Public Reporting &
The Quality Leader’s Role

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Manager
Quality, Safety, Performance Improvement

Objectives

After this session, attendees will be able to:

- State two reasons that CMS publicly displays healthcare quality measures
- Name one source for measure specifications
- For one outcome measured by the VBP program, name an approach to improvement
Agenda

Why do we have public reporting?

Measures and Financial Impact

Quality Leader Role

Strategy #1: Build a Case for Action and Explain “Why”

If you ask people to change, or to address quality outcomes, make it meaningful by explaining

WHY?
**American Healthcare 2013: Effective, if You Can Pay for the Waste and Duplication**

<table>
<thead>
<tr>
<th>Country Rankings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top 3</td>
</tr>
<tr>
<td>Middle</td>
</tr>
<tr>
<td>Bottom 3</td>
</tr>
</tbody>
</table>

**Overall Ranking (2013):**

- **Quality Care:**
  - Australia (AUS): 4
  - Canada (CAN): 9
  - France (FRA): 8
  - Germany (GER): 7
  - Netherlands (NETH): 6
  - New Zealand (NZ): 5
  - Norway (NOR): 4
  - Sweden (SWE): 3
  - Switzerland (SWITZ): 2
  - United States (US): 1

- **Safety Care:**
  - Australia (AUS): 4
  - Canada (CAN): 7
  - France (FRA): 9
  - Germany (GER): 6
  - Netherlands (NETH): 3
  - New Zealand (NZ): 1
  - Norway (NOR): 3
  - Sweden (SWE): 1
  - Switzerland (SWITZ): 4
  - United States (US): 3

- **Effective Care:**
  - Australia (AUS): 6
  - Canada (CAN): 8
  - France (FRA): 10
  - Germany (GER): 2
  - Netherlands (NETH): 1
  - New Zealand (NZ): 4
  - Norway (NOR): 6
  - Sweden (SWE): 8
  - Switzerland (SWITZ): 2
  - United States (US): 8

- **Patient-Centered Care:**
  - Australia (AUS): 7
  - Canada (CAN): 9
  - France (FRA): 2
  - Germany (GER): 10
  - Netherlands (NETH): 4
  - New Zealand (NZ): 7
  - Norway (NOR): 3
  - Sweden (SWE): 7
  - Switzerland (SWITZ): 6
  - United States (US): 1

- **Access:**
  - Australia (AUS): 2
  - Canada (CAN): 3
  - France (FRA): 7
  - Germany (GER): 10
  - Netherlands (NETH): 6
  - New Zealand (NZ): 10
  - Norway (NOR): 4
  - Sweden (SWE): 4
  - Switzerland (SWITZ): 1
  - United States (US): 2

- **Cost-Related Problems:**
  - Australia (AUS): 1
  - Canada (CAN): 4
  - France (FRA): 10
  - Germany (GER): 8
  - Netherlands (NETH): 9
  - New Zealand (NZ): 10
  - Norway (NOR): 8
  - Sweden (SWE): 7
  - Switzerland (SWITZ): 6
  - United States (US): 2

- **Timeliness of Care:**
  - Australia (AUS): 3
  - Canada (CAN): 10
  - France (FRA): 2
  - Germany (GER): 4
  - Netherlands (NETH): 6
  - New Zealand (NZ): 10
  - Norway (NOR): 9
  - Sweden (SWE): 7
  - Switzerland (SWITZ): 8
  - United States (US): 3

- **Efficiency:**
  - Australia (AUS): 10
  - Canada (CAN): 8
  - France (FRA): 9
  - Germany (GER): 6
  - Netherlands (NETH): 10
  - New Zealand (NZ): 7
  - Norway (NOR): 9
  - Sweden (SWE): 6
  - Switzerland (SWITZ): 8
  - United States (US): 3

- **Equity:**
  - Australia (AUS): 6
  - Canada (CAN): 10
  - France (FRA): 7
  - Germany (GER): 8
  - Netherlands (NETH): 9
  - New Zealand (NZ): 10
  - Norway (NOR): 4
  - Sweden (SWE): 7
  - Switzerland (SWITZ): 8
  - United States (US): 2

- **Healthy Lives:**
  - Australia (AUS): 2
  - Canada (CAN): 5
  - France (FRA): 7
  - Germany (GER): 3
  - Netherlands (NETH): 9
  - New Zealand (NZ): 4
  - Norway (NOR): 8
  - Sweden (SWE): 5
  - Switzerland (SWITZ): 6
  - United States (US): 1

**Source:** Commonwealth Fund. 2013.

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**U.S. Health Care Ranks Last Among Wealthy Countries**

A recent international study compared 11 nations on health care quality, access, efficiency, and equity, as well as indicators of healthy lives such as infant mortality.

**Overall Health Care Ranking**

- U.K.
- Switzerland
- Sweden
- Australia
- Germany
- The Netherlands
- New Zealand
- Norway
- Canada
- U.S.


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**Figure:** Commonwealth Fund. 2014.
But, We’re Healthier as a Nation, Right?

- No

EXHIBIT 8. HEALTHY LIVES MEASURES

<table>
<thead>
<tr>
<th>Raw Scores</th>
<th>Ranking Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aus</td>
<td>Can</td>
</tr>
<tr>
<td>Aus</td>
<td>Can</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**Global Benchmark Rankings**

- Mortality attributable to health care (deaths per 10,000)²
- Infant mortality (deaths per 1,000 live births)²
- Healthy life expectancy at age 60 (average of women and men)²

* 2005-06 World Health Organization (WHO) mortality data; Canada data from 2003-04. * Data not available for Switzerland. For more details on sources see the methodology appendix.

**CMS’ Goal for Partnership with Healthcare Centers**

Goal: To create a healthcare financing system that promotes joint clinical and financial accountability

Action: Adjust payment system toward rewards for value, outcomes, innovation

**What Gets Measured Gets Managed**

<table>
<thead>
<tr>
<th>VBP Economics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Health Management to Decrease Healthcare Spending</td>
</tr>
<tr>
<td>• Disease prevention</td>
</tr>
<tr>
<td>• Health improvement</td>
</tr>
<tr>
<td>Transforming the Delivery System to Reduce Waste/Increase Value</td>
</tr>
<tr>
<td>• Fragmented, inefficient, wide variation in quality and cost</td>
</tr>
<tr>
<td>• Current fee-for-payment system drives clinical delivery system</td>
</tr>
<tr>
<td>• Changing payment system will lead the transformation</td>
</tr>
</tbody>
</table>
Anticipated Reduction in Medicare Expenditure

<table>
<thead>
<tr>
<th>Health Care Reforms from the Affordable Care Act (2010)</th>
<th>Savings from Law’s enactment through 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing excessive Medicare payments to private insurers who operate in Medicare Advantage</td>
<td>$688 billion</td>
</tr>
<tr>
<td>Reforming provider payments, including improved productivity</td>
<td>$855 billion</td>
</tr>
<tr>
<td>Improving patient safety through the Partnership for Patients</td>
<td>$10 billion through 2013*</td>
</tr>
<tr>
<td>Cracking down on fraud and abuse in the Medicare system, and getting the best value for Medicare beneficiaries and taxpayers for durable medical equipment</td>
<td>$77 billion**</td>
</tr>
<tr>
<td>Additional provisions, including the net effect of expanded benefits, lowered payments for hospital acquired conditions, readmissions reductions, and adjustment to premium subsidies</td>
<td>$41 billion</td>
</tr>
</tbody>
</table>

* Amount shown represents the reduction in Medicare expenditures that could be achieved if the CMS goals for reducing readmissions and hospital-acquired conditions are met.

** Estimated savings for Medicare program integrity provisions in the Affordable Care Act; does not include other, ongoing CMS initiatives.


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Billions Paid to Hospitals and Providers to Incentivize More Efficient and Effective Care (EHR Program)

<table>
<thead>
<tr>
<th>State</th>
<th>Romania</th>
<th>MEXICO</th>
<th>MEXICO</th>
<th>TOTAL</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1,179,657</td>
<td>4,579,041,594</td>
<td>5,057,199,253</td>
<td>5,636,850,918</td>
<td>5,829,177,471,209</td>
</tr>
</tbody>
</table>

Electronic Health Record Program alone!


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**CMS Goals and Methods**

**Improve Quality, Outcomes and Experience**
- Incentivize evidence based care through “value based payments” and transparency of outcomes

**Reduce Cost**
- Actively purchase value (based on health outcomes), not passively purchasing on volume of services

**Improve Population Health**
- Expand coverage, effectively prevent and treat chronic disease and engage people in their own care


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**CMS Has Many Quality and Reporting Programs (991 Unique Measures!)**

**Hospital Quality Reporting**
- Medicare and Medicaid EHR Incentive Program
- PPS-Exempt Cancer Hospitals
- Inpatient Psychiatric Facilities
- Inpatient Quality Reporting
- I/HAC Payment Reduction Program
- Readmission reduction program
- Outpatient Quality Reporting
- Ambulatory Surgical Centers

**Physician Quality Reporting**
- Medicare and Medicaid EHR Incentive Program
- Physician Quality Reporting System (PQRS)
- Value-based Payment Modifier (VM)
- Maintenance of Certification

**PAC and OTHER Setting Quality Reporting**
- Inpatient Rehabilitation Facility
- Nursing Home Compare Measures
- LTCH Quality Reporting
- Hospice Quality Reporting
- Home Health Quality Reporting

**Payment Model Reporting**
- Medicare Shared Savings Program
- Hospital Value-based Purchasing
- Physician Feedback
- ESRD QIP
- Innovations Flits

**“Population” Quality Reporting**
- Medicaid Adult Quality Reporting
- CHIPRA Quality Reporting
- Health Insurance Exchange Quality Reporting
- Medicare Part C
- Medicare Part D

* = Public Reporting Focus for Hospitals/ CAHs/ Eligible Providers

### CMS Working to Align Metrics Across Programs

- Inpatient Quality Reporting (IQR)
- EHR Incentive Program (Meaningful Use)
- Physician Quality Reporting System (PQRS)
- Hospital Acquired Condition (HAC) Reduction
- Value Based Purchasing (VBP)
- Patient Experience (CAHPS/HCAHPS)
- Readmissions Reduction

### Local Needs, Mission, Efficiency

- **Tradeoffs between paying bills and paying for healthcare?**
  - High deductible plans

- **Meeting the mission to care for the community?**
  - Prevention
  - Access
  - Self management
  - Coordinated across the continuum

- **Is the patient the source of control?**
  - Does the provider arrival or the schedule run the OR?
  - Are clinics accessible, or is that why we have an ED?
Hospital Compare Shares Participating Hospital Data with Consumers

Source: www.Medicare.gov/hospitalcompare/

CMS Provides Transparency to Consumers
Access to Quality Scorecards Allows Consumers to Choose, and Better Hospital Systems to Profit

Insurers also Have Access to These Scorecards, In Some Cases, Slowing the Rate of Price Increases

- Newly available public data has been used by insurers
- The rate of price increases has slowed for some common procedures, placing pressure on hospitals
- As more people gain access to private insurance, negotiations between hospitals and insurers may intensify

Health Affairs. Jan 2015.
Commercial Payers Mimic CMS Measures to Move Toward Payment for Value, Not Just Volume

PG5 P4P Program Component Weights

- Health of the Community 30%
- Clinical Quality Indicators 30%
- Quality Initiatives 40%

- CMS Outpatient Measures:
  - OP – 4a
  - OP – 5a
  - OP – 18b
  - OP – 20

Payers target both rural/CAH & IPPS hospitals

CMS Public Reporting – Hospital Compare

- Value Based Purchasing Program
  - Clinical care - Outcome
  - Clinical care - Process
  - Inpatient Experience - HCAHPS
  - Safety – Complications, Healthcare Associated Infections
  - Payment (Medicare Spending per Beneficiary)

- Hospital Acquired Condition Reduction Program
- Readmission Reduction Program
- Additional measures: Emergency Care, Surgical Care, Medical Care, Imaging
CMS Public Reporting – Physician Compare

- CMS Hospital Compare
- CMS Physician Compare
- CMS Nursing Home Compare
- CMS Home Health Compare
- CMS Dialysis Compare

- PQRS
- Value Based Modifier

Practice Strategy #1

QD Role: If you ask people to change, or to address quality outcomes, make it meaningful from their perspective

Exercise: You have a new board member at your Board meeting tonight who asks:
- Why does CMS make us report publicly on the web?
- When would prospective patients actually use these data?
Strategy #2: Stay Up to date

Know where to locate information about VBP measures, benchmarks, and the current process

What Are Quality Measures?

Quality measures are tools that help us measure or quantify

- healthcare processes
- outcomes
- cost/value
- patient perceptions
- continuity of systems of care
“Do We Have to Report these Quality Measures?”

**IPPS Hospitals vs. Critical Access Hospitals**

**Acute Care Hospitals (IPPS)**
- Access full payment after withholds - IPPS Hospitals are financially impacted by VBP, HAC and Readmissions Reduction Programs
- Improve transparency with consumers
- Prioritize improvements

**Critical Access Hospitals (CAH)**
- No financial impact related to CMS Readmissions Reduction, HAC Reduction and Value Based Purchasing programs
- May voluntarily report quality measures for transparency, benchmarking, anticipation of future value based payment models
- Public reporting eligibility
  - Hospital must report at least four Hospital VBP measures during the performance period, minimum ten cases per measure
- Current exclusion from programs
  - Related, in part, to challenge with risk adjustment in remote areas and financial impact of withholds in low profit-margin hospitals

**Overview of Measure Categories**

**Hospital Compare (VBP, Readmissions, HACs)**
- Emergency Department
- Inpatient
- Outpatient
- Patient experience (HCAHPS)
- Medicare Spending Per Beneficiary (MSPB)
- Readmissions
- Healthcare Acquired Conditions (HACs)

**Physician Compare (PQRS)**
- Patient experience
- Care coordination
- Preventive care
- Care of the at-risk population
- Cost effectiveness
Resource 1: Quality Measure Specifications and Guidance Are Located on QualityNet.org

QualityNet Email Notifications

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### Core Measures - Compare Against the Top 10%

**Benchmark for Hospital-Abstracted Pneumonia (PN) - Fourth Quarter 2013**

*The benchmarks reported here are unrelated to the 95th percentiles that are published on Hospital Compare for individual measures.*

<table>
<thead>
<tr>
<th>Performance Measure Name</th>
<th>Benchmark Rate (%)</th>
<th>Numerator (Benchmark)</th>
<th>Denominator (Benchmark)</th>
<th>Number of Hospitals (Benchmark)</th>
<th>National Rate (%)</th>
<th>Numerator (National)</th>
<th>Denominator (National)</th>
<th>Number of Hospitals (National)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PN-3a: Blood Cultures Performed Within 24 Hours Prior to or 24 Hours After Hospital Arrival for Patients Who Were Transferred or Admitted to the ICU Within 24 Hours of Hospital Arrival</td>
<td>99.9</td>
<td>2,959</td>
<td>2,961</td>
<td>85</td>
<td>98.3</td>
<td>27,892</td>
<td>28,371</td>
<td>3,019</td>
</tr>
<tr>
<td>PN-3b: Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital</td>
<td>99.9</td>
<td>12,938</td>
<td>12,948</td>
<td>116</td>
<td>97.8</td>
<td>123,964</td>
<td>126,746</td>
<td>3,984</td>
</tr>
<tr>
<td>PN-6: Initial Antibiotic Selection for CAP in Immunocompetent Patients</td>
<td>99.9</td>
<td>8,412</td>
<td>8,424</td>
<td>141</td>
<td>95.8</td>
<td>76,949</td>
<td>80,322</td>
<td>4,088</td>
</tr>
</tbody>
</table>

**Note:**

- Benchmark Rate(%) are calculated using the Top 10% Sample.
- National Rate(%) is calculated using the 100% Eligible Sample.

**Acronym Description:**

- ICU = Intensive Care Unit
- CAP = Community Acquired Pneumonia

Source: QualityNet. Org, Benchmarks of Care
Resource 2: CMS and Measure Inventory Listing

- Measure name
- CMS program (e.g. IQR vs. VBP vs. PQRS vs. Hospital Compare)
- Numerator/ denominator
- Measure type (process, outcome, cost)
- Updated by CMS


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Hospital Compare Provides Data Collection Time Periods for All Measures

After looking up your hospital data on Hospital Compare, find these links to data details:

Source: http://www.medicare.gov/hospitalcompare/Data/Data-Updated.html

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VBP Time Periods: Patient Experience Example

|------------|------------------------------------------|--------------------------------------------|--------------------------------------------------|
Two “Point” Scores Are Calculated for Each Raw Score

**Achievement Points**
Awarded by comparing an individual hospital’s rates during the performance period with all hospitals’ rates from the baseline period.*
- Rate equal to or better than the benchmark: 10 points
- Rate worse than the achievement threshold: 0 points
- Rate equal to or better than the achievement threshold and worse than the benchmark: 1-10 points

**Improvement Points**
Awarded by comparing an individual hospital’s rates during the performance to that same individual hospital’s rates from the baseline period.
- Rate equal to or better than the benchmark: 9 points
- Rate equal to or worse than the baseline period rate: 0 points
- Rate between the baseline period rate and the benchmark: 1-9 points

Final Point Scores Range from Zero to Ten

**Measure: PN Pneumococcal Vaccination**

50th Percentile Performance from Baseline Period

Hospital B Earns: 10 points for achievement performance exceeding the benchmark
Hospital B Score = 10 points on this measure

Top 10% Performance Level
**Assess Points Based on Scale and Proximity to Benchmark**

Hospital “B”

<table>
<thead>
<tr>
<th>Measure: PN Pneumococcal Vaccination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achievement Threshold</td>
</tr>
<tr>
<td>67</td>
</tr>
<tr>
<td>87 Benchmark</td>
</tr>
<tr>
<td>Score</td>
</tr>
<tr>
<td>Hospital B</td>
</tr>
</tbody>
</table>

Hospital B Earns: 10 points for achievement performance exceeding the benchmark

Hospital B Score = 10 points on this measure

**Hospital “I”**

<table>
<thead>
<tr>
<th>Measure: PN Pneumococcal Vaccination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achievement Threshold</td>
</tr>
<tr>
<td>47</td>
</tr>
<tr>
<td>87 Benchmark</td>
</tr>
<tr>
<td>Score</td>
</tr>
<tr>
<td>Hospital I</td>
</tr>
</tbody>
</table>

Hospital I Earns: 7 points for improvement

Hospital I Score = maximum of achievement improvement + 7 points on this measure

**Maximum number of points (10) because score is above benchmark**

**Receive the higher value of either achievement or improvement points (7)**

**VBP: FY 2017**

5% Clinical Care – Process

25% Clinical Care – Outcomes

20% Safety - AHRQ PSI Composite & NHSN

25% Patient & Caregiver Experience of Care - HCAHPS

25% Efficiency Measure - MSPB

100% Total

*Increase withhold from 1.75% to 2.00%*
# Clinical Care - Process Measures (5%)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Achievement</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMI – 7 a</td>
<td>Fibrinolytic w/in 30 minutes of hospital arrival</td>
<td>95.45%</td>
<td>100.00%</td>
</tr>
<tr>
<td>IMM – 2</td>
<td>Influenza Immunization</td>
<td>95.16%</td>
<td>99.77%</td>
</tr>
<tr>
<td>PC – 01</td>
<td>Elective Delivery Prior to 39 Completed Weeks Gestation</td>
<td>3.12%</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

Baseline Period – 1/1/13 to 12/31/13
Performance Period – 1/1/15 to 12/31/15

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# Clinical Care - Outcome Measures (25%)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Achievement</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>MORT – 30 – AMI</td>
<td>AMI</td>
<td>85.14%</td>
<td>87.16%</td>
</tr>
<tr>
<td>MORT – 30 – HF</td>
<td>HF</td>
<td>88.17%</td>
<td>90.39%</td>
</tr>
<tr>
<td>MORT – 30 – PN</td>
<td>PN</td>
<td>88.29%</td>
<td>90.81%</td>
</tr>
</tbody>
</table>

Baseline Period: 10/1/10 to 6/30/12
Performance Period: 10/1/13 to 6/30/15
### Patient & Caregiver Centered Experience of Care/Care Coordination (HCAHPS) (25%)

**Baseline Period - 1/1/13 to 12/31/13**  
**Performance Period – 1/1/15 to 12/31/15**

<table>
<thead>
<tr>
<th>Question</th>
<th>Floor Lowest</th>
<th>Achievement 50th Percentile</th>
<th>Benchmark Top 10%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicate with Nurses</td>
<td>58.14%</td>
<td>78.19%</td>
<td>86.61%</td>
</tr>
<tr>
<td>Communicate with Doctors</td>
<td>63.58%</td>
<td>80.51%</td>
<td>88.80%</td>
</tr>
<tr>
<td>Responsiveness of Staff</td>
<td>37.29%</td>
<td>65.05%</td>
<td>80.01%</td>
</tr>
<tr>
<td>Pain Management</td>
<td>49.53%</td>
<td>70.28%</td>
<td>78.33%</td>
</tr>
<tr>
<td>Communication about Medication</td>
<td>41.42%</td>
<td>62.88%</td>
<td>73.36%</td>
</tr>
<tr>
<td>Hospital Cleanliness and Quietness</td>
<td>44.32%</td>
<td>65.30%</td>
<td>79.39%</td>
</tr>
<tr>
<td>Discharge Information</td>
<td>64.09%</td>
<td>85.91%</td>
<td>91.23%</td>
</tr>
<tr>
<td>Overall Hospital Rating</td>
<td>35.99%</td>
<td>70.02%</td>
<td>84.60%</td>
</tr>
</tbody>
</table>

### Safety Measures (20%) – Part I is PSI

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Achievement</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSI – 90</td>
<td>Patient Safety for Selected Indicators</td>
<td>77.79%</td>
<td>54.78%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Description</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSI – 03</td>
<td>Pressure Ulcer</td>
<td>13.57%</td>
</tr>
<tr>
<td>PSI – 06</td>
<td>Iatrogenic Pneumothorax</td>
<td>6.14%</td>
</tr>
<tr>
<td>PSI – 07</td>
<td>CLABSI</td>
<td>8.31%</td>
</tr>
<tr>
<td>PSI – 08</td>
<td>Postop Hip Fx</td>
<td>0.05%</td>
</tr>
<tr>
<td>PSI – 12</td>
<td>Postop PE or DVT</td>
<td>22.09%</td>
</tr>
<tr>
<td>PSI – 13</td>
<td>Postop Sepsis</td>
<td>5.36%</td>
</tr>
<tr>
<td>PSI – 14</td>
<td>Postop Wound Dehiscence</td>
<td>1.59%</td>
</tr>
<tr>
<td>PSI – 15</td>
<td>Accidental Punctures/ Laceration</td>
<td>42.89%</td>
</tr>
</tbody>
</table>
### Safety Measures – Part II is NHSN

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Achievement</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAUTI</td>
<td>Catheter-Associated Urinary Tract Infections</td>
<td>0.8450</td>
<td>0.0000</td>
</tr>
<tr>
<td>CLABSI</td>
<td>Central Line-Associated Blood Stream Infections</td>
<td>0.4570</td>
<td>0.0000</td>
</tr>
<tr>
<td>SSI – Colon</td>
<td>Surgical Site Infection – Colon</td>
<td>0.7510</td>
<td>0.0000</td>
</tr>
<tr>
<td>SSI – Abdominal Hysterectomy</td>
<td>Surgical Site Infection – Abdominal Hysterectomy</td>
<td>0.6980</td>
<td>0.0000</td>
</tr>
<tr>
<td>C. Difficile</td>
<td>Clostridium Difficile</td>
<td>0.7990</td>
<td>0.0000</td>
</tr>
<tr>
<td>MRSA</td>
<td>Methicillin Resistant Staph Aureus</td>
<td>0.7500</td>
<td>0.0000</td>
</tr>
</tbody>
</table>

**Baseline Period** 1/1/13 to 12/31/13  
**Performance Period** 1/1/15 to 12/31/15

### Efficiency Measures – 25%

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Achievement</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSPB – 1</td>
<td>Medicare Spending Per Beneficiary</td>
<td>Median MSPB ratio across all hospitals during the performance period</td>
<td>Mean of the lowest decile of MSPB ratios across all hospitals during the performance period</td>
</tr>
</tbody>
</table>

**Baseline Period: 1/1/13 to 12/31/13**  
**Performance Period: 1/1/15 to 12/31/15**
### Measure Types: As Process Becomes Reliable, Greater Focus on Outcomes and Efficiency

<table>
<thead>
<tr>
<th>Process</th>
<th>Outcome</th>
<th>Cost/ Efficiency</th>
</tr>
</thead>
</table>
| • Reflects adherence to provision of evidence-based care  
  • Example: *Aspirin administered for patient with chest pain* | • Reflects the results of care, rather than whether or not a specific treatment or intervention was performed.  
  • Examples: *30 Day Mortality for a patient with AMI, PN or HF*  
  • VBP Safety Measures - PSI-90 composite  
  • Readmissions  
  • HACs | • Reflects the cost of services provided for an episode of care or timeframe  
  • Example: *Cost of care for AMI encounter during hospitalization and 30d after* |

---

**QUALITY MEASURES IN THE ED AND OUTPATIENT SETTING**
Emergency Department Measures on Hospital Compare

- Measures reflect timely and effective care in the ED
  - ED volume
  - Wait time to see provider
  - Left without being seen - volume
  - Wait time to be admitted
  - Wait time for pain medication
  - Time spent in the ED
  - Stroke symptoms – CT result wait time

Outpatient Publicly Reported Measures (OPPS Hospitals)

- Outpatient Acute Myocardial Infarction (AMI)
- Chest Pain (CP)
- Emergency Department (ED) - Throughput
- Pain management
- Stroke
- Imaging efficiency

Up to 2% reduction of annual payment update factor if OPPS Hospital doesn’t participate or fails to meet reporting requirements

For more information on OPPS: http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1391250879084
QUALITY MEASURES IN THE HOSPITAL SETTING (VBP, HAC, READMISSIONS)

Hospital Compare Inpatient Measures

- List of measures updated annually, growing every year
- Currently visible Hospital Compare topics
  - HCAHPS: Patient experience
  - AMI, HF, PN care
  - Surgical care
  - IMM: Preventive care – influenza
  - Children's asthma care
  - VTE: Blood clot treatment and prevention
  - Elective Delivery before 39 weeks
  - AMI, PN, HF, COPD readmissions, mortality
  - HACs: Surgical complications and more
  - HAI: Central line, catheter, surgical, blood and C.diff infections
  - MSPB
11 HCAHPS Measures on Hospital Compare

- Composite measures
  - Communication with nurses
  - Communication with doctors
  - Staff responsiveness
  - Pain management
  - Communication about medicines
  - Discharge information
  - Care transition
- Individual items
  - Cleanliness of hospital environment
  - Quietness of hospital environment
- Global items
  - Recommend hospital
  - Overall hospital rating

HCAHPS Survey Administration

- Sample of adult inpatients (medical, surgical, maternity)
  - 300 responses/year minimum in IPPS hospitals
  - Sent 48 hours - 6 weeks post discharge by mail, telephone, interactive voice recognition
  - Data adjusted post-survey by CMS for survey mode or characteristics of patients beyond a hospital's control
- The HCAHPS survey should be administered prior to any other inpatient satisfaction survey
  - Hospital departments conducting own survey must not ask HCAHPS satisfaction questions
- HCAHPS reports were designed to compare between hospitals
  - Not designed to be used for comparisons of units or providers within hospitals
**Future: Pediatric HCAHPS**

- Survey was submitted to AHRQ and CMS in February 2014, piloted 2015
- 39 questions about inpatient experience
- Medicaid payments could be adjusted based on survey data in future years

---

**HCAHPS Public Reporting Based on “Top Box” & Stars**

- Patient survey summary star rating: More stars are better.
- **Top Box**
  - Patients who reported that their nurses “Always” communicated well
  - Patients who reported that their doctors “Always” communicated well

<table>
<thead>
<tr>
<th>H-CAHPS Scales</th>
<th>Always</th>
<th>Usually</th>
<th>Sometimes</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definitely Yes</strong></td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td>8</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td><strong>Never</strong></td>
<td><strong>Definitely No</strong></td>
<td><strong>4</strong></td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

---

http://pediatrics.aappublications.org/content/early/2015/07/15/peds.2015-0946
HCAHPS Star Ratings Began April 2015

• Why change?
  ▪ Consumers are the primary audience
  ▪ Make the ability to choose care simple and clear
  ▪ Incentivize providers to retain current patients and attract new patients

• Star ratings computed from minimum of 100 surveys
  ▪ Includes full range of scores, not just “top box”
  ▪ Includes CAH and IPPS hospitals
  ▪ Survey responses converted to a score from 0-100
    ▪ E.g. “never” = 0, “sometimes” = 33.3, “usually” = 66.6, “always” = 100
    ▪ E.g. “yes” = 100, “no” = 0
  ▪ If fewer than 100 received, information is published without star ratings
  ▪ Stars do not impact VBP calculations

HCAHPS: Example Calculation of Star Rating

<table>
<thead>
<tr>
<th>HCAHPS Composite Measures</th>
<th>9 Star Ratings Used in HCAHPS Summary Star Rating</th>
<th>HCAHPS Summary Star Rating Averaged (rounded)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication with Nurses</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Communication with Doctor</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Responsiveness of Staff</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Pain Management</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Communication about Medications</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Discharge Information</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Care Transition</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>HCAHPS Individual Items</td>
<td>5 (5+5)/2</td>
<td>5</td>
</tr>
<tr>
<td>Cleanliness of Hospital Environment</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Quietness of Hospital Environment</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>HCAHPS Global Items</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Overall Hospital Rating</td>
<td>3</td>
<td>3.5</td>
</tr>
<tr>
<td>Recommend the Hospital</td>
<td>3</td>
<td>3.5</td>
</tr>
</tbody>
</table>

• Overall hospital rating is based on just one question
• HCAHPS Summary star rating is based on ALL included questions
• These two scores may or may not be the same

**Stroke Measures Assess the Process of Care**

- Measures a hospital’s adherence to evidence-based intervention for stroke
  - Timely medications for ischemic stroke
  - VTE prevention for ischemic and hemorrhagic stroke in the hospital and at home
  - Statin prescriptions when indicated
  - Patient education
  - Stroke rehabilitation assessment

---

**Your Neighbor, Your Parents, Your Community All Have Access to Death Rate Comparisons**

<table>
<thead>
<tr>
<th></th>
<th>KNOX COMMUNITY HOSPITAL</th>
<th>U.S. NATIONAL RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of unplanned readmission for heart attack patients</td>
<td>No Different than U.S. National Rate</td>
<td>18.3%</td>
</tr>
<tr>
<td>Death rate for heart attack patients</td>
<td>No Different than U.S. National Rate</td>
<td>15.2%</td>
</tr>
<tr>
<td>Rate of unplanned readmission for heart failure patients</td>
<td>No Different than U.S. National Rate</td>
<td>23.0%</td>
</tr>
<tr>
<td>Death rate for heart failure patients</td>
<td>No Different than U.S. National Rate</td>
<td>11.1%</td>
</tr>
<tr>
<td>Rate of unplanned readmission for pneumonia patients</td>
<td>No Different than U.S. National Rate</td>
<td>17.0%</td>
</tr>
<tr>
<td>Death rate for pneumonia patients</td>
<td>No Different than U.S. National Rate</td>
<td>11.9%</td>
</tr>
<tr>
<td>Rate of unplanned readmission after hip/knee surgery</td>
<td>No Different than U.S. National Rate</td>
<td>5.4%</td>
</tr>
<tr>
<td>Rate of unplanned readmission after discharge from hospital (hospital-wide)</td>
<td>No Different than U.S. National Rate</td>
<td>16.0%</td>
</tr>
</tbody>
</table>
VBP Efficiency Data on Hospital Compare

Medicare Spending per Beneficiary (MSPB)
- Payment rate comparison
  - MSPB compares a hospital’s payment rates during the performance period with all hospitals’ rates from the performance period
- Inclusive time period
  - Includes all Medicare Part A and Part B claims paid during the period from 3 days prior to a hospital admission (i.e., index admission) through 30 days after discharge from the hospital

New: Payment for AMI, PN, HF patients
- Payments made on the first day of hospitalization through the following 30d
- Placed alongside the death rate for AMI, PN, HF
- Adjusted for differences that are not related to clinical care (e.g. population characteristics)


Hospital Acquired Conditions (HACs)
The HAC reduction program is designed to encourage hospitals to reduce the incidence of HACs
- Targeted conditions of high cost, high volume, or both
- Selected HACs chosen because they:
  - result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis
  - could reasonably be prevented through the application of evidence-based guidelines
Safety Measures Used in CMS VBP & HAC Reduction Program

- Each PSI measure is calculated by comparing actual, observed rates to predicted (expected) rates; combined into composite ratio & risk-adjusted
- “0” is the desired score
  - For example, a hospital with a CAUTI score of 0.5 represents higher quality than the national median (i.e., threshold) of 0.845

<table>
<thead>
<tr>
<th>Patient Safety Indicator Measure</th>
<th>(Combined into PSI-90 Composite Ratio)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSI 15 - Accidental Puncture or Laceration</td>
<td></td>
</tr>
<tr>
<td>PSI 12 - PostPE Or DVT</td>
<td></td>
</tr>
<tr>
<td>PSI 3 - Decubitus Ulcer</td>
<td></td>
</tr>
<tr>
<td>PSI 7 - Selected Infection Due to Medical Care</td>
<td></td>
</tr>
<tr>
<td>PSI 6 - Iatrogenic Pneumothorax</td>
<td></td>
</tr>
<tr>
<td>PSI 13 - Postop Sepsis</td>
<td></td>
</tr>
<tr>
<td>PSI 14 - Postop Wound Dehiscence</td>
<td></td>
</tr>
<tr>
<td>PSI 8 - Postop Hip Fracture</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI</td>
<td>0.507</td>
<td>0.0000</td>
</tr>
<tr>
<td>CAUTI</td>
<td>0.845</td>
<td>0.0000</td>
</tr>
<tr>
<td>SSN Colonized</td>
<td>0.751</td>
<td>0.0000</td>
</tr>
<tr>
<td>SSN Abdominal Hernia</td>
<td>0.938</td>
<td>0.0000</td>
</tr>
<tr>
<td>Neonatal G. sepsis</td>
<td>0.750</td>
<td>0.0000</td>
</tr>
<tr>
<td>Neonatal NRS</td>
<td>0.750</td>
<td>0.0000</td>
</tr>
</tbody>
</table>

Readmissions Measures Are Expanding on Hospital Compare

- Includes unplanned readmission to an acute care hospital within 30 days of discharge and requires three years of discharge data and a minimum of 25 cases
- CMS calculates “excess readmissions” (hospital vs. national average)
- Hospital readmissions may cause undue suffering to patients and their families and may lead to significant increase in health care spending
- High readmission rates within 30-days of discharge from the hospitals may result from such factors as:
  - Complications from treatments received during a hospital stay
  - Inadequate treatment
  - Inadequate care coordination and follow up care in community
  - Unexpected worsening of disease after discharge from hospital

Initial program:
- AMI*
- HF*
- PN*

Additions:
- Total Hip*
- Total Knee*
- COPD*
- Stroke*
- Hospital Wide All Cause

Latest, July 2015:
- CABG

Source: http://www.qualitynet.org/docs/ContentServer?docid=121906955273&pagename=QnetPublic%2FPage%2FQnetTier3&c=Page
Hospital Readmission Score Is Listed for HF, AMI, PN, COPD, Hip/Knees

In October 2012, CMS began reducing Medicare payments for Inpatient Prospective Payment System hospitals with excess readmissions. Excess readmissions are measured by a ratio, by dividing a hospital’s number of “predicted” 30-day readmissions for heart attack, heart failure, pneumonia, hip/knee replacement, and COPD by the number that would be “expected,” based on an average hospital with similar patients. A ratio greater than 1 indicates excess readmissions.

More information on how payments are adjusted.
More on the calculations.

Hospital Readmissions Reduction Program Data

Source: http://www.medicare.gov/hospitalcompare/readmission-reduction-program.html

Scroll Across to Find the Count of Discharges, Readmission Ratio, and Expected Rate

Current date range: 7/1/2011 - 6/30/14

Hospital Readmissions Reduction Program

In October 2012, CMS began reducing Medicare payments for Inpatient Prospective Payment System hospitals with excess readmissions. Excess readmissions are measured by a ratio, by dividing a hospital’s number of “predicted” 30-day readmissions for heart attack, heart failure, pneumonia, hip/knee replacement, and COPD by the number that would be “expected,” based on an average hospital with similar patients. A ratio greater than 1 indicates excess readmissions.

More information on how payments are adjusted.
More on the calculations.

Hospital Readmissions Reduction Program Data

Source: http://www.medicare.gov/hospitalcompare/readmission-reduction-program.html
## VBP 2018 (Performance Period 2016)

### Safety (16% of Total Performance Score)

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Description</th>
<th>Baseline period</th>
<th>Performance period</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAUTI</td>
<td>Catheter-associated urinary tract infection</td>
<td>0.906</td>
<td>0.000</td>
</tr>
<tr>
<td>CLABSI</td>
<td>Central line-associated blood stream infection</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>C. difficile</td>
<td>Clostridium difficile infection</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>MRSA</td>
<td>Methicillin-resistant Staphylococcus aureus bacteraemia</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>SSI</td>
<td>Surgical site infection</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>PSN-10</td>
<td>Complications in patients requiring selected indicators comparable</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>PC-01</td>
<td>Elective delivery prior to 39 completed weeks of gestation</td>
<td>0.000</td>
<td>0.000</td>
</tr>
</tbody>
</table>

### Patient Experience of Care (26% of Total Performance Score)

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Description</th>
<th>CY 2016</th>
<th>FY 2017</th>
<th>Benchmark%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication with Nurse</td>
<td>86.85</td>
<td>80.65</td>
<td>80.65</td>
<td></td>
</tr>
<tr>
<td>Communication with Doctors</td>
<td>86.44</td>
<td>86.44</td>
<td>86.44</td>
<td></td>
</tr>
<tr>
<td>Responsiveness of Hospital Staff</td>
<td>86.69</td>
<td>88.00</td>
<td>88.00</td>
<td></td>
</tr>
<tr>
<td>Pain Management</td>
<td>79.20</td>
<td>79.20</td>
<td>79.20</td>
<td></td>
</tr>
<tr>
<td>Communication about Medications</td>
<td>73.89</td>
<td>73.89</td>
<td>73.89</td>
<td></td>
</tr>
<tr>
<td>Hospital-Centered Outcomes</td>
<td>78.36</td>
<td>78.36</td>
<td>78.36</td>
<td></td>
</tr>
<tr>
<td>Readmission Information</td>
<td>91.03</td>
<td>91.03</td>
<td>91.03</td>
<td></td>
</tr>
<tr>
<td>Care Transition</td>
<td>62.84</td>
<td>62.84</td>
<td>62.84</td>
<td></td>
</tr>
<tr>
<td>Overall Rating of Hospital</td>
<td>84.58</td>
<td>84.58</td>
<td>84.58</td>
<td></td>
</tr>
</tbody>
</table>

### Efficiency (26% of Total Performance Score)

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Description</th>
<th>CY 2014</th>
<th>CY 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIPR-1</td>
<td>Medicare spending per beneficiary</td>
<td>87,159</td>
<td>90,000</td>
</tr>
<tr>
<td>MIPR-2</td>
<td>Median MIPR ratio for all hospitals during performance period</td>
<td>88,088</td>
<td>90,000</td>
</tr>
</tbody>
</table>

### Clinical Care (25% of Total Performance Score)

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Description</th>
<th>Baseline period</th>
<th>Performance period</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHR-02-AH</td>
<td>Acute myocardial infarction (AMI) 30-day mortality rate</td>
<td>87,159</td>
<td>90,000</td>
</tr>
<tr>
<td>NHR-20-PR</td>
<td>Pneumonia (POe): 30-day mortality rate</td>
<td>88,088</td>
<td>90,000</td>
</tr>
</tbody>
</table>

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**Provider Measures**
Physician Compare Is a New Public Reporting Tool

- Part of the Physician Quality Reporting Program (PQRS)
- Applies to doctors, practitioners, and therapists in Medicare FFS systems
- Publicly reported measures will be available on Physician Compare
- Affects payments to individual providers in 2017, based on 2015 data

PQRS Domains

PQRS measures address six (6) NQS domains
  - Patient safety
  - Effective clinical care
  - Person and caregiver-centered experience and outcomes
  - Community/Population health
  - Communication and care coordination
  - Efficiency and cost reduction

NQS = National Quality Strategy
PQRS Eligibility

- Includes providers whose professional services are paid based on Medicare Physician Fee Schedule (MPFS)
- Does not include Federally Qualified Health Center (FQHCs) or Rural Health Clinics (RHCs)
- Applies to payment of groups of providers now
- Applies to payment of all eligible providers as of January 1, 2017 (based on 2015 data)


PQRS Eligible Professionals 2015

<table>
<thead>
<tr>
<th>Physicians</th>
<th>Practitioners</th>
<th>Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor of Medicine</td>
<td>Clinical Nurse Specialist</td>
<td>Qualified Speech-Language Therapist</td>
</tr>
<tr>
<td>Doctor of Podiatric Medicine</td>
<td>Physician Assistant</td>
<td>Physical Therapist</td>
</tr>
<tr>
<td>Doctor of Osteopathy</td>
<td>Nurse Practitioner</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>Doctor of Optometry</td>
<td>Certified Registered Nurse</td>
<td></td>
</tr>
<tr>
<td>Doctor of Oral Surgery</td>
<td>Anesthetist</td>
<td></td>
</tr>
<tr>
<td>Doctor of Dental Medicine</td>
<td>Anesthesiologist Assistant</td>
<td></td>
</tr>
<tr>
<td>Doctor of Chiropractic</td>
<td>Certified Nurse Midwife</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical Social Worker</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical Psychologist</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Registered Dietician</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nutrition Professional</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Audiologists</td>
<td></td>
</tr>
</tbody>
</table>

Note: Beginning in 2014, professionals who reassign benefits to a Critical Access Hospital (CAH) that bills professional services at a facility level, such as CAH Method II billing, can now participate (in all reporting methods except for claims-based). To do so, the CAH must include the individual provider National Provider Identifier (NPI) on their Institutional (FI) claims.

PQRS Reporting Options - 2015

- **Groups or Individuals**: 9 Measures, covering at least three National Quality Strategy (NQS) Domains and including one cross cutting measure:
  - Patient safety
  - Person and caregiver-centered experience and outcomes
  - Communication and care coordination
  - Effective clinical care
  - Community/ population health
  - Efficiency and cost reduction
  - Over 250 measures available

- **Individuals**: One complete Measures Group (20 patients)

- **Groups Using Web Interface**: For ACO or 25+ Eligible Providers, must report all **17 measures**

---

PQRS Reporting Options - 2016

- **Groups or Individuals**: 9 Measures, covering at least three National Quality Strategy (NQS) Domains and including one cross cutting measure:
  - Patient safety
  - Person and caregiver-centered experience and outcomes
  - Communication and care coordination
  - Effective clinical care
  - Community/ population health
  - Efficiency and cost reduction
  - 46 new measures added to the total list (total 281)

- **Individuals**: One complete Measures Group (20 Patients)
  - 3 new sets (total 25): Cardiovascular Prevention, Diabetic Retinopathy, and Multiple Chronic Conditions

- **Groups Using Web Interface**: For ACO or 25+ Eligible Providers, must report all **18 measures**
Specialty Measures Expand in 2016

Specialty Measure Sets

- Potential Cardiology Preferred Measure Set
- Potential Emergency Medicine Preferred Measure Set
- Potential Gastroenterology Preferred Measure Set
- Potential General Practice/Family Preferred Measure Set
- Potential Internal Medicine Preferred Measure Set
- Potential Multiple Chronic Conditions Preferred Measure Set
- Potential Obstetrics/Gynecology Preferred Measure Set
- Potential Oncology/Hematology Preferred Measure Set
- Potential Ophthalmology Preferred Measure Set
- Potential Pathology Preferred Measure Set
- Potential Radiology Preferred Measure Set
- Potential Surgery Preferred Measure Set

CMS has proposed five new Potential Specialty Measure Sets for 2016 PQRS

- Proposed Dermatology Preferred Specialty Measure Set
- Proposed Physical Therapy/Occupational Therapy Preferred Specialty Set
- Proposed Mental Health Preferred Specialty Measures Set
- Proposed Hospitalist Preferred Specialty Measures Set
- Proposed Urology Preferred Specialty Measures Set

Electronic Health Record Incentive Program (Meaningful Use)

Stage 2 Objectives

1. Protect Patient Health Information
2. Clinical Decision Support
3. CPOE
4. Electronic Prescribing (eRx)
5. Health Information Exchange
6. Patient Specific Education
7. Medication Reconciliation
8. Patient Electronic Access (VDT)
9. Secure Messaging (EPs only)
10. Public Health and Clinical Data Registry Reporting

- EHR/ Meaningful Use data will be available on Physician Compare
2016 PQRS Measure Specification and Measure Flow Guide for Claims and Registry Reporting of Individual Measures

Utilized by Individual Eligible Professionals for Claims and Registry Reporting and Clinical Practices Participating in Group Practice Reporting Option (GPRO) for Registry Reporting

11/27/15

2015 PQRS Pathways

I WANT TO PARTICIPATE IN 2015 PQRS FOR AVOIDING 2017 NEGATIVE PAYMENT ADJUSTMENT

SELECT REPORTING METHOD

[Refer to the 2015 Physician Quality Reporting System (PQRS) Implementation Guide for a listing of all 2015 measures and associated NQF taxonomy for a specific reporting method. Also refer to the appropriate measure specifications for the selected reporting methodology for 2015 PQRS]

Choose Claims-Based Reporting Options to Avoid 2017 PQRS Negative Payment Adjustment

[Diagram showing various options and pathways]


Proprietary & Confidential
Over 280 Measures on the 2015 Measure List

<table>
<thead>
<tr>
<th>Measure Title</th>
<th>Measure Number</th>
<th>Measure Description</th>
<th>NGS Domain</th>
<th>Reporting Methodology</th>
<th>Measure COD EMR</th>
<th>Reporting Methodology</th>
<th>Measure Group</th>
<th>Measure Group</th>
<th>Measure Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic Hemoglobin A1c Post Control (2015)</td>
<td>1224 0039</td>
<td>Percentage of adults ≥18 years of age with diabetes who achieved HbA1c level ≤7.0% during the measurement period</td>
<td>Effective Clinical Care</td>
<td>NLG/EMR</td>
<td>GPRD</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Diabetes - All List -</td>
</tr>
<tr>
<td>Diabetic Low Density Lipoprotein (LDL) Control (2015)</td>
<td>0953 0061</td>
<td>Percentage of patients ≥18 years of age with diabetes whose LDL cholesterol level ≤100 mg/dl during the measurement period</td>
<td>Effective Clinical Care</td>
<td>NLG/EMR</td>
<td>GPRD</td>
<td>X</td>
<td>-</td>
<td>-</td>
<td>Diabetes - All List -</td>
</tr>
<tr>
<td>Heart Failure (HF) Hospitalization (2015)</td>
<td>0953 0023</td>
<td>Percentage of patients ≥18 years of age with a diagnosis of heart failure in a hospital or a nursing facility who have a recent HF hospitalization and are discharged alive</td>
<td>Effective Clinical Care</td>
<td>NGS/EMR</td>
<td>GPRD</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Hospitalization - List -</td>
</tr>
<tr>
<td>Coronary Artery Bypass Surgery (2015)</td>
<td>0007 0086</td>
<td>Percentage of infants aged 18 years and older with a diagnosis of coronary artery disease who underwent CABG surgery within a 12-month period</td>
<td>Effective Clinical Care</td>
<td>NGS/EMR</td>
<td>GPRD</td>
<td>X</td>
<td>-</td>
<td>-</td>
<td>Coronary Artery Bypass Surgery - List -</td>
</tr>
</tbody>
</table>

Hospitalist Example: PQRS Measures Options

<table>
<thead>
<tr>
<th>PQRS #</th>
<th>Measure Title</th>
<th>NGS Domain</th>
<th>Reporting Methodology</th>
<th>Relevant CPT Codes in Measure Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>47</td>
<td>Advance Care Plan (2015)</td>
<td>Communication, Care Coordination</td>
<td>C, R</td>
<td>Hospital admission, follow-up, Observation admission.</td>
</tr>
</tbody>
</table>
PQRS Includes Three Payment Factors

1. PQRS Participation
   - Pay for reporting

2. Value Modifier
   - Payments or reductions related to quality/value of care provided (includes quality and cost as in the Quality-Tiering Methodology below)

3. Maintenance of Certification
   - For Board certified physicians


PQRS Providers in the Group Affect Measures, but currently, only the Physician Is Subject to the Value Modifier

<table>
<thead>
<tr>
<th></th>
<th>PQRS</th>
<th>Value Modifier</th>
<th>EHR Incentive Program</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Eligible for Incentive</td>
<td>Subject to Payment Adjustment</td>
<td>Included in Definition of &quot;Group&quot;</td>
</tr>
<tr>
<td>Medicare Physicians</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor of Medicine</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Doctor of Osteopathy</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Doctor of Podiatric Medicine</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Doctor of Optometry</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Doctor of Oral Surgery</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Doctor of Dental Medicine</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Doctor of Chiropractic</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Practitioners</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Assistant</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Certified Registered Nurse Anesthetist</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Certified Nurse Midwife</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Clinical Social Worker</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Clinical Psychologist</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Registered Dietitian</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Nutrition Professional</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Audiologists</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Therapists</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapist</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Group size is affected by all providers of care but the value modifier only affects physicians accepting Medicare payments currently (New: VM affects non physicians in 2018 and beyond)
PQRS Value Modifier for Quality-Tiering 2017

<table>
<thead>
<tr>
<th></th>
<th>Cost/Quality</th>
<th>Low Quality</th>
<th>Average Quality</th>
<th>High Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual providers &amp; groups under 10</strong></td>
<td>Low Cost</td>
<td>+0.0%</td>
<td>+1.0x*</td>
<td>+2.0x*</td>
</tr>
<tr>
<td></td>
<td>Average Cost</td>
<td>+0.0%</td>
<td>+0.0%</td>
<td>+1.0x*</td>
</tr>
<tr>
<td></td>
<td>High Cost</td>
<td>+0.0%</td>
<td>+0.0%</td>
<td>+0.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Cost/Quality</th>
<th>Low Quality</th>
<th>Average Quality</th>
<th>High Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Groups with 10 or more providers</strong></td>
<td>Low Cost</td>
<td>+0.0%</td>
<td>+2.0x*</td>
<td>+4.0x*</td>
</tr>
<tr>
<td></td>
<td>Average Cost</td>
<td>-2.0%</td>
<td>+0.0%</td>
<td>+2.0x*</td>
</tr>
<tr>
<td></td>
<td>High Cost</td>
<td>-4.0%</td>
<td>-2.0%</td>
<td>+0.0%</td>
</tr>
</tbody>
</table>

* Eligible for an additional +1.0x if reporting PQRS quality measures and average beneficiary risk score in the top 25% of all beneficiary risk scores

- Positive adjustments must be budget neutral (requires CMS to first take the downward adjustments and make that money available for positive adjustments)

Source: How to Meet Quality Reporting Requirements, Earn Incentives, and Avoid Negative/Downward Payment Adjustments in 2017 for CMS Medicare Quality Programs September 24, 2015

PQRS Measure Selection Factors

- Clinical conditions usually treated
- Types of care typically provided – e.g., preventive, chronic, acute
- Settings where care is usually delivered – e.g., office, emergency department (ED), surgical suite
- Quality improvement goals for 2016
- Other quality reporting programs in use or being considered
- Inclusion of cross-cutting measures (a measure that is broadly applicable across multiple providers and specialties)

What Will Be Visible on Physician Compare?

Data Today (12/11/15)

What Will Be Visible on Physician Compare?

2015 Data from Individual Providers, Viewable in 2016

<table>
<thead>
<tr>
<th>Data Year</th>
<th>Public Reporting Year</th>
<th>Reporting Mechanism(s)</th>
<th>Reporting Level</th>
<th>Quality Measures and Data Available for Public Reporting</th>
</tr>
</thead>
</table>
| 2015      | Late 2016             | ERR, Registry, Claims  | Individual EPs  | A green check mark indicator on the individual profile page for:  
  Satisfactory reports under PQRS  
  Participants in the EHR Incentive program  
  Reporters of the four individual PQRS measures* in support of Million Hearts  |
|           |                       | ERR, Registry, Claims* | Individual EPs  | The performance rates for all PQRS measures  |
|           |                       | ERR, Registry, Claims**| Individual EPs  | The performance rates for the four individual PQRS measures* in support of Million Hearts  |
|           |                       | QCDR**                 | Individual EPs  | The performance rates for all Qualified Clinical Data Registry (QCDR) measures:  
  PQRS and non-PQRS measures  
  No first year measures  |

*Satisfactory reports at the PQRS Incentive level.  
**The reporting mechanisms used to collect the measures will be noted.


Source of Truth

FEDERAL REGISTER
Vol. 80  Monday,  
No. 220  November 16, 2015  

Part II  
Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
Medicare Program: Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016; Final Rule

And, Just When You Started to Get Familiar with PQRS....

PQRS ends in 2018  
MACRA takes effect  

MACRA  

Medicare Access and CHIP Reauthorization Act of 2015
**MACRA**

*New mandates affect payments beginning in 2019, based on 2017 performance*

- Replaces the sustainable growth rate
- Requires public reporting
- Physicians will choose either:
  - Merit-Based Incentive Payment System (MIPS)
  - Alternative payment models (e.g. ACO, medical home)

---

**MIPS Performance Domains**

- **EHR meaningful use (MU) requirements**
- **Quality measures**
  - Current Physician Quality Reporting System (PQRS) measures + others developed in collaboration with physicians
- **Resource use**
  - Risk adjusted cost per patient
- **Clinical practice improvement activities**

*http://medicaleconomics.modernmedicine.com/medical-economics/news/mips-vs-apm-4-things-physicians-need-consider*
Measures Will Be Reported Publicly and Have Strong Impact on Reimbursements

<table>
<thead>
<tr>
<th>CY</th>
<th>Potential Bonus</th>
<th>Potential Penalty</th>
<th>Physicians in APM Bonus*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>12%</td>
<td>-4%</td>
<td>5.0%</td>
</tr>
<tr>
<td>2020</td>
<td>15%</td>
<td>-5%</td>
<td>5.0%</td>
</tr>
<tr>
<td>2021</td>
<td>21%</td>
<td>-7%</td>
<td>5.0%</td>
</tr>
<tr>
<td>2022</td>
<td>27%</td>
<td>-9%</td>
<td>5.0%</td>
</tr>
<tr>
<td>2023</td>
<td>27%</td>
<td>-9%</td>
<td>5.0%</td>
</tr>
<tr>
<td>2024</td>
<td>27%</td>
<td>-9%</td>
<td>5.0%</td>
</tr>
<tr>
<td>2025</td>
<td>27%</td>
<td>-9%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

*APM = Alternative Payment Model, which means ACO, bundled payments, Medical Home, and other value-based purchasing type models

Not All Quality Measures Are Publicly Reported

How did CMS decide what measures to post on Physician Compare?

- All measures available for public reporting on Physician Compare are decided via rulemaking. However, not all measures available are publicly reported on the website. The specific measures included on the website are chosen based on their reliability, validity, accuracy, and consumer relevance. A Technical Expert Panel (TEP) is consulted, as well as CMS measure experts, and consumer testing is also conducted.
Healthcare Organizations Urge CMS to Choose Measures Wisely

CMS, American Hospital Association, and other stakeholders aim to publicly report measures that are:

1) supported by the latest clinical evidence
2) risk adjusted appropriately
3) clear in describing data sources and sample size

<table>
<thead>
<tr>
<th>Purpose: What is the goal of the report?</th>
<th>Transparency: How are the measures calculated? How should the results be interpreted?</th>
<th>Validity: Is the measurement appropriate?</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ Dashboards should have a clear, concise purpose statement, including the intended audience.</td>
<td>+ Methodology must be transparent addressing but not limited to:</td>
<td>+ Measures should be tested, validated, and widely endorsed by the National Quality Forum (NQF).</td>
</tr>
<tr>
<td>+ Dashboard content should be tailored to the intended audience.</td>
<td>o Clearly identified data sources</td>
<td>+ Measures need to be supported by the latest clinical evidence.</td>
</tr>
<tr>
<td>+ Measures should be clearly supported by the latest clinical evidence.</td>
<td>o Identified data sources</td>
<td>+ Data collection and data sources need to be rigorously defined, validated, and verified to ensure comparability.</td>
</tr>
<tr>
<td>+ Risk adjusted appropriately</td>
<td>o Balanced specifications for individual measures and composite, with sufficient detail to facilitate replications of results</td>
<td>+ Outcome measures should be risk adjusted and risk-adjusted methodology validated to conform to industry standards.</td>
</tr>
<tr>
<td>+ Clear in describing data sources and sample size</td>
<td>o Detailed scoring methodology</td>
<td>+ Categories of performance (grades or ratings) should be developed using rigorous statistical methods.</td>
</tr>
</tbody>
</table>


---

Strategy #3: Engage Staff Stories Linking Cost and Quality

Learn to tell stories about the link between cost and quality

![Diagram showing the linkage between time, cost, and quality](image)
Rethinking “Prospective Payment” for IPPS Hospitals

**2008**: No payment for “Never Events”

**Now**: Addition of VBP PSI 90 & HAC Reduction Program

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and Trauma
- Manifestations of poor glycemic control
- CAUTI
- Vascular catheter-related infection
- Certain SSI’s
- DVT/PE after certain orthopedic procedures
- Iatrogenic pneumothorax with venous catheterization

*Separate measures and penalty from HAC reduction program
*Does not apply to Critical Access Hospitals
Up to 6% of Medicare Reimbursements Are at Risk, Incentivizing a Focus on Quality

<table>
<thead>
<tr>
<th>Hospital Medicare Payment at Risk, Year by Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value-Based Purchasing 1% 2%</td>
</tr>
<tr>
<td>30-Day Readmissions 1% 2% 3%</td>
</tr>
<tr>
<td>Hospital-Acquired Conditions</td>
</tr>
<tr>
<td>TOTAL 2% 3% 5% 6%</td>
</tr>
</tbody>
</table>

Value Based Purchasing – Up to 2%

• Under hospital VBP, Medicare is adjusting a portion of payments to hospitals on either:
  • How well they perform on each measure compared to all hospitals, or
  • How much they improve their own performance on each measure compared to their performance during a prior baseline period.
CMS Shares Payment or Penalty Results for VBP

Most participating hospitals gained or lost up to ~$40,000

The most lost was $811,664

The most gained was $711,894

Readmissions Reduction: Up to 3% Penalty

• Began October 1, 2012

• Counterbalances the financial incentive for early discharge in the DRG payment system

• Readmission penalty based on ratio of readmissions as compared to risk-adjusted expected readmissions to identify “excess readmissions”
**Hospital Acquired Condition Reduction Program: 1% Penalty**

- Payment reductions began October 2014

- Penalty only affects hospitals with total HAC score in the worst performing quartile

  - Hospitals in the lowest performing quartile would receive 99% of the amount of payment that would otherwise apply to discharges

**Connect Cost and Quality for the Workforce**

- Best practices
  - Adhere to professional guidelines/ evidence based medicine
    - Set a standard or protocol and treat patients the same, with sections for allergies and exclusions
  - Team input on protocols, plans, ordering, storage
    - Nursing, Pharmacy, Quality, Materials Mgmt, Physicians, etc.
  - Price transparency/ learn actual costs
  - Teach others to think longitudinally about the cost across the continuum
    - Illustrate with stories, e.g. An inpatient who falls, breaks a hip and needs rehab

Figure: CVS. Caremark. 2014.
**Practice Strategy #3**

**QD Role: Learn to tell stories about the link between cost / quality**

**Exercise:** You attend the 11 pm med/surg huddle. One of the staff is talking about how “It’s normal for those nursing home patients to get serious pressure ulcers here….”

- Where do you find data that links cost and quality?
- How do you team up with the Med/Surg manager to deliver a compelling cost/quality story? Who would you involve?

---

**Strategy #4: Get Organized, Connect Ideas, Help Others Act**

Help others learn and act
Get Organized, Gather Information

### Develop a set of reference tools
- Use CMS timelines and tools
- Support with QIO resources and webinars

### Carve out time every day to get familiar
- Keep a list of questions and read a section of reference material before you start the day
- Set a schedule for yourself to stay updated with CMS transcripts, payment updates, reports, data deadlines

### Get familiar with data systems
- Get familiar with current data storage and collection systems
- When new data are required, work with front line on feasibility/reliability of collection

### Observe the current process
- Learn why the process works well and why the process doesn’t work well at other times
- Coach others to observer and see

---

Partner with Leadership to Design Physician Compensation Program that Includes Quality Metrics

**Transition from FFS to MIPS + Shared Savings**

### 1. Standard Base
- **Base salary**
  - Salary inclusive of all needed services
  - Negotiate as a package
  - Benefits standard
  - Specialty
  - Time in grade
  - Prior performance
  - Expected production based on wRVU model
  - Market factors vs. business model

### 2. Practice Variable
- **Base on what you want more of**
  - Visits (chronic, annual)
  - Procedures
  - Revenue
  - Practice success metrics
  - Production costs
  - OK to build the model with wRVUs but show the real metric you want

### 3. Health System Variable
- **Base on system goals**
  - MD leadership
  - Medical directorships
  - Quality metrics
  - Patient satisfaction
  - Cost control/lean
  - Use EHR and CPOE
  - Standardization of preferences
**Ensure a Balanced Scorecard Is Shared with the Board**

Develop a one-page balanced scorecard for the Board to evaluate whole system progress toward strategic goals

- Board leadership would like a Board scorecard to provide valuable information about priorities at-a-glance:
  - What is our status?
  - How are we performing on key performance indicators?
  - Are we accomplishing our mission?
  - Where do we need to prioritize or investigate?
- Begin with six to ten key performance indicators
- Department dashboards (LEM goals) and physician quality agenda should both contribute to the success of these measures

**Study Reports to Know if the Goals Are Appropriate**

Scenario: Hospital Scores 97% on a Core Measure

**Composite Score: Surgical Care Improvement Project**

- Does this indicate exceptional performance?
- Safe, reliable care?
100% Is the “New Normal” for Many Core Measures

Composite Score: Surgical Care Improvement Project

Compare Against the Top 10%

Benchmark for Hospital-Abstracted Pneumonia (PA) - Fourth Quarter 2013
Using the ABC Technique*

*The benchmarks reported here are unrelated to the 90th percentiles that are published on Hospital Compare for individual measures.

<table>
<thead>
<tr>
<th>Performance Measure Name</th>
<th>Benchmark Rate (%)</th>
<th>Numerator (Benchmark)</th>
<th>Denominator (Benchmark)</th>
<th>Number of Hospitals (Benchmark)</th>
<th>National Rate (%)</th>
<th>Numerator (National)</th>
<th>Denominator (National)</th>
<th>Number of Hospitals (National)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PN-3a: Blood Cultures Performed Within 24 Hours Prior to or 24 Hours After Hospital Arrival for Patients Who Were Transferred or Admitted to the ICU Within 24 Hours of Hospital Arrival</td>
<td>99.9</td>
<td>2,959</td>
<td>2,961</td>
<td>85</td>
<td>98.3</td>
<td>27,892</td>
<td>28,371</td>
<td>3,019</td>
</tr>
<tr>
<td>PN-3b: Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital</td>
<td>99.9</td>
<td>12,938</td>
<td>12,948</td>
<td>116</td>
<td>97.8</td>
<td>123,964</td>
<td>126,746</td>
<td>3,984</td>
</tr>
<tr>
<td>PN-6: Initial Antibiotic Selection for CAP in Immunocompetent Patients</td>
<td>95.9</td>
<td>8,412</td>
<td>8,424</td>
<td>141</td>
<td>95.8</td>
<td>76,949</td>
<td>80,322</td>
<td>4,088</td>
</tr>
</tbody>
</table>

Note: Benchmark rates (%) are calculated using the Top 10% Sample. National rates (%) are calculated using the 100% Eligible Sample.

Acronym Description:
ICU = Intensive Care Unit
CAP = Community Acquired Pneumonia

Source: QualityNet. Org, Benchmarks of Care
Proprietary & Confidential
Study Measure Structure to Know High Impact Areas

First 4 Conditions Account for >85% of the PSI Calculation

<table>
<thead>
<tr>
<th>Patient Safety Indicator Measure (^1) (Combined into PSI-90 Composite Ratio)</th>
<th>Measure Weight in PSI-90 Composite</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSI 15 - Accidental Puncture or Laceration</td>
<td>42.89%</td>
</tr>
<tr>
<td>PSI 12 - Postop PE Or DVT</td>
<td>22.09%</td>
</tr>
<tr>
<td>PSI 3 - Decubitus Ulcer</td>
<td>13.57%</td>
</tr>
<tr>
<td>PSI 7 - Selected Infection Due to Medical Care</td>
<td>8.31%</td>
</tr>
<tr>
<td>PSI 6 - Iatrogenic Pneumothorax</td>
<td>6.14%</td>
</tr>
<tr>
<td>PSI 13 - Postop Sepsis</td>
<td>5.36%</td>
</tr>
<tr>
<td>PSI 14 - Postop Wound Dehiscence</td>
<td>1.59%</td>
</tr>
<tr>
<td>PSI 8 - Postop Hip Fracture</td>
<td>0.05%</td>
</tr>
</tbody>
</table>

An Approach to Patient Experience

- **Foundation**
  - Culture – safe to speak up, suggestions are addressed
  - Senior leader sponsor/ PXO
  - Department focus – not more than one or two focused efforts at a time
  - Patient Family Advisory Councils (PFACs) – go to the source
  - Share data – post updates on department PI Boards
  - First impressions exercise
An Approach to Patient Experience

**Transition measures**
- After care plan and medications
  - Second learner
  - Teach back
  - Patient activation
  - Making the post hospitalization appointment
  - One page reference sheets for symptom management
  - Pharmacist to educate high risk patients

- Track and trend findings from post discharge calls
  - What have we learned in the last six months?

---

**Rounding Reliability**

- Create time for staff
  - Identify the top 5 reasons that call lights are activated and trouble shoot
  - Cut the waste of hunting and gathering of supplies; put most needed items at point of use

- Assign rounding roles that meet patient needs
  - Set a structure, e.g. even hours for nurses, odd hours for care assistants
  - Hardwire comfort rounds before shift change and known surges in admissions or discharges
  - Nurse leaders to follow up with patients & staff; humanize the experience

---

*An Approach to Patient Experience*
An Approach to Immunizations

- Raise awareness among staff for their own coverage
  - Board gets immunized, photographed, and put in patient newsletter
  - ICP and nurse managers sign up for shifts to bring immunization cart to each department

- Inpatients
  - Executive sponsor
  - Standing orders approved by MEC with criteria and protocol
  - Nursing policy update to allow RNs to order/provide immunization
  - Discuss immunization status at daily interdisciplinary care rounds
  - Immunization wallet card for patients; communication to PCP
  - Track daily/monthly progress on units, and as part of high level scorecards

Source: Figure: IHI. http://www.ihi.org/resources/Pages/ImprovementStories/AnInstitutionalStrategyforInpatientImmunization.aspx

Investigate the Factors Not Contained in Data (Check the Process)

Patient did not receive discharge instructions
- Medications not reconciled at admission and discharge
- Appointment not made for follow-up visit
- Inability to pay for prescriptions, follow-up visits
- Lack of transportation to attend follow-up appointment
- Low health literacy contributing to non-compliance with discharge instructions

Source: Clinical Advisory Board 2010 Member Survey on Readmissions: Clinical Advisory Board Interviews and analysis.
Physician Orders Determine Cost and Quality

- Labs and imaging
  - Consider utilization of tests per 100 patients seen
    - Study variability over time and between providers
    - Build protocols where appropriate
  - Are the outcomes or prevention measures better for any group or time period?
    - Share best approaches to management of patient conditions among all providers

- Medications
  - Collaborate with pharmacy and physicians to consider lower cost with equally effective alternatives
    - Have providers guess the cost of an antiemetic or antibiotic
    - Make a list of substitutions and evaluate the list with providers

Reduce Mortality Rate with Targeted Interventions and a Focus on Learning

Interventions & Learning Opportunities

- Evidence-based care
- Adherence to MEC approved order sets
- Care pathways
- Early detection
  - Interdisciplinary rounds
  - Rapid response teams
  - RN initiated order sets for sepsis in ED
- Learning to learn
  - Morbidity and mortality conference
Listen to Customers

• Patient feedback:
  ▪ Not getting what I need, when I need

• Staff feedback:
  ▪ Process is cumbersome, error prone

• CFO feedback:
  ▪ Cost increases (without improvement patients)

Prioritize Improvements

1) Voice of your customers (patients/ families/ staff/ community/ Board)
2) Strategic Plan/ Balanced Scorecard (data trended over time)
3) Internal and public reporting/ QIC
   ▪ Cost/ quality/ experience
   ▪ Where to measures fall short of goal?
4) Further define opportunities with:
   ▪ Comparison to the best (not national averages!)
   ▪ Comparison to local competitors
   ▪ Learning from process observation
Practice Strategy #4

QD Role: Help people develop reliable processes (and therefore reliable outcomes) through prioritization, measurement, making processes visible

Exercise: Exercise: During a Quality Steering Meeting, the CFO says, “These hospital acquired conditions are costing the hospital thousands of dollars every year.”

- How do we prioritize?

A Word about Pace

Quality leader’s desired pace of change
Yet...

Staff perception of daily work

Set the Plan for PDSA Cycles

Data:
- Daily: Simple hand tallied process measures (“leading measures”)
- Monthly: Internal reports
- Quarterly: Publicly reported outcome measures (“lagging measures”)

- Prioritize
- Leadership sponsorship of high level plan
- Communicate plan and timeline
- Learn about customer and staff experience
- Observe the process with team members
- Update or create scorecards for staff
- Connect care, cost, process and measures (ongoing)
- Problem solve as a team with multiple PDSA cycles
To Move Forward

- Lead with leadership – visible executive sponsor
- Share the reason why – and why now
- Connect ideas (mission, cost/quality) and tell stories
- Know the specs
- Create time – remove the waste
- Help them see the current process and challenges BEFORE addressing best practices

Plan for Value-Based Quality Measures
(Even in Critical Access Hospitals!)

- Improving quality takes time
- Build quality and reliability now
- Publicly report data for consumer comparison and identification of priorities

If you’re waiting for a sign THIS IS IT.
Questions

Supplemental Quality Leader Resources for Publicly Reported Measures
**Value Based Purchasing:**
Aligning Health Care Industry with Other Industries

**Performance measurement**
- Carriers, hospitals, physicians
- Quality and outcomes

**Payment innovation**
- Pay-for-performance vs. fee-for-service
- Capitated payment aligns with population health

**Transparency**
- Convert reported measures to useful information for employers and patients
- Understandable to allow informed consumer choice

**Informed consumer choice**
- Decisions made based on *value* first
Value Based Purchasing: Evidence of Implementation

- **Performance measurement**
  - Hospital VBP, HAC, readmissions
  - Physicians in PQRS and now MIPS in 2019

- **Transparency**
  - Compare website
  - State reporting requirements in some cases
  - Hospital pricing information available (ACA requirement)
  - "Bluebook" website and other vendors

- **Payment innovation**
  - ACOs and bundled payments: Medicare and private carriers
  - Medical Homes

- **Informed consumer choice**
  - Insurance exchanges: Public and private
  - High deductible plans forcing consumerism
  - Carriers with limited networks:
    - Forcing consumers to use select providers

---

**Annual Inpatient Prospective Payment Rule: ACA Quality Programs and Quality Reporting**

<table>
<thead>
<tr>
<th>Program</th>
<th>Start Date</th>
<th>Max Penalty FY 2016</th>
<th>Actual Penalty</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value Based Purchasing</td>
<td>10/01/12</td>
<td>1.75%</td>
<td>Table 16, Proxy Est.</td>
<td>Removal/addition of quality measures</td>
</tr>
<tr>
<td>Readmissions</td>
<td>10/01/12</td>
<td>3.0%</td>
<td>Table 15: Proxy Est.</td>
<td>Minor modifications</td>
</tr>
<tr>
<td>Hospital Acquired Conditions</td>
<td>10/01/14</td>
<td>1.0%</td>
<td>Table 17</td>
<td>Hospitals in lowest performing 25th percentile</td>
</tr>
<tr>
<td>IQR: Quality Reporting</td>
<td>2004</td>
<td>2.0%</td>
<td>2.0% if hospital fails to submit</td>
<td>Go to Hospital Compare website for complete list of quality indicators that must be submitted:</td>
</tr>
<tr>
<td>Electronic Medical Records: Meaningful Use Criteria</td>
<td>10/01/14</td>
<td>75% of MBI by FY 2017</td>
<td>.675</td>
<td>FY 2015 first year for penalty if hospital or physician not meeting Meaningful Use</td>
</tr>
</tbody>
</table>

Tables referenced above as part of the Annual Medicare Inpatient Prospective Payment System Final Rule, published every August 1st. Tables finalized last week except for HAC
### IP PPS Rule: VBP Base and Performance Years

<table>
<thead>
<tr>
<th>Measure</th>
<th>BY: Base Year</th>
<th>PY: Performance Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Process of Care</td>
<td>CY 2011</td>
<td>CY 2012</td>
</tr>
<tr>
<td></td>
<td>CY 2013</td>
<td>CY 2014</td>
</tr>
<tr>
<td>HCAHPs</td>
<td>CY 2011</td>
<td>CY 2012</td>
</tr>
<tr>
<td></td>
<td>CY 2013</td>
<td>CY 2014</td>
</tr>
<tr>
<td>Outcome: Clinical Care</td>
<td>10/1/10-6/30/11</td>
<td>10/1/10-6/30/11</td>
</tr>
<tr>
<td></td>
<td>10/1/11-6/30/12</td>
<td>10/1/12-6/30/14</td>
</tr>
<tr>
<td>Outcome Safety: PSI 90</td>
<td>10/15/10-6/30/11</td>
<td>10/15/10-6/30/11</td>
</tr>
<tr>
<td></td>
<td>10/15/11-6/30/12</td>
<td>10/15/12-6/30/14</td>
</tr>
<tr>
<td>Outcome Safety: CLABSI</td>
<td>CY 2011</td>
<td>CY 2012</td>
</tr>
<tr>
<td></td>
<td>2/1/13-12/31/13</td>
<td>CY 2014</td>
</tr>
<tr>
<td>Efficiency</td>
<td>5/1/11-12/31/11</td>
<td>CY 2012</td>
</tr>
<tr>
<td></td>
<td>5/1/13-12/31/13</td>
<td>CY 2014</td>
</tr>
</tbody>
</table>

BY: Base Year, PY: Performance Year

### IP PPS Rule: VBP Domain Scoring

<table>
<thead>
<tr>
<th>Domain</th>
<th>Federal Fiscal Year</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>2013</td>
</tr>
<tr>
<td>Clinical Process of Care</td>
<td>70%</td>
</tr>
<tr>
<td>HCAHPs</td>
<td>30%</td>
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<tr>
<td>Clinical Care: Outcome</td>
<td>25%</td>
</tr>
<tr>
<td>Clinical Care: Safety</td>
<td></td>
</tr>
<tr>
<td>Efficiency</td>
<td>20%</td>
</tr>
</tbody>
</table>

Emphasis shifting to Outcomes and Safety and Cost Reductions
**Value Based Purchasing: Largest Insurance Carrier in the USA Actions**

- Inpatient reporting to avoid 2% payment penalty
- Hospital acquired conditions (HACs) reporting
  - Reduced payment if patient acquires conditions after admission
- Electronic medical records (EMRs): March 2009
  - $29B to industry to develop and implement EHR
  - Meaningful Use criteria leaning towards processes
- Patient Protection and Affordable Care Act (ACA): April 2010
  - Expand insurance coverage to 32 million citizens and legal aliens
  - Quality incentive programs
  - Medical Homes, bundled payments, and ACOs
  - All other provider types start transition to quality reporting and then VBP incentive payments
- Value-based purchasing (VBP) for physicians: March 2015
  - Payment adjustments start January 1, 2019

**Value Based Purchasing: Largest Insurance Carrier in the USA Actions**

- Breaking developments
  - CMS finalizes EHR Phase III on Oct 6, 2015
    - CY reporting periods and decreased reporting objectives and other “simplification” revisions
    - Moving to quality outcomes and patient-centered data exchange
  - GAO Report on Hospital Valued Based Purchasing Incentive Program
    - No Apparent shift in hospital performance trends
    - Bonuses and penalties less than +0.5% of inpatient payments
    - GAO emphasizes shift could occur as measures shift more to clinical process measures
    - May shift policy debate in D.C.
**QRUR Report for PQRS**

![QRUR Report for PQRS](image)

Source: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2014-Sample-Annual-QURR.pdf

**Measure Specifications and Updates**

**Quality Net Tools**


**HCAHPS**

- Survey information: [http://www.hcahpsonline.org/home.aspx](http://www.hcahpsonline.org/home.aspx)
- HCAHPS and VBP: [http://www.hcahpsonline.org/HospitalVBP.aspx](http://www.hcahpsonline.org/HospitalVBP.aspx)

**E-Measures (eCQM)**


**Outpatient Surgery**

Outpatient Quality Reporting (OPPS Hospitals)

1.1 - Outpatient Acute Myocardial Infarction (AMI)
1.2 - Chest Pain (CP)
1.3 - Emergency Department (ED)-Throughput
1.4 - Pain Management
1.5 - Stroke
1.6 - Imaging Efficiency
1.7 - Web-based Measures

- OP-12 The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their Office of the National Coordinator for Health Information Technology (ONC) Certified Electronic Health Record (EHR) System as Discrete Searchable Data
- OP-17 Tracking Clinical Results Between Visits
- OP-25 Hospital Obstetric Patient Volume for Selected Outpatient Surgical Procedures
- OP-27 Influenza Vaccination Coverage Among Healthcare Personnel
- OP-29 Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients
- OP-30 Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use
- OP-31 Cataracts – Improvement in Patient’s Visual Function within 90 Days Following Cataract Surgery

1.8 - Outcome Measures

- OP-32 Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy

For more information on OPPS:
http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPPage%2FQnetTier2&cid=1191255879384

Q&A Tools

QIO Contact for Each State

www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPPage%2FQnetTier3&cid=1138900297541

Quality Net Measure Q&A Tool

QualityNet’s Q&A will allow you to submit questions and to review previously submitted questions and responses.
1. Go to www.qualitynet.org
2. Find the Q&A links on the right side of the page, in the box labeled “Questions and Answers.” Select either “Hospitals–Inpatient” or “Hospitals–Outpatient”; on the page that opens, select a specific topic. Please note: first-time users must register.
3. If you can’t find what you are looking for, click the “Ask a Question” link at the top or the right side of the page and use the form provided

The Joint Commission Measure Q&A

TJC: https://manual.jointcommission.org/Manual/Questions/UserQuestionDatabase
**VBP Tools/ Readmissions Tools**

- **VBP FAQs**

- **Find Your Hospital’s VBP Total Performance Score**
  [https://data.medicare.gov/Hospital-Compare/Hospital-Value-Based-Purchasing-HVBP-Total-Perf/ypbt-wvdk](https://data.medicare.gov/Hospital-Compare/Hospital-Value-Based-Purchasing-HVBP-Total-Perf/ypbt-wvdk)

- **CMS Readmissions Reduction Program**
  [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html)

- **Quality Net Readmissions Resources**
  [https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228772412995](https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228772412995)

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**Physician Compare Resources**

- **PQRS Resources and Help Desk**

- **PQRS Data**:
  [https://data.medicare.gov/data/physician-compare](https://data.medicare.gov/data/physician-compare)
EHR Incentive Program/ Meaningful Use Resources

EHR Incentive Program

Getting Started Video
https://www.youtube.com/watch?v=4g914YgCI6g&list=UUhTRPz8awulGaTMfh3SAA&index=199

Stay informed about the latest eHealth news
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• Read the blog at www.cms.gov/eHealth/
• Follow on Twitter (@CMSGov) and join the eHealth conversation by using the #CMSeHealth hashtag.

Quality Director Resources – CMS Number and Guidelines

Your Hospital’s CMS Certification Number (CCN)
https://data.medicare.gov/Hospital-Compare/Hospital-General-Information/xubh-q36u

CMS Interpretive Guidelines & Transmittals
CMS interpretive guidelines - Hospitals
CMS interpretive guidelines – Critical Access Hospitals
CMS transmittals
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