

Opportunities for Nursing in the Interprofessional Practice team



***NATIONAL ADVISORY COUNCIL ON
NURSE EDUCATION AND PRACTICE
(NACNEP)***

AGENDA

November 5 – 6, 2014

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Center for Medicare & Medicaid
Innovation***

Thank You

- For the care you are providing every day
- For the hard work you are doing to improve your care systems every day
- For your commitment to health care reform, innovation and transformation

- **Our Goals and Early Results**
- **Value-based purchasing and quality improvement programs**
- **Center for Medicare and Medicaid Innovation**
- **Future and Opportunities for collaboration**

We need delivery system and payment transformation

Current State –

Producer-Centered

Volume Driven

Unsustainable

Fragmented Care
Systems

FFS Payment Systems

PRIVATE
SECTOR

PUBLIC
SECTOR

Future State –

People-Centered

Outcomes Driven

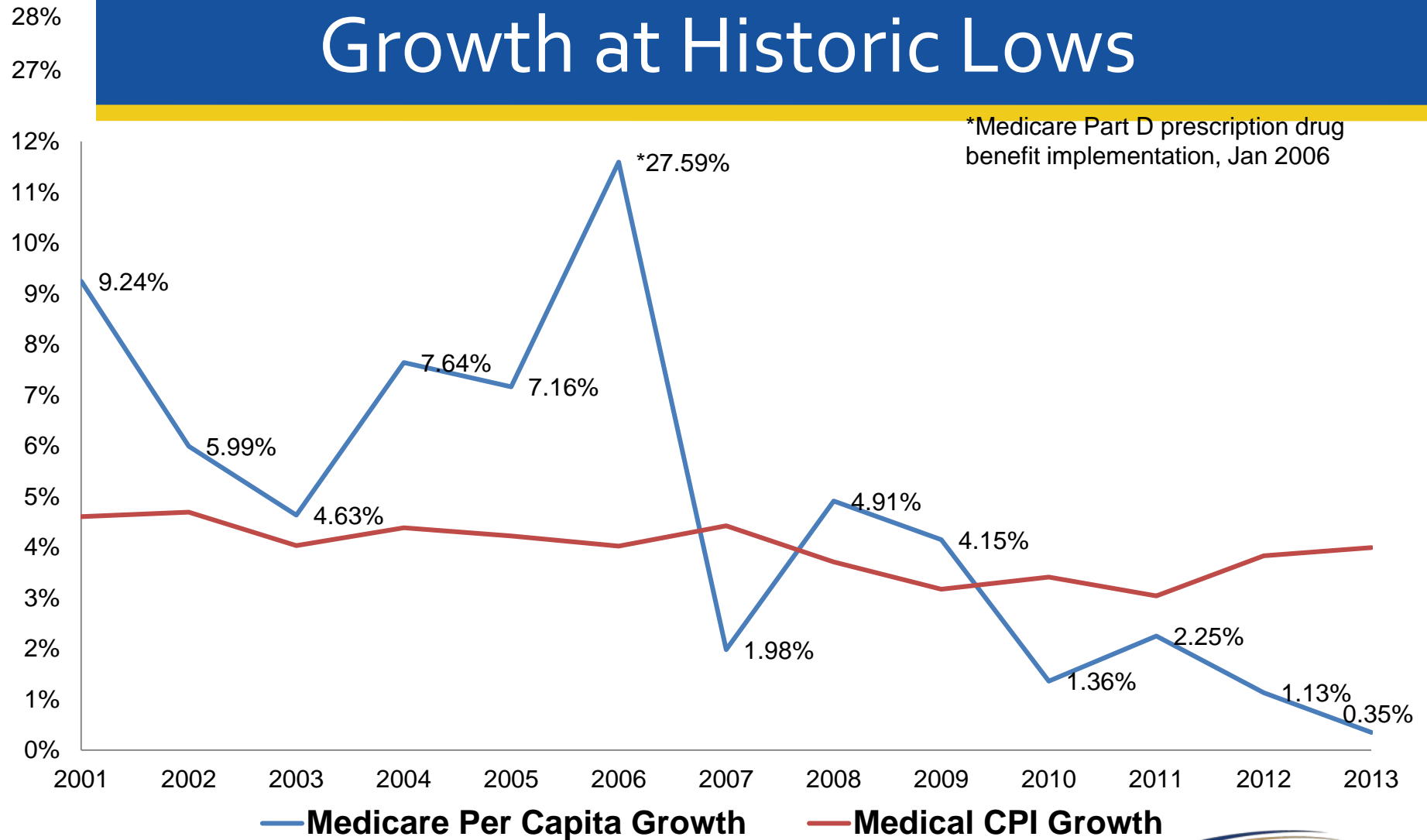
Sustainable

Coordinated Care
Systems

New Payment
Systems

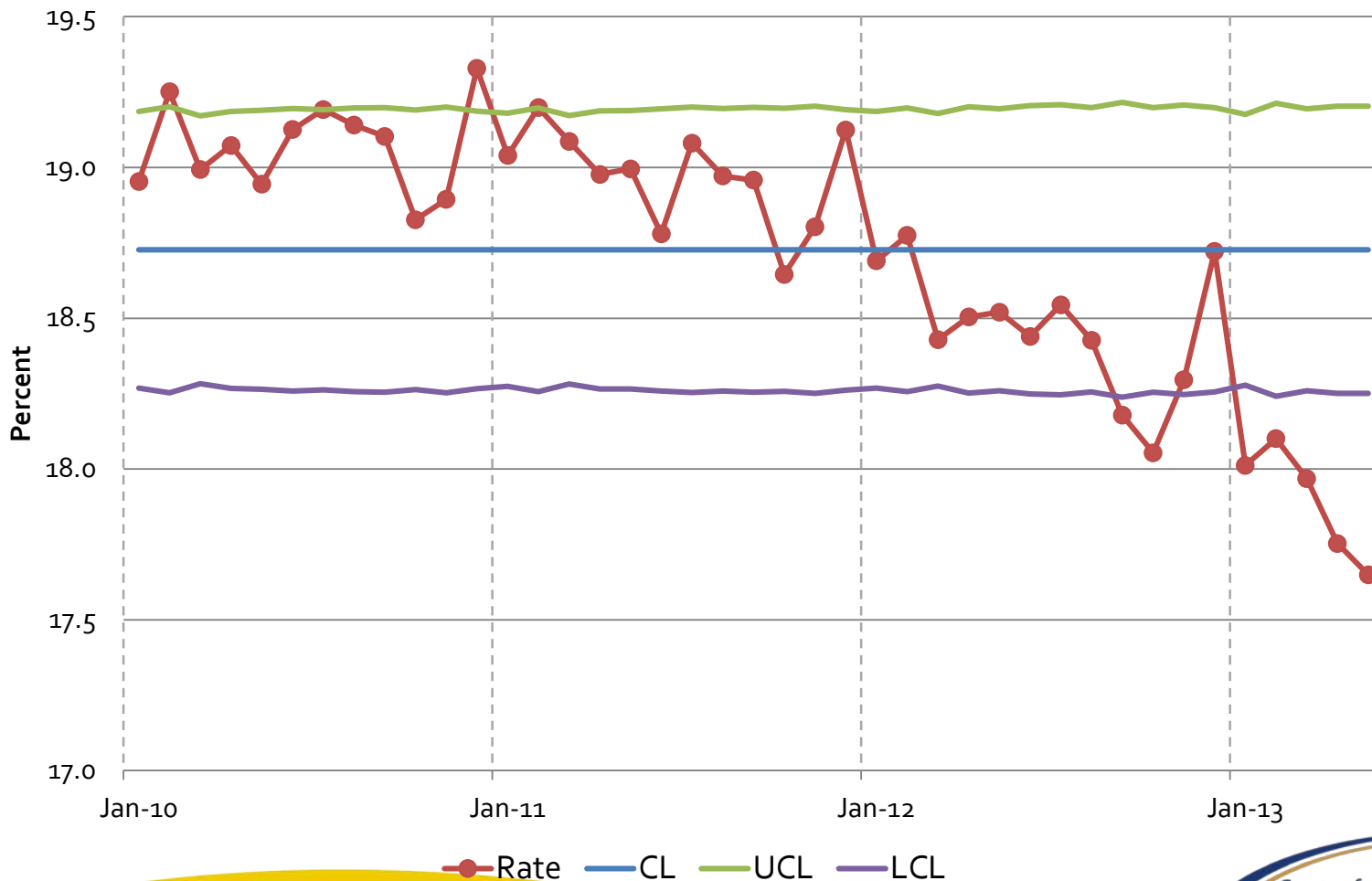
- Value-based purchasing
- ACOs Shared Savings
- Episode-based payments
- Care Management Fees
- Data Transparency

Results: Medicare Per Capita Spending Growth at Historic Lows



Source: CMS Office of the Actuary

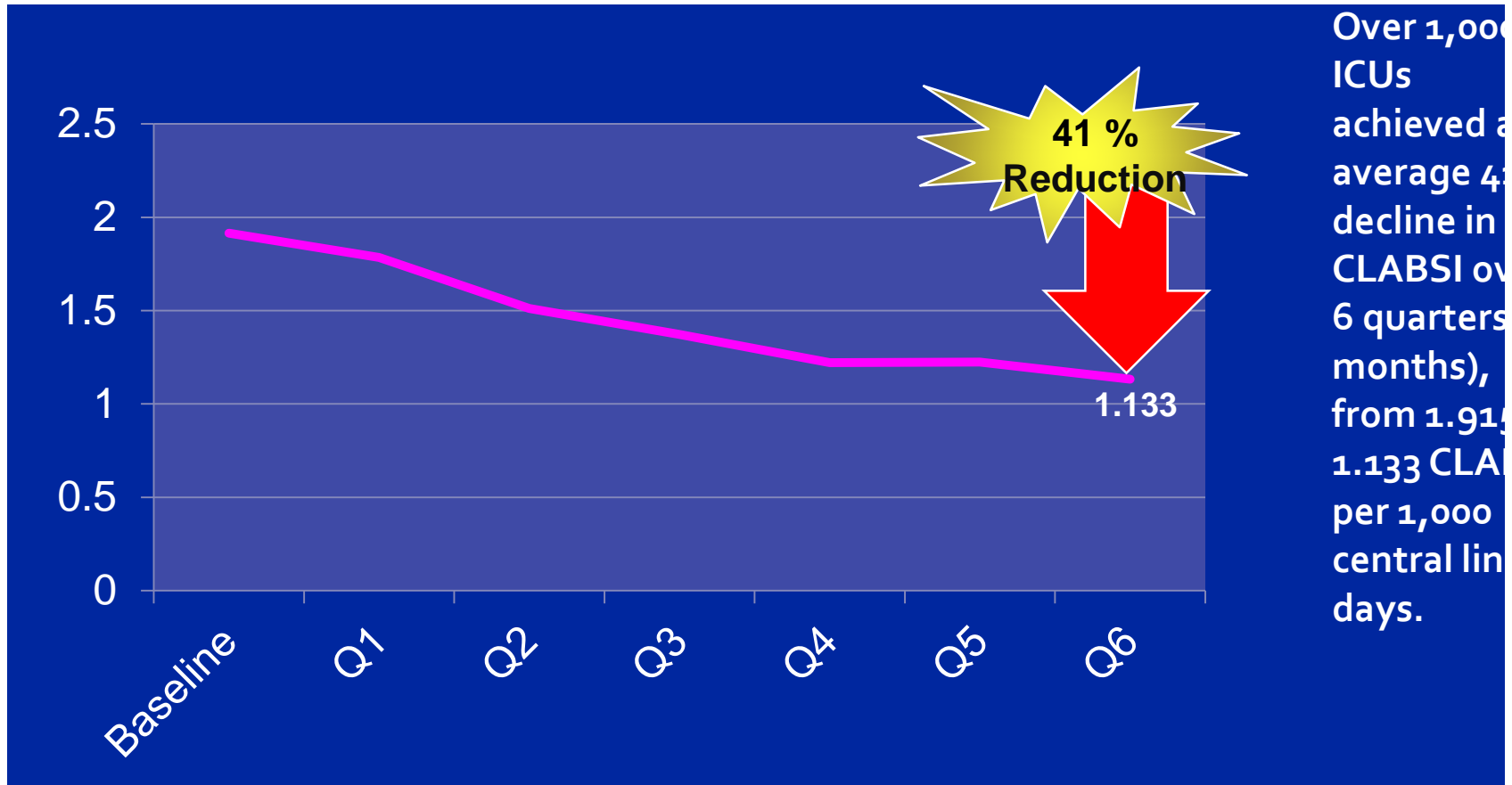
Medicare All Cause, 30 Day Hospital Readmission Rate



Source: Office of Information Products and Data Analytics, CMS

National Bloodstream Infection Rate

CLABSIs per 1,000 central line days



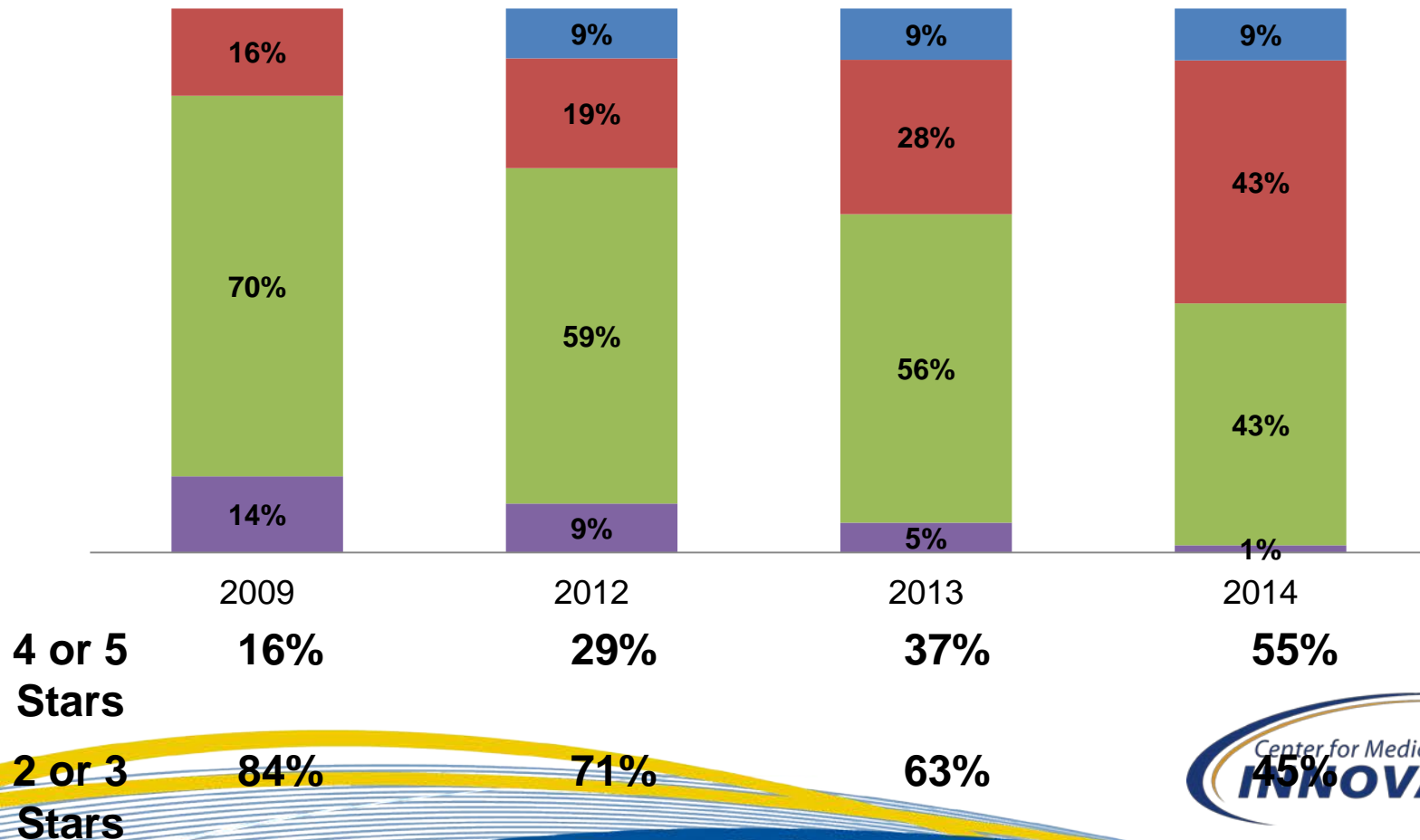
Over 1,000 ICUs achieved an average 41% decline in CLABSI over 6 quarters (6 months), from 1.91 to 1.133 CLABSI per 1,000 central line days.

Quarters of participation by hospital cohorts, 2009–2012

Beneficiaries Moving to MA Plans with High Quality Scores

Medicare Advantage (MA) Enrollment Rating Distribution

■ 2-Star ■ 3-Star ■ 4-Star ■ 5-Star



- **Our Goals and Early Results**
- **Value-based purchasing and quality improvement programs**
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Value-Based Purchasing

- Goal is to reward providers and health systems that deliver better outcomes in health and health care at lower cost to the beneficiaries and communities they serve.
- Five Principles
 1. Define the end goal, not the process for achieving it
 2. All providers' incentives must be aligned
 3. Right measure must be developed and implemented in rapid cycle
 4. CMS must actively support quality improvement
 5. Clinical community and patients must be actively engaged

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The CMS Innovation Center

Identify, Test, Evaluate, Scale

“ The purpose of the [Center] is to test innovative payment and service delivery models to reduce program expenditures...while preserving or enhancing the quality of care furnished to individuals under such titles.

- *The Affordable Care Act*

Our Strategy: Conduct many model tests to find out what works

The Innovation Center portfolio of models will address a wide variety of **patient populations, providers, and innovative approaches to care and payment**

CMS Innovations Portfolio

Accountable Care Organizations (ACOs)

- Medicare Shared Savings Program (Center for Medicare)
- Pioneer ACO Model
- Advance Payment ACO Model
- Comprehensive ERSD Care Initiative

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 Nurse Education Demonstration

Bundled Payment for Care Improvement

- Model 1: 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 Program
- Million Hearts

Health Care Innovation Awards

State Innovation Models Initiative

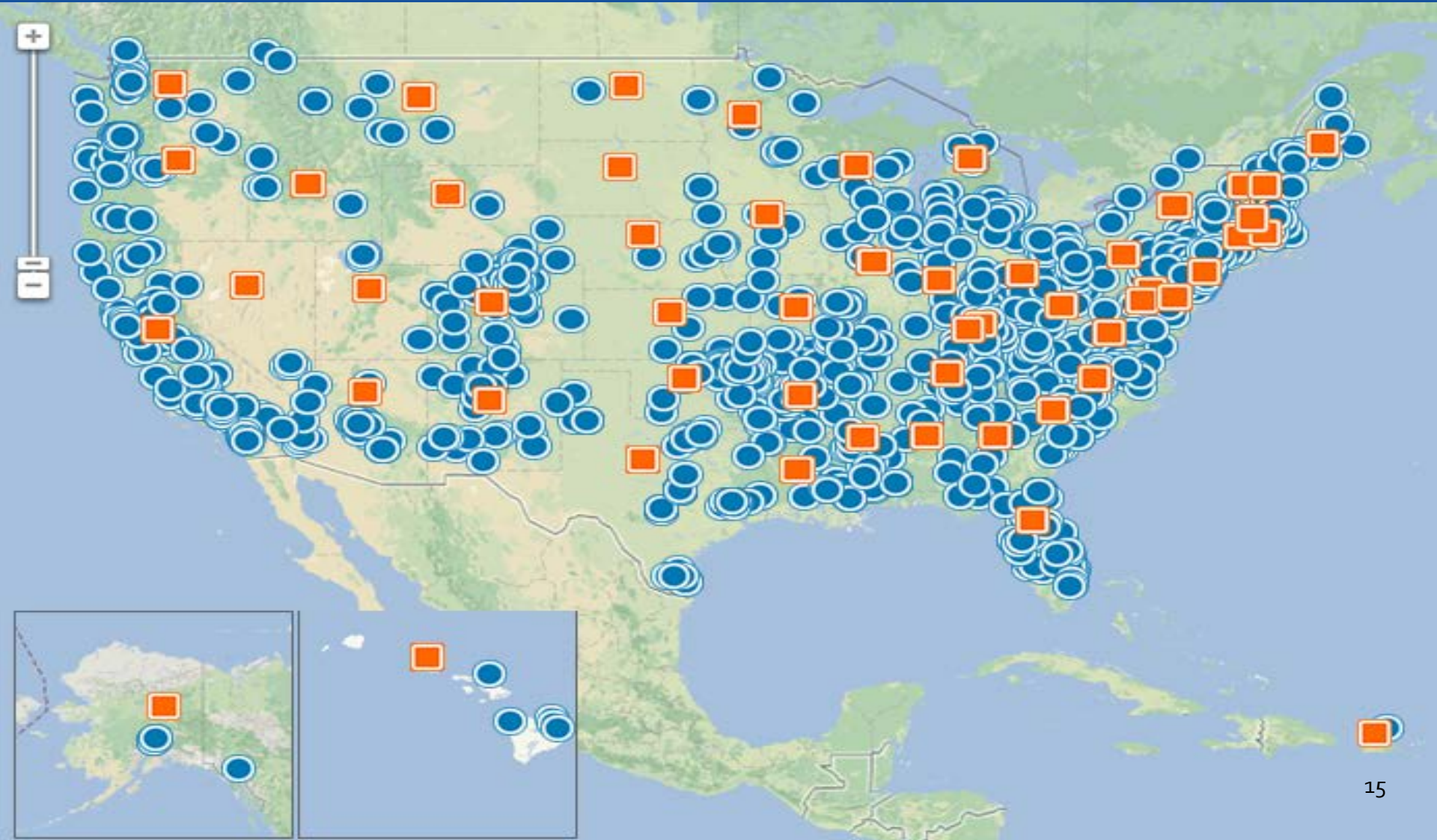
Initiatives Focused on the Medicaid Population

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

Medicare-Medicaid Enrollees

- Financial Alignment Initiative
- Initiative to Reduce Avoidable Hospitalizations of Nursing Facility Residents

Innovation is happening broadly across the country



Accountable Care Organizations

- Encourage and support physicians, hospitals, and other providers to lower costs by providing better quality care and rewarding success by allowing providers to share in the resulting savings.
- Goals for ACOs:
 - Give providers incentives to achieve savings and tools to help coordinate and improve care, while assuring quality of care.
 - Assure patients get coordinated care, without overly burdensome regulations.
 - Promote better coordination between primary care providers and specialists.

Quality Measurement & Performance for ACOs

- Quality measures (33) are separated into the following four key domains:
 - Better Care
 1. Patient/Caregiver Experience
 2. Care Coordination/Patient Safety
 - Better Health
 3. Preventative Health
 4. At-Risk Population
- Must meet quality targets to share in savings and amount of savings shared depends on quality performance



Bundled Payments for Care Improvement

GOAL: Test payment models that link payments for multiple services patients receive during an episode of care for effectiveness in promoting coordination across services and reducing the cost of care.

Four models:

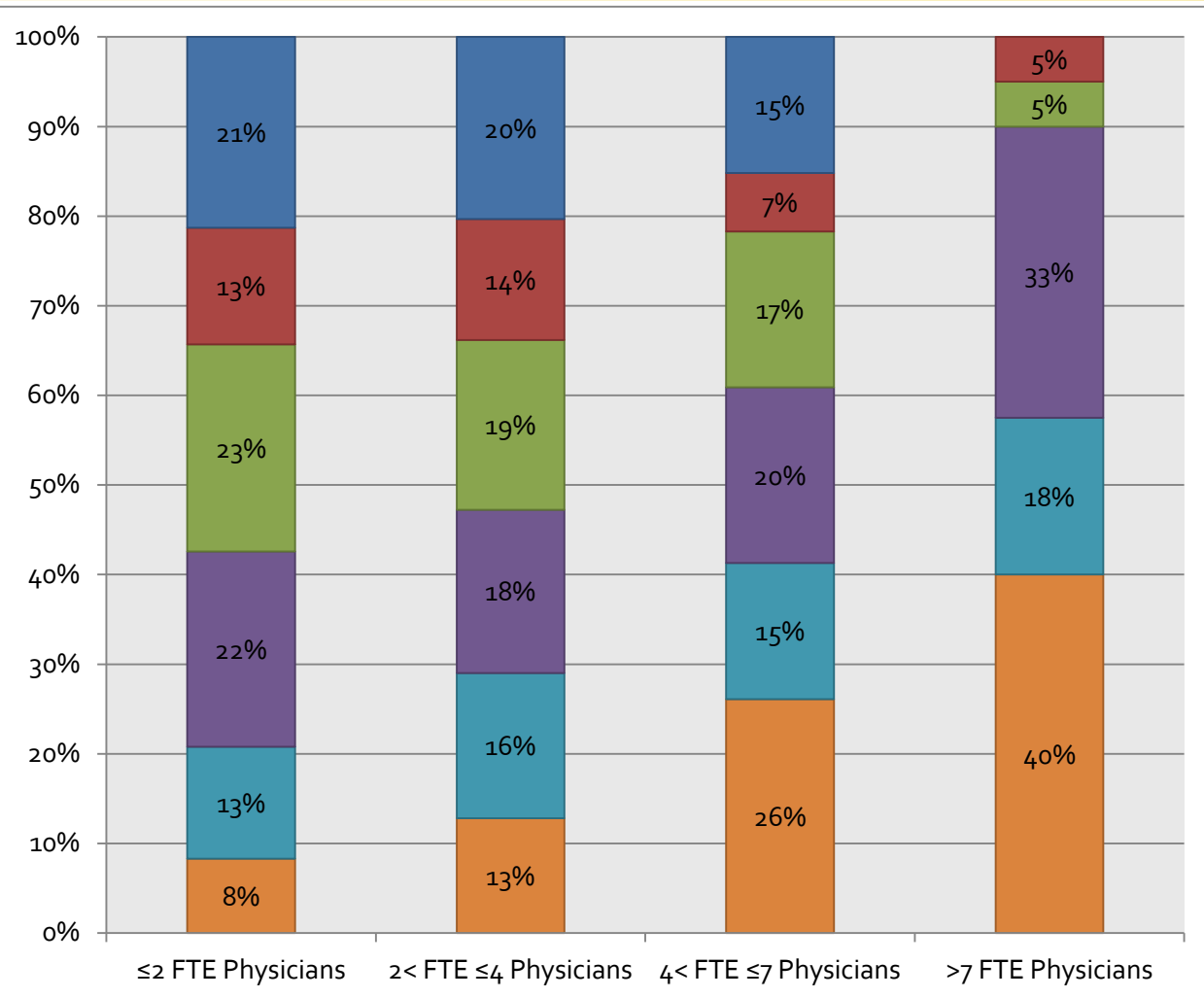
1. Acute care hospital stay only
2. Acute care hospital stay plus post-acute care
3. Post-acute care only
4. Prospective payment of all services during inpatient stay

Comprehensive Primary Care Initiative

GOAL: Test a multi-payer initiative fostering collaboration between public and private health care payers to strengthen primary care.

- **Collaborating with public and private insurers in purchasing high value primary care in communities they serve.**
 - Requires investment across multiple payers
 - individual health plans, covering only their members, cannot provide enough resources to transform primary care delivery.
- Medicare will pay approximately \$20 per beneficiary per month (PBPM) then move towards smaller PBPM to be combined with shared savings opportunity.
- The 7 markets selected: Ohio (Dayton), Oklahoma (Tulsa), Arkansas, Colorado, New Jersey, Oregon, New York (Hudson Valley)

CPC Staffing Mostly Traditional at Baseline



Physician + at least 1 of the following:

- Administrative Staff
- Medical Assistant

Above + NP or PA

Above + LPN/LVN

Above + RN

Above + Care Coordinator/Manager

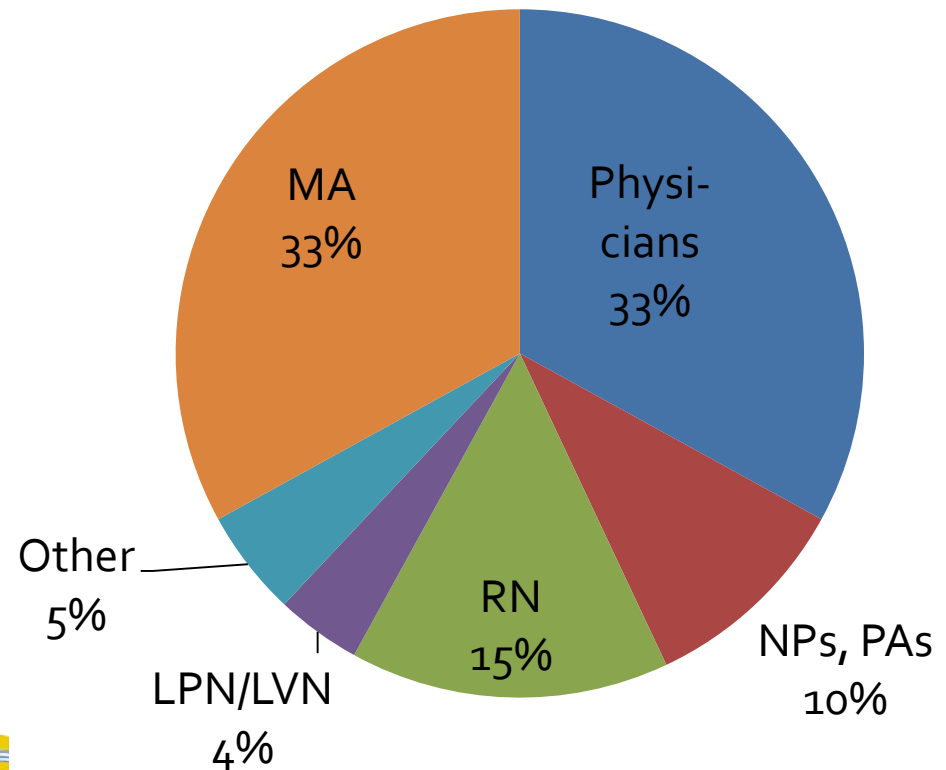
All Other Staff
At least 1 of the following:

- Social Worker
- Pharmacist
- Health Educator
- Nutritionist
- Community Service Coordinator

Care Management in CPC

- Practices hired 1100 care managers in first year
 - Reported having ~1000 at baseline
- “Dueling” care managers

Personnel Conducting Care Management



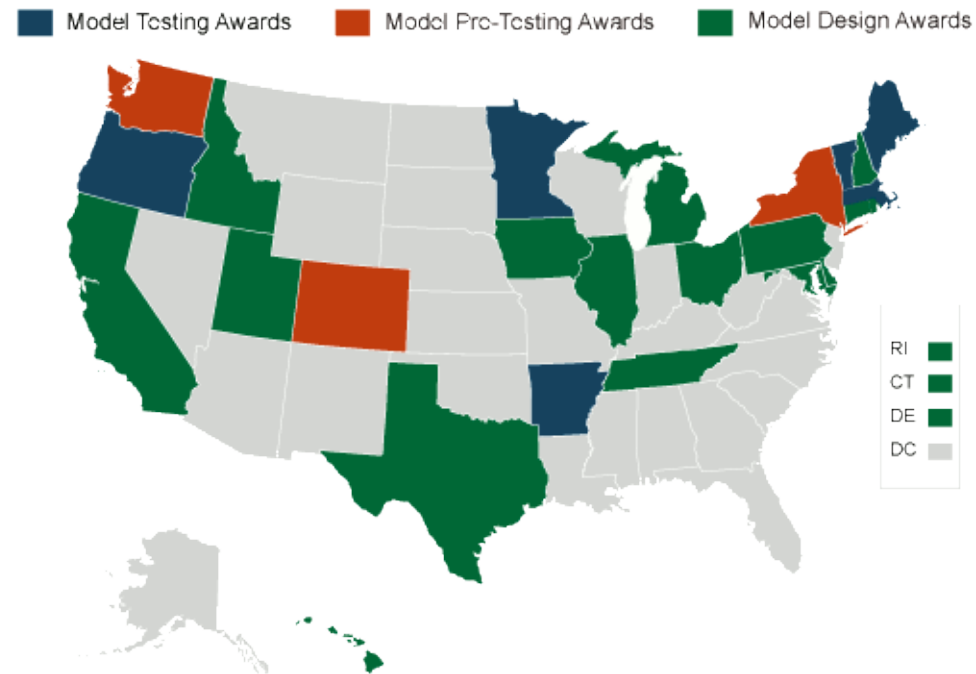
Strong Start

GOAL: Test effectiveness of prenatal care approaches to reduce preterm births for women covered by Medicaid or CHIP who are at risk for preterm births

- Testing 3 approaches to delivery of enhanced prenatal care:
 1. Care delivered in Birth Centers
 2. Care delivered by centering approach
 3. Care delivered in Maternity Care Home
- Targets women receiving Medicaid and at risk for having a preterm birth

State Innovation Models (SIM)

- Partner with states to develop broad-based State Health Care Innovation Plans
- Plan, Design, Test and Support of new payment and service and delivery models
- Utilize the tools and policy levers available to states
- Engage a broad group of stakeholders in health system transformation



Source: Centers for Medicare & Medicaid Services

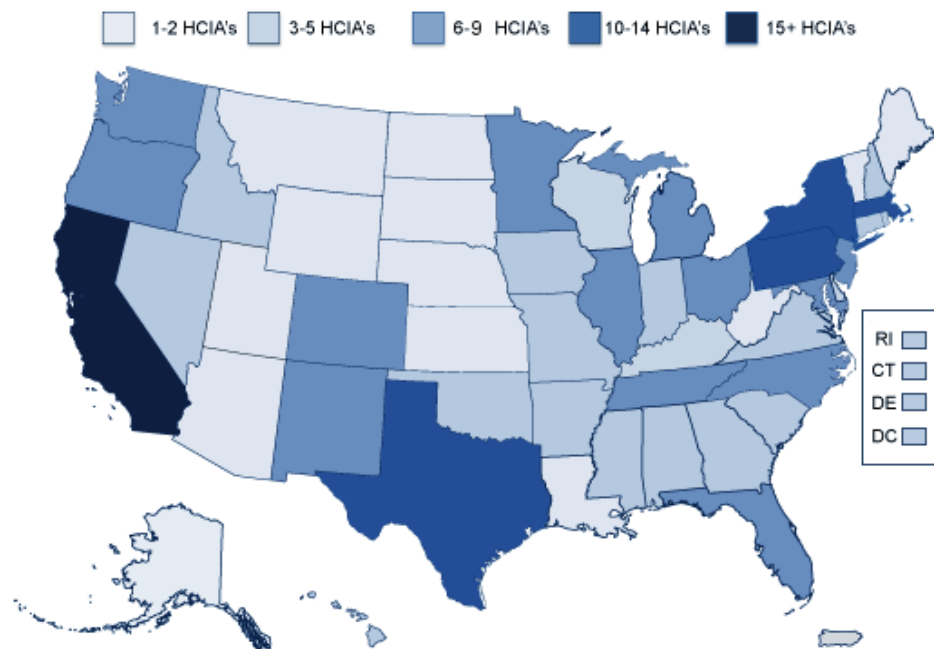


Workforce in SIM

- Several test states integrating new providers, especially to serve populations in remote areas
- Reviewing state health professions laws and scope of practices
- Looking at barriers for NPs and PAs as leader of and participant in primary care team
- Leveraging state licensure renewal process to identify shortages
- Interest in understanding future demand for physicians, especially in primary care shortage areas

Health Care Innovation Awards (HCIA)

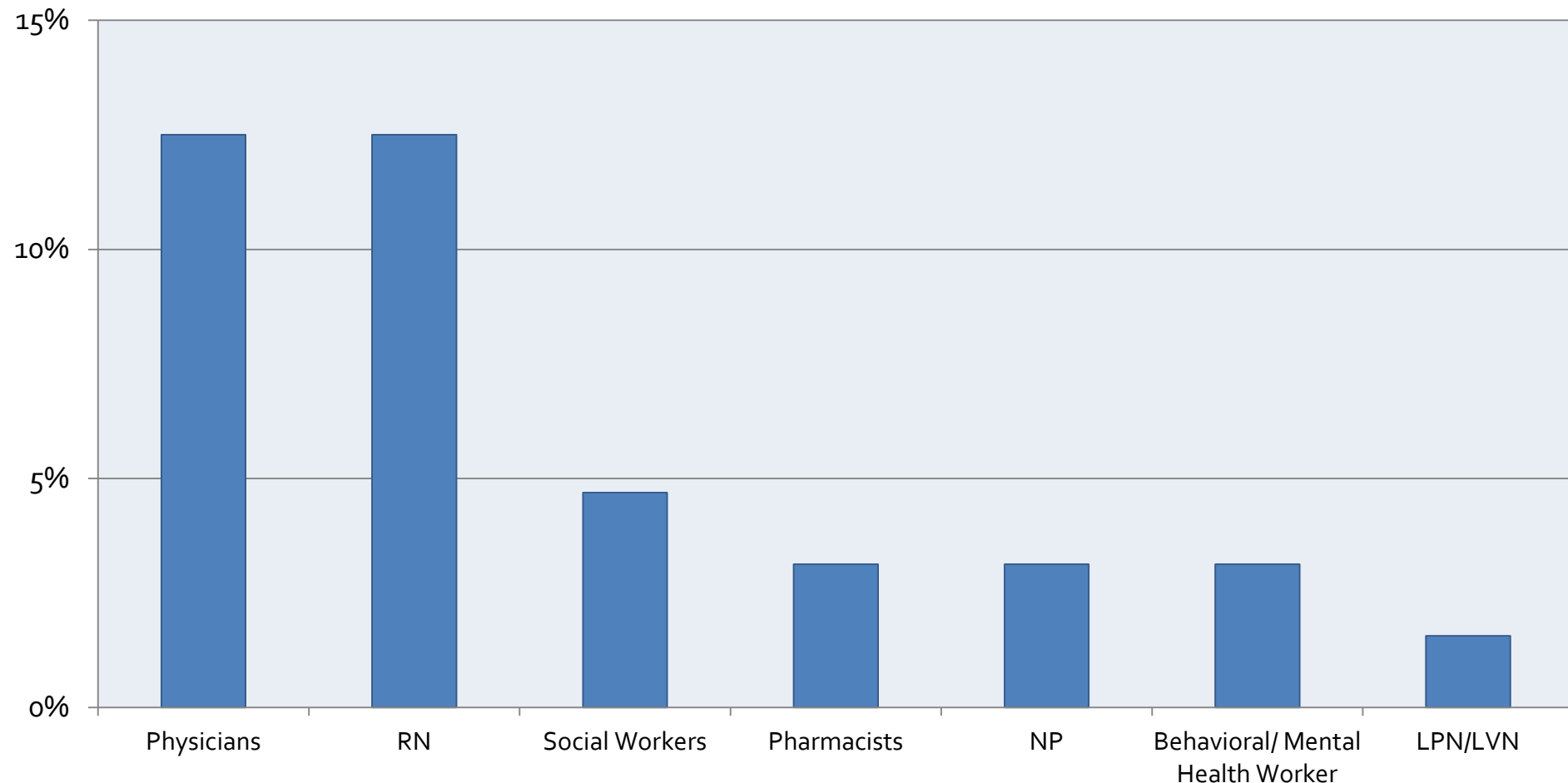
- Awarded 108 projects to broad range of innovators
- Goal: Identify models that produce better care, better health, and reduced cost through improvement 3 year test period
- Awards range \$1m to \$30m
- Seeks to identify new models of workforce development and deployment and related training



Source: Centers for Medicare & Medicaid Services

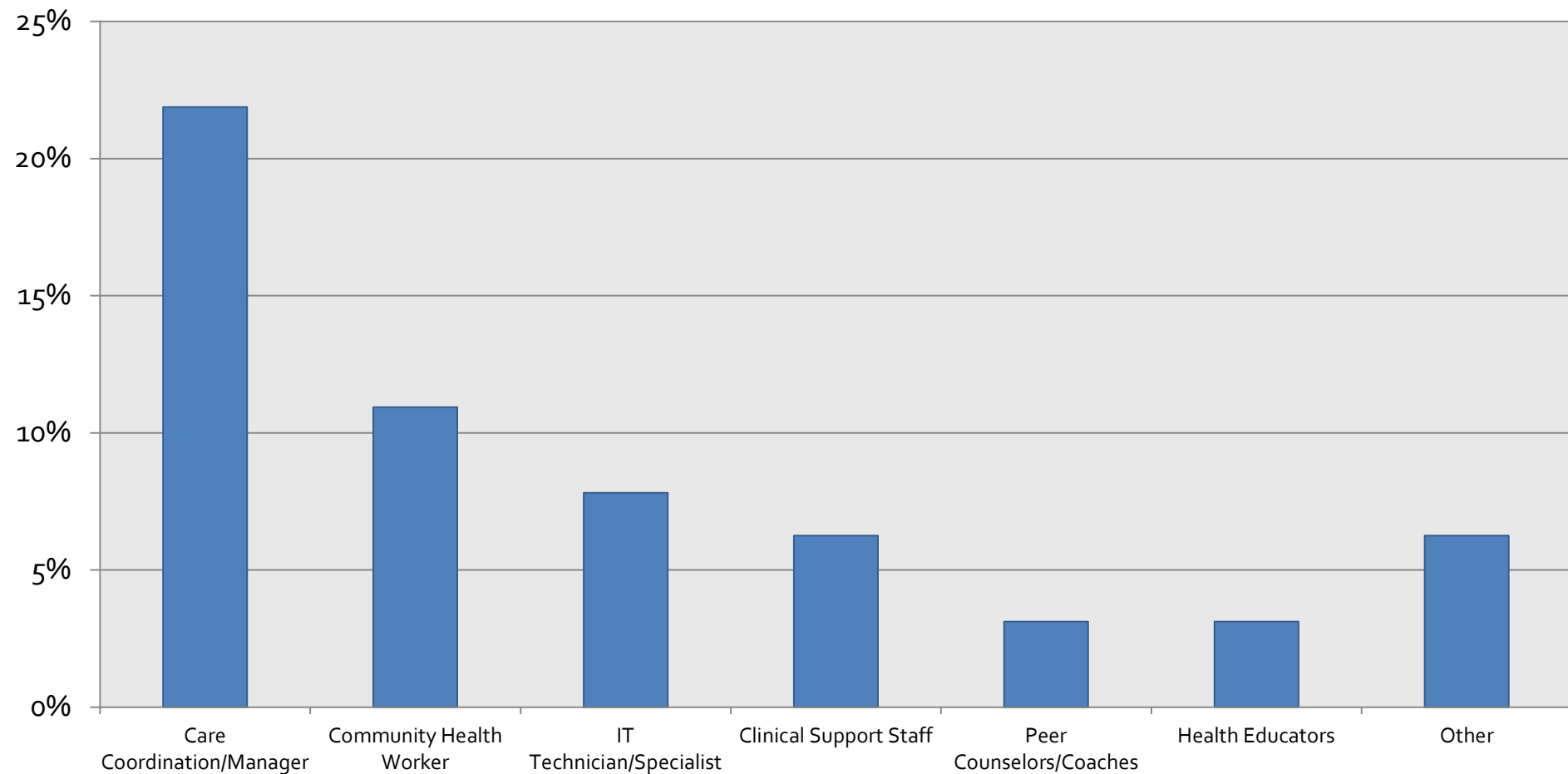
Retraining and Redeploying Workforce to Date in HCIA

Proportion of Workforce Deployed under HCIA



Training and Adding New Workforce to Date in HCIA

Proportion of Workforce Deployed under HCIA



Independence at Home

GOAL: Testing the effectiveness of providing chronically ill beneficiaries with home-based primary care.

- Medical practices provide chronically ill beneficiaries with home-based primary care.
- Beneficiaries with multiple chronic diseases
- Incentive payments for practices successful in:
 - meeting quality standards; and reducing total expenditures
- 15 independent practices and 3 consortia participating

Innovation Center 2014

Looking Forward

We're Focused On

- Implementation of Models
- Monitoring & Optimization of Results
- Evaluation and Scaling
- Integrating Innovation across CMS
- Portfolio analysis and launch new models to round out portfolio

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The Future of Quality Measurement for Improvement and Accountability

- Meaningful quality measures increasingly need to transition away from setting-specific, narrow snapshots
- Reorient and align measures around patient-centered outcomes that span across settings
- Measures based on patient-centered episodes of care
- Capture measurement at 3 main levels (i.e., individual clinician, group/facility, population/community)
- Why do we measure?
 - Improvement

Source: Conway PH, Mostashari F, Clancy C. The Future of Quality Measurement for Improvement and Accountability. JAMA 2013 June 5; Vol 309, No. 21 2215 - 2216

Thank You

innovation.cms.gov

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