



# Where Policy and Practice Meet to Improve Quality and Patient Safety

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# Health System Transformation

- Variable quality, expensive, wasteful → reliably safe, high quality care; efficient; lower cost
- From 'pay for volume' → 'pay for quality'
- From 'pay for transactions' → 'pay for care-based episode'
- From quality assessment based on provider and setting (process) → quality assessment based on patient experience (OUTCOMES)



# National Quality Strategy 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

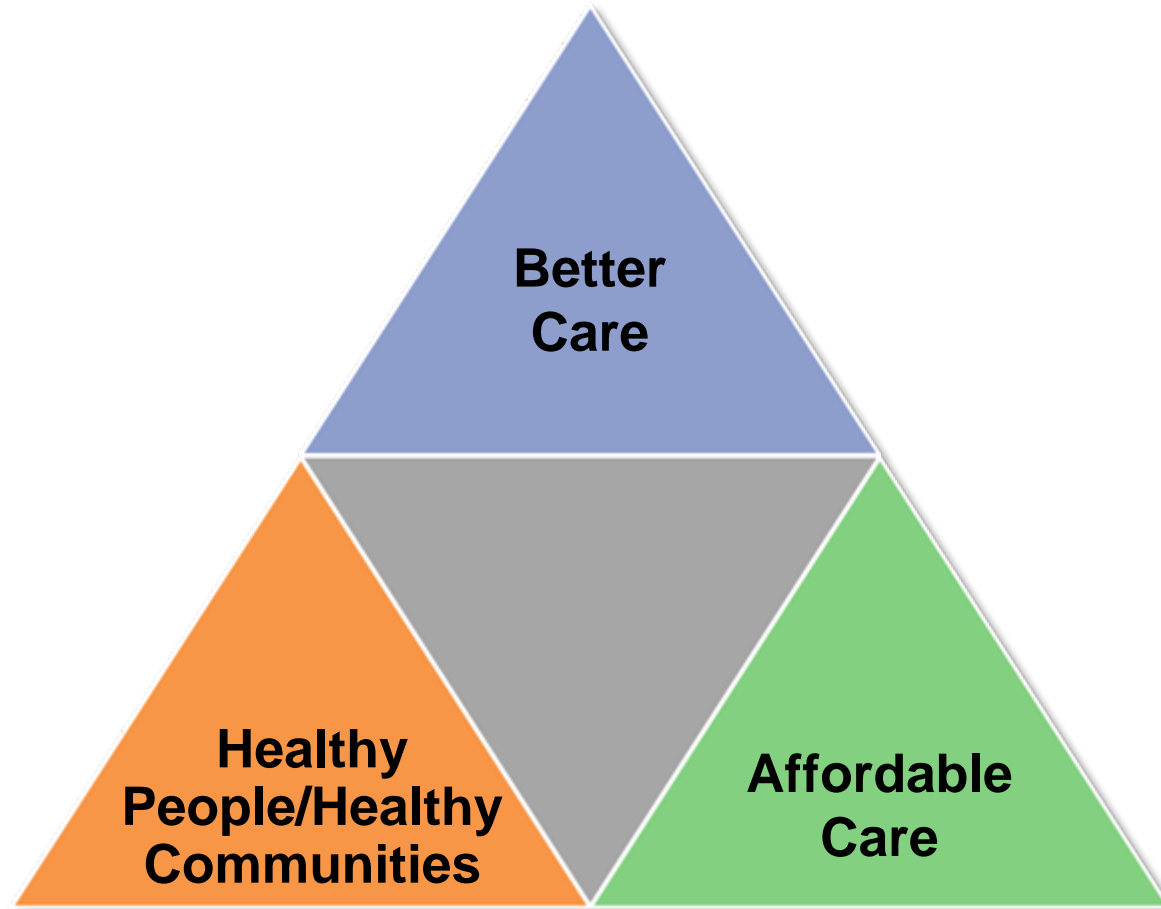


# Background on the National Quality Strategy

- The Strategy is for the **nation** and serves as a catalyst and compass for **nationwide** focus.
- The Strategy has been iteratively designed by public and private stakeholders and provides an opportunity to **align quality measures and quality improvement actions**.



The strategy is to concurrently pursue three aims:



# 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



# Ongoing Implementation Activities

- Regular meetings of the Interagency Working Group on Health Care Quality, including senior representatives from 24 Federal agencies
- Annual updates to the Agency-Specific Plans developed by HHS operating divisions, which are available on the Working for Quality site
- Active engagement of stakeholders in the dissemination of the National Quality Strategy through the National Priorities Partnership and the Measures Application Partnership
- Publication of toolkits and presentations for use by community partners
- Ongoing alignment between the National Quality Strategy and other Federal quality reports, including the National Healthcare Quality and Disparities Report





Priority 1: Making care safer by reducing harm caused in the delivery of care

### LONG-TERM GOALS

1. Reduce preventable hospital admissions and readmissions.
2. Reduce the incidence of adverse health care-associated conditions.
3. Reduce harm from inappropriate or unnecessary care.





## Priority 1 (continued): Making care safer by reducing harm caused in the delivery of care

### NATIONAL TRACKING MEASURES

Measure Focus	Measure Name/Description	Most Recent Rate	Aspirational Target
Hospital-Acquired Conditions	Incidence of measurable hospital-acquired conditions	142 HACs per 1,000 admissions in 2011	Reduce preventable HACs by 40% by the end of 2014
Hospital Readmissions	All-payer 30-day readmission rates	14.4% based upon 32.7 million admissions in 2011	Reduce all readmissions by 20% by the end of 2014



## Priority 2: Ensuring that each person and family members are engaged as partners in their care

### LONG-TERM GOALS

1. Improve patient, family, and caregiver experience of care related to quality, safety, and access across settings.
2. In partnership with patients, families, and caregivers—and using a shared decision making process—develop culturally sensitive and understandable care plans.
3. Enable patients and their families and caregivers to navigate, coordinate, and manage their care appropriately and effectively.



## Priority 2 (continued): Ensuring that each person and family members are engaged as partners in their care

### NATIONAL TRACKING MEASURES

Measure Focus	Measure Name/Description	Most Recent Rate	Aspirational Target
Timely Care	Adults who needed care right away for an illness, injury, or condition in the last 12 months who sometimes or never got care as soon as wanted	Update available in Fall 2013	Reduce to <10% by 2017
Decisionmaking	People with a usual source of care whose health care providers sometimes or never discuss decisions with them	Update available in Fall 2013	Reduce to <10% by 2017



## Priority 3: Promoting effective communication and coordination of care

### LONG-TERM GOALS

1. Improve the quality of care transitions and communications across care settings.
2. Improve the quality of life for patients with chronic illness and disability by following a current care plan that anticipates and addresses pain and symptom management, psychosocial needs, and functional status.
3. Establish shared accountability and integration of communities and health care systems to improve quality of care and reduce health disparities.



## Priority 3 (continued): Promoting effective communication and coordination of care

### NATIONAL TRACKING MEASURES

Measure Focus	Measure Name/Description	Most Recent Rate	Aspirational Target
Patient-Centered Medical Home	Percentage of children needing care coordination who receive effective care coordination	66.1%	Increase to 90% by 2017
3-Item Care Transition Measure®	<ul style="list-style-type: none"> <li>• During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left</li> <li>• When I left the hospital, I had a good understanding of the things I was responsible for in managing my health</li> <li>• When I left the hospital, I clearly understood the purpose for taking each of my medications</li> </ul>	Update available in Fall 2013	Increase to 50% by 2017



## Priority 4: Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease

### LONG-TERM GOALS

1. Promote cardiovascular health through community interventions that result in improvement of social, economic, and environmental factors.
2. Promote cardiovascular health through interventions that result in adoption of the most healthy lifestyle behaviors across the lifespan.
3. Promote cardiovascular health through receipt of effective clinical preventive services across the lifespan in clinical and community settings.



## Priority 4 (continued): Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease

### NATIONAL TRACKING MEASURES

Measure Focus	Measure Name/Description	Most Recent Rate	Aspirational Target
Aspirin Use	Outpatient visits at which adults with cardiovascular disease are prescribed/maintained on aspirin	53%	Increase to 65% by 2017
Blood Pressure Control	Adults with hypertension who have adequately controlled blood pressure	53%	Increase to 65% by 2017
Cholesterol Management	Adults with high cholesterol who have adequate control	32%	Increase to 65% by 2017
Smoking Cessation	Outpatient visits at which current tobacco users received tobacco cessation counseling or cessation medications	22%	Increase to 65% by 2017





## Priority 5: Working with communities to promote wide use of best practices to enable healthy living

### LONG-TERM GOALS

1. Promote healthy living and well-being through community interventions that result in improvement of social, economic, and environmental factors.
2. Promote healthy living and well-being through interventions that result in adoption of the most important healthy lifestyle behaviors across the lifespan.
3. Promote healthy living and well-being through receipt of effective clinical preventive services across the lifespan in clinical and community settings.





## Priority 5 (continued): Working with communities to promote wide use of best practices to enable healthy living

### NATIONAL TRACKING MEASURES

Measure Focus	Measure Name/Description	Most Recent Rate	Aspirational Target
Depression	Percentage of adults who reported symptoms of a major depressive episode in the last 12 months who received treatment for depression in the last 12 months	68.1% for 2011	Increase to 78.2% by 2020
Obesity	Proportion of adults who are obese	Update available in 2014	Reduce to 30.5% by 2020



## Priority 6: Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models

### LONG-TERM GOALS

1. Ensure affordable and accessible high quality health care for people, families, employers, and governments.
2. Support and enable communities to ensure accessible, high quality care while reducing waste and fraud.



## Priority 6 (continued): Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models

### NATIONAL TRACKING MEASURES

Measure Focus	Measure Name/Description	Most Recent Rate	Aspirational Target
Out-of-Pocket Expenses	Percentage of people under 65 with out-of-pocket medical and premium expenses greater than 10% of income	Update available in Fall 2013	See footnote
Health Spending Per Capita	Annual all-payer health care spending per person	\$8,680 per person in 2011	See footnote

See the HHS Budget in Brief for a discussion of investments and proposals to reduce health care spending. U.S. Department of Health and Human Services. Fiscal Year 2014: Budget in Brief. April 2013.

<http://www.hhs.gov/budget/fy2014/fy-2014-budget-in-brief.pdf>



# Highlighted Initiatives

NQS Priority	Highlighted Initiative	Web Site
1. Making care safer by reducing harm caused in the delivery of care	Partnership for Patients	<a href="http://www.healthcare.gov/center/programs/partnership">http://www.healthcare.gov/center/programs/partnership</a>
2. Ensuring that each person and family members are engaged as partners in their care	Consumer Assessment of Healthcare Providers and Systems (CAHPS)	<a href="http://www.cms.gov/Hospital-Value-Based-Purchasing">http://www.cms.gov/Hospital-Value-Based-Purchasing</a>
3. Promoting effective communication and coordination of care	Multi-payer Advanced Primary Care Practice Demonstration (MAPCP)	<a href="http://www.cms.gov/demoprojects/evalrpts/md/itemdetail.asp?itemid=cms1230016">http://www.cms.gov/demoprojects/evalrpts/md/itemdetail.asp?itemid=cms1230016</a>
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease	Million Hearts	<a href="http://www.millionhearts.hhs.gov">http://www.millionhearts.hhs.gov</a>



# Highlighted Initiatives (continued)

NQS Priority	Highlighted Initiative	Web Site
5. Working with communities to promote wide use of best practices to enable healthy living	Community Transformation Grants (CTG)	<a href="http://www.cdc.gov/communitytransformation/">http://www.cdc.gov/communitytransformation/</a>
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models	CMS Innovation Center	<a href="http://www.innovations.cms.gov">http://www.innovations.cms.gov</a>



# Current and Future Measure Examples

- **SAFETY:** current -- central line infections, claims-based HAC's; Future: all-cause patient harm, including clinical data.
- **CARE COORDINATION:** current – care transition measure, hospital readmissions; Future – patient-reported care coordination across settings.
- **CLINICAL CARE:** current – setting-specific process measures by condition; Future – patient-centered and patient-reported outcome measures; measures for patients with multiple chronic conditions.
- **POPULATION / COMMUNITY HEALTH:** current – smoking, immunizations; Future – determinants of health, reduction in disparities.



# Challenges and Opportunities

- Urgent need for more agile quality measurement enterprise.
- Opportunity to present quality information to patients and caregivers in clear, relevant terms – including how people can manage their health and health care.
- Increased availability of health IT → opportunity to use data from multiple applications.
- Getting to a ‘learning health system’ will require test beds, unprecedented collaboration between clinicians, patients, scientists and measure developers, as well as patients, caregivers and communities.



# For more information:

- Contact: [Carolyn.clancy@va.gov](mailto:Carolyn.clancy@va.gov)
- Visit: [www.ahrq.gov/workingforquality](http://www.ahrq.gov/workingforquality)
- Download the 2013 Annual Progress Report:  
[www.ahrq.gov/workingforquality/nqs/nqs2013annlrpt.pdf](http://www.ahrq.gov/workingforquality/nqs/nqs2013annlrpt.pdf)

