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Healthcare Quality Watch

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NEWS BRIEFS FOR MANAGERS AND OPINION LEADERS

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IPRO Wins Four ESRD QI Contracts

IPRO has won four regional End-Stage Renal Disease (ESRD) Network quality improvement contracts to support dialysis patients, families and providers in 13 states across the U.S. IPRO will be responsible for Network 1 (Maine, New Hampshire, Vermont, Rhode Island, Connecticut and Massachusetts); Network 2 (New York); Network 6 (North Carolina, South Carolina and Georgia—under protest); and Network 9 (Ohio, Indiana and Kentucky). IPRO was the incumbent ESRD Network contractor in New England and New York but is a first-time awardee in Networks 6 and 9. "We're pleased and grateful that the Centers for Medicare & Medicaid Services (CMS) renewed our contracts in New York and New England while extending our Network leadership responsibilities to two other regions of the U.S.," says IPRO Chief Executive Officer Theodore O. Will. The ESRD Networks, created by statutory mandate in 1978, were developed "to improve cost-effectiveness, ensure quality of care, encourage kidney transplantation and home dialysis, provide assistance to ESRD beneficiaries and providers, and increase ESRD Network Program accountability." According to the CMS, ESRD beneficiaries make up less than one percent of the Medicare population, but account for 7.1 percent of total Medicare spending. "With the assistance of our large volunteer community, our organization will be responsible for supporting 117,000 patients, 1684 facilities and 52 transplant facilities, across the four regions," says IPRO ESRD Network CEO Susan Caponi, RN, MBA. "That translates to one-quarter of our nation's ESRD patient population." CMS announced it is awarding a total of $110 million in five-year Medicare funding to seven entities nationwide.

New Report Cites Harms Reductions

A new report from a federal agency that monitors healthcare quality in the U.S. is documenting substantial gains in the effort to reduce patient harm in hospitals across the nation. The report just released by the U.S. Agency for Healthcare Research and Quality (AHRQ), shows dramatic reductions in key indicators like adverse drug events, pressure ulcers and infections. The AHRQ study examined frequency in the overall category of hospital-acquired conditions (HACs), at acute-care hospitals in the U.S.—using a baseline finding of 145 HACs per 1,000 discharges in 2010. The sharp decline to 121 HACs in 2014 translates to an estimated 87,000 fewer patient deaths and an estimated savings of $19.8 billion over what would have been experienced had the baseline rate remained unchanged. This 17% reduction in HACs can't be explained by any single factor, according to AHRQ, but rather by a number of influences working together synergistically. These include payment incentives, public/private collaborations like the Partnership for Patients, increased levels of technical assistance to hospitals from Quality Improvement Organizations and Hospital Engagement Networks, and technological advances such as the emergence of electronic health records. The largest reduction in the estimated 2.1 million fewer harms occurred in the category of adverse drug events; AHRQ estimates that fewer drug catastrophes accounted for 40% of the overall reduction, followed by reductions in pressure

ulcers (28% of the decline), and catheter-associated urinary tract infections (16% of the decline). The authors attribute 87,000 fewer deaths to the decline in HACs from 2010–2014 and view the finding that 70,000 of the deaths were averted in 2013 and 2014 alone as "encouraging." In a similar fashion, AHRQ finds that the bulk of the dollar savings estimated to have taken place ($16 billion of a total estimated $19.8 billion savings), occurred in 2013 and 2014. *Saving Lives and Saving Money: Hospital-Acquired Conditions Update, Interim Data from National Efforts to Make Care Safer, 2010–2014,* is available at www.ahrq.gov.

Feds Outlines Challenges in Payment Reform

A new paper developed for the Centers for Medicare & Medicaid Services (CMS) outlines the challenges the government faces in implementing a new approach to physician payment under the Medicare program—scheduled to begin in 2019. Under a law passed earlier this year, CMS is required to develop quality measures in all medical specialties to transition to Medicare Merit-based Incentive Payment System (MIPS) reimbursements for most payments to physicians, as well as to support alternative payment model (APM) reimbursements to a subset of physicians across the U.S. The paper focus on a few key challenges, such as including patients in measure development, reducing data collection burdens for providers, shortening time frames for new measure development, speeding data acquisition in order to test measures, and developing measures that focus on outcomes of care. Additional challenges outlined in the paper include focusing on patient-reported quality measures and on measures that evaluate coordination across settings and provider groups. CMS notes that the new law doesn't require that measures be submitted for consensus endorsement prior to implementation but does require that measures be submitted for publication in peer-reviewed journals. The draft CMS *Quality Measure Development Plan,* which was prepared by the Health Services Advisory Group, Inc., is available at www.cms.gov.

QIO Program Brand Recognition Improving

In a just-released survey of healthcare experts, nearly two-thirds of respondents (63%) describe the QIO program as useful in improving quality, up slightly from findings in 2014. Survey participants included healthcare providers and beneficiary advocates as well as government representatives and thought leaders drawn from health quality groups across the U.S. Conducted by Virginia-based Sage Communications on behalf of the Centers for Medicare & Medicaid Services, the survey analyzed responses from 302 individuals to a variety of questions meant to determine QIO brand effectiveness. Individuals most likely to respond positively to questions about QIO impact included representatives of government agencies and hospitals, as well as experts who work directly with QIOs. More than half of respondents in 2015 (53%), say they're aware of major changes in the QIO program—far more than the percentage of experts who were aware of major changes in 2014 (36%). These changes include the recent separation of QIOs that work on quality improvement, from other QIOs that focus on case review of appeals lodged by Medicare beneficiaries and families. The positive attributes most closely associated with QIOs in the 2015 survey included being trustworthy, credible, patient-centered and collaborative. For more information on the survey, contact Sage Communications at http://sagemarcomm.com.

Senate Examines Diabetes Coverage

Congress should consider changing Medicare eligibility requirements to permit diabetes self-management training (DSMT) for individuals at risk of developing the disease, according to a new paper published by a work group of the Senate Finance Committee. Currently Medicare Part B DSMT coverage is available for individuals with diabetes but not for those at risk of diabetes ("prediabetes"). Trainings include glucose blood level self-monitoring, instruction on proper diet and exercise regimens, individualized insulin treatment planning, medication management and motivational counseling. The workgroup proposes consideration of Part B coverage for individuals at risk of developing the disease, using criteria that would be established by the Centers for Disease Control and Prevention. The work group is also discussing whether to permit service delivery by non-profits and health departments—Quality Improvement Organizations like IPRO's Atlantic Quality Innovation Network are currently providing DSMT services under a Medicare-funded, five-year workplan that began in August 2014. The workgroup proposal is one of a series of recommendations included in a 30-page draft on chronic care innovation released December 18. Comments will be accepted through January 26. For more information, visit the Committee's website at www.finance.senate.gov.

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For an electronic version of *Healthcare Quality Watch,* visit **http://ipro.org/about/publications/newsletters/quality-watch**.

We welcome your comments and suggestions. Please forward them to the Editor, Spencer Vibbert, at svibbert@ipro.org.

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IPRO is a national organization providing a full spectrum of healthcare assessment and improvement services that foster more efficient use of resources and enhance healthcare quality to achieve better patient outcomes. For 30 years, IPRO has been highly regarded for the independence of its approach, the depth of its knowledge and experience, and the integrity of its programs. IPRO holds contracts with federal, state and local government agencies and corporate clients, in more than 33 states and the District of Columbia. A not-for-profit organization, IPRO is headquartered in Lake Success, NY.