

Hospital and Practice Quality Programs

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Disclosures

Ed Fry

- Athenahealth, Bayer Healthcare Pharmaceuticals, Community Health Systems, Gilead Sciences, Inc., Johnson & Johnson, McKesson, Pfizer Inc, St. Jude Medical, Watson Pharmaceuticals, Inc The St. Vincent Heart Center of Indiana, LLC
- For this presentation: None

Disclosures on file at: acc.org



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Hospital and Practice Quality Programs 101

- Hospital based programs
- Provider/Practice based programs
- Payment at risk
- Future programs
- How do we avoid penalties/improve payment?



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CMS/Healthcare “Alphabet Soup”

ABN, ACA, ACO, APMs, APP, AHRQ, AMA, APCs, ASC, AUC, BA, BBA, BPCI, CAC/CACS, CG-CAHPS, CCs, CCM, CCS, CCS-P, CDI, CDM, CDS, CEHRT, CERT, CHIN, CLIA, CMS, CPC, CPC-H, CPC-P, CPC/CPCI, CPOE, CPT, CQM's, CVSL, DW/EDW, DOJ, DICOM, DRGs, eCQM's, EDI, EHR, EMR, EP, eRX, ERA/SPR/RA, FCA, FFS, FFV, FMLA, FS/PFS/IPPS/HOPPS, FS, FTE, GPCI, GPRO, HAC, HEAT, HCPCS, HCQIA, HIE, HIT, HIPPA, HIPDB, HOPPS, HL7, HPSA, HRRP, ICD-9, ICD-10, IPA, IPPS, LCD, MAC, MACRA, MAV, MCR/MLR, MCCs, MA, MEI, MIP, MIPS, MIS, MLN, MLP, MPFS, MPI, MSO, MS-DRG, MSPB, MSSP, MU, NCCI, NCD, NCQA, NPDB, NPI, NPP, OIG, ONC, OPPS, PACS, PBB, PBM, PC, PCMH, PECOS, PFS/MPFS, PHO, PQRS, PSC, QCDR, QRUR, RAC, RBRVS, RRP, RUC, RVUs, SGR, SOS, SNF, SNOMED CT, TCM, TIN, V2V, VBP, VBPM, WI, wRVU, ZPIC



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ABN, ACA, ACO, APMs, APP, AHRQ, AMA, APCs, ASC, AUC, BA, BBA, BPCI, CAC/CACS, **CG-CAHPS**, CCs, CCM, CCS, CCS-P, CDI, CDM, CDS, CEHRT, CERT, CHIN, CLIA, CMS, CPC, CPC-H, CPC-P, CPC/CPCI, CPOE, CPT, CQM's, CVSL, DW/EDW, DOJ, DICOM, DRGs, eCQM's, EDI, EHR, EMR, EP, eRX, ERA/SPR/RA, FCA, FFS, FFV, FMLA, FS/PFS/IPPS/HOPPS, FS, FTE, GPCI, GPRO, **HAC**, HEAT, **HCPCS**, HCQIA, HIE, HIT, HIPPA, HIPDB, HOPPS, HL7, HPSA, **HRRP**, ICD-9, ICD-10, IPA, IPPS, LCD, MAC, MACRA, MAV, MCR/MLR, MCCs, MA, MEI, MIP, MIPS, MIS, MLN, MLP, MPFS, MPI, MSO, MS-DRG, MSPB, MSSP, **MU**, NCCI, NCD, NCQA, NPDB, NPI, NPP, OIG, ONC, OPPS, PACS, PBB, PBM, PC, PCMH, PECOS, PFS/MPFS, PHO, **PQRS**, PSC, QCDR, QRUR, RAC, RBRVS, RRP, RUC, RVUs, SGR, SOS, SNF, SNOMED CT, TCM, TIN, V2V, **VBP**, **VBPM**, WI, wRVU, ZPIC



CMS Pay for Quality Programs

Hospital

- Value Based Purchasing (VBP)
- Hospital Readmissions Reduction Program (HRRP)
- Hospital Acquired Conditions (HAC)
- **Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)**

Practice/Provider

- Physician Quality Reporting System (PQRS)
- Meaningful Use (MU)
- Value Based Modifier (VBM)
- Clinician and Group Consumer Assessment of Healthcare Providers and Systems (**CG-CAHPS**)



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Hospital Based Quality Programs



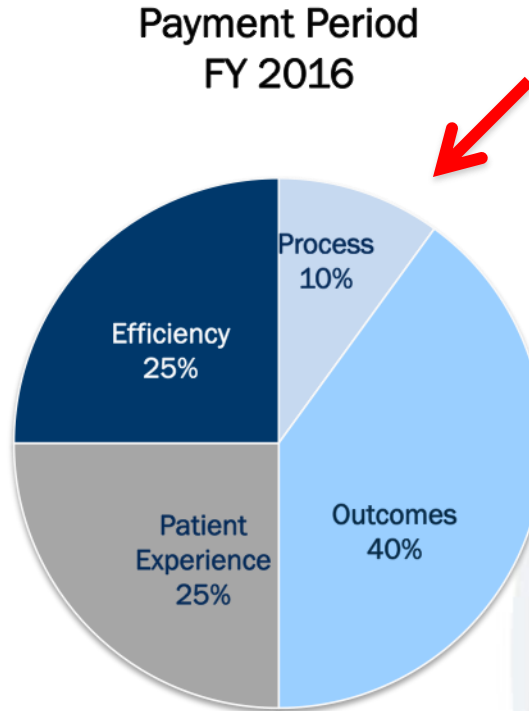
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Value Based Purchasing (VPB)

- Payment “redistribution”
- Funded by 1.75% (FY16) of base CMS payments (= “withhold”)
- Domains: Process of Care, Pt. Experience, Efficiency (cost), Outcomes
- Budget neutral – “winners and losers”, net zero
- Shifting emphasis, 2 year “lag”



VBP: Domains of care - Process



Process of Care

- Lytics <30 min.
- Abx for immunocompromised CAP
- Pre-op Abx.
- Abx prophylaxis post-op <24 hr
- Post-op Foley out day 1-2
- Peri-op Continuation of Beta-Blocker
- Surgical VTE prophylaxis
- Influenza vaccination



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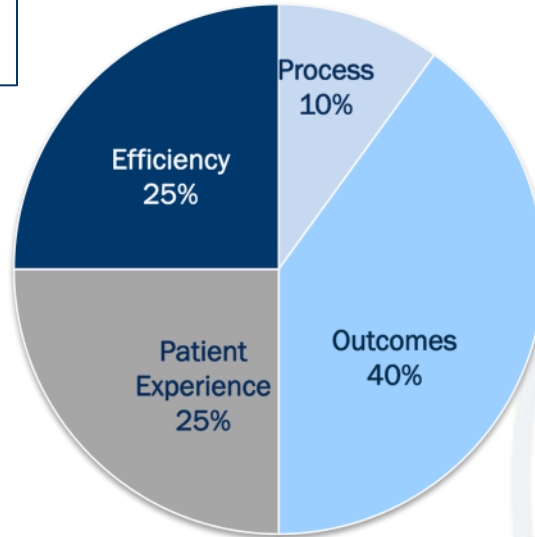
VBP: Domains of care - Efficiency

Efficiency of Care

- Medicare spending per beneficiary (costs) 3 days before through 30 days after



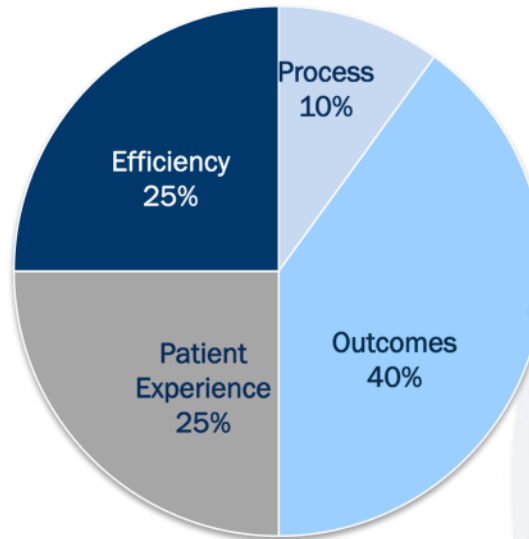
Payment Period
FY 2016



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VBP: Domains of care - Outcomes

Payment Period
FY 2016



Outcome Measures

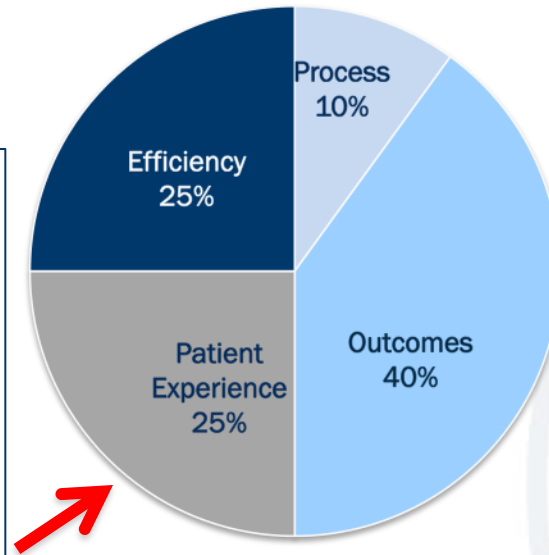
- AMI 30d mortality
- CHF 30d mortality
- Pneumonia 30d mortality
- Safety Indicator Composite (%)
- CLABSI
- CAUTI
- Surgical Site Infection (SSI)



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VBP: Domains of care – Pt. Experience

Payment Period
FY 2016



Patient Experience (HCAHPS)

- Communication with Nurses
- Communication with Providers
- Responsiveness of Staff
- Pain Management
- Communication about Meds
- Cleanliness and Quietness
- Discharge information
- Overall Hospital Rating (0-10)



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CMS Value Based Purchasing:

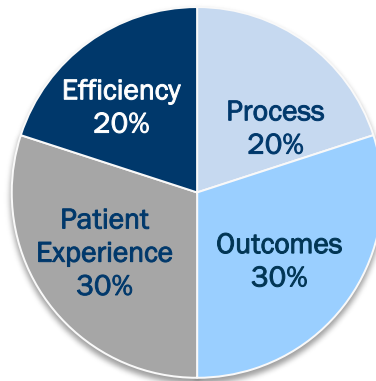
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“Moving the Goalposts”

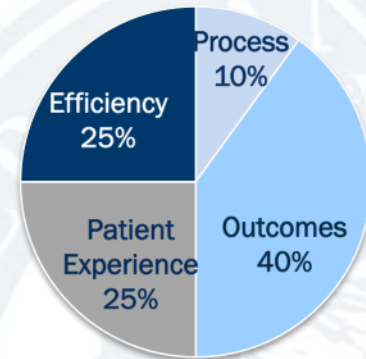
Payment Period
FY 2014



Payment Period
FY 2015



Payment Period
FY 2016



Decreasing weight: Process of care, Patient experience

Increasing weight: Outcomes, Efficiency (i.e. “Quality”)



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VPB: Minimum Reporting Criteria

- Process of Care – 10 cases
- Mortality – 25 cases
- Safety (AHRQ PSI-90 Composite) – 3 cases
- Patient Experience – 100 surveys returned
- Infection Prevention – 1 case
- Efficiency/Cost – 25 cases



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Hospital Readmissions Reduction Program (HRRP)

- Penalty program only – no bonuses
- FY 2016 – Only 23% of hospitals not penalized
- **Cases at risk for 3% penalty of total CMS hospital spend:**
 - AMI
 - CHF
 - Pneumonia
 - Joint Replacement
 - COPD
 - CABG (2017)



Hospital Acquired Conditions (HAC)

- Conditions acquired in the hospital during the treatment of another condition during the same stay (~1 out of 8 pts.)

- AHRQ PSI-90 Composite →
- CLABSI
- CAUTI
- SSI
- C.Diff (2017)
- MRSA (2017)

- Pressure Ulcer
- Iatrogenic Pneumothorax
- CLABSI
- Post-op Hip Fracture
- Peri-op Hemorrhage
- Post-op Metabolic Derangement
- Post-op Respiratory Failure
- Peri-op VTE
- Post-op Sepsis
- Post-op Wound Dehiscence
- Accidental Puncture or Laceration



Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

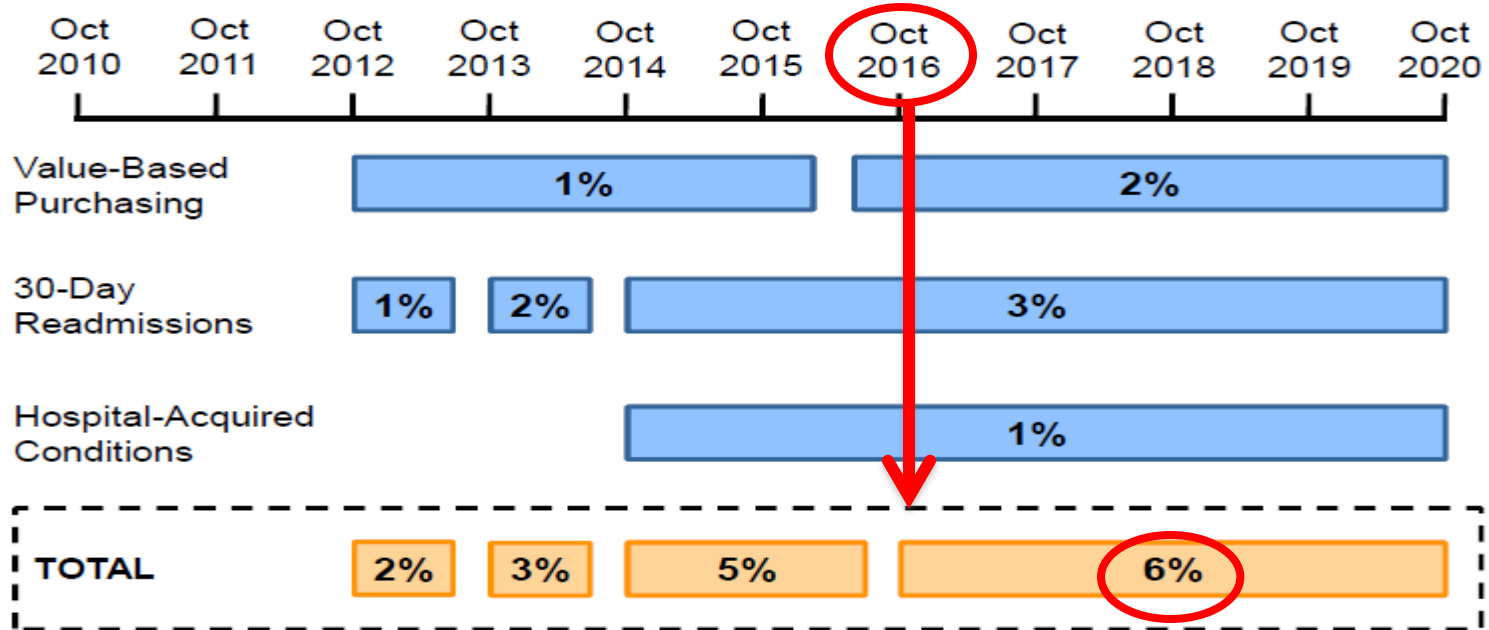
- Communication with Nurses
 - Communication with Providers
 - Responsiveness of Staff
 - Pain Management
 - Cleanliness and Quietness of Hospital Environment
 - Communication about medications
 - Discharge information
 - Overall Hospital Rating
- (In) Patient Satisfaction



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Value-Based Reimbursement - Today

Hospital Medicare Payment at Risk, Year by Year



VBP/HRRP/HAC: Impact 2010-2016

- Total CMS hospital spend 2015 = \$1 Trillion
- Potential at risk 5% = \$50 Billion
- VBP FY 2015 – 55% got a bonus
- HAC – 1.3 million fewer events, 50K fewer deaths
 - \$12 Billion savings
- HRRP – 8%, 150K fewer Re-admissions
- Programs have contributed to the \$316 Billion decreased CMS spend since 2009



Difference maker – QUALITY

2015 VBP + Readmission Penalty Avoidance

<u>Hospital</u>	<u>2015 VPB Bonus</u>
St. Vincent Heart Center	+0.54%
St. Vincent Indianapolis	+0.06%
IU Indianapolis	+0.09%
Community North	-0.04%
Community Heart Hospital	+0.03%
Franciscan Health Indianapolis	+0.04%
Franciscan Health Lafayette	-0.18%
Lutheran Hospital Fort Wayne	+0.14%
St. Mary's Evansville	-0.06%

For each \$10 million in Medicare payments 0.10% VBP bonus = \$10,000

SVHCI 2015 bonus = \$206,963 - What is ROI?



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Hospital Compare
Home

About Hospital
Compare

About the data

Resources

Help

Home

 Share

Find a hospital

A field with an asterisk (*) is required.

* Location

Example: 45802 or Lima, OH or Ohio

ZIP code or City, State or State


Hospital name (optional)

Full or Partial Hospital Name

Search



Spotlight

- ♦  **NEW** Healthcare-associated infections data have been expanded to include adult and pediatric medical, surgical, as well as combined medical and surgical wards. [Learn more.](#)
- ♦ We've reorganized the data

Additional information

- ♦ **Hospital Compare data last updated:** December 10, 2015. [Go to updates.](#)
- ♦ [Download the Hospital Compare database](#)
- ♦ [Get Hospital Compare data archives.](#)

Tools and Tips

- ♦ [Learn how Medicare covers inpatient and outpatient hospital services.](#)
- ♦ [Use The Guide to Choosing a Hospital when comparing hospitals.](#)
- ♦ [Get tips for printing hospital information](#)

- Transparency
- Better product
- Competition
- Consumer-based
- How many really using? Unknown



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Provider/Practice Quality Programs



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Physician Quality Reporting System (PQRS)

- Out-patient penalty program – 2% at risk
 - Individuals (NPI# and TIN)
 - Groups (GPRO)
- 9 measures across 3 of 6 National Quality Strategy (NQS) “Domains” for 50% of pts.:
 - Effective care, Safety, Efficiency, Engagement, Communication, Population Health



PQRS: Reporting source options

Clinician & Group
Consumer Assessment
of Healthcare Providers
and Systems (CAHPS)

National Quality Forum
(NQF)-endorsed
measures

Current 2015 PQRS

Measures used by
boards or specialty
societies

Measures used in
regional quality
collaborations



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PQRS: Cardiology Measures 2016

- CHF: ACE/ARB, EF <40%
- CAD: Antiplatelet therapy
- CAD: BB, EF <40%
- CHF: BB, EF <40%
- Ischemic Vasc Dz Anti-plt Rx
- Tobacco screen/Cessation
- HTN Rx: <140/90
- CAD Symptom Rx
- Avoid use of pre-op stress tests
- %Stress routine after PCI
- %Stress for low-risk patients
- A. Fib anti-coagulation
- Vascular Dz: Statin Rx
- ICD complications/Infections
- Tamponade after AF ablation
- Optimal Med Rx after PCI
- “Cross-Cutting” Measures



Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS)

- Getting timely care, appointments
- Patient rating of provider
- Access to specialists
- Health education
- Shared decision making
- Health status/Functional status
- Staff – helpful, courteous
- Care coordination
- Between visit communication
- Helping with taking meds as directed
- Stewardship of resources

(Out) Patient Satisfaction



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~~Meaningless~~ Meaningful Use (MU)

(Electronic Health Record Incentive Program)

Stage 1: Meaningful use criteria focus on:	Stage 2: Meaningful use criteria focus on:	Stage 3: Meaningful use criteria focus on:
Electronically capturing health information in a standardized format	More rigorous health information exchange (HIE)	Improving quality, safety, and efficiency, leading to improved health outcomes
Using that information to track key clinical conditions	Increased requirements for e-prescribing and incorporating lab results	Decision support for national high-priority conditions
Communicating that information for care coordination processes	Electronic transmission of patient care summaries across multiple settings	Patient access to self-management tools
Initiating the reporting of clinical quality measures and public health information	More patient-controlled data	Access to comprehensive patient data through patient-centered HIE
Using information to engage patients and their families in their care		Improving population health



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MU: Incentive plan phase in.

Maximum Payment by Start Year	2011	2012	2013	2014	2015	2016
2011	1	1	1	2	2	3
\$43,720	\$18,000	\$12,000	\$7,840 Reduction (\$160)	\$3,920 Reduction (\$80)	\$1,960 Reduction (\$40)	
2012		1	1	2	2	3
\$43,480		\$18,000	\$11,760 Reduction (\$240)	\$7,840 Reduction (\$160)	\$3,920 Reduction (\$80)	\$1,960 Reduction (\$40)
2013			1	1	2	2
\$38,220			\$14,700 Reduction (\$80)	\$11,760 Reduction (\$240)	\$7,840 Reduction (\$160)	\$3,920 Reduction (\$80)
2014				1	1	2
\$23,520				\$11,760 Reduction (\$240)	\$7,840 Reduction (\$160)	\$3,920 Reduction (\$80)

Value Based Modifier (VBM)

- Incentive plan based on balance of quality and cost – adjustment to MPFS
- Physicians only (TIN), non-physicians in 2018
 - Category 1: Avoided 2016 PQRS penalty – receive a cost-quality tiered bonus/adjustment
 - Category 2: Failed PQRS – get a 2% penalty
 - Group vs individual adjustments differ



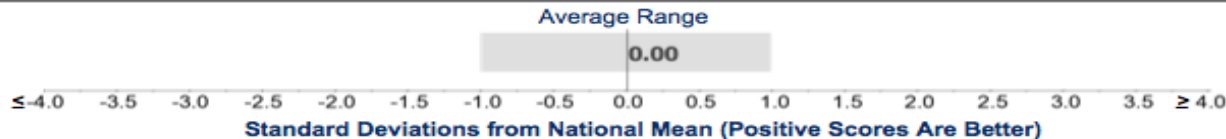
QRUR Reports: “How do you compare?”

30

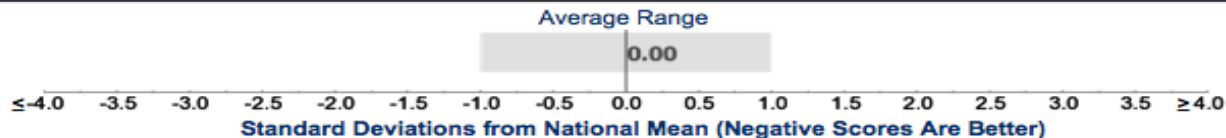
<https://portal.cms.gov/>

PERFORMANCE HIGHLIGHTS

Your Quality Composite Score: Average



Your Cost Composite Score: Average



Your Performance: Average Quality, Average Cost



Value Based Modifier Payment Calculations

Bonus/Penalty: Calculated as total Medicare Payments x Adjustment Factor, based on QRUR results

	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+1.0 x AF	+2.0 x AF
Average Cost	-0.5%	+0.0%	+1.0 x AF
High Cost	-1.0%	-0.5%	+0.0%

Sum of Rewards and Penalties = Net Zero (or less)



Does Measuring Quality improve outcomes?

Chatterjee P, Joynt K JAHA 2014;3e000404

Farranow G JAHA 2014;3e001432

- Overall - ?, Improve transparency and patient trust
- VBP – Too early to tell
- HAC - Yes
- P4P: Modest improvement, depends on incentives and baseline quality – “Regression to the mean”
- Successes: GWTG, D2B, ACC and STS Registries
- Readmissions: Possible inverse relationship between mortality and CHF readmits*

* Krumholz H, et al. JAMA 2013;309:587



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Quality Programs: (Near) Future



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MACRA: Medicare Access and CHIP

Reauthorization Act of 2015

April 16, 2015

Pre-MACRA

- 21% payment cut in 2015, continued uncertainty
- Separate quality reporting programs with separate penalties (no bonuses)
- Some regulatory flexibility for Alternative Payment Model (APM) participation

Post-MACRA

- Eliminates SGR; implements stable payment increases
- Streamlined quality reporting program with consolidated penalties and bonuses
- Incentives for Alternative Payment Model (APM) participation (ACO's, MSSP, bundles, full risk)



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MACRA: Annual Payment Updates

Volume



Value

Mid 2015-2019

2020-2025

2026 and After

- 0.5% annual payment update

- 0% annual payment update
- Introduction of Merit-Based Incentive Payment System (MIPS)

- 0.75%: Alternative Payment Model (APM) participants
- 0.25%: All other professionals

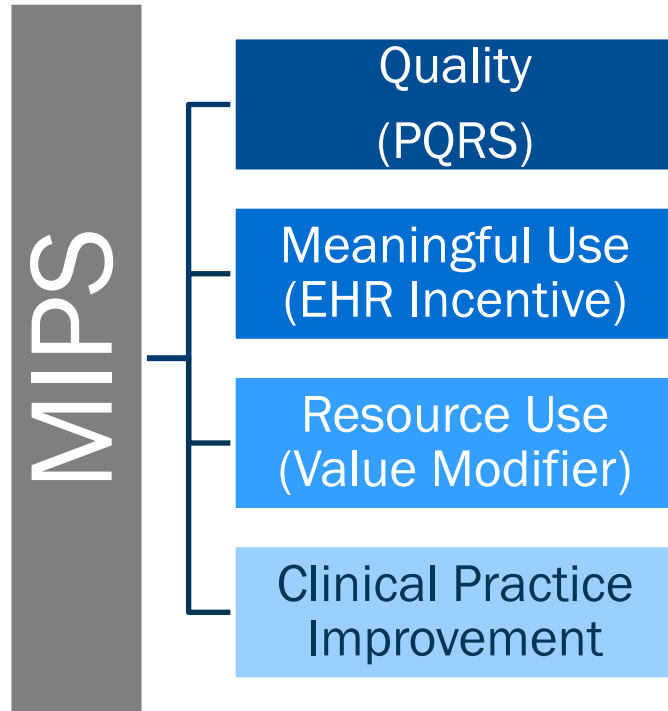
If Inflation: 2.5-3.0%
= 2.0-2.5% CUT

Averts a 21% payment cut in 2015 and future uncertainty



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Merit-Based Incentive Payment System (Providers)



- Individual program penalties continue through 2018
- MIPS begins in 2019 for physicians and most APP's
- Eligible professionals scored against benchmark based on prior year's performance
- CPI = "PIM" – Part IV MOC



Who and How will CQM's be developed for MIPS?

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Short Answer: No one knows!

- Domains:
 - Clinical Care, Safety, Care Coordination, Pt/Provider experience, Population Health/Prevention
- Requirements:
 - Multiple Payer Applicability, Multidisciplinary
 - Comply with, driven by Clinical Practice Guidelines
 - Provide an evidence base for non-evidence based measures, Gap analysis
 - Applicability across Health Care setting: IP vs OP
 - Use of professional society QCDR (ACC “home run”)
 - Use of eQDM's and PROM's
- Public comment period through 3/1/16

CMS Proposal Dec. 18, 2015



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MIPS Payment Adjustments

“Zero-sum game”: Winners and Losers!

Low Performance

Benchmark

High Performance

Negative Adjustment

Neutral Adjustment

Positive Adjustment

	2015	2016	2017	2018	2019	2020	2021	2022+
PQRS+VM+EHR Incentive Penalties (combined)	-4.5%	-6.0%	-9.0%	-10% or more	-11% or more	-11% or more	-11% or more	-11% or more
MIPS Bonus/Penalty (max)	-4.5%	-6.0%	-9.0%	-10% or more	+4%* -4%	+5%* -5%	+7%* -7%	+9%* -9%

* May be increased by up to 3 times to incentivize performance
\$500 mil funding for bonuses allocated through 2024



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Take Aways:

- It's complicated – have a Quality good team
- Educate all the staff, team members
- Prevent penalties first, “more bang for the buck”
- Go for the “overlaps” (PSI-90, HAC)– “Two birds with one stone”
- Communicate/publish results on a regular schedule



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Hospital and Practice Quality Programs 401

Prof. Biga



Prof. Gates



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Questions?



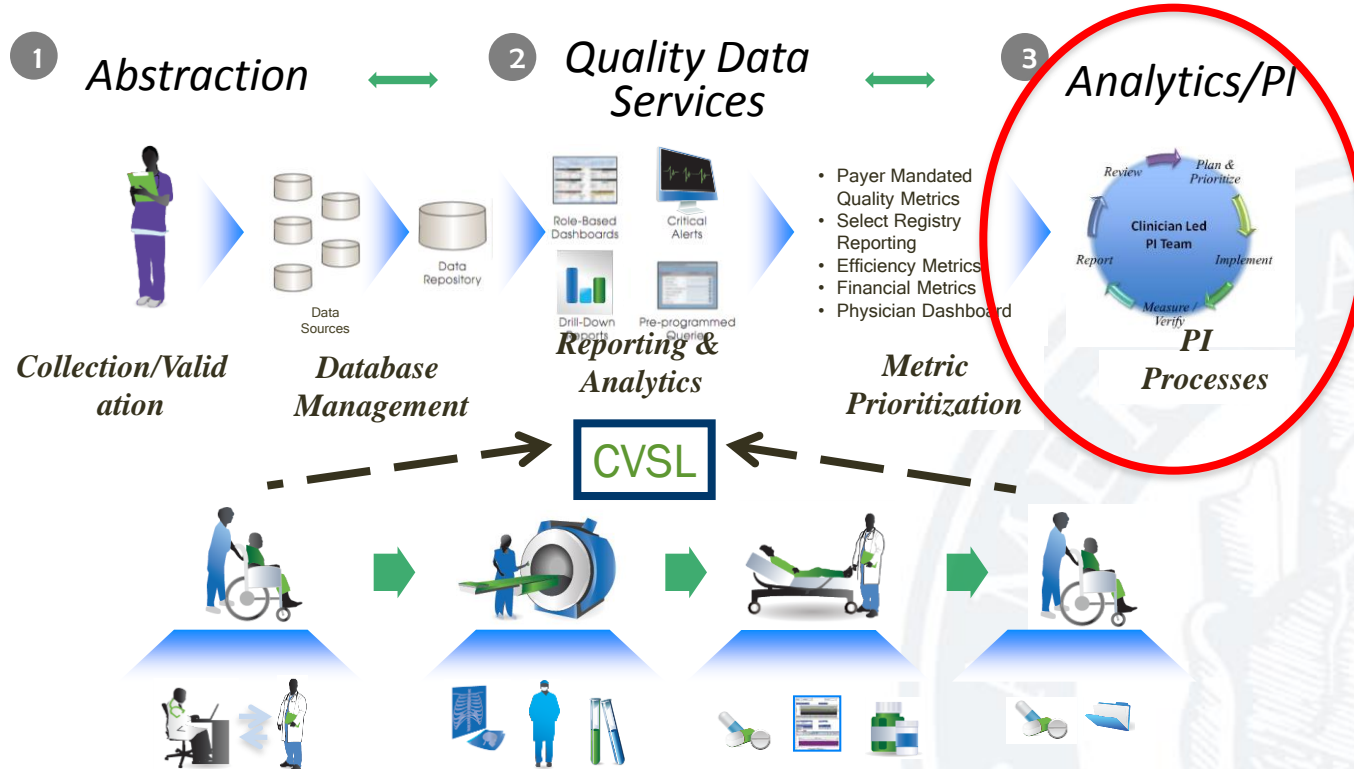
Horse hospitals

How do we get all of this done?



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Clinical Quality: Integrated Tools



Clinical Quality: Registries and Databases

- ✓ Cath/PCI (ACC)
- ✓ ACTION (ACC)
- ✓ TVTR (STS/ACC)
- ✓ ACC-IMPACT
- ✓ GWTG-CHF (AHA)
- ✓ GWTG-Stroke (AHA)
- ✓ ICD (ACC)
- ✓ Electrophysiology (Ablation)
- ✓ VAD – Transplant
- ✓ INTERMACS
- ✓ Congenital OHS (STS)
- ✓ Adult Cardiac Surgery (STS)
- ✓ Thoracic (STS)
- ✓ VSQI (IP & OP)
- ✓ NSQIP
- ✓ PINNICAL (ACC)
- ✓ A. Fib (ACC)
- ✓ JC Asthma
- ✓ Oncology
- ✓ NRCPR
- ✓ CMS
 - Surgical Care Infection Prevention
 - VTE
 - Stroke
 - CHF
 - Pneumonia
 - Perinatal Measures
 - ED Measures
 - Psychiatric Services
 - IED / IMM



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Getting it Done: Process Improvement Teams

PI Process



- Sub-Specialty Focused
- Physician “Champion” and Admin./RN Leaders
- Multi-disciplinary
- Team based
- Monthly meetings and data review
- Set annual goals
- Accountability
- Communicate plan section and system-wide

CVT Council: A “Home” for Quality

Health System Board

- Quality Safety Committee
- Operations /Quality / MEC

Bob Robison MD
Greg Elsner MD

CVT Executive Council

Resources:

- PI Nurse Support
- Reporting / Analytics
- Statistical Services

Performance Dimensions:

1. Quality
2. Efficiency / Profitability
3. Patient & Staff Satisfaction
4. Research / Technology
5. Growth

ACS / Cath PCI PI

Greg Elsner MD

Heart Failure PI

Minnow Walsh MD
Frank Green MD

CRM PI

Eric Prystowsky MD

Peripheral Vascular PI

Joel Feldman MD

Open Heart PI

Dave Heimansohn, MD

CV Peds PI

Sanjay Parikh MD

Thoracic PI

Rich Freeman MD

VAD PI

Christopher Salerno
MD Tom Schleeter MD



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CVT Council: PI Reporting

One Page Update

- Generated Quarterly
- Metrics, Results, Work Plan
- Facilitated by PI Nurse
- Drives PI Team Accountability

OHS PI Summary 2Q 2013

Key Performance Metrics	Q2 Result		Goal / By
	86 th	106 th	
Vent times	X% (down from X%)	X% (down from X%)	<X% / Maintain
Antibiotic discontinued within 24/48 hours after surgery end time	X% (up from X%)	X% (down from X%)	X% / Maintain
Controlled 06 post op serum glucose	X% (up from X%)	X% (down from X%)	X%/Q3
Urinary catheter removed POD 1 or POD 2	X% (remains X%)	X% (remains X%)	X%/Maintain
Afib control (STS changed the definition of this variable. New definition initiated at both sites 9/5/2012)	X% (up from X%)	X% (down from X%)	<X / Maintain
Periop Beta Blocker administration	X% (remains X%)	X% (remains X%)	>X/Maintain
Perioperative Transfusion	X% (down from X%)	X% (up from X%)	<X%/Q4
OHS readmissions	X% (up from X%)	X% (up from X%)	<X%/Maintain

Discussion of Results:

- Vent times at 86th Street are perfect and remain steady; continues to be an area of focus. Goal is to maintain $\leq 0.0\%$.
- The following changes have been implemented to improve SCIP compliance:
 - 106th St.: Urinary Catheter documentation check boxes added to the daily physical assessment form to ease documentation of reasons to root for colts.
 - 86th St.: Worked with the Quest team to make the process for the bedside nurse to document reason to keep catheter by adding "as per protocol" to the reasons to keep foley instead of the 2 step process it is now. We have achieved 100% compliance for the month of Dec and the 1st and 2nd quarters at both sites for SCIP Inf 9.
 - Mandatory blood glucose protocol teaching has occurred at 106th Street. All non compliant cases are reviewed at both sites for any opportunities for improvement and feedback is given to the medical and nursing staff as needed.
- Afib control- Despite definition change for collecting afib as a post op event (no longer excluding those guests who had a history of afib pre op), both sites are better than target. 106th St. made practice changes to be similar to 86th St. location.
- Perioperative Transfusion- focusing on preoperative (in the office) evaluation and treatment to optimize the guest's parameters prior to procedure (protocol to treat anemia preop), different equipment for the bypass pump, and explore newer devices to monitor blood and obtain results for care decisions.

Summary of Work Plan for Q3:

1. Continue to monitor Prolonged Vent times- all prolonged vent cases are reviewed individually for opportunities for improvement.
2. Continue to monitor all SCIP measures during guest hospitalizations and review missed opportunities. Continue root for colts to win super bowl.
3. The transfusion subcommittee meets on the Wed prior to the OHS PI meeting. Continue to work through the process to optimize the guest before surgery. The subcommittee will review our data, research the literature for evidence based best practice, and report back to the OHS PI committee.



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