Value-based Purchasing Support

Presenter Vicki Tang Olson, RN, MS

Event: Core Measures Meeting for PPS Hospitals
Date: July 22, 2014
Objectives

• Discuss best practices for VBP
• Explain use of FY2016 VBP template
• Describe suggestions for CMS report management
• Understand changes with CMS 11th Scope of Work
Site Visit Recap
Topics

• 11th SOW
• Changes with VBP program
• Difference between VBP, RRP and HAC
• Best practices, opportunities and barriers for clinical process measures, HCAHPS, Mortality, HAI, PSI-90, MSPB
• Hospital specific opportunities
Changes with VBP program

- FY2013 – 50/52 hospitals eligible
- FY2014 – 44/52 hospitals eligible
- FY2015 all 50/50?
  - Now reallocation of domain percentages if not enough eligible measures in domain
## Differences between incentive programs

<table>
<thead>
<tr>
<th>Program</th>
<th>VBP</th>
<th>RRP</th>
<th>HAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type</td>
<td>Incentive &amp; penalty</td>
<td>Penalty</td>
<td>Penalty</td>
</tr>
<tr>
<td>Hierarchy</td>
<td>#1</td>
<td>#2</td>
<td>#3</td>
</tr>
<tr>
<td>Started</td>
<td>FY2013</td>
<td>FY2013</td>
<td>FY2015</td>
</tr>
<tr>
<td>FY2015 percentage</td>
<td>3%</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Timeframe</td>
<td>Must be in IQR and publically reported for 1 yr.</td>
<td>No requirement</td>
<td>No requirement</td>
</tr>
<tr>
<td>Measures</td>
<td>IQR program</td>
<td>Readmission measures</td>
<td>IQR PSI-90 and NHSN HAI</td>
</tr>
</tbody>
</table>
Clinical Process Measures

• Influenza immunization is the measure that will continue in future years
• OB is often identified as the challenging unit to get percentages up
• Successful hospital either set expectation that admission screening is followed-up before discharge or tie to a process in stay like transfer to postpartum
HCAHPS

• Domain that is becoming the priority for improvement
• MD, Nurse communication and Responsiveness correlated with overall rating
• Medication communication and Quietness most often the lowest measures
HCAHPS and Patient Safety Culture
Correlation Results

- Higher HSOPS scores (12 out of 15 measures) were related to a higher HCAHPS overall composite average
  
  \( r = 0.30 \text{ to } 0.47 \)

- No HSOPS measures were related to
  - HCAHPS Willingness to Recommend
  - HCAHPS Hospital Rating
Regression Results

- Controlled for hospital bed size and government/non-government ownership

- Higher HSOPS scores (9 out of 15 measures) were related to a higher HCAHPS overall composite average
  \( (\beta = 0.25 \text{ to } 0.38) \)
Higher patient safety culture scores associated with better patient experience scores
\( r = 0.41 \)
HSOPS Measures Related to Overall HCAHPS Composite Average

1. Communication openness
2. Feedback & communication about error
3. Frequency of event reporting
4. Handoffs & transitions
5. Management support for patient safety
6. Nonpunitive response to error
7. Organizational learning--continuous improvement
8. Overall perceptions of patient safety
9. Staffing
10. Supv/mgr expectations & actions promoting patient safety
11. Teamwork across units
12. Teamwork within units
   • Number of events reported in past 12 months
   • Patient safety “grade” (Excellent to Poor)
   • HSOPS Composite Average
Back to Site visit Recap
Medication Communication

• Work on three main strategies – assess where your focus should be:
  – Assess nurse’s understanding of meds and explaining purpose and side effects
  – Hardwire into process
  – Assess patient’s understanding with teachback

• Educate on “side effects” as a term
Mortality

• End of Life Care
• Sepsis
• VTE
• Rapid response teams
End of Life

• Increase hospice and home care utilization
• Increase use of advance directives
• Look at inpatient mortality review criteria
• Build communication channels with providers or patients to get 30 day feedback
End of Life

• Look at bounce-backs from nursing homes or other settings
• Build community stakeholder groups to look at opportunities
• Build community projects
  – AMI – bystander CPR, EMS care
  – Cultural issues of accepting home care and hospice
PSI-90

• Most common indicators where there are cases
  – PE/DVT
  – Accidental puncture or laceration
• Evaluate physician documentation
• Build in concurrent review process with coders
PSI 15 Regional ‘Complication’ Notation in the Operative Report

- Complication: None, 72, 32%
- Complication: Yes, 59, 26%
- No Notation, 87, 38%
- Questionable Coding, 8, 4%

N=226
10.1.12-10.31.13

Oregon results, 226 charts
All Oregon professional staff who perform procedures must:

1. Include a completed “Complications” line in every operative or procedure report, whether complications are present or not. The clearer the documentation, the better.

2. Add details and context to every operative report. Was the laceration or puncture unavoidable or necessary due to patient complexity? Was it accidental?

3. Avoid ambiguous language such as, “In the setting of…” or “Needle was placed instead in…” Self-reporting is uncomfortable, but it is better that the surgeon or proceduralist drive the complications decision than leave the documentation open to misinterpretation.
HAI

• Need SIR rate to get measure score
• Many hospitals do not have CLABSI or CAUTI score so would not have score for VBP results this year (FY2015) or for the HAC program (which means that the PSI-90 counts for 100% of the score)
• MRSA and CDI will have FY2017 HAC performance period in CY2015
Medicare Spending per Beneficiary

- Although benchmark and achievement threshold is not identified for FY2015/16 VBP, .82 is the benchmark identified in the IPPS rule.
- We will be refreshing the 2011 bar charts that we sent out showing MN results in the next month.
Readmissions

• Look ahead at any added measures since they can be incorporated into readmission reduction program quickly
• MDH/RARE is working on providing data that will include readmissions to other hospitals
• Look at CMS patient level files
Readmissions

• Readmission reduction excess readmissions report out last week
• Payment (Readmissions adjustment factor) should be out on CMS website in August

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html
CMS reports
Blue File Folders

• Clip 1 – Value-based purchasing
• Clip 2 – Readmissions
• Clip 3 – HAC program
• Clip 4 – Inpatient reporting program
• Clip 5 – Outpatient reporting program
• Clip 6 – PSI – 90/Complications
• Clip 7 – Mortality
• Clip 8 – MSPB
Blue File Folder Organization

CMS Hospital Reports
Inpatient, Outpatient reporting programs
Value-based Purchasing program, Readmission Reduction program, Hospital Acquired Conditions program
July 2014

<table>
<thead>
<tr>
<th>Section</th>
<th>Report</th>
<th>Date Received</th>
<th>QualityNet access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clip 1 Value-Based Purchasing</td>
<td>FY 2016 Baseline measure report</td>
<td>April 2014</td>
<td>run</td>
</tr>
<tr>
<td></td>
<td>FY 2015 Baseline measures report</td>
<td>March 2014</td>
<td>run</td>
</tr>
</tbody>
</table>
## Sample “scorecard”

CMS data for current/potential future measures for Value-based Purchasing, Readmission Reduction and Hospital Acquired Conditions programs

<table>
<thead>
<tr>
<th>Measure</th>
<th>Dates of Service</th>
<th>CMS Report (Date received)</th>
<th>Hospital specific</th>
<th>MN average</th>
<th>National average (or *median)</th>
<th>National Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>VBP</td>
<td>See VBP fact sheet</td>
<td>FY2015 HVBP payment summary report (July 2014)</td>
<td>TPS___</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VBP</td>
<td>See VBP fact sheet</td>
<td>FY2014 HVBP payment summary report (July 2013)</td>
<td>TPS___</td>
<td>47.30</td>
<td>46.52</td>
<td></td>
</tr>
<tr>
<td>VBP</td>
<td>See VBP fact sheet</td>
<td>FY2013 HVBP payment summary report (July 2012)</td>
<td>TPS___</td>
<td>53.98</td>
<td>55.45</td>
<td></td>
</tr>
<tr>
<td>AMI-7a</td>
<td>4Q12-3Q13</td>
<td>Hospital Compare Inpatient Preview report (April 2013)</td>
<td>___%</td>
<td>0%</td>
<td>50.4 / 91.154*</td>
<td>100%</td>
</tr>
<tr>
<td>PN-6</td>
<td>4Q12-3Q13</td>
<td>Hospital Compare Inpatient Preview report (April 2013)</td>
<td>___%</td>
<td>94%</td>
<td>95.6 / 96.552*</td>
<td>100%</td>
</tr>
<tr>
<td>SCIP-2</td>
<td>4Q12-3Q13</td>
<td>Hospital Compare Inpatient Preview report (April 2013)</td>
<td>___%</td>
<td>99%</td>
<td>99.2 / 99.074*</td>
<td>100%</td>
</tr>
<tr>
<td>SCIP-3</td>
<td>4Q12-3Q13</td>
<td>Hospital Compare Inpatient Preview report (April 2013)</td>
<td>___%</td>
<td>99%</td>
<td>98.2 / 98.086*</td>
<td>100%</td>
</tr>
<tr>
<td>SCIP-9</td>
<td>4Q12-3Q13</td>
<td>Hospital Compare Inpatient Preview report (April 2013)</td>
<td>___%</td>
<td>97%</td>
<td>97.9 / 97.059*</td>
<td>100%</td>
</tr>
<tr>
<td>SCIP-Card</td>
<td>4Q12-3Q13</td>
<td>Hospital Compare Inpatient Preview report (April 2013)</td>
<td>___%</td>
<td>98%</td>
<td>98.0 / 97.727*</td>
<td>100%</td>
</tr>
<tr>
<td>SCIP-VTE</td>
<td>4Q12-3Q13</td>
<td>Hospital Compare Inpatient Preview report (April 2013)</td>
<td>___%</td>
<td>98%</td>
<td>98.3 / 98.225*</td>
<td>100%</td>
</tr>
</tbody>
</table>
Incentive Programs
Fact Sheets
Understanding Value-Based Purchasing

Starting in October 2012, Medicare began rewarding hospitals that provide high-quality care for their patients through the new Hospital Value-Based Purchasing (VBP) Program. Hospitals paid under the Inpatient Prospective Payment System (IPPS) are paid for inpatient acute care services based on quality of care—not the volume of services they provide.

As the Medicare Quality Improvement Organization for Minnesota, Stratis Health offers technical assistance and support for Minnesota hospitals to be successful in a value-driven environment.

“Instead of payment that asks, How much did you do?, the Affordable Care Act clearly moves us toward payment that asks, How well did you do?, and more importantly, How well did the patient do?”

Don Berwick

UNDERSTANDING THE HOSPITAL READMISSIONS REDUCTION PROGRAM

The Hospital Readmissions Reduction Program, mandated by the Affordable Care Act (CMS) to reduce readmissions to hospitals with excess readmissions, began October 1, 2012.

Readmission is defined as an admission to an IPPS hospital within 30 days of a discharge from the same inpatient IPPS acute care hospital.

Understanding the Hospital-Acquired Condition Reduction Program

Beginning in FY 2015, the Hospital-Acquired Condition (HAC) Reduction Program, mandated by the Affordable Care Act, requires the Centers for Medicare & Medicaid among the lowest-performing 25 percent with regard to HAC.

Hospital-Acquired Conditions are defined as:

- Conditions that patients acquire while receiving treatment for another condition in an acute care health setting.
## Eligibility Criteria

### Fiscal Year 2013

<table>
<thead>
<tr>
<th>Clinical Process of Care Domain</th>
<th>Patient Experience of Care Domain</th>
<th>Outcome Domain</th>
<th>Efficiency Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Criteria: Requires at least 10 cases</td>
<td>Case Criteria: Requires at least 100 HCAHPS surveys in the performance period</td>
<td>Case Criteria: 30-day Mortality for AML, HF, and PN; each requires 10 cases minimum</td>
<td>Measure Criteria: Requires four or more measures</td>
</tr>
</tbody>
</table>

**Domain Criteria:** Requires scores in both domains to receive a Total Performance Score and be eligible for the VBP program.

### Fiscal Year 2014

<table>
<thead>
<tr>
<th>Clinical Process of Care Domain</th>
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<td>Measure Criteria: Requires four or more measures</td>
</tr>
</tbody>
</table>

**Domain Criteria:** Requires scores in all three domains to receive a Total Performance Score and be eligible for the VBP program.

### Fiscal Year 2015-2016

<table>
<thead>
<tr>
<th>Clinical Process of Care Domain</th>
<th>Patient Experience of Care Domain</th>
<th>Outcome Domain</th>
<th>Efficiency Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Criteria: Requires at least 10 cases</td>
<td>Case Criteria: Requires at least 100 HCAHPS surveys in the performance period</td>
<td>Case Criteria: 30-day Mortality for AML, HF, and PN; each requires 25 cases minimum</td>
<td>Measure Criteria: Requires four or more measures</td>
</tr>
</tbody>
</table>

**Domain Criteria:** Requires scores in at least 2 of the 4 domains to receive a Total Performance Score. For hospitals with at least 2 domain scores, the excluded domain weight will be proportionately distributed to the remaining domains.

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## Eligibility Criteria

### Fiscal Year 2017

<table>
<thead>
<tr>
<th>Clinical Care Domain</th>
<th>Clinical Care Domain</th>
<th>Patient Experience of Care Domain</th>
<th>Safety Domain</th>
<th>Efficiency Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Criteria: Requires 3 cases as a minimum for at least one of the included measures</td>
<td>Case Criteria: Requires at least 100 HCAHPS surveys in the performance period</td>
<td>Case Criteria: PSQ-60 requires 3 cases as a minimum for at least one of the included measures</td>
<td>Measure Criteria: Requires a minimum of two measures</td>
<td>Measure Criteria: Requires a minimum of three measures</td>
</tr>
</tbody>
</table>

**Domain Criteria:** Requires scores in at least 2 of the 4 domains to receive a Total Performance Score. For hospitals with at least 2 domain scores, the excluded domain weight will be proportionately distributed to the remaining domains.

*Clinical Care = Outcome and Clinical Care = Process are subdomains of the Clinical Care domain. If a hospital does not have sufficient data for one of the subdomains for the Clinical Care domain score, either the Process or Outcome subdomains can be counted as one domain. The weighting from the missing subdomain will be proportionately reallocated across all domains.*
**Clinical Process of Care**

**Patient Experience of Care**

**Outcome**

**Efficiency**

---

**Clinical Process of Care Resource**

<table>
<thead>
<tr>
<th>Resource</th>
<th>Pre-Performance Score</th>
<th>Performance Score</th>
<th>Pre-Performance Score</th>
<th>Performance Score</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCCPDR</td>
<td>45.3</td>
<td>50.95</td>
<td>44.2</td>
<td>51.15</td>
<td>2016</td>
</tr>
<tr>
<td>CQI</td>
<td>50.6</td>
<td>55.43</td>
<td>49.9</td>
<td>56.33</td>
<td>2016</td>
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</tbody>
</table>

**Patient Experience of Care**

<table>
<thead>
<tr>
<th>Resource</th>
<th>Year 2015</th>
<th>Year 2016</th>
<th>Pre-Performance Score</th>
<th>Performance Score</th>
<th>Year</th>
</tr>
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<td>49.9</td>
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<td>2016</td>
</tr>
</tbody>
</table>

**Outcome**

<table>
<thead>
<tr>
<th>Resource</th>
<th>Year 2015</th>
<th>Year 2016</th>
<th>Pre-Performance Score</th>
<th>Performance Score</th>
<th>Year</th>
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<td>2016</td>
</tr>
</tbody>
</table>

**Efficiency**

<table>
<thead>
<tr>
<th>Resource</th>
<th>Year 2015</th>
<th>Year 2016</th>
<th>Pre-Performance Score</th>
<th>Performance Score</th>
<th>Year</th>
</tr>
</thead>
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<tr>
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<td>45.3</td>
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<td>CQI</td>
<td>50.6</td>
<td>55.43</td>
<td>49.9</td>
<td>56.33</td>
<td>2016</td>
</tr>
</tbody>
</table>

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Reports

• Baseline section
  – MN_240xxx_FY2016_20140421_baseline_measure_report

• Performance section
Add as new information becomes available.
Start with:
  – MN_240xxx_20140415_preview
  240xxx_MSPBHospitalSpecificReport_052013
# Clinical Process of Care

## VBP FY2016 Worksheet

<table>
<thead>
<tr>
<th>Clinical Process of Care Measures</th>
<th>Input</th>
<th>Output</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Your Baseline</td>
<td>Your Performance</td>
</tr>
<tr>
<td></td>
<td>Jan 2012</td>
<td>Dec 2012</td>
</tr>
<tr>
<td>AMI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMI-7c: Fibrinolytic Therapy Received Within 90 Minutes of Hospital Arrival</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PNEUMONIA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PNEUM: Initial Antibiotic Selection for CAP Immunocompetent Patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCIP (Surgical Care)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCIP-14: Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCIP-15: Urinary Catheter Removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) within 24 Hours of Surgery; Day 2, 300</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCIP-Card 2: Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta-Blocker During the Preoperative Period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCIP-VTE 2: Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery; 24 Hours After Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza Immunization</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Need at least 4 process measures with # of cases ≥ 10*

### Your VBP Process Earned Points

### Your VBP Process Potential Points

### Your VBP Process Domain Score = (Your Earned Points / Your Potential Earned Points)

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*Quality Improvement Organizations*
*Stratis Health*

8/12/2016**

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Patient Experience of Care

<table>
<thead>
<tr>
<th>HCAHPS Survey Dimensions</th>
<th>Year HCAHPS Survey</th>
<th>HCAHPS Performance Standard</th>
<th>Achievement Improvement Points</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
<td>Performance</td>
<td></td>
</tr>
<tr>
<td></td>
<td># of Surveys</td>
<td># of Surveys</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Jan 2012</td>
<td>Jan 2014</td>
<td></td>
</tr>
<tr>
<td>Composite 1 (Q3 to Q8): Communication with Nurses (% Always)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Composite 2 (Q5 to Q7): Communication with Doctors (% Always)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Composite 3 (Q4 &amp; Q9): Responsiveness of Hospital Staff (% Always)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Composite 4 (Q13 &amp; Q16): Pain management (% Always)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Composite 5 (Q20 &amp; Q21): Communication about Medicines (% Always)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q8: Cleanliness of Hospital Environment (% Always)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Q9: Quietness of Hospital Environment (% Always)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average of Q8 &amp; Q9: Cleanliness and Quietness (% Always)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Composite 6 (Q19 &amp; Q20): Discharge information (% Yes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q21: Overall Rating of Hospital (% 5 and 4 Ratings)</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Your VBP Patient Experience Base Earned Points (max 80 points)**

**Your VBP Patient Experience Consistency Points (max 20 points)**

**Your VBP Patient Experience Domain Score = (Your Patient Experience Earned Points + Your Patient Experience Consistency Score) / 100**

Need HCAHPS data
## Outcome Measures

<table>
<thead>
<tr>
<th>Outcome Measures</th>
<th>Your Baseline</th>
<th>Your Performance</th>
<th>Outcomes Measures Performance Standard</th>
<th>Achievement Improvement Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-day Mortality, AMI</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>MORT-30-AMI</td>
<td></td>
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<tr>
<td>30-day Mortality, Heart Failure</td>
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<tr>
<td>MORT-30-HF</td>
<td></td>
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<td></td>
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<tr>
<td>30-day Mortality, Pneumonia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MORT-30-PN</td>
<td></td>
<td></td>
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<tr>
<td>Complication/Patient Safety for Selected Indicators</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>PSA-09, APFO PQ composite</td>
<td></td>
<td></td>
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<tr>
<td>Healthcare Associated Infection</td>
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<tr>
<td>Central Line Associated Bloodstream Infection</td>
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<tr>
<td>Catheter Associated Urinary Tract Infection</td>
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<tr>
<td>SSI-Colon Surgery</td>
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<tr>
<td>SSI-Abdominal Steritons</td>
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<tr>
<td>Composite SSI</td>
<td></td>
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<tr>
<td>Your VBP Outcome Earned Points</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Your VBP Outcome Potential Points</td>
<td></td>
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</tr>
<tr>
<td>Your VBP Outcome Domain Score = (Your Earned Points/Your Potential Earned Points)</td>
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</tbody>
</table>

**Quality Improvement Organizations**
Meeting Knowledge, Improving Health Care.
CENTER FOR MEDICAL ARTIFICIAL SERVICES
## Efficiency Measures

<table>
<thead>
<tr>
<th>Efficiency Measures</th>
<th>Your Baseline</th>
<th>Your Performance</th>
<th>Efficiency Measures Performance Standard</th>
<th>Achievement</th>
<th>Improvement</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSFD-1 Medicare spending per beneficiary</td>
<td></td>
<td></td>
<td>0.62 : 0.98</td>
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</tr>
</tbody>
</table>

- Your VBP Efficiency Earned Points
- Your VBP Efficiency Potential Points
- Your VBP Efficiency Domain Score = (Your Earned Points / Your Potential Earned Points)
Your VBP Total Performance Score

\[(\text{Process Domain})(10\%)+(\text{Patient Experience Domain})(25\%)+(\text{Outcome Domain})(40\%)+(\text{Efficiency Domain})(25\%)\]

Need Process/HCAHPS/Outcome/Efficiency data

This material was prepared by Stratis Health, the Medicare Quality Improvement Organization for Minnesota, under a contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). The contents do not necessarily reflect CMS policy. TOC204-991-C7-14-65-050214

VBP FY2016 Worksheet

TPS Formulas

Disclaimer: This worksheet can be used to estimate your hospital's performance in the FY 2016 Hospital Value-Based Purchasing program. However, actual performance will be calculated by CMS. In particular, the performance for MSPB cannot be calculated until the performance period is over and the benchmark and threshold are calculated by CMS.

Variations in Computing Total Performance Score including the domain weighting

Total Performance Score Formula:
Copy & Paste into Row 74, Column I of VBP Worksheet tab

No score for Outcome domain:
    Clinical Process of Care: Yes (16.7%)
    Patient Experience of Care: Yes (41.7%)
    Outcome: No (0.0%)
    Efficiency: Yes (41.7%)

Use this formula:

\[=\text{IF}((\text{AND}(G21)<>"", \text{ADD}(\text{IF}(\text{IN fileList1}1, \text{IF}(\text{AND}(\text{ISNUMBER}(Q37), \text{ISNUMBER}(Q38)), \text{IF}(\text{AND}(\text{G72}<>"", \text{Need Efficiency data})), \text{TEXT}((\text{SUM}(Q9,G11,Q13,Q17,Q19)), \text{COUNT}(Q9,G11,Q13,Q17,Q19)*10)), 0, 167)+(G37+Q38)*0.417+(\text{SUM}(Q76,\text{COUNT}(Q76)*10)*0.8147), 0.00, & "", \text{Need Process/HCAHPS/Efficiency data})))\]
CMS 11th SOW
AIM: Healthy People, Healthy Communities

Goal 1: Promote Effective Prevention and Treatment of Chronic Disease

- Improving Cardiac Health and Reducing Cardiac Healthcare Disparities
- Reducing Disparities in Diabetes Care: Everyone with Diabetes Counts (EDC)
- Using Immunization Information Systems to Improve Prevention Coordination
- Improving Prevention Coordination through Meaningful Use of HIT and Collaborating with Regional Extension Centers
AIM: Better Healthcare for Communities

Goal 2: Make Care Safer by Reducing Harm Caused in the Delivery of Care
• Reducing Healthcare-Associated Infections
• Reducing Healthcare-Acquired Conditions in Nursing Homes

Goal 3: Promote Effective Communication and Coordination of Care
• Coordination of Care
AIM: Better Care at Lower Cost

Goal 4: Make Care More Affordable

- Quality Improvement through Physician Value-Based Modifier and the Physician Feedback Reporting Program
- QIN-QIO proposed Projects that Advance Efforts for Better Care at Lower Cost

Other Technical Assistance Projects

- Quality Improvement Initiatives
Clinical Review Change

Beginning Friday, August 1, 2014
Two QIO structure

- Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO)
- Quality Innovation Network QIOs (QIN-QIO)
Change August 1, 2014

KEPRO
5201 W. Kennedy Blvd, Suite 900
Tampa, FL 33609

1-855-408-8557 or TTY 1-855-843-4776
www.ohiokepro.com
Steps needed

• Update “Important Message from Medicare”
• For hospitals with swing beds, update Notice of Medicare Non-coverage forms
• Replace all print and electronic copies of beneficiary resources with QIO contact info
• Update policies and procedures that reference to contact Stratis Health
Value Incentives and Quality Reporting Centers
Program Contract Structure
as of 8/1/2014

Program Collaboration Center

Value Incentives and Quality Reporting Centers
- O&E Hospital Inpatient Psych-Cancer
- O&E ASC and Outpatient
- M&E/Analytics
- Validation Support
- Appeals

BFCC Oversight & Review Center

BFCC NCC

BFCC - QIOs
- BFCC-QIO Area 1
- BFCC-QIO Area 2
- BFCC-QIO Area 3
- BFCC-QIO Area 4
- BFCC-QIO Area 5

QIN NCC

QIN - QIOs
- QIO AREAS TBD
  # and distribution of awards based on results of full-and-open competition

BFCC = Beneficiary and Family Centered Care
M&E = Monitoring and Evaluation
NCC = National Coordinating Center
O&E = Outreach and Education
QIN = Quality Innovation Network

Quality Improvement Organizations
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Quality Improvement Organizations
Meeting Knowledge. Improving Health Care.
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VIQR Hospital Inpatient, Psychiatric Facility and PPS-Exempt Cancer Hospitals

Award: 6/16/14 to FMQAI

This contractor provides national outreach, education, and technical assistance to subsection (d) hospital inpatient departments, CAH’s, PPS-exempt cancer hospitals, and inpatient psychiatric facilities to report quality data to CMS. The contractor also educates hospitals and QIN’s on CMS Hospital Value Based Purchasing (VBP) program requirements, performance scores, and other Hospital VBP information linking payment to quality. Supports CMS to administer the following programs:

- Hospital VBP Program
- Hospital Inpatient Quality Reporting Program
- PPS-Exempt Cancer Hospital Quality Reporting Program
- Inpatient Psychiatric Facility Quality Reporting Program
VIQR Hospital Outpatient and Ambulatory Surgical Centers (ASC)

Award: To Be Announced

This contractor provides national outreach, education, and technical assistance to subsection (d) hospital outpatient departments, CAH’s, and ambulatory surgical centers to report quality data to CMS. Supports CMS to administer the following programs:

• Hospital Outpatient Quality Reporting Program
• Ambulatory Surgical Center Quality Reporting Program
VIQR Hospital Quality Reporting Validation Support Center

**Award: To Be Announced**

The contractor supports the Hospital Inpatient and Outpatient Quality Reporting programs to verify accuracy and completeness of quality data reported by hospitals. Assists CMS to collect healthcare associated infection lab culture and Intensive Care Unit information from providers to improve sampling efficiency. Partners with CMS measures maintenance contractor and CDC to educate CMS Clinical Data Abstraction Center on validation methodology and abstraction instructions, and provides technical assistance to CMS in updating validation processes to align with new measures and technologies.
VIQR Appeals Center

Award: To Be Announced

This contractor assists CMS to administer our appeals, reconsideration, provider reimbursement review board cases, and other post-payment determination reviews. This contract provides outreach and education to affected providers and ASC’s, and assists CMS to collect and review necessary appeals information from providers, CMS and Federal partners collecting data on behalf of our quality programs.
VIQR Monitoring and Evaluation Center

Award: To Be Announced

This contractor supports CMS to monitor and evaluate the Hospital VBP program and CMS quality reporting programs relative to supporting CMS three-part aim of lowering cost, improving patient care, and improving population health. Assesses both positive impact of programs and potential unintended consequences to beneficiaries and the health delivery system. The contractor also provides ad-hoc analytic data reports to CMS upon request.
Reporting change discussion
SQRMS
Questions?

Vicki Tang Olson, Program Manager

952-853-8554 or 877-787-2847

volson@stratishealth.org

www.stratishealth.org
Stratis Health is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.
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