

CMS 2010 Regional PACE Conference

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TRANSCRIPT

CMS Quality Initiatives

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I can't stop laughing. Thank you, Jill, very much and thank you. I just want to really thank the organization, committee, the conference planning committee, for inviting me to speak. This has been a wonderful experience for me. I've learned so much, and it's given me the chance to share some of my thoughts with you and to hear your thoughts, so I just want to say thank you. Well this is a subject near and dear to my heart, and I think being last today helps to emphasize a point I made yesterday that--still a little bit too loud for me. We forgot to add a fun fact, and I'm a very quiet person. But it brings home the point that quality--all roads lead to quality. All the work that we do really is wrapped up in quality, and I think that's one of the messages that rings loud and clear for me.

This is just really--the main focus of this talk this afternoon is on the quality assessment and performance improvement program. There are a few other things that we'll talk about related to that, but really that's what we're going to focus on. My purpose, primarily, although there's three bullets up there, I think one of the things I want to focus on and primarily get you to think about is the third bullet--where can we go with crappy--or quality improvement--I'll probably just say quality improvement because crappy doesn't sound very good--but with quality improvement in the long term for Pace?

How do you define quality? Well, it has many meanings, obviously, and I think the key for us when we talk about quality in Pace is what does that mean. We talked a lot about that yesterday, and ultimately, of course the goal is to provide the best health care possible for our patients. This is the definition from the institute of medicine for quality that came out in every port from 2001. Many of the quality initiatives that we're working on at CMS really take hold in the report that came out in 2001. You saw from Karen Millgate's side yesterday, the six aims from the Institute of Medicine report that are linked to the triple aim that Dr. Burwick is using as our framework for CMS. We have started, when I came back to CMS in November last year, we started doing the same thing, to focus our quality improvement, first beginning with Medicare Advantage and the SNIT program, and then picking up with the Pace program, on the six aims from the Institute of Medicine report.

So this is their definition. But for Pace, we have to take that definition and figure out what really works for us. How do we design a quality improvement program that is specific for Pace? And we have a similar situation for Medicare advantage, and especially with the special needs plans. That program has to be designed for that particular program, and so Pace is even more unique in how we design what we want to do, to emphasize and show that we have a quality program.

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These are some of the components that we've already talked about. It's not the total list of the factors that go into a quality model, but these are some of the key aspects that we need to keep on the front burner when we're talking about quality for Pace. One of the things that we haven't talked a lot about here, but I think we need to keep that in mind, is financial solvency. You can't provide the care for the beneficiaries, for the patients, for the participants, if we do not have the fiscal means to do that. So it's incumbent upon your organizations to really make sure that the financial solvency is there, and that's one of the reasons why, in the whole Pace package, the application and that whole organizational process, we really spend a lot of time with you, when you come into being a Pace organization, to focus on that.

Ultimately, we want to make sure that the patients who participate in Pace, their families, their caregivers, are satisfied with the care that we give. We have to be satisfied in the end as well, because we're going to be accountable to those patients. So patient satisfaction, although we tend not to measure it in the same way that we do with the MA program, it's still a key component of quality for our patient.

This should look familiar. You're going to see this a lot, and it's something that, again, I'm using over and over to represent quality across all of our programs. So that's our (inaudible). Okay, specifically within the quality improvement area, we have tools to assist us in terms of assessing what is quality. We have tools that can be qualitative and tools that can be quantitative. A lot of our tools are really qualitative, and that's fine for what we need to look at. The larger sort of more national measures like (inaudible) are going to be the qualitative type--the quantitative type, sorry. But when we look at the development of your quality assessment and performance improvement plan, there we're looking for more of the qualitative types of measures that you're looking at. What is your intervention? Have you made a change in that patient's life, in the outcome for that patient? The other piece is that any event, any event, plus or minus, doesn't have to be something that is reported in level two necessarily or level one, but any event can be looked at as an opportunity to develop a quality improvement program, to take that opportunity, to develop an innovative intervention that could be a model for, or best practice, for another program. I think it was an excellent opportunity yesterday when we shared best practices, because we don't do that enough. There are many, many best practices out there. You think about what you're doing in your organization, and there may be another Pace organization who has a patient that has a similar situation, or even a cultural experience that might be unique in one part of the country, but the Pace in the next state could benefit from that same cultural experience that you've had with that patient.

So we need to think better about how we can use the best practices and other information to communicate the strength and weaknesses across our Pace programs. We can use that information then to drive these quality improvement activities for our programs. The quality improvement program--this is just a list of all the people that are part of your organization that should be involved in quality improvement, but it's really--if I had to pick one slide other than my hug from this slide deck, to really focus on what is important for quality, it's the next one.

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The bottom line: quality improvement is everyone's responsibility. It's my responsibility at central office, the regional office's responsibility, and the Pace organization's responsibility, and it's everyone in that chain that has to take quality improvement and the quality of care seriously. The next couple of slides just talk about what other elements that would go into your quality improvement plan. I think what I find very troublesome here is the fourth bullet, and part of it is because I've been at CMS in my role now for a year, and other than for a Pace organization coming into--a new Pace organization coming into our program, I haven't seen anyone's quality assessment and performance improvement program or plan. Hmm. So it tells me one of two things might be happening. Maybe you have such good plans that there's no need to assess or reassess them, and you've been using the same plan for maybe ten years or so if you've been in the program. I don't know, I don't think so. I think you're working those plans.

The other thing it says to me is that, well, at central office, we haven't taken the initiative to reach out to the account managers, to the Pace organizations, and say when you submit your revised quality improvement plan to the account manager, because you've changed it, you've done an intervention and you've now modified that plan, that we at central office haven't said to our regional office account managers, by the way, we want to see that too. And I tend to think it's probably the latter rather than the former situation, and the reason I think that this bothers me is that we want, at central office, we want to be a part of this. We are all partners in this quality improvement program, and so we--talking about me and my team--we have to reach out more and let the regional offices know that we are there to support them, and we want to be included, and we want you to know that we want to be included as well. So we have to--we have some work on our part, and you can bet when I go back tomorrow we'll be convening our team--as small as it might be--to start to address some of these issues, because we need to look at the quality improvement plans.

If we don't, then how can we help you to make sure that you're meeting the regulation requirements? How can we help you, so when you have an audit, you know, if nothing else, that your quality improvement plan is solid? And that's our job, to make sure that you have that, and that as a tool for you, that it's working. So hold me to that.

Okay, these are some of the other elements that should be included in your quality improvement plan, and I want to focus on the last bullet here. Well, let me go back to the satisfaction piece. Talked a little bit about that already, but I think that that cannot be understated. We really want the patient and the patient's family, the caregivers, to be satisfied with the care that's being given, especially in this program. Other programs, they don't have the opportunity that we have with Pace, to really make sure that this vulnerable population is really taken care of and gets everything that is needed.

But I want to address that last bullet a little bit. I talked a little bit yesterday about some of the non-clinical pieces, because those are critical to the holistic piece of care as well. It's not just the medical history and physical, the functional status, but I just mentioned a few minutes ago about culture, providing culturally competent care, or culturally

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competent enrollment, I think is important, and those are some of the non-clinical pieces that help to make the Pace experience special and unique for that patient.

But the other piece in terms of non-clinical that ties to this quality improvement plan--again, all roads lead to quality, and I think it was maybe number 18 on a slide from this morning, and that's the emergency preparedness plan. I want to spend two seconds on that. Don't forget to make sure that you have a solid disaster and emergency preparedness plan, because from my perspective, knowing that all roads lead to quality, I will definitely be looking for that emergency preparedness plan, and testing that emergency preparedness plan is also part of quality improvement.

We've talked about the reporting a lot yesterday. We didn't say much about the health outcomes survey, but that modified version is important. Although it's used for the frailty, part of the frailty assessment, it's really important for us to take a better look at the data, and that's something that we haven't done, and we will be doing. We talked yesterday about the data, the need for data. We need to understand what makes Pace work. We need to be able to say, why is Pace better for these patients than going to a nursing home? I mean, intuitively, obviously, we know it's better. We know that you can't compare the experience to living at home, living in the community, to being a resident in a long-term care facility. We know that, but we haven't really put out in the public domain--we haven't published articles on Pace. We haven't really talked about, even if it's only in newsletter, this is a good program. We've been able to keep X number of patients out of long-term care facilities over this timeframe. Where are the data? I haven't seen it.

So we are going to have to do that, because without doing that, we are constantly questioned on, well, why is Pace a good program? We say that it is, we believe it. I believe it, but I'm being asked, show me the data. So I need everyone as part of their quality improvement plans, to really look at your data, really look at what data you're using to drive your program. We will be looking at the data. We heard earlier from the HPMS staff, the level one reporting data. We haven't really looked at that enough. We haven't looked at the health outcomes survey. So we need to do that, and part of quality improvement is using data to drive change, to move the program along, to make it better. But--I'm saying that but you all know that.

I won't focus on the level one. We've talked about that yesterday and just a little bit before, but it is something that we will emphasize more in our internal reports and working with you on how to use that data. Level two clearly--sorry, this is still level one. Level two data, don't forget, we will have training in December on this, and those data and those reporting elements, not to be reported, again, in the patient's chart, but to be used to drive the quality improvement projects. And these are some more of the level two examples.

I mentioned this already to some extent. I think you are aware that the frailty scores are used from the health outcome survey. You've seen this before also, but what's important for us here is that it really is the continuous cycle, as we move through this circle, from plan, do, study, and act, and it's not stationary. Quality improvement is not a

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stationary activity, so that's what this schematic helps me to convey to you, that we're going to continue, the wheel would be continuing to move along the continuum, from one point of quality to the other end of that continuum, where we'd have high quality, good outcomes, the best outcomes that we could have for our patients.

Okay, the fun part: where do we want to go? We have to watch out, because I will take you with me on this ride, because I'm very passionate about quality improvement and I hope that I'm having a lot of supporters out there in terms of what we need to do, think about what we want to do. I don't have all the answers today, and I'm not going to try to give you all the answers, but I have a few ideas of where we might be going, and some of the things that we might want to do, and I'm open to hear what you have in mind as well.

One of the things that we really need to do is make sure that our guidance stays current. That's kind of ho-hum boring, but we can't have years and years go by without revising and updating guidance, and that's where we were up to this point. Others who came before me, Judith Sutcliffe and others, and the teams that helped to work on the clinical team that have to work on the care planning guidance, and the teams I mentioned yesterday on the level two, it took them some time to get to that point. But prior to their efforts, it had been years and years before any guidance had been updated. So we can't let that happen, and once we have current guidance it's easier to revise and add the pieces that we need. So guidance and standard operating procedures, those are our tools for laying our path to quality improvement.

I think what's really important for me is the improved coordination and communication, and I've already talked about that to some extent, but that is a key part of how we can move forward. Conferences like this allow us to be able to share information, to get feedback, to reach out and find out what works and what doesn't work, but we need to hear that, and we can't necessarily wait for conferences. We need probably to have more conference calls, have some of these topics. I know we have some of them on our user group calls, but make those user group calls a priority, and a chance to share and showcase what works and what doesn't work. We may even need to have some smaller types of calls, with focuses on certain conditions or specific issues. Maybe there's an issue with just one section of the level two reporting, or maybe there's an issue with looking at hospital readmissions in level one, or something like that, topic-specific calls. But we need to expand that communication method for us, up and down our chain, and with our partners. And I know the National Pace Association was here and I was glad to see that they were as well, because we need to make sure that we connect with all of our partners.

We're trying to look at training. I'm a big training and technical assistance person. I feel that it's very hard to effect change if you don't also include the pieces that go along with that, and by developing new guidance, new thoughts, new processes, we also have to have the other pieces, that training and then the technical assistance, to make sure that when we're asking you to implement something, that you have the tools to make it work on the ground.

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Whoops, I'm going backwards. I guess--all right. Well, it's been a long two days, and I wanted to make sure we kept this short and to the point, so I'm going to wrap up here a little bit, and I just want to emphasize that quality improvement is ongoing. It's continuous. I said yesterday, it's reassessment, reassessment, reassessment, and it is. But it's not a fruitless type of reassessment, because at each point we're developing or actually targeting some specific intervention, some condition, some particular patient's need that we're trying to improve. So it shouldn't be for naught, and it should be something that we learn from and move on. And I guess in closing that these goals are definitely ours from CMS central office and working very closely with our regional office, so I'm hoping that you'll embrace this effort, this environment, this aura of continuous quality improvement, so we can improve our Pace program for all of our patients. Thank you.

Okay, I know it's late in the day, so any question--I see--where's the microphone? I see a hand all the way to the right. Do you want to (inaudible) you want to come up? I can see. Okay, thanks.

Hi, Donna Rezien. I'm Medical Director of Mercy Life in Philadelphia. Thank you very much. I just wanted to just clarify, for the state of Pennsylvania, we have been told to give our quality report to the state and that was what the clear direction has always been, so the state has been where we've sent our report, our annual report, and our work plan.

Okay, thank you.

Jane Taylor here. I'd like to just put in a plug to all the Pace organizations here--I'm from CMS--to please direct attention to training your data entry staff on entry. I mean, it sounds simplistic and fundamental, but when we go out on site and we see a problem with the reported quality data, no matter whether it's into HPMS or your own internal data, when we have questions about it, very often when we walk it back, what we find is that there was just a plain error in entry. Somebody didn't know what they were doing. Somebody was on vacation, somebody else stepped in--there's many, many examples of that. So I just can't help myself. Thank you for listening.

Okay, before I step down, I do want to make an announcement, because I want you to make sure that if you hear any rumors, that you put them in a context and you heard it first from me. First of all, you know that I'm currently the acting director of the Division of Medicare Advantage Operations. I am also the Chief Medical Office for the Medicare Drug and Health Plan Contract Administration Group and the coordinator for quality improvement for MA, SNIT, and Pace.

I will be stepping down as the acting director for the Division of Medicare Advantage Operations. I never intended to apply for the program because of my other two hats. I'm not going anywhere with respect to quality improvement and working with the Pace program from the clinical standpoint and from quality improvement. So I wanted to assure you that now that you have a face with a name, that when--and our new director, Catherine Coleman, has already been announced for the division and will be coming on board more actively in December, and I'm looking forward to working with her in her role,



and transitioning all the things I've learned as I've been Division Director during this detail.

But some of you know that--but some of you know that during my detail, I've been asked to continue to do all the other duties, and it's been exciting and difficult. But I wanted to assure you that I'm not going anywhere, and I'm going to be continuing to be involved in Pace and quality improvement from a clinical standpoint as well. Thank you.