The M.A.G.I.C. of LTC: Clinical Leadership Is Critical to Success!

Lisa Thomson, Vice President
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OBJECTIVES

- Review the health care shifts and initiatives driving change in post-acute care
- Understand the Three Pillars of tomorrow’s health care and the clinical leaders role for positive outcomes
- Describe the push for data driven quality outcomes, compliance history and importance as well as consumer engagement – the future of healthcare
- Identify 5 leadership strategies to implement change for positive outcomes

Health Care Shift
Post Acute Care Clinical Leadership
THE JOURNEY BEGINS…

Leadership Strategies

Success is not an Illusion!

It is M.A.G.I.C!
Success Is Not An Illusion

“M” Momentum of Change

Industry Landscape

- Trends and Health Care Reform
  - Post Acute Care Impact
- Reality Check
  - Operational Challenges
  - Impact on Consumers
  - Examples of Redesign in new environment
Challenges - Post Acute Care

- Government Unrest
- Reform of Health Care as we know
- Reimbursement Changes
- Increased Costs
- Regulatory Changes
- External Oversight

Challenges – Post Acute Care

Health Care Climate
Medicare Rate - Current

Medicare Rate (per 1,000 persons) by ZIP Code

Medicare is the Fastest-Growing Major Entitlement
CHANGE SINCE 2002 IN INFLATION-ADJUSTED DOLLARS (2012)

- **Social Security**: +36.8% from $565 billion to $773 billion
- **Medicare**: +67.7% from $285 billion to $478 billion
- **Medicaid**: +37.8% from $185 billion to $255 billion


Challenges - Post Acute Care

Nine of ten Medicare patients die of chronic diseases, and caring for them in their final six months of life absorbs one-third of all Medicare dollars. During that time, more than a third of chronically ill Medicare patients are treated by 10 or more doctors.
Government Response

Need to Reform Health Care!
• Decrease Costs
• Decrease Reimbursement
• Increase Quality
• Increase Access

Government Response

Patient Protection and Affordable Care Act (PPACA)
– Signed into effect March 23, 2010
– Reform Private Insurance
– Reform Public Insurance
– Improve coverage to those with pre-existing conditions
– Expand access to care
– Reduce long term costs of health care
– Significant legislative change!

Three Pillars: The Future of Health Care

Affordable Care Act

Quality and Performance
Consumer Engagement and Satisfaction
Compliance

National Quality Strategy
HR 4302
QAPI
HHS/CMS Strategic Plan/Triple Aim/Work Plans
OIG - Work Plans/Compendium
Fraud Prevention System
Health Care Reform Outcomes

Accountable Care Act (ACA)
- Link reimbursement to quality outcomes
- Move from Fee for Service to Bundled Payment methods
- Person Centered Care
- Consumer engagement and access to data

Destination: Quality + Value = Lower Cost

Start 2010

Arrival 2015 and beyond

Complex Health Care Environment
Innovation Center: A new engine for revitalizing and sustaining the Medicare, Medicaid and CHIP programs and ultimately to help to improve the healthcare system for all Americans.

- Flexibility and resources
- Test innovative care models
- Test innovative payments models

Accountable Care Organizations

- Approximately 522 accountable care organizations (ACOs) serving:
  - 15-17 percent of the U.S. population,
  - 46 to 52 million people.
- More than two thirds of the U.S. population now live in localities served by ACOs.

ACO - network of doctors, hospitals, and partners that share the responsibility for providing coordinated care to patients in order to limit unnecessary spending.

- Goal: Lower Health Care Costs, Increase Quality and Consumer Engagement!
- Those that save money while also meeting certain "quality targets" are entitled to keep a portion of the savings.

Dual Eligible Initiative: Reforming Medicaid

- Dual Eligibles as a Percent of State Medicare Populations, 2008
- National Average: 15% - 25%

- Dual Eligible Beneficiaries as a Percent of Medicare and Medicaid Enrollees and Spending, 2006

- Medicaid - 37 million beneficiaries
- Medicare - 11 million beneficiaries
- Total - 48 million beneficiaries

- Millions of dual eligibles are covered by both Medicare and Medicaid.
Medicaid Expansion

Current Status of State Medicaid Expansion Decisions, 2014

Medicaid Case Mix Increase

- 32 Case Mix States
- 18 Non-Case Mix States

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Accountable Care Act Initiatives

- Remember – Still in Effect
  - Sequestration
  - Across the board federal budget reductions
  - March 1/2013
  - State Survey Agencies are affected
    - S&C Memo 13-23-ALL
    - Revisit survey protocols
    - Special Focus Facility
      - Last chance – FINAL survey
    - Home Health Targeted Surveys
    - Complaint Investigations
Accountable Care Act Initiatives

Initiatives currently in motion
- Hospital Readmission Reduction Program
- Fraud and Abuse
- QAPI
- Corporate Compliance
- Bundle Payment Demonstration
- Community Based Services
- Enhancing Patient Safety

Accountable Care Act Initiatives

- Initiatives in motion
  - Dementia Initiative
  - Unnecessary Medications - Antipsychotic
  - Abuse prevention training updates
  - National program for background checks
  - Person Centered Care
  - Equalize certain payments between Inpatient Rehab and SNF
  - Health Information Technology

Accountable Care Act Initiatives

- Initiatives in motion
  - Expand Medicare and Medicaid sharing of information between entities – DATA!
  - Quality Initiatives – Benchmark data, standards of practice, compliance and set expectations for reimbursement
  - Bundle Payment methodology by 2017!
  - Medicare Value Based Purchasing
    - Performance based pay
    - Quality metrics
    - “P4P” models
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Accountable Care Initiatives

CMS Strategic Plan 2014

ACA Partner Initiatives
CMS and OIG Updates

CMS
QAPI Development
• POC to be aligned with QAPI approach
• Surveyors, regulatory guidance and QAPI – next steps
• Involve residents and families with QAPI

OIG Work Plan 2014
Medicare Part A Billing
• ¼ of all claims billed in error
• High Therapy RUGs vs Resident characteristics
Medicare Part B Billing
State Agency Verification of Deficiency Outcomes
• QoC and Safety
• Verifying POCs and actual quality outcomes
National Background Checks
Hospitalizations of nursing home residents for manageable and preventable conditions
• 25% of SNF Med A beneficiaries were hospitalized as a result of condition that to be manageable or preventable in SNF

HEALTH CARE QUALITY

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National Quality Strategy

Introduction

The Affordable Care Act (ACA) requires the Secretary of the Department of Health and Human Services (HHS) to establish a national strategy that will improve:

- The delivery of health care services
- Patient health outcomes
- Population health

The strategy is to concurrently pursue three aims:

1. **Better Care**: Improve the overall quality of care, by making health care more patient-centered, reliable, accessible, and safe.
2. **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.
3. **Affordable Care**: Reduce the cost of quality health care for individuals, families, employers, and government.

National Quality Strategy

- From the National Strategy for Quality Improvement in Health Care
  
- Guiding force in quality improvement efforts across the nation and health care entities
- Develop a national QAPI model
National Quality Strategy

- Adopts unified measures
- Across federal government, private sector, States, health systems and providers
- Gauge performance outcomes
- Create continuity
- Consistency between provider
- Creates a “buying Value” initiative (VBP)

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

LONG-TERM GOALS
1. Reduce preventable hospital admissions and readmissions.
2. Reduce the incidence of adverse health care-associated conditions.
3. Reduce harm from inappropriate or unnecessary care.
Priority 2: Ensuring that each person and family members are engaged as partners in their care

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

Priority 3: Promoting effective communication and coordination of care

LONG-TERM GOALS
1. Improve the quality of care transitions and communications across care settings.
2. Improve the quality of life for patients with chronic illness and disability by following a current care plan that anticipates and addresses pain and symptom management, psychosocial needs, and functional status.

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

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

Reducing costs must be considered hand-in-hand with the aims of better care, healthier people and communities, and affordable care.

The National Quality Strategy will foster strategies that reduce waste from undue administrative burdens and make health care costs and quality more transparent to consumers and providers, so they can make better choices and decisions.
New Health Care Environment

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Accountable Care Act Initiatives

ICD 9 to ICD 10 Transition

Education

Implementation

Preparation

Operational Readiness

Delayed: HR. 4302
H.R. 4302 – Protecting Access to Medicare 2014

- Sustainable Growth Rate – SRG
- “Doc” fix – repeals the 24% cut for Physicians
- Extension of Therapy Caps
- Extension of the two –midnight rule for acute care
- Skilled Nursing Facility Readmission Measure (10/1/15 – All Cause All condition hospital readmission factor must be specified by the Secretary phase in 2016 and beyond
- Public Reporting of SNF – Readmission and other performance measures

SNF Readmission Measure

NEW - Readmission Measure
- 10/1/15 – All-cause all-condition hospital readmission measure
- 10/1/16 – Resource Use Measure
  - Measure to reflect an all-condition risk adjusted potentially preventable hospital readmission rate for SNF
  - Quarterly feedback to SNF on performance from CMS
  - Public Reporting of readmission rate!

HR 4302 Components For SNF VBP

- SNF Performance Scores
- SNF Ranking Based on Performance Scores
- Readmission Rate – first measure
- Quality Measures – alignment with health care providers
- Value Based Incentive Payment
- Public Reporting
NEW Initiative!
Value Based Purchasing - VBP

Value = Quality
- Payment

HR 4203 – full implementation
10/2019

Kaufman Figure 1. Source: Kaufman, Hall & Associates, Inc.

Drivers and Effects of Value-Based Care

Hospital-Centric Model Today
- Physician and Clinical Services
- Prescription Services
- Home Health and Nursing/Home Care
- Other
- Coordinated Care Network

Population-Centric Model Tomorrow

New Era of Healthcare – Quality and Efficiency

The goal is to move providers into quadrant 4 – high quality and efficiency
VBP – Acute Care

Acute Care
- Affects payment for inpatient stays in 2,985 hospitals across the country
  - Quality Measures
  - Clinical Processes of Care
  - Outcomes of Care
  - Patient Care Experience – Satisfaction
  - Mortality
  - Efficiency
  - Penalties (HRRP, HAI, QM, Care Transitions, more)
  - Specific Dx and Bundled/Episodic payment

VBP It’s Not Going Away – Acute Care and SNF

SNF VBP Premise
- Quality Oversight
  - Broad infrastructure exists to support quality oversight
  - SNF prospective payment system (PPS),
    - Based on costs and resources
    - Does not provide strong incentives for furnishing high quality care
- CMS views implementation of a SNF VBP program as an important step in revamping how Medicare pays for health care services
- Move Medicare towards rewarding better value, outcomes, and innovations instead of the volume of services provided.

VBP – Acute Care and SNF Initiatives

SNF VBP Premise
- Using financial incentives to reward quality and improvement in health care
- VBP programs aim to hold providers accountable for the quality of care they provide to Medicare beneficiaries,
  - Promote more effective, efficient and high quality care processes, and address the variation in quality across care settings.


http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/SNF-VBP-RTC.pdf

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/SNF-VBP-RTC.pdf
VBP – Acute Care and SNF Initiatives

- SNF/VBP program will align with many of the Department of Health and Human Services (HHS) and CMS's efforts to improve coordination of care.
- CMS's plan to implement a SNF/VBP - consistent with the National Quality Strategy to promote health care that is focused on the needs of patients, families, and communities.
  - Better Care: Improve the overall quality of the health care system, by making health care more patient-centered, reliable, accessible, and safe.
  - Healthy People and Communities: Improve the health of the United States 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 health care for individuals, families, employers, and government.

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CMS: Steps to Design SNF VBP

1. Continuous Quality Improvement Framework - QAPI
2. Consider adoption of Structural measures related to EHR
3. Defining SNF/VBP Population (Medicare, Medicaid and other)
4. Enhanced Data Infrastructure and Validation process
5. Performance Scoring and Evaluation Model considerations (specific targets and overall improvement)
   a. MDS Measures
   b. Survey and Certification
   c. Staffing
5. Performance Scoring and Evaluation Model (continued)
   a. Readmission rates
   b. Satisfaction Surveys
   c. Five – Star Quality Rating
6. Funding Source/Performance Incentive Funds
7. Transparency and Public Reporting
8. Coordination across Medicare Payment System – Align with all other VBP programs

VBP is Around the Corner

“A” Assess Readiness
Assess Organizational Readiness

Assess Organization Systems
- Corporate Programs and Outcomes
- Facility specific protocols

Assess need to change
Benchmark internal systems for review
- Current status
- Industry standards
- Best practice approach

Identify opportunities

Assess Organizational Readiness

Assess Clinical Readiness
- Your Role
- Industry initiatives
- Market initiatives and expectations
- Quality Outcomes
  - Payer and External Expectations
  - Consequences
- Internal competency process
- Right People and Right Roles
Leadership Implementation Strategies

1. Clarify Change
   • Clear about why change is needed and being implemented
   • Work through with your team
   • Will change?…
     • Require unknown tasks
     • New relationships
     • New methods of working
     • Threats to current operations
     • New training or retraining
     • Right people in right roles (Resources and Capabilities)

Leadership Implementation Strategies

2. Build a case for change
   • Outline what organization will look like at end of change
   • Outline clear case – quantitative and qualitative needs
   • Assess Drivers for Change
   • Business as usual? Impact?
   • Barriers
   • Performance metrics in terms of business objectives
   • Link to vision of future if change is successful

Leadership Implementation Strategies

3. Communicate Need for Change
   • Your team at ALL levels needs to understand the need for change and respective roles
   • Communicate clear vision
     • Current State of organization
     • Desired future state
   • Define, document and specify the change
   • Anticipate and address staff responses to change
4. Develop Teams
   • Action oriented team
   • Mix of technical competencies, expertise, levels of seniority and informal leaders
   • Engage “Mavericks”
   • Appoint leads to streamline plan and actions for implementation

5. Identify Barriers
   • Acknowledge and address barriers
     • Organizational
     • Operational
     • Clinical
     • Organization Readiness
     • Training, Knowledge, Resources
     • Talent Management
   • Obstacles to Opportunities

After Internal Review, Determination of Readiness and Communicating Change.... Develop Quality and Implementation Strategy
   • Goals
     • Prioritize
     • Impact
   • Systems and tools needed to change processes
     • Resources applied or needed
     • Time frames
     • Approval/Agreement
“G” GO FOR THE GOLD
DATA AND QUALITY

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We are transforming Medicare from a passive payer, to an active purchaser of value
Tom Valuck, Assistant CMS Administrator

Quality Outcomes: Data

Quality Care + Data = Reimbursement
Data = Quality

Today's Healthcare!

One thing you can control to some degree is performance!

Data = Quality

Data and Performance
- Who is measuring your performance?
  - Customers, consumers, the facility
  - State, consumers, press/media
- How are you measuring your performance?
  - Quality Improvement processes
  - Consumer Surveys
  - External Surveys
  - Compliance History
Data = Quality

• Outcome data and performance
  – Industry and Regional Trends
  – Consumer Satisfaction
  – Quality Measures
  – MDS 3.0, OASIS C, Quality Initiatives
  – Hospital, Nursing Home, Home Care
  Compare websites
  – Regulatory data
  – Re admission Rates
  – Billing Data
  – Audit Data – MAC, RAC, ZPIC, UPIC

#1 Data Tool!

Long Stay Measures
One or More Falls with Major Injury
Self-report Moderate to Severe Pain
High-Risk Residents with Pressure Ulcers
Assessed and Appropriately Given the Seasonal Influenza Vaccine
Assessed and Appropriately Given the Pneumococcal Vaccine
Urinary Tract Infection
Loss Control of their Bowels or Bladder
Catheter Inserted and Left in Their Bladder
Physically Restrainted
Need for Help with Activities of Daily Living Has Increased
Loss Too Much Weight
Have Depressive Symptoms
Received An Antipsychotic Medication

Short Stay Measures
Self-report Moderate to Severe Pain
Pressure Ulcers that are New or Worsened
Assessed and Appropriately Given the Seasonal Influenza Vaccine
Assessed and Appropriately Given the Pneumococcal Vaccine
Received An Antipsychotic Medication

Leadership Strategies

• Determine Quality Profile: Assess Organization Data
• Review Internal Processes: Optimize Data
• Establish an Information Agenda for Planning
• Plan to handle “bad” or “inaccurate” data
  – “GIGO”
• Leadership today – Data Driven Decisions!

Your data is key to positive outcomes
Leadership Strategies

- Data Driven Decisions
  - Understand what the real business question is. (Who, What, Why, When, How)
  - Create an analysis plan with hypotheses.
  - Collect or review the "right" data
  - Gather insights
  - Make recommendations
  - Take action

Benchmarking Data

- Your organization’s performance is being compared, right now, to other facilities across town and across the country.
  - Hospital performance data is readily available
  - Gathering meaningful data is vital in the era of “pay for performance,” and payers and agencies are calling for more transparency in quality improvement data.
  - Need for benchmarking is growing
Benchmarking Data

Process of establishing a standard of excellence
- continuous process
- measure and compare processes with those of organizations that are leaders in a particular area

Comparing a business function or activity, a product, or an enterprise as a whole with that standard

Used increasingly by healthcare institutions
- Reduce expenses
- Simultaneously improve service quality

Part of Quality Improvement

Benchmarking Data

Four kinds of benchmarking:
- Internal: Functions within an organization are compared with each other
- Competitive: Business in the same market - provide a direct comparison of services
- Functional: Performed with organizations with similar function, but in a different business
- Generic

Benchmarking metrics usually classified:
- Productivity
- Quality
- Time
- Cost-related

Quality Benchmarks

Enterprise dashboards to track healthcare KPI

Hospital Score Card
www.hospitalcompare
Quality Benchmarks

Enterprise dashboards to track healthcare KPI

Hospital Score Card
www.hospitalcompare

Dashboards
- Internal
  - QAPI
  - Performance
  - Compliance
- External
  - Benchmark
  - Partners
  - Reimbursement
  - Outcomes
  - Consumer

Utilize Data for Quality Outcomes

- Facility
  - Strategic Positioning Readiness
  - Benchmark Data
  - Compare Data
    - Nursing Home Compare
      http://medicare.gov/nursinghomecompare
    - Hospital Compare:
      http://www.hospitalcompare.hhs.gov
    - Home Health Compare:
      http://medicare.gov/homehealthcompare
Facility Overall Goals
- Increase communication
- Efficiency and effectiveness
- Collaboration with partners
- Measure performance
- Reduce redundancy
- Determine roles and anticipated processes
- Improve patient outcomes
- Successful Care Transitions
- Consumer Satisfaction
- Achieve Goals and Vision – Sustainability!
- The New Way to do Business - QAPI

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Utilize Data for Quality Outcomes

Systemic Analysis and Systemic Action
Performance Improvement Projects
Design and Scope
Governance and Leadership
Quality of Care, Quality of Life, Resident Choice
“I” Improvement and Prevention – A Must!

Preparedness and Prevention

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  - National Quality Strategy
  - HR 4302
  - QAPI
  - OIG Strategic Plan/Triple Aim/Work Plan
  - OIG - Work Plans/Compendium
  - Fraud Prevention System
Partners (fight fraud and abuse, uphold the Medicare Program’s integrity, save and recoup taxpayer funds, and maintain health care costs and quality of care):

- Program Safeguard Contractors
- (PSCs)/Zone Program Integrity Contractors (ZPICs);
- Medicare Drug Integrity Contractors (MDICs);
- State and Federal law enforcement agencies, such as the
- OIG, Federal Bureau of Investigation (FBI), Department of
- Justice (DOJ), and State Medicaid Fraud Control Units (MFCUs);

Preparedness and Prevention
Centers for Medicare & Medicaid Services (CMS) Partners (continued):
- Medicare beneficiaries and caregivers;
- Senior Medicare Patrol (SMP) program;
- Physicians, suppliers, and other providers;
- Medicare Carriers, Fiscal Intermediaries (FIs), and Medicare
  Administrative Contractors (MACs) who pay claims and enroll
  providers and suppliers;
- Accreditation Organizations (AOs);
- Recovery Audit Program Recovery Auditors; and
- Comprehensive Error Rate Testing (CERT) Contractors.

Preparedness and Prevention

RAC  Recovery Audit Contractors
      — Medicare RACs
      — Medicaid RACs
ZPIC  Zone Program Integrity Contractors
      — PSC – Program Safeguard Contractor
MIC   Medicaid Integrity Contractors
MAC   Medicare Administrative Contractor
      — FI – Fiscal Intermediary (now MAC)
HEAT  Health Care Fraud Prevention and Enforcement Action Team (HEAT)
UPIC  Unified Program Integrity Contractor
Preparedness and Prevention

- High Risk Areas
- Sudden changes in billing
- Spikes in billing
- Compromised identities (provider/beneficiary)
- High error rates
- RUG changes or discrepancies
- Overpayments/underpayments

- Identified by CMS as being potentially at risk for improper Medicare payments.

Six PEPPER Target Areas

- Therapy RUGs with High ADLs
- Non-Therapy RUGs with High ADLs
- COT Assessment
- Ultrahigh Therapy RUGs
- Therapy RUGs
- 90+ Day Episodes of Care
Other Data Sources

- CASPER
  - Certification and Survey Provider Enhance Reporting system
- QIES
  - Quality Improvement and Evaluation System
  - ASAP
    - Assessment Submission and Processing System
- ASPEN
  - Automated Survey Processing Environment

Preparedness and Prevention

Strategies

- Internal and External monitoring
- Education/Knowledge
- Documentation
- Policies and Procedures
- Staffing – Right Roles

Monitor MAC and Government trends

www.oig.hhs.gov/reports/html
www.cms.hhs.gov/rac
www.cms.hhs.gov/tpc
www.cms.hhs.gov/cert
Preparedness and Prevention

OIG and fraud, https://oig.hhs.gov/fraud
OIG e-mail updates, https://oig.hhs.gov/contact.us
CMS Fraud Prevention Toolkit, which contains information for providers and information providers can give to beneficiaries, http://www.cms.gov/Outreach-and-Education/Outreach-Partnerships/FraudPreventionToolkit.html
OIG Advisory Opinions, https://oig.hhs.gov/compliance/advisoryopinions

Preparedness and Prevention

“C” Change and Innovation
Implementation

• Facility Overall Goals
  – Increase communication
  – Efficiency and effectiveness
  – Collaboration with partners
  – Reduce redundancy
  – Determine roles and anticipated processes
  – Improve patient outcomes
  – Care Transitions

Implementation

• Facility
  – Strategic Positioning Readiness
  – Benchmark Data
  – Compare Data
    • Nursing Home Compare
      http://medicare.gov/nursinghomecompare
    • Hospital Compare:
      http://www.hospitalcompare.hhs.gov
    • Home Health Compare:
      http://medicare.gov/homehealthcompare

Implementation and Innovation For Sustainability

  Preparation
  Operational Readiness Assessment
  Services
  Internal Systems
  Team composition
  Increase clinical competencies
  Validation and benchmark data
  Excellent outcomes – quality and financial
    Evaluate, reposition, partner and implement
Provider of Choice - Redesign

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<th>Clinical Competency</th>
<th>Operational Efficiency</th>
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<tr>
<td>Patient Centered</td>
<td>Innovative Care Delivery Approaches</td>
<td>Benchmark Performance</td>
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<tr>
<td>Customer Satisfaction</td>
<td>Access to Care and Services</td>
<td>Create demand</td>
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<td>Needs vs. Lifestyle</td>
<td>Diagnostic Capabilities</td>
<td>Specialty Programs</td>
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<td>Value Proposition</td>
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<td>Workforce Development</td>
<td>Robust Quality Systems and Monitoring</td>
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Sustainability and the future

Organizational Change Management

Communication | Education | Training | Support

Leadership

I KNOW | I CARE | I CAN | I DO
Awareness | Understanding | Commitment | Environment

Strategy

Vernacular Leadership

1st Century Principal

Infrastructure Leadership

Collaborative Leadership
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Success Is Not An Illusion
Create Your Own M.A.G.I.C.

M = Momentum
A = Assess Readiness
G = Go for the Gold! Data and Quality
I = Improvement and Prevention
C = Change and Innovation

As a leader you know the way, your go the way and you show the way. Lead and Learn - Create your own M.A.G.I.C!

Clinical Leadership – It’s Not An Illusion It’s M.A.G.I.C!
Thank You!
Lisa Thomson, Vice President
Pathway Health