

CREATING A CULTURE OF QUALITY: The Critical Role of Communication In Improving ESRD Patient Safety

A National Perspective

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A Very Special Thank You

*None of us got to where we are alone.
Whether the assistance we received was obvious
or subtle, acknowledging someone's help
is a big part of understanding the importance
of saying thank you.*

~ Harvey Mackay

**The National Strategy for
Quality Improvement in Health
Care
National Quality Strategy (NQS)**

The Commitment of the
Forum of ESRD Networks

HEALTH POLICY REPORT

Coordinating Care — A Perilous Journey through the Health Care System

Thomas Bodenheimer, M.D.

In the United States, 125 million people are living with chronic illness, disability, or functional limitation.¹ The nature of modern medicine requires that these patients receive assistance from a number of different care providers. Between 2000 and 2002, the typical Medicare beneficiary saw a median of two primary care physicians and five specialists each year, in addition to accessing diagnostic, pharmacy, and other services. Patients with several chronic conditions may visit up to 16 physicians in a year.² Care among multiple providers must be coordinated to avoid wasteful duplication of diagnostic testing, perilous polypharmacy, and confusion about conflicting care plans.

The particularities of American health care, with its pluralistic delivery system that features large numbers of small providers, magnify the number of venues such patients need to visit. Care must be coordinated among primary care physicians, specialists, diagnostic centers, pharmacies, home care agencies, acute care hospitals, skilled nursing facilities, and emergency departments. Within each of these centers, a patient may be touched by a number of physicians, nurses, medical assistants, pharmacists, and other caregivers, who also need to coordinate with one another. Given this level of complexity, the coordination of care among multiple independent providers becomes an enormous challenge.

Care coordination has been defined as “the deliberate integration of patient care activities between two or more participants involved in a patient’s care to facilitate the appropriate delivery of health care services.”³ Not only is care coordination needed among multiple providers, but coordination is also required between providers and patients and their families. Particularly for young children and elderly patients, the number of coordination relationships can multiply geometrically in the not-unusual case of three different provider organizations (with several caregiv-

ers in each organization) having to interact with a patient plus three distinct family members.

Care coordination is required when traditional continuity of care — the relationship between a single practitioner and a patient that extends beyond specific episodes of illness or disease⁴ — is lacking. Continuity and fragmentation of care can be viewed as opposite ends of a spectrum. In unusual cases in which continuity is nearly total, coordination is rarely needed. In the most common situation in which continuity is limited and care is fragmented, coordination is essential. This report assesses the quality of care coordination, lists barriers to coordinated care, and discusses some solutions to improve care coordination.

COORDINATING CARE — HOW ARE WE DOING?

Recent research strongly suggests that failures in the coordination of care are common and can create serious quality concerns. Table 1 lists several studies documenting some of these problems. For example, referrals from primary care physicians to specialists often include insufficient information, and consultation reports from specialists back to primary care physicians are often late and inadequate.^{5,6} When patients are hospitalized, their primary care physicians may not be notified at the time of discharge, and discharge summaries may contain insufficient information or never reach the primary care practice at all.¹¹ The studies listed in Table 1 do not comprise a rigorous review of the literature but provide examples of the kinds of difficulties in care coordination that patients and their families and caregivers face. In addition to research studies, the voices of patients and their families remind us that the coordination of their care among multiple providers is often flawed.¹⁷

National Quality Strategy

A brief history - 1

- **We must fundamentally change the ways in which we deliver care**
- 2008: National Quality Forum (NQF) convened the National Priorities Partnership
 - Public-private partnership of 28 → 52 organizations
 - *National Priorities and Goals: Aligning Our Efforts to Transform America's Healthcare. Washington, DC: National Quality Forum; 2008*
- Pillars – 3 Aims
 - Better care
 - Healthy people and communities
 - Affordable care
- Principles
 - Patient–centeredness and family engagement
 - Care for patients of all ages, populations, service locations and source of coverage
 - Elimination of disparities
 - Alignment of public and private sectors

National Quality Strategy

A brief history - 2

- **2010: ACA required HHS to develop a NQS**
 - improve delivery of healthcare services, patient health outcomes and population health
 - March 2011: *Priorities for the 2011 National Quality Strategy (collaboration with AHRQ)*
- **3 Aims**
 - Better care
 - Healthy people and communities
 - Affordable care
- **6 Priorities**
 - Making care safer
 - Patient and family engagement
 - Coordination of care and effective communication
 - Prevention and treatment for the leading causes of mortality
 - Promotion of best practices in communities for healthy living
 - Making quality care affordable by developing new healthcare models

National Quality Strategy

A brief history - 3

- September 2011: **Partnership for Patients (HHS)**
 - Patient Safety (reduce HAC)
 - Reduce 30 day re-admissions
 - **Forum joins and encourages all ESRD Networks to join**
 - Focus on “5 Diamond Safety Program” and HAI
- April 2012: 1st annual progress report to Congress
 - 3 Strategic Opportunities
 - National strategy for data collection, measurement and reporting
 - Develop infrastructure at the community level
 - Develop payment and delivery system reforms – VBP

National Quality Strategy

A brief history - 4

- October 2012: NQF convened the **Measures Application Partnership**
 - **“When all payers use the same measures, stakeholders have consistent information to gauge performance and outcomes, and providers have a lower reporting burden”**
 - Consensus based entity of 60+ public and private organizations
 - Families of measures across 4 topics
 - Safety, Care Coordination, CV conditions, DM
- 2012: **Buying Value initiative**
 - 19 private health purchasers and representatives
 - Leveraging work by the MAP
 - 35 measures
- July 2013: 2nd annual progress report to Congress
 - Alignment of measures across reporting programs
 - Aspirational targets for measures within the 6 priorities

National Priorities for Kidney Disease Prevention and Treatment - 1

- Fall 2011: Forum convenes a workgroup
- Embraces the NQS as a framework for action
- Engages CMS and all ESRD Program stakeholders
- “Maps” specific projects focused to the NQS
- Signs on with the Partnership for Patients
- 2011-2013: Focus of the Forum Quality Conferences are the NQS priorities
- 2013: CMS frames the 2013 ESRD Network SOW based on the NQS

National Priorities for Kidney Disease Prevention and Treatment - 2

- 2013: Forum in partnership with NRAA, creates the ESRD HIT Coalition
- Principles agreed upon for building a HIT Infrastructure specific to ESRD
- Scheduled meeting with ONC and CMS Oct 7, 2013 to discuss next steps (following 2 prior meetings)