Improving Renal Outcomes Collaborative

Demonstrating Value

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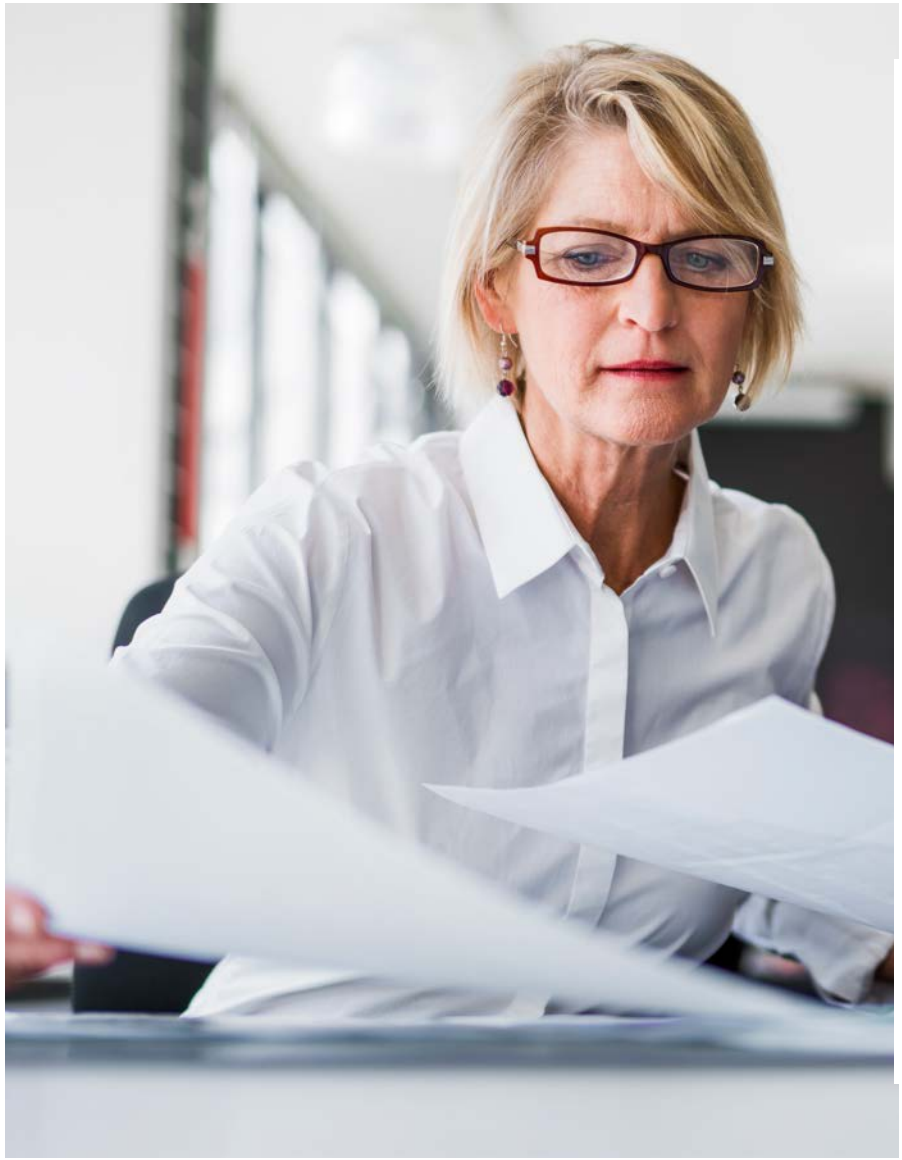
Demonstrating Value

1. Understand what the administrators want
   - Ethnography
2. Align yourself with core goals
   - Each of these hospitals declares that it is their mission to “provide the best care and achieve the best outcomes”
     - ? How do you know if you are providing the best care and achieving the best outcomes if you aren’t measuring care and outcomes and using that data to improve?
     - You get what you pay for
3. Tell a compelling patient centered stories focused on outcomes
4. Find early adopters and advocates within the medical center
   - Division chiefs, program directors, patients and families
   - “Partner” with them to ”find” the individuals who hold the purse
     - Hospital QI administration
     - Hospital Safety administration
     - Center within the hospital (e.g. transplant center)
     - Division (e.g. nephrology)
     - Research Foundation (internal grants)
     - Philanthropy
5. Ensure that you look at both the numerator and denominator: value = Quality/Cost
   - Need measures that address both quality and cost and that they are motivated to improve
     - Hospital admissions
     - ED visits
     - Procedures/adverse events

Teresa: The Program Administrator



What Teresa Needs

For practitioners and others who are impacted by her decisions to appreciate the underlying complexities, even if they disagree with the choice or result.

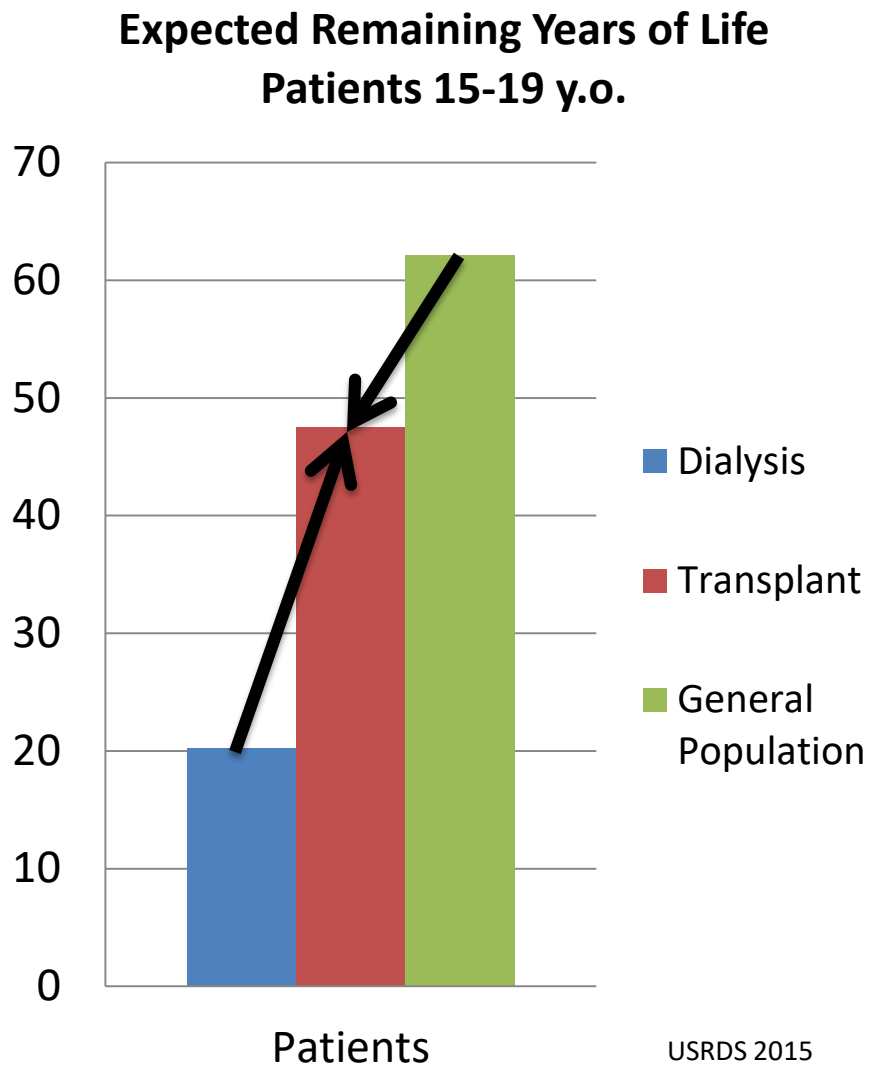
Both broad information and system-specific assessments to better inform future decisions.

Opportunities to see frequent and tangible results of her decisions as they play out in the care of children.

How We Might Serve Her

Provide quality information to promote best practices and inform continual quality improvement.

Spread communication about the complexities of significant decisions to help other understand, if not support, the results.



USRDS 2015

IROC
Improving Renal Outcomes Collaborative

To partner with ***patients*** with kidney disease and their ***caregivers*** to achieve ***health***, ***longevity*** and ***quality of life*** equivalent to the general population.

By harnessing the inherent ***motivation and expertise*** of ***all*** stake holders to ***improve*** care,
spawn ***innovation*** and conduct ***research*** that
improves ***health and outcomes***.

IROC Core Values

- Focus on **improving outcomes** as singular priority
- **Engagement** of all stakeholders: patients, families, clinicians, researchers, existing networks
- Culture of transparency, sharing and collaboration to **accelerate dissemination and implementation of ideas that work**
- **Effective use of technology** to efficiently capture learning from the point of care, and create a learning health system
- **Seamless integration of research with clinical care;** learn from every patient every day and implement research findings as they are generated
- **Core resources** to train, mentor, and support centers in local quality improvement efforts and to facilitate the **sharing and spread** of ideas that work

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IROC 2019 Clinical Improvement Aim

- To design and implement a ***system*** of ***co-production*** that will result in decreased acute rejection risk for thousands of children nationally, by identifying and addressing adherence barriers in clinic.
- By December 2020
  - Decrease Acute Rejection — Important and costly clinical outcome
  - Decrease ”for cause” biopsies — Quality of Life, Healthcare Utilization
  - Decrease biopsy and rejection related hospitalizations — Quality of Life, Healthcare Utilization

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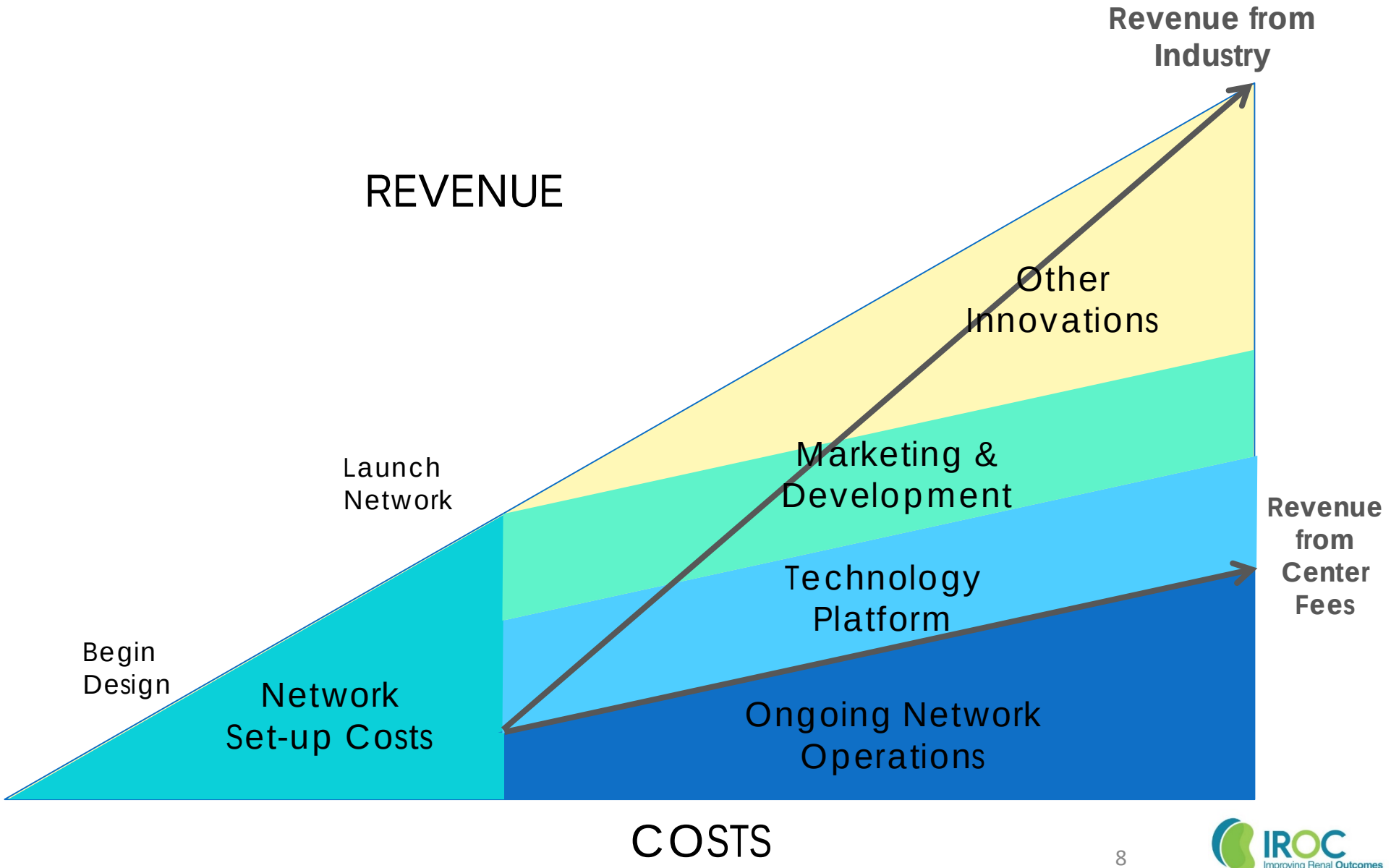
IROC Network Sustainability Model



Costs to Participating Centers

- Site participation fee ($20,000/year)
- Time: MD/RN leaders ~1-3 hrs./week; At least one other staff (MA/CRC, on average 10 hrs./week depending on program size)
- Local IT programming to configure electronic health record
- Travel to learning sessions
  - IROC covers travel/hotel for 1 non-physician staff and one parent
- Commitment/support from division/institutional leadership

Value to Participating Centers

- Improved outcomes for patients
  - Training in quality improvement and the Chronic Care Model® interventions
  - Tools to facilitate, streamline and improve the care you provide
  - Collaboration to share ideas, approaches, and tools
- Electronic data transfer ('data-in-once'), with automated reporting and decision support
  - Reduced effort, higher quality data
  - Advanced analytics to support clinical care and develop predictive models
- Accelerate generation of new knowledge through research
  - "Reagent Grade" practice exposes knowledge gaps and generates rich clinical data
  - Network allows for increased patient numbers for comparative effectiveness research
  - Central IRB, virtual biorepositories, linkage with data holders
- Regulatory/Payer
  - Meet some CMS Quality Assurance Process Improvement requirements
  - MOC Part 4 Credit
  - Positions centers for broad system change (Value-based care)

Value Based Payments are Coming

Value-Based Purchasing: Why Your Timeline Just Got Shorter


Bobbi Brown, Vice President of Financial Engagement

CMS made a bold announcement in January 2015: It plans to ramp up its timeline for transitioning Medicare from fee-for-service (FFS) payments to value-based reimbursement. For the first time, CMS is being incredibly specific about its timeline and methodology. It plans to take the following two actions:

- 30 percent of payments will be tied to alternative payment ACO or bundled payment arrangements by the end of 2016. Payments related to these models will increase to 50 percent by the end of 2018.
- 85 percent of all traditional Medicare payments will be tied to quality or value by 2016 and 90 percent by 2018 through programs such as Hospital Value Based Purchasing and Hospital Readmissions Reduction.

At about the same time, on the commercial front, a group of payers, patients, providers, and purchasers formed a value-based coalition with similarly aggressive goals. The coalition, which includes Aetna, Blue Cross, Health Care Services Corporation, Ascension Health, and Trinity Health, stated that 75 percent of their respective businesses would be operating under value-based payments by 2020.

https://www.healthcatalyst.com/value-based-purchasing-why-timeline-just-got-shorter, April 26, 2016

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Value Proposition

- Consider the cost of one failed allograft due to late rejection:
  - Most will be highly sensitized
  - Most will require months or years of dialysis which costs twice as much as transplant care for far worse outcomes
  - Most will require costly desensitization: IVIG, Rituximab, Pheresis, Bortezomib, other experimental therapies
  - All will require adherence/psychosocial interventions
  - Another kidney transplant will cost $80,000…
  - AND…

…. someone else's kidney

Questions?

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