CMS Quality Strategy
2013 – Beyond

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Contents

Overview

The Centers for Medicare & Medicaid Services (CMS), working collaboratively with our public and private partners, is well on its way to transforming the way the Agency conducts its business and operations. CMS is working to support the delivery of consistent high-quality care, promote efficient outcomes in our healthcare system, and ensure that health insurance remains affordable for the millions of Americans who seek coverage. As shown in the following diagram, CMS is using all its policy levers and program authorities to ensure that these goals can be achieved, including rewarding innovation in the delivery of services, implementing initiatives to reduce burden, and employing state-of-the-art technologies to assure program integrity across our healthcare coverage programs. CMS has created this strategy in accordance with legislation in the Patient Protection and Affordable Care Act (ACA) of 2010 [§3011(b)(2)(A)-(D)], which requires that each agency within the Department of Health and Human Services (HHS) report on its progress and development of a Quality Strategy.

BETTER CARE, ACCESS TO COVERAGE AND IMPROVED HEALTH

The CMS Strategy is Built on Four Main Goals:

GOAL 1
Better Care
and
Lower Costs

Beneficiaries receive high quality, coordinated, effective, efficient care. As a result, health care costs are reduced.

GOAL 2
Prevention
and
Population Health

All Americans are healthier and their care is less costly because of improved health status resulting from use of preventive benefits and necessary health services.

GOAL 3
Expanded Health
Care Coverage

All Americans have access to affordable health insurance options that protect them from financial hardship and ensure quality health care coverage.

GOAL 4
Enterprise Excellence

We will have achieved "Enterprise Excellence" when CMS' high quality, diverse workforce develops, supports and utilizes innovative strategies, tools and processes, and collaborates effectively with its partners and agents to reach its goals.

Driving quality improvement is a core function of CMS. This commitment is particularly evident as CMS enhances its partnerships with a delivery system in which providers are supported in achieving better outcomes in health and healthcare, at lower cost, for the beneficiaries and communities they serve. The Agency must strategically implement these efforts to ensure that providers meet goals without harming the people most affected by policy decisions surrounding payment and quality.

The CMS Quality Strategy is designed to guide the activities of the Agency's components that are vital in completing this transformation. It is built on the foundation of the CMS Strategy and the HHS National Quality Strategy. The National Quality Strategy was developed through a participatory, transparent, and collaborative process that included the input of a wide array of stakeholders.

Introduction

Americans are not receiving the healthcare they need, at the time they need it, or at a cost that is affordable. Although current CMS programs and initiatives have succeeded at reimbursing providers for services they render, in the past these reimbursements have not been tied to quality or incentivized for efficiencies. To improve, a broad-based and seamless reform approach is necessary to address challenges in our healthcare system—escalating costs, inadequate coverage, and inefficient care of variable quality.

The ACA seeks to increase access to high-quality, affordable healthcare for all Americans. The National Quality Strategy articulates broad aims and priorities that have been informed by extensive consultation with stakeholders across the country. At the federal level, the National Quality Strategy has guided the development of HHS programs, regulations, and strategic plans for new initiatives, in addition to serving as a critical tool for evaluating the full range of federal healthcare efforts. It has kick-started implementation planning across HHS and established a mechanism to obtain additional private sector input on specific goals, benchmarks, and quality metrics in 2011. The CMS Quality Strategy pursues and aligns with the three broad aims of the National Quality Strategy:

- **Better Care:** Improve the overall quality of care by making healthcare more patient-centered, reliable, accessible, and safe.
- **Healthy People, Healthy Communities:** Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care.
- **Affordable Care:** Reduce the cost of quality healthcare for individuals, families, employers, and government.

To advance the three aims, the National Quality Strategy identified six priorities:

1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that each person and family is engaged as partners in their care.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new healthcare delivery models.

Each of these priorities maps to the three National Quality Strategy aims and has become a goal in the CMS Quality Strategy. This document identifies quality-focused objectives that CMS can drive or enable to further these goals. Quality interventions are inherently interrelated, thus many goals include concepts that could be articulated under more than one goal. As we organized and structured objectives, we sought to put them in the place that captures where the primary driver of change occurs.

Organizational Tenets

Vision

The vision of the CMS Quality Strategy is to optimize health outcomes by improving clinical quality and transforming the health system.

Mission

We, the CMS Quality components, serve CMS, HHS, state Medicaid and Children's Health Insurance Program (CHIP) agencies, and the public as a trusted partner with steadfast focus on improving outcomes, beneficiary experience of care, and population health, and reducing healthcare costs through improvement. To maintain this focus, we will:

- Lead quality measurement alignment, prioritization, and implementation and the development of new innovative measures
- Guide quality improvement across the nation and foster learning networks that generate results
- Reward value over volume of care
- Develop and implement innovative delivery system and payment models to improve care and lower costs
- Collaborate across CMS, HHS, and with external stakeholders
- Listen to the voices of beneficiaries and patients as well as those who provide healthcare
- Foster an environment that will create the capacity for providers to improve quality through use of locally generated data and local innovations in care delivery
- Be a model of effective business operations, customer support, and innovative information systems that excel in making meaningful information available
- Develop individuals, create high-functioning teams, foster pride and joy in work at all levels, continuously learn, and strive to improve

Values

The CMS Quality Strategy aligns with the CMS Organizational Strategy's values, and we commit our work to the following:

- **Beneficiaries and Patients Come First** – We put first the best interest of the people we serve.
- **Public Service** – We take pride in our unique and privileged role in the healthcare of the nation.
- **Integrity** – We hold ourselves to the highest standards of honesty and ethical behavior.
- **Accountability** – We earn trust by being responsible for the outcomes of our actions.
- **Teamwork** – We foster unconditional teamwork and regard every employee in CMS as available and willing to help others.
- **External Collaboration** – We strive to work in full cooperation with the private sector.

- **Innovation** – We encourage finding and testing new ideas in all that CMS does.
- **Excellence** – We are committed to strengthening our organizational culture of striving for excellence in our products and services as well as in how we do business.
- **Respect** – We treat all our stakeholders and one another with the utmost respect and professionalism.

We strive to continually refine our processes, systems, and services for the benefit of our internal and external stakeholders. Throughout our work to improve quality, we will seek input and actively listen, collaborate and partner with stakeholders outside CMS, be responsive to beneficiary and provider needs, learn from others and foster learning networks, be a catalyst for health system improvement, and focus on what is best for patients.

The CMS Quality Strategy

This Quality Strategy lays out goals, objectives, and intended outcomes to guide action to realize six broad and interrelated goals. As previously noted, these CMS Quality Strategy goals reflect the six priorities set out in the National Quality Strategy:

- Goal 1: Make care safer by reducing harm caused in the delivery of care
- Goal 2: Strengthen person and family engagement as partners in their care
- Goal 3: Promote effective communication and coordination of care
- Goal 4: Promote effective prevention and treatment of chronic disease
- Goal 5: Work with communities to promote best practices of healthy living
- Goal 6: Make care affordable

Foundational Principles

Four foundational principles guide the Agency's action toward each of these goals. Unless these four principles are explicitly incorporated into the Operational Plan to achieve our goals, CMS will not succeed in driving change to improve the quality and cost of care for all. To ensure that these principles are actively addressed, CMS will continuously evaluate how the Agency is embedding the foundational principles within each goal.

Eliminate Racial and Ethnic Disparities

Despite the steady improvements in the overall health of the United States, racial and ethnic minorities experience a lower quality of health services, are less likely to receive routine medical procedures, and have higher rates of morbidity and preventable conditions than non-minorities. Disparities in healthcare exist even when controlling for gender, condition, age, and socioeconomic status. Eliminating disparities is essential for performance excellence and improved community health. CMS is dedicated to helping eliminate racial and ethnic disparities in healthcare by aligning to the National Plan for Health Literacy (http://www.health.gov/communication/hlactionplan/pdf/Health_Literacy_Action_Plan.pdf) and the HHS Action Plan to Reduce Racial and Ethnic Disparities (http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf). In addition, CMS is committed to improving health literacy that enables people to effectively navigate our healthcare system.

To realize an equitable healthcare system, all physicians, nurses, and allied health professionals must be aware of healthcare disparities as well as the care management needed at the patient level to identify and eliminate them. All providers must work actively in their practices to eliminate such disparities. Additionally, all patients in CMS programs must have access to and receive patient-centered, equitable, effective, safe, timely, and efficient care.

Strengthen Infrastructure and Data Systems

Data and information are essential aspects of a healthy, robust public health infrastructure. Patient treatment and care rely on various components of the healthcare system, and care is delivered through different levels of a health system. Thus, strengthening infrastructure and data systems for public reporting and using electronic data collection are essential to all CMS activities. Specifically, these efforts

enhance CMS's ability to monitor trends in critical health measures among priority populations; monitor health status, healthcare, and health policy concerns at the national, state, local, and tribal levels; and conduct in-depth studies of population health at the community level and for specific subpopulations. New payment models being implemented by CMS (e.g., the Medicare Shared Savings Program, the Medicare Fee-for-Service Physician Feedback Program/Physician Value-Based Payment Modifier, and state Medicaid agency-developed shared savings models) require new capacities in CMS information systems, including the ability to align programs and administer population-based and value-based payments. CMS will transform its infrastructure and data systems to allow for payment and management of accountable, value-based care.

Enable Local Innovations

CMS promotes innovation at all levels of the healthcare system. The effectiveness of healthcare service delivery often depends on the availability and quality of social services and programs in a given community. Because each local community is unique, CMS will enable programs that allow local communities to address their challenges in ways that best meet their needs. Improving access to essential services requires three forms of innovation: (1) *technological*, to ensure availability of services that are more cost-effective than existing interventions, (2) *social*, to ensure the equitable distribution of essential services, and (3) *adaptive*, involving both providers and communities to tailor the adoption of services to local settings.

Foster Learning Organizations

A learning organization is one that continually expands its ability to shape its future. For a modern, knowledge-based, service-focused Agency to be successful, learning must be linked to the organization's strategic goals. CMS intends to make continual learning a way of life within the Agency to improve the performance of the organization as a total system.

But CMS must also think about the need to support learning on the delivery system side. As we introduce new programs requiring core competencies in improvement and population health management, we need to be mindful of our role in providing educational support for providers to succeed in these new models. Education does not end when a provider receives credentials or a patient is discharged. Education is increasingly continuous, deliberate, and an integral part of organizational learning. CMS is committed to promoting learning and education as key parts of its quality programs and initiatives. By fostering learning organizations, CMS will use funding more effectively and continue to explore the best methods for delivering healthcare and disseminating best practices.

Drivers and Policy Levers

CMS is working to achieve these objectives through multiple drivers and policy levers of quality including, but not limited to:

- Measuring and publicly reporting providers' quality performance
- Providing technical assistance and fostering learning networks for quality improvement
- Adopting evidence-based national coverage determinations
- Setting clinical standards for providers that support quality improvement
- Creating survey and certification processes that evaluate capacity for quality assurance and quality improvement

Agents and Partners

Many agents—including CMS; state Medicaid and CHIP agencies; other federal, state, tribal, and local governmental organizations; and health providers—will be necessary to shape initiatives and implement activities to further the goals and objectives articulated in this plan. CMS will play the leading role as both a driver and enabler of activities, while other federal agencies, state Medicaid programs, healthcare organizations, and advocacy groups have critical roles to play in improving the quality of healthcare for all Americans.

CMS

As a lead agent, CMS plays two roles in implementing this Quality Strategy: driver and enabler. In some cases, CMS has the capacity to directly "drive" or implement changes to payments, regulations, and transparency in service of the quality improvement objectives articulated in this strategy. In other cases, CMS can enable external agents, such as health systems, hospitals, and physicians, to implement initiatives and activities by supporting demonstration projects, developing educational materials and guidance, and facilitating the exchange of promising practices. This strategy document presents CMS-driven and CMS-enabled initiatives together. One of the first steps of the implementation phase will be to identify lead agents for priority action items.

Partners

To achieve its goals, CMS forges partnerships among federal, state, territorial, tribal, and local governments; business, industry, and other private sector partners; philanthropic organizations; community and faith-based organizations; and with everyday Americans to improve health through prevention. For the first time in the nation's history, we are embarking as a federal partner on a cross-sector, integrated National Quality Strategy that identifies priorities for improving the health of Americans.

CMS is working to promote ongoing engagement of federal partners to align programs and understand and act upon advancements and developments that may affect health and wellness.

The Agency also works closely with state Medicaid and CHIP agencies that help implement our publicly financed healthcare programs. Another key set of partners is private sector insurers who often model their approaches to payment on CMS approaches. We will cultivate relationships with these public and private sector payers to leverage the impact of new payment models and quality improvement best practices.

In addition, CMS components coordinate efforts with other federal entities through quality initiatives and issue-based workgroups. These partners and workgroups include the Quality Improvement Council (QIC), the Agency for Healthcare Research and Quality (AHRQ), the Veterans Health Administration (VHA), Centers for Disease Control and Prevention (CDC), the office of the Assistant Secretary for Planning and Evaluation (ASPE), the Medicare Payment Advisory Commission (MedPAC), the Office of Legislation (OL), and the Office of the National Coordinator for Health Information Technology (ONC). CMS components also work closely with non-governmental organizations such as The Joint Commission, the National Committee for Quality Assurance (NCQA), the American Medical Association, and the American Hospital Association to strive for better care throughout the healthcare system.

CMS Quality Strategy
Goals

Goal 1: Make care safer by reducing harm caused in the delivery of care

Strategic Result: Healthcare-related harms are reduced

Healthcare-related errors harm millions of American patients each year and add billions of dollars to healthcare costs. Two prominent examples: The CDC estimates that at least 1.7 million healthcare-associated infections occur each year, and these conditions lead to 99,000 deaths; adverse medication events cause more than 770,000 injuries and deaths each year. The cost of treating patients who are harmed by these events is estimated to be as high as $5 billion annually.

CMS strives to make care safer by supporting a culture of safety, eliminating inappropriate and unnecessary care that can lead to harm, and reducing rates of healthcare-acquired conditions in all healthcare settings (see National Action Plan to Prevent Healthcare-Associated Infections: Road Map to Elimination, http://www.hhs.gov/ash/initiatives/hai/actionplan/). These objectives can be achieved through improved communication among patients, families, and providers; empowering patients to become more engaged in their care; better coordination of care within and across settings; and broad implementation of evidence-based safety best practices wherever care is provided. Payment systems that reward the avoidance of rather than incentivizing unnecessary tests and treatments will minimize the harm that can result from inappropriate care.

Through programs and initiatives such as 1115 Medicaid Waivers, Partnership for Patients, Hospital Value-Based Purchasing, patient-centered medical homes, Medicare Advantage Quality Bonus Payments, and the End-Stage Renal Disease Quality Incentive Program, CMS provides financial incentives that reward providers for adopting best practices that can decrease harm. CMS also provides opportunities for providers to work together to diffuse best practices that emphasize quality improvement and patient safety, thus accelerating the rate of adoption of new knowledge in the delivery system. CMS also assures patients' safety through its survey and certification authority by assessing compliance with federal health and safety-related standards, including those related to quality assessment and performance improvement.

CMS aims to partner with healthcare providers in a continual effort to reduce the risk for injury from care, aiming for zero harm whenever possible and striving to create a system that reliably provides high-quality healthcare for everyone. We believe this kind of system can make a substantial difference in improving care by preventing serious medication events and eliminating healthcare-associated infections and other preventable conditions.

Goal 1 – Foundational Principles

Eliminate disparities

- Educate healthcare professionals about health disparities and cultural and linguistic competencies as part of a curriculum to promote a culture of safety
- Improve safety and reduce unnecessary and inappropriate care by teaching healthcare professionals how to better communicate with patients of low health literacy and more effectively link healthcare decisions to patient goals
- Promote the use of healthcare interpreters and translation services in the cultivation of a culture of safety

Strengthen infrastructure and data systems

- Use health information technology (e.g., electronic health records, registries, health information exchanges) to improve safety across settings of care
- Implement and test value-based payment models that link payment incentives to measures of safety and appropriateness
- Link quality measurement to clinical decision support to promote greater use by providers and to reduce inappropriate use of medications, diagnostics, etc.

Enable local innovations

- Support the collection of data locally to identify and target issues of harm and inappropriately delivered care within a community or practice location
- Support multi-stakeholder meetings that include local front-line providers, patients, and families in order to identify innovative solutions to reduce harm in all settings

Foster learning organizations

- Support health worker education about reducing inappropriate and unnecessary care, starting with treatments and tests highlighted in the Choosing Wisely® campaign, which promotes dialogue between physicians and patients
- Encourage multidisciplinary, cross-sector learning communities that bring together clinicians, other licensed providers, patients, caregivers, community health workers, and other community stakeholders to disseminate best practices and learn from high performers

Goal 1: Make care safer by reducing harm caused in the delivery of care

Objectives	Desired Outcomes
Improve support for a culture of safety	• Improved application of safety practices in our programs involve all team members, patients, and families and assure that patient voices are heard • Organizations exhibit strong leadership that educates and empowers the workforce to recognize harm and increase reporting of errors and potential errors • Increased access to understandable health Information is provided • Expanded use of evidence-based services and primary care is evident • Disparities of care are eliminated
Reduce inappropriate and unnecessary care	• Healthcare organizations continually assess adverse events in accordance with evidence-based practices • Healthcare cost reductions are attributable to the reduction of unnecessary, duplicative, and inappropriate care • Improved achievement of patient-centered goals of care is evident • Disparities of care are eliminated
Prevent or minimize harm in all settings	• Hospital-acquired conditions (HACs) and healthcare-associated infections (HAIs) are reduced • Medication error rates are improved • Falls are decreased • Visibility of harm is improved in all settings • Use of evidence-based services and primary care is expanded • Patient and family access to understandable health information is increased • Disparities of care are eliminated

Goal 2: Strengthen person and family engagement as partners in their care

Strategic Result: Patients and families are engaged as informed, empowered partners in their care.

CMS is at the forefront of a nationwide effort to transform healthcare delivery around meeting the needs of the patient. The Institute of Medicine defines patient-centered care as "respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions." In addition to improving the patient experience, studies have found that patient-centered care models improve quality of care and health outcomes, engage patients more actively in their healthcare, and can reduce costs and disparities in care (Epstein et al 2010; Delanco et al 2012).

The patient-centered care approach considers a person as a multifaceted individual, not merely as the carrier of a particular symptom or illness. This approach to clinical practice demands that the provider and patient share power and responsibility in decision-making and care management. This requires giving patients access to understandable information and decision support tools to equip them and their families to manage their health and navigate the healthcare delivery system. This is achieved by education, verbal follow-up, repetition, and ensuring understanding through discussion.

CMS has embarked on Quality Improvement Organization (QIO) initiatives, such as the Every Diabetic Counts program, which gives each individual patient and family an active role in their care. In addition, the 1115 Medicaid Waiver allows states to design experimental, pilot, or demonstration projects that can adapt care to individual and family circumstances as well as differing cultures, languages, disabilities, health literacy levels, and social backgrounds.

CMS aims to strengthen person and family engagement in healthcare by promoting patient-centered care delivery with a focus on improved experience, patient self-management, and enhanced shared decision-making. A shift towards patient-centered care will mean defining success not just by the resolution of clinical conditions, but also by whether patients achieve their desired health outcomes.

Goal 2 – Foundational Principles

Eliminate disparities

- Ensure the use of culturally, linguistically, and ability-appropriate patient and family educational materials
- Tailor patient self-management education and support programs to minority and underserved populations

Enhance infrastructure and data systems

- Use health information technology (IT) to ensure communication and collaboration between providers and patients, and families and caregivers
- Promote and support providers in creating health IT-enabled environments for their patients that are driven by data

Enable local innovations

- Encourage providers to develop innovative interventions to improve communication with patients and caregivers
- Reward health plans and providers that deploy effective patient-centric tools and resources

Foster learning organizations

- Improve quality measurement of patient and caregiver engagement and promote transparency in access to quality data
- Educate providers about self-management best practices and how to teach these best practices to patients

Goal 2: Strengthen person and family engagement as partners in their care

Objectives	Desired Outcomes
Ensure all care delivery incorporates patient and caregiver preferences	• Patients are partners at all levels of care • Care and treatment reflect the patient's personal values and goals • Coordination and communication occurs within and across care teams, including patients, families, and caregivers • Patient and family preferences are central in decision processes and implementation • Joint development of treatment goals and longitudinal plans of care • Information is updated and available for use by patients • Achievement of patient-centered goals that focus on prevention • Improved coordination and communication within and across organizations • Disparities in care are eliminated
Improve experience of care for patients, caregivers, and families	• Improved support for integrated care models • Expanded use of evidence-based services and primary care • Increased access to understandable health information • Improved promotion of community-clinical partnerships and services aimed at managing and improving care at the community level
Promote patient self-management	• Improved application of self-management practices in our programs • Improved visibility of self-management • Improved support for integrated care models • Increased access to understandable health information • Updated and available information for use by patients • Improved patient confidence in managing chronic conditions • A respectful, trustworthy, transparent healthcare culture

Goal 3: Promote effective communication and coordination of care

Strategic Result: Communication and care coordination is improved.

Poor coordination of healthcare can result in medication errors, unnecessary procedures and treatment, avoidable hospital admissions and readmissions, and other harms to patients, many of which increase costs. Most healthcare payment systems do not foster coordination or understanding of patient preferences, but instead pay for volume over value. Rewarding providers for doing more rather than for working together effectively compromises their ability to achieve the best outcomes for patients and communities.

Jencks et al. (2009) found that nearly 1 in 5 Medicare patients discharged from the hospital is readmitted within 30 days. Medication errors and poor communication between providers in the inpatient setting and other post-acute care settings are some of the key drivers for readmissions within 30 days. Readmissions are also a major source of patient and family stress and may contribute substantially to loss of functional ability, particularly in older patients. Yet some readmissions are unavoidable and result from inevitable progression of disease or worsening of chronic conditions. Current readmission rates hover at 18.8% for Medicare and 14.4% for all payers. CMS estimates that readmissions within 30 days cost the Medicare program more than $17 billion dollars annually.

Effective care coordination models can often deliver better healthcare quality at lower costs in settings that range from small physician practices to large hospital centers. Gaps and duplication in patient care delivery can be reduced or eliminated through proven technologies such as interoperable electronic health records, e-prescribing, and telemedicine.

CMS encourages care coordination across the healthcare continuum and supports providers to care for patients with chronic diseases so they get seamless and effective care. Hospitals, long-term care and rehabilitation facilities, and community-based long-term services and support providers—along with physicians, nurses, and other clinicians working together—are helping recently discharged patients avoid unnecessary re-hospitalization. CMS promotes this patient-centered approach to care and recognizes the downstream effects of having or not having certain critical pieces of information communicated across providers and settings.

Examples of CMS initiatives that further this goal include:
- Partnership for Patients initiative
- Advancing primary care services and medical homes
- Promoting the development of Accountable Care Organizations (ACOs) for providers to better coordinate care
- Electronic Health Record Incentive Program
- Integrating care for populations and communities within the QIO 10th Scope of Work (SoW)
- Bundled payment initiatives
- Financial alignment initiative to integrate care for Medicare-Medicaid enrollees
- Medical health homes

When all of a patient's healthcare providers coordinate their efforts, it helps ensure that the patient gets the care and support s/he needs and wants, when and how s/he needs and wants it. Improved care coordination and communication across providers and healthcare facilities are essential to realizing the goals of better healthcare and lower costs.

Goal 3 – Foundational Principles

Eliminate disparities

- Ensure that health information is culturally and linguistically appropriate and that patients and caregivers understand instructions given upon discharge
- Enable effective healthcare system navigation by empowering patients and families through educational and outreach strategies that are culturally, linguistically, and health literacy-appropriate

Enhance Infrastructure and data systems

- Build and apply data systems to facilitate coordination of care across the healthcare continuum
- Use health IT to support effective healthcare system navigation for patients, families, and caregivers

Enable local innovations

- Encourage use of community health workers and other community-based professionals to support patient and family activation and healthcare system navigation
- Promote the use of community-based organizations to facilitate post-hospitalizations services for patients

Foster learning organizations

- Encourage analysis of program performance data and use of Plan-Do-Study-Act (PDSA) model http://www.ihi.org/knowledge/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx in the design and implementation of initiatives to reduce readmissions and improve care transition
- Improve measurement of effective care transitions and promote transparency and access to data

Goal 3: Promote effective communication and coordination of care

Objectives	Desired Outcomes
Reduce admissions and readmissions	• Patient self-management and activation efforts result in reduced admission and readmission rates • Increased health literacy rate • Survey results demonstrate measurable reduction in deficiencies related to discharge planning and transitions of care • Evidence-based best practices that promote appropriate discharge planning and care transition are embedded in the routine practice of care across the healthcare continuum • Appropriate interventions prevent development of health conditions that require acute care • Wasteful expense from avoidable admissions and readmissions is reduced drastically • All those who provide care in a particular community work in coordination to optimize patient care
Embed best practices to manage transitions to all practice settings	• Integrated, patient-centric discharge tools are used across all practice settings • Community-based support systems integrated with healthcare delivery (e.g., National Long-term Care Ombudsman's Resource Centers, senior centers, faith-based organizations, etc.) are developed and employed • Patient activation efforts/self-management training are a standard part of care
Enable effective healthcare system navigation	• Evidence-based best practices that enable patient activation/self-management are embedded in the routine practice of care (e.g., certified diabetes educators) • Payer reimbursement is expanded beyond traditional patient education to include chronic disease self-management education programs • Cross-setting discharge planning tools that include patient/family goals and preferences are routinely employed

Goal 4: Promote effective prevention and treatment of chronic disease

Strategic Result: Leading causes of mortality are reduced and prevented.

More than 133 million Americans have at least one chronic illness, and many Americans have several. Cardiovascular disease, the most deadly chronic illness accounting for one in three deaths in the United States, costs over $503 billion in treatment annually. Likewise, one in three American adults is obese, a condition that increases the risk of heart disease, stroke, Type 2 diabetes, and certain types of cancer. Medical costs associated with obesity are estimated to be nearly $150 billion per year.

As individuals and health systems feel the strain of treating individuals with chronic disease, healthcare providers must to do a better job preventing, screening for, and treating the leading causes of mortality and illness in adults and children, including cardiovascular disease, cancer, stroke, diabetes, premature births, and behavioral health conditions.

CMS strives to make preventive healthcare services accessible and affordable, and thus reduce healthcare costs. We are working to serve our beneficiaries and other stakeholders by:

- Working with providers, states, partner agencies, and stakeholder groups to increase awareness of preventive healthcare services available to Medicare, Medicaid, and CHIP beneficiaries, and all Americans

- Reducing disparities in access to and utilization of primary and specialty healthcare, preventive services, and reducing disparities in care for at-risk and special needs populations

- Improving the use of data for monitoring and continuous improvement in population health by aligning population health programs and metrics so that prevention can be tracked

- Improving access to coordinated services so that prevention-focused healthcare and community prevention efforts are available, integrated, and mutually reinforcing

- Strengthening links between public health and clinical care

- Creating systems to allow for health information exchange across providers and settings

- Creating access to information about insurance options for individuals

For example, CMS is a lead partner in the Million Hearts initiative, which seeks to reduce the incidence of heart attacks and strokes by 1 million by 2017. This will be accomplished by increasing awareness of the risk factors for cardiovascular disease and promoting and utilizing proven interventions. Decades of research and practice have demonstrated that public health and clinical preventive strategies can greatly reduce the risk of cardiovascular disease. The key interventions are referred to as the "ABCs": appropriate aspirin therapy, blood pressure control, cholesterol management, and smoking cessation.

CMS has incorporated and continues to incorporate prevention measures in their quality reporting programs related to the Surviving Sepsis Campaign, Healthy People 2020, as well as screening and treatment for high blood pressure, high cholesterol, smoking cessation, and aspirin use for individuals with ischemic heart disease. Moreover, Medicaid provisions such as Health Homes, Adult Healthcare Quality Measures, and the Program for All-inclusive Care for the Elderly (PACE) (for Medicare and Medicaid enrollees) facilitate achievement of these goals.

Goal 4 – Foundational Principles

Eliminate disparities

- Coordinate with existing initiatives and focus new initiatives on improving access to utilization of preventive services in lower income and minority communities (e.g., self-management initiatives)
- Study effectiveness of prevention initiatives in minority communities
- Promote education of health professionals about disparities in chronic disease incidence and care

Strengthen infrastructure and data systems

- Use health information technology (e.g., electronic health records, data management systems) to support the integration of clinical preventive services and community prevention
- Implement and test value-based payment models for the treatment and management of chronic disease

Enable local innovations

- Encourage public health and primary care integration at the local level (community, hospital, provider network), so that prevention initiatives are tailored to the needs and conditions of the local population
- Identify ways to align state and federal level activities to support local integration of prevention efforts (e.g., How can CMS and CDC work more effectively together to enable and encourage local innovation around prevention and primary care/public health integration?)

Foster learning organizations

- Support clinician and health worker education about multiple chronic conditions, population health,
self-management tools, and strategies for effective coordination among clinical and community preventive services
- Encourage multidisciplinary, cross-sector learning communities that bring together clinicians, other licensed providers, patients, caregivers, community health workers, urban planners, and other community stakeholders

Goal 4: Promote effective prevention and treatment of chronic disease

Objectives	Desired Outcomes
Increase appropriate use of screening and prevention services	• Communities that promote health and wellness through prevention are created, sustained, and recognized • Prevention-focused healthcare and community efforts are available, integrated, and mutually reinforcing • Persons are supported in making healthy choices related to screening and prevention • Disparities in the use of screening and prevention services are eliminated, improving the quality of life for all Americans • Rates of primary, secondary, and tertiary prevention are increased
Strengthen interventions to prevent heart attacks and strokes	• Improved cardiovascular health through evidence-based community interventions • Expanded adoption of healthy lifestyle behaviors across the life span • Increased access to effective clinical preventive services in clinical and community settings • Improved care and quality of life for all Americans through the elimination of disparities Decreased rates of heart attacks and strokes
Improve quality of care for patients with multiple chronic conditions (MCCs)	• Individuals are empowered to use self-care management • Providers are equipped with tools, information, and other interventions that address MCC • Targeted research focused on individuals with MCCs and effective interventions is supported • Development of quality measures focused on MCC management and care for individuals with MCCs • Disparities of care are eliminated • Morbidity and mortality from MCCs are decreased

Objectives	Desired Outcomes
Improve behavioral health (BH) access and quality care	• Better use of mental health and substance abuse screens to identify, refer, and treat individuals with a BH condition • Increased use of electronic health records (EHRs) by BH providers to share information with primary care providers, and increased sharing of EHR data by primary care providers with BH providers • Individuals initially identified with a BH condition receive services within 30 days of screening/ identification • Better availability of evidenced-based practices for individuals with BH conditions • Reduced admission to inpatient facilities or emergency rooms of individuals with BH conditions (regardless of reason for admission)
Improve perinatal outcomes	• Reduced elective deliveries prior to 39 weeks (by induction or caesarian section) • Improved appropriateness and timeliness of perinatal care for all pregnant women • Decreased premature births • Improved inter-conception care

Goal 5: Work with communities to promote best practices of healthy living

Strategic Result: Best practices are promoted and disseminated in communities.

Health and wellbeing is influenced by many factors including individual behavior, access to health services, and the environment in which we live. Many environmental health hazards disproportionately affect low-income communities and individuals. For instance, excess mold, allergens, and lead contamination are more often found in low-income housing. Perceptions of safety affect the amount of time children and adults engage in physical activity outdoors. People with limited access to affordable, healthy foods, due to geography or transportation constraints, are less likely to consume the recommended amounts of fruits, vegetables, and whole grains.

Public health agencies, community planners, and social service organizations have taken on many of these issues at local, state, and tribal levels. But much of this work is disconnected from healthcare providers and systems due to lack of communication, knowledge gaps, and siloed payment systems.

Successful efforts to improve social determinants of health and access to appropriate healthcare rely on deploying evidence-based interventions through strong partnerships between local healthcare providers, public health professionals, community and social service agencies, and individuals. CMS is committed to building and strengthening relationships with partners at local, state, tribal, and federal levels to better link Medicare, Medicaid, and CHIP beneficiaries, and the providers that serve them, with communities and resources that support good health. In particular, CMS will encourage providers to partner with local and state public health improvement efforts so that Medicaid, Medicare, and CHIP enrollees can benefit from the high-quality, community-based programs and services that support healthy living. Such services may include exercise classes, self-management programs, health management support groups, lead abatement services, school-based health and fitness programs for youth, food assistance programs, farmers' markets, and tobacco cessation programs.

Other federal efforts underway to promote healthy living and healthy communities include:

- Let's Move!
- Safe Routes to School National Partnership
- CDC: Communities Putting Prevention to Work
- CDC: Community Transformation Grants program
- WIC Farmers' Market Nutrition Program/U.S. Department of Agriculture Senior Farmers' Market Nutrition Program
- The Surgeon General's National Prevention Strategy
- The Surgeon General's Call to Action to Promote Healthy Homes
- The White House's Neighborhood Revitalization Initiative
- Medicaid's Community First Choice Option
- CMS's Program for All-inclusive Care for the Elderly (PACE)

Goal 5 – Foundational Principles

Eliminate disparities

- Target environmental health initiatives, like lead abatement and asthma self-management programs, in lower income and minority communities that are disproportionately exposed to hazardous chemicals and allergens
- Evaluate effectiveness of initiatives aimed at addressing societal/social determinants of health
- Promote best practices that address societal/social determinants of health
- Promote education of health professionals regarding disparities in social and environmental determinants of health

Strengthen infrastructure and data systems

- Develop systems to facilitate and sustain coordination among community and government agencies that can affect social and environmental determinants of health
- Use health information technology (e.g., electronic health records, data management systems) to support the integration of public health and primary care

Enable local innovations

- Use the community health needs assessment (CHNA) process to engage partners across sectors to identify and prioritize community development opportunities to promote health
- Identify ways that better integration at state and federal levels can support local integration of resources that promote healthy communities (e.g., transportation, planning, education, and environment)

Foster learning organizations

- Support clinician and health worker education about population health and strategies for effective coordination among clinical and community preventive services
- Encourage multidisciplinary, cross-sector learning communities that bring together clinicians, other licensed providers, patients, caregivers, community health workers, urban planners, public health agencies, and other community stakeholders

Goal 5: Work with communities to promote best practices of healthy living

Objectives	Desired Outcomes
Partner with and support federal, state, and local public health improvement efforts	• Promote successful interoperability of health IT systems • Improve population health outcomes • Reduce disparities in health outcomes • Reduce healthcare costs through better coordination across health sectors
Improve access within communities to best practices of healthy living	• Children and adults have increased access to community-based preventive services • Evidence-based preventive services are widely shared and adopted by schools, families, and communities • Schools, families, and communities have the tools for promoting healthy living • Prevention-focused healthcare and community efforts are available, integrated, and mutually reinforcing
Promote evidence-based community interventions to prevent and treat chronic disease	• Promote effective diet, exercise or behavioral health habits that can ameliorate or control chronic diseases
Increase use of community-based social services support	• Patients are routinely connected to relevant services offered by community organizations • Improved integration of health infrastructure and social services

Goal 6: Make care affordable

Strategic Result: Quality care is affordable for individuals, families, employers, and governments.

Healthcare spending has grown at a faster rate than the economy has grown nearly every year for the last 30 years. Higher costs to patients lead to underutilization of appropriate care, greater financial burden on the sickest and most vulnerable, and increased burden on providers and payers. CMS is the largest payer of healthcare in the United States, providing health coverage for more than 100 million individuals—about one in three Americans. As a major payer, CMS has the ability to drive change in the system to reward high-value care.

Making sure the right care is delivered to the right person at the right time, every time, can also make care more affordable. Reducing costs goes hand-in-hand with the aims of expanding access, providing high-quality care, and promoting population health. Specifically, costs can be lowered by:

- Reducing medical errors and improving care coordination
- Investing in health IT
- Public reporting of cost and quality data
- Paying providers based on the quality and efficiency of care delivered
- Developing and promulgating clinical guidelines and quality standards
- Improving team management of complex patients with multiple comorbidities
- Increasing administrative efficiency

CMS will foster these strategies by:

1. Establishing common measures that will help assess the cost impact of new programs and payment systems
2. Improving data systems by establishing health information exchanges for administrative simplification
3. Making healthcare costs and quality more transparent to consumers and providers, enabling them to make better choices and decisions.

For example, the Medicare Shared Savings Program promotes the goal of reducing growth in expenditures for Medicare FFS beneficiaries while delivering high-quality care through outcomes-based payment arrangements that link incentives to quality performance and total costs of care in Medicare Parts A and B. Other initiatives include the Hospital Value-Based Purchasing program, which uses performance on clinical processes of care, outcomes, and patient experiences to determine hospital payments.

CMS must also improve its ability to manage cost information internally to better identify key drivers of high costs and to look for outliers. Such information can identify opportunities to implement policies that drive down costs and can also be linked with efforts to reduce fraud and abuse.

Goal 6 – Foundational Principles

Eliminate disparities

- Identify disparities in care through the use of claims data as well as clinical data from health information exchanges and other sources to recognize care patterns that do not adhere to established guidelines

Strengthen infrastructure and data systems

- Implement and test value-based payment models that link payment incentives to measures of cost and quality
- Support health IT adoption and health information exchanges to track patterns of care and patient outcomes, which can identify opportunities to reduce cost and improve quality
- Provide more frequent feedback on quality and cost data to providers to promote understanding of care patterns and gaps and to identify opportunities for improvement and care redesign

Enable local innovations

- Support the collection and interpretation of quality and cost data at the local level, which providers can use to target interventions for improving quality and reducing cost
- Support local providers in developing innovative ways to make cost information transparent and understandable to patients and consumers

Foster learning organizations

- Support health worker education about reducing inappropriate and unnecessary care, starting with treatments and tests highlighted in the Choosing Wisely® campaign
- Strengthen the availability and delivery of team-based primary care by supporting Learning and Action Networks and other community forums that can disseminate best practices and learn from high performers

Goal 6: Make care affordable

Objectives	Desired Outcomes
Develop and implement payment systems that reward value over volume	• Payment systems reward value over volume • New payment models lead to improved patient health • New outcome and patient experience metrics are used for payment determinations • Outcomes-based payment arrangements link incentives to quality measures • Provider administrative burden is reduced • Access to quality primary and team-based care is expanded • Reduced cost and increased quality in all settings of care
Use cost analysis data to Inform payment policies	• Routinely review cost data by line of service and region to determine practice patterns and to identify outliers • Improved analytic capacity to investigate cost drivers that inform payment model design and policies • Quality and cost data inform program integrity and fraud investigations Center for Program Integrity and other auditing and review capacities at CMS

CMS Quality Strategy
Implementation and Evaluation

Implementation and Evaluation

For CMS to manage its many healthcare quality improvement activities, quickly respond to new program priorities and requirements, and address an ever-growing workload with limited resources, we must excel at strategy management, strategic thinking, and action. This CMS Quality Strategy is designed as a tool to help CMS ensure that resources are directed towards quality improvement priorities, operational risks are immediately identified, employees are held accountable for meeting the agency's quality goals and desired outcomes, and performance is effectively measured and reported. The strategy is a living document that will evolve over time as initiatives are adjusted to meet the desired strategy outcomes and performance targets. The existing Quality Improvement Committee subgroup will continue working to develop an implementation plan and evaluation strategy.

Implementation

The implementation of the CMS Quality Strategy will begin as soon as the document is released. The full implementation plan will be developed after release. The Quality Improvement Committee subgroup will begin determining ownership of the various strategic objectives. These objective-led subgroups will convene small working groups to further develop and prioritize the initiatives and activities identified in the plan. They will then identify lead agents (implementers) and appropriate performance metrics for the priority activities.

Evaluation

CMS will develop a comprehensive, agency-wide process to define, capture, and report short-term performance measures and long-term performance outcomes as well as project milestones for all CMS Quality Strategy activities. Evaluation of this Quality Strategy has two main components: First, we must assess is the extent to which the planned activities are implemented at CMS over the next few years. Second, we must evaluate the impact and effectiveness of the quality improvement activities implemented throughout the national healthcare network. While the first component is primarily internal, the second is largely external and will rely on collaboration with many partners and stakeholders to develop, implement, and report performance data from a broad array of quality improvement activities across healthcare settings.

Reporting

The strategic planning process is ongoing. The CMS Quality Strategy will be revisited and updated annually. Performance targets will be evaluated quarterly. Planning and evaluation for each initiative will be built into its specific calendar.

To showcase our accomplishments and progress toward achieving CMS's strategic goals, the Quality Improvement Committee will issue periodic progress reports on the CMS Quality Strategy to feature progress on our performance compared to the strategic goals and to identify and address any mid-course strategy adjustments. A performance management framework will align the agency's progress on its strategic goals and objectives to the performance commitments for the senior executives responsible for moving those priorities forward. In turn, these expectations will be incorporated into the performance plans of managers and employees.

Consistent with the Government Performance and Results Act (GPRA) (P. L. 103-62), CMS has been on the forefront of using meaningful, outcome-oriented, public-facing performance measures that highlight fundamental program purposes and focus on the Agency's role as a steward of taxpayer dollars. We will solidify our commitment to achieving performance outcomes by developing a comprehensive and integrated approach to performance management that will directly support this plan as well as the CMS Strategy and the National Quality Strategy. This evolution is consistent with our commitment to achieve Enterprise Excellence (CMS Strategic Plan Goal 4) and embraces the best practices reflected in the GPRA Modernization Act of 2010 (GPRAMA) (P. L. 111-352).

Evaluation Methods

The evaluation of this ambitious quality improvement undertaking will require the use of multiple methods integrating quantitative and qualitative measures, process and outcome metrics, and innovative assessment strategies. The following sections describe some evaluation methods that will be used.

Rapid Cycle Data-driven Improvement

To meet the need for urgent improvement that the nation's healthcare system requires, CMS will conduct its quality work with a strong commitment to continuous review of data and rapid testing of new interventions. Rate of testing should be a crucial, primary concern for all CMS work to make delivery systems more effective and affordable. This will include a cross-program commitment to:

- Set one or two quantifiable, project-level goals with a deadline, preferably defined in terms of outcomes, against which progress can be tracked regularly

- Review data and respond to it—with tests of new solutions and ideas—every week

- Set up simple, interim measurement systems, based on self-reported data and sampling, that can be shared at the local level and are sufficient for the purposes of improvement (complementing summative evaluation approaches)

- Invest more in field-based learning than in other education methods used in the past, since it is more effective to support learning and exchange at the front lines where care is delivered

Formative Evaluation

Formative evaluation is conducted during and throughout a project to assess progress while a project is underway and to help agents and drivers identify ways to change activities to improve effectiveness. Formative evaluation questions include:

- What are the criteria for conducting formative evaluations of the effectiveness of goals and policies?

- What are the goals and objectives of the projects, and how well is CMS achieving them at this time?

- What will the Agency do with the information gathered during formative evaluation?

- What corrective actions should be taken based on the results of formative evaluation? This can include discontinuing project activities.

- To what extent does the progress align with the Strategic Plan's vision, mission, and values?

Summative Evaluation

Summative evaluation is conducted at the end of a project or project term to assess the impact of the initiative and the extent to which goals and objectives were realized. Summative evaluation questions include:

- What are the criteria for conducting summative evaluation of the effects of the strategy's goals and policies?

- To what extent have CMS's Operational Plan and various reports addressed the Strategic Plan?

- How can CMS use the data gathered from summative evaluation to inform the next cycle of strategic planning?

- How valid were CMS's tenets over the course of the Strategic Plan? Do they still apply, and if not, how and why should they be revised?

Sampling

Healthcare quality improvement work happens in real-world, complex contexts influenced by a myriad of uncontrolled forces. In these situations, the assumptions of classical sampling theory cannot be met, and meeting those assumptions would not be desirable. Therefore, judgment sampling is used for the majority of quality initiatives identified in this strategy. A judgment sample is a type of non-random sample based on the opinion of experts. Judgment sampling relies upon subject matter experts to select useful samples for learning about process performance and the impact of changes over time. In many cases, where the goal is to learn about or improve a specific process or system, judgment samples are the most convenient and economical approach as well as the most technically and conceptually appropriate approach.