient’s history</td>
</tr>
<tr>
<td>– Review of medications, including questions to the individual patient regarding potential side effects and compliance issues</td>
</tr>
<tr>
<td>• Therapeutic recommendations to the medical provider</td>
</tr>
<tr>
<td>– Optimization of therapy, such as reaching target doses</td>
</tr>
<tr>
<td>– Dose adjustment based on renal or hepatic status of the patient</td>
</tr>
<tr>
<td>– Avoidance of contraindicated medications or drug interactions</td>
</tr>
<tr>
<td>– Recommendations for laboratory monitoring, if indicated</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pharmacist Run Chronic Care Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patient education</td>
</tr>
<tr>
<td>– Discuss any medication changes with the patient</td>
</tr>
<tr>
<td>– Describe purpose of the medication along with potential adverse effects</td>
</tr>
<tr>
<td>– Provide written information along with a medication calendar</td>
</tr>
<tr>
<td>– Incorporate lifestyle modifications into the educational session</td>
</tr>
<tr>
<td>– Educate on the disease states to help reinforce the need for the appropriate medication</td>
</tr>
<tr>
<td>• Follow-up monitoring by telephone</td>
</tr>
<tr>
<td>– May depend on the need of the patient</td>
</tr>
<tr>
<td>– At 72 hours after the appointment or at other times based on the findings at the appointment</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>CMS Innovation Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>• State Innovation Models</td>
</tr>
<tr>
<td>• Next Generation ACOs</td>
</tr>
<tr>
<td>• Comprehensive End-Stage Renal Disease (ESRD) Care Initiative</td>
</tr>
<tr>
<td>• Primary Care Transformation</td>
</tr>
<tr>
<td>– Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration</td>
</tr>
<tr>
<td>– Independence at Home Demonstration</td>
</tr>
<tr>
<td>• Initiatives Focused on the Medicaid Population</td>
</tr>
<tr>
<td>– Medicaid Emergency Psychiatric Demonstration</td>
</tr>
<tr>
<td>– Medicaid Incentives for Prevention of Chronic Diseases</td>
</tr>
<tr>
<td>• Medicare-Medicaid Enrollees</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Management Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Primary Care Provider (PCP)</td>
</tr>
<tr>
<td>• Mid-Level Practitioner</td>
</tr>
<tr>
<td>• Registered Nurse</td>
</tr>
<tr>
<td>• Non-clinician employees</td>
</tr>
<tr>
<td>– May focus on the first seven days after discharge</td>
</tr>
<tr>
<td>– Make appointments</td>
</tr>
<tr>
<td>– Make sure the patient has what they need at home</td>
</tr>
<tr>
<td>– May visit patients in the home (community health worker; community paramedics)</td>
</tr>
<tr>
<td>– May help patients navigate the healthcare system</td>
</tr>
<tr>
<td>• Social worker/ Patient Navigator</td>
</tr>
<tr>
<td>– May help with housing, meals, financial support</td>
</tr>
<tr>
<td>• Pharmacist</td>
</tr>
<tr>
<td>– Necessary for appropriate medication management</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Redesign Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Respected, established champion and program manager to innovate and lead</td>
</tr>
<tr>
<td>• Broad multi-disciplinary stakeholder participants from across the continuum</td>
</tr>
<tr>
<td>• Evidence, current state and opportunities for improvement</td>
</tr>
<tr>
<td>• Episode of care stages with alignment across continuum</td>
</tr>
<tr>
<td>• Domains of improvement: Best Practice, Flow and Coordinated Care</td>
</tr>
<tr>
<td>• Stakeholders develop standardized, evidence-based practices</td>
</tr>
<tr>
<td>• Agreements with stakeholders to follow developed guidelines</td>
</tr>
</tbody>
</table>
Care Redesign Process

Assess Current State & Create Future State

- Deeply understand current episode processes
- Future State with optimized workflows
- Develop coordinated care processes for episode

Establish Metrics To Measure And Monitor

- Process and outcome measurement over time
- Reporting and feedback to support CQI

Implement Plan And Continuously Improve

- Prototype implementation
- Iterative processes
- Improvements over time

Confirm the Medication Plan

- One of the most important functions of any care redesign plan
- Pharmacists as the medication expert are most qualified for this role!
  - Medication Reconciliation
    - At admission
    - During the hospital stay
    - At discharge
  - Communicate the medication plan to everyone, everywhere
    - Across the continuum of care

Pharmacist as a Health Coach

- Pharmacist serves as the patient’s advocate after discharge
- Post-discharge telephone calls
- Follow-up face-to-face appointments, often at the patient’s home
- Confirm services that are needed and appointments are in place
- Be able to refer to additional support services if needed
- Patient’s care will be improved if an issue can be quickly identified and addressed
- Combines elements of medication reconciliation and MTM services

Other Innovative Approaches

- Discharge Prescription Delivery
  - Process discharge prescriptions prior to patient leaving the hospital
  - Education is provided before the patient leaves
  - Disadvantage is this information needs to be communicated to the patient’s pharmacy and that doesn’t always occur
- Home-Based Services
  - Working with home care services
  - Pharmacist visits patients at their home to review medications and to answer questions
  - Determines any special needs and addresses
    - Such as filling pill boxes or providing a medication reminder system
  - May see the health-system pharmacist or partner with a community pharmacist

Strengthen Person and Family Engagement

- Ensure care delivery incorporates patient and caregiver preferences
  - Coordination and communication occurs within and across care teams
  - Bundled payment projects helps to make this a reality
- Improve experience of care for patients, caregivers, and families
  - Surveys of perception of care at all levels: hospitals; physician practices; long-term care facilities
- Promote patient self-management
  - Application of self-management practices in daily activities

PATIENT ENGAGEMENT
Strengthen Person and Family Engagement

- Hospital Consumer Assessment of Healthcare Providers and Systems survey
- National, standardized, publicly reported survey of patients’ perspectives of hospital care
- Allows for objective and meaningful comparisons of hospitals on topics that are important to consumers
- Incentive for hospitals to improve care
- Increases transparency of the quality of care since the information is publicly reported
- New questions incorporated into the survey as of 2014, specifically address the involvement of the patient and the family

Transitions of Care Questions

- During this hospital stay, staff took my preferences and those of my family/caregiver into account in deciding what my healthcare needs would be when I left.
- When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
- When I left the hospital, I clearly understood the purpose for taking each of my medications.
  - Always?
  - Usually?
  - Sometimes?
  - Never?

Publically Reported Data

- Hospital Compare is the consumer-oriented website that provided information on how well hospitals are providing care
  - www.hospitalcompare.hhs.gov
- The website was created through the efforts of CMS
- Consumers can look at one particular hospital or compare up to three hospitals at a time
- The information that is available is what is thought to be important to a Medicare beneficiary
- Data is typically old and is updated only four times per year
- Important to note the time frames for the reported data

CMS Survey

- Participation in the Medicare and Medicaid programs requires “certification” that the provider meets the “Conditions of Participation” (CoPs)
- There is a State Operations Manual (SOM)
  - Outlines CMS policy regarding the survey and certification activities and procedures prescribed by the Medicare statute and its regulations
- Hospitals that participate in Medicare or Medicaid must meet the CoPs for all patients in the facilities and not just those who are Medicare or Medicaid
- Hospitals accredited by other qualified organizations, such as The Joint Commission (TJC) have what is called “deemed status”
Types of CMS Surveys

- Certification/ recertification survey
- Complaint/ allegation survey
- Validation survey of accredited deemed provider
  - About 1% of all TJC surveys are followed within 60 days with a CMS validation survey
- Follow-up survey based on findings
- Surveys are conducted on-site by either the federal regional office or state agency
  - There are ten federal regional office across the United States
  - CMS contracts with state agencies to perform the surveys

Survey Process

<table>
<thead>
<tr>
<th>CMS Survey</th>
<th>TJC Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unannounced survey</td>
<td>Unannounced survey</td>
</tr>
<tr>
<td>Do not know the surveyors are coming until that come into the lobby</td>
<td>Find out at 0730 each morning from a posting on the TJC website</td>
</tr>
<tr>
<td>The type of survey will determine team size and composition of surveyors</td>
<td>The type of survey will determine team size and composition of surveyors</td>
</tr>
<tr>
<td>For example, a full survey would have a different composition than a focused survey</td>
<td>For example, a Critical Access Hospital survey would only include 2 surveyors, whereas a Hospital survey would likely include at least 4 surveyors</td>
</tr>
<tr>
<td>Surveyors will have access to all previous survey reports</td>
<td>Surveyors will have access to all previous survey reports – no matter which organization did the survey</td>
</tr>
</tbody>
</table>

Surveyors should only answer direct questions – surveyors will often write down verbatim employee comments
Surveyors do not act as consultants – do not want to “teach”
At the exit, will present preliminary findings
Generally, no communications throughout the survey
Any findings require a Plan of Corrective Action to be submitted
Timeframe for submission depends on what the finding might be

Surveyors are more open to discuss how they provide care to the patients
Surveyors may make recommendations about best practices that are not findings
At the exit, will present preliminary report
Usually communicate potential findings throughout the survey and at the daily briefing
Any Recommendations for Improvements (RFIs) require an Evidence of Standards Compliance (ESC) to be submitted
Timeframe is either within 45 days or within 60 days

Findings - CMS

- Standard Level
  - Not considered systemic or severe as there are no significant negative outcomes from non-compliance
  - Does require an acceptable plan of correction for achieving compliance (usually within 60 days)
  - Need to be cautious because several individual standard level deficiencies can roll up to a condition level
**Findings - CMS**

- **Condition Level**
  - One or more deficiencies considered systemic or severe
  - Triggers a 90 day action or the hospital’s Medicare Provider Agreement can be terminated
  - Requires a credible allegation of compliance
    - Follow-up survey

- **Immediate Jeopardy (IJ)**
  - A situation in which the provider’s non-compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death
  - Very serious and requires prompt attention

**CMS Hot Topics**

- **Life Safety Code Compliance**
- **Patient Rights**
  - Grievances
  - Informed Consent
  - Advance Directives
  - Privacy/Confidentiality
- **Performance Improvement (QAPI)**
- **Infection Prevention**
  - Infection control breaches
  - Safe injection practices
  - Use of insulin pens
- **Discharge Planning**
- **Medication Management**
  - Weight-based dosing, especially for pediatrics
  - Medication storage
  - Safe opioid use
- **Medical Records**
  - Verbal orders
  - History and physicals
  - Orders prior to administration
- **EMTALA**

**Quality Assessment Performance Improvement – Adverse Events (AE)**

- Often, AE are not reported
- Need to track, analyze, and implement actions to prevent the AE from occurring in the future
- Need to include near misses
- Examples
  - Patient given wrong medication but no harm
  - Blood or blood products
  - Falls
  - Pressure ulcers
  - Healthcare-associated infection
  - Adverse reactions to a medication that patient was not known to be allergic
  - Development of DVT or PE
- Ties back to many of the quality measures that are part of pay for performance

**MEDICATION/ PHARMACY SPECIFIC HOT TOPICS**

**Safe Injection Practices**

- A single dose vial (SDV) cannot be used on multiple patients
- CMS requires hospitals to follow nationally recognized standards of care, such as the CDC guidelines
- Rationale:
  - SDV typically lack an antimicrobial preservative
  - Once the vial is entered, the contents can support the growth of microorganisms

**Insulin Pens**

- Using the same needle for more than one individual
- Using the same syringe, pen, or injection device for more than one individual
- Re-using a needle or syringe which has already been used to administer medication to an individual to subsequently enter a medication container (e.g., vial, bag), and then using contents from that medication container for another individual
- If insulin pens are being used, each patient must have their own insulin pen
  - More than 2000 VA patients were notified in 2011 because an insulin pen was used on more than one patient
High-Alert and Hazardous Medications

- Because of the concerns associated with compounding, both TJC and CMS have an intense review on medication safety, especially medication preparation and administration
  - Not implementing effective actions
  - Not following own policy
  - Nursing staff not able to talk about high-alert or hazardous medications
  - Certain topics, such as pharmaceutical waste may also come up during the separate Life Safety survey
- Need to have a list with specific strategies for high-alert medications
- Also need a list with specific storage and training information for hazardous medications

Medication Storage

- This is not new!
- All drugs and biologicals be kept in a secure area and locked when appropriate
- Schedules II, III, IV, and V drugs must be kept locked within a secure area
- Only authorized personnel may have access to locked areas
- Medications not secured
  - Medications found lying on counter tops or on the automated dispensing cabinets
- Medication carts not in a secure area or appropriately locked
  - Emergency department; Surgery; Radiology; Procedural areas

Other Problematic Issues with Medication Storage

- Medications are stored according to manufacturer’s recommendations
- Written policy addressing the control of medication between receipt by an individual and administration of the medication
  - Tube systems or dumb waters
- Medications and chemicals are properly labeled
- Removes expired, damaged, and/or contaminated medications and stores them separately
- Medications in patient care areas are in the most ready-to-administer forms
- Single dose vials are used for just one patient

Safe Opioid Use

- Close monitoring of patients taking opioid medications
  - Respiratory status
  - Clinical signs such as confusion, agitation, unsteady gait
  - Potential risk factors for an adverse event
    - Liver or kidney failure
    - History of sleep apnea
    - Obesity
    - Opioid naïve patient
    - Potential drug-drug interactions
  - Sedation scales
    - Richmond agitation sedation scale (RASS) or Pasero Opioid-Induced Sedation Scale (POSS)

Resources/References

- There are MANY resources and references available for all of these topics
- CMS
  - www.cms.gov
- Value-Based Purchasing
- Core Measures

Resources/References

- HCAHPS
  - www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Hospital-HCAHPS
- PSI-90
- Joint Commission
  - www.jointcommission.org
- CMS State Operations Manual
  - www.cms.hhs.gov/manuals/downloadscom107
Key Points

- For health-system pharmacists, the initiatives and activities of CMS have a direct impact on patient care
- The relationship between quality and reimbursement is just going to get stronger
- The concepts associated with the Triple Aim and Pay for Performance must permeate daily activities
- Pharmacists must have awareness of the importance of various payment reform efforts such as value-based purchasing, HCAHPS, mortality, readmissions, bundled payments, ACOs

Key Points

- Pharmacists need to determine how they can positively improve the quality of the care for patients and how that improved quality may also impact metrics
  - Evidence-based practice is more important than ever
  - The role of the pharmacist for documentation purposes is important
- Pharmacists are uniquely positioned to be able to bridge the gap between inpatient and outpatient
- Don’t forget pharmacy technicians, students, interns, or residents if resources are limited
- Pharmacists have long been involved in survey readiness and the emphasis on medications is under even tighter scrutiny

1. Which of the following statements is true regarding the Centers for Medicare and Medicaid (CMS)?
   A. CMS is the single largest payor for health care in the United States.
   B. Each state has a CMS regional office.
   C. Although responsible for the creation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), CMS has no other activities with the administrative actions of HIPAA.
   D. CMS defers quality standards for various healthcare entities, such as hospitals to other accrediting organizations.

2. Which of the following is not included in the Healthcare Delivery System Reform by CMS?
   A. Provider payment reform
   B. Care delivery reform
   C. Enhanced patient engagement
   D. Limiting services that are paid for by Medicare

3. Which of the following statements are true regarding the readmission penalty?
   A. The readmission penalty takes into account all readmissions in a 30 day period of time.
   B. There are only certain disease states, such as heart failure, acute myocardial infarction, and COPD that are part of the penalty.
   C. The readmission penalty gives some allowances to those hospitals located in poorer states or states with higher percentages of patients with chronic conditions.
   D. The vast majority of hospitals in the United States are not impacted by the readmission penalty.

4. There are many important functions that a pharmacist may have to positively impact quality. Which of the following has not been demonstrated to be beneficial?
   A. Pharmacist involvement in Accountable Care Organizations (ACOs).
   B. Pharmacist development and review of standing orders.
   C. Pharmacist not providing any education to the patient/family regarding medications.
   D. Pharmacist responsibility for medication reconciliation.
5. Which of the following has been identified as a “hot topic” during CMS surveys?

A. Pharmacist involvement in critical care rounds
B. Medication storage
C. Safe injection practices involving multi-dose vials (MDV)
D. Safe use of benzodiazepines

Questions?

Thank you!

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