3 STEPS for complying with

How to maximize success within this evolving care model

VALUE-BASED CARE MODELS CONTINUE TO ENTER THE HEALTHCARE MARKET IN A DRIVE TO REDUCE COSTS AND IMPROVE QUALITY. Back in 2001, the report "Crossing the Quality Chasm" highlighted the quality gap in healthcare and prompted the government to focus on funding quality of care instead of quantity. Though value-based care was originally introduced by the Centers for Medicare & Medicaid Services (CMS) as a way to transition away from a fee-for-service system, many private payers have followed.

"What I like to say to people is, where Medicare goes, others will follow," says **Karen Bush**, MSN, FNP, BC, NCRP, Director of Clinical Research & Education at HealthTrust. "Generally speaking, every payer source has programming that incorporates value-based care and/or penalty avoidance."

STEP 1

RECOGNIZE THE BENEFITS & OPPORTUNITIES

Studies have shown that value-based care programs demonstrate a correlation between improved outcomes of care and increased patient experience or satisfaction. They also bring benefits to healthcare providers, as participation in CMS programs is mandatory for Medicare-certified hospitals—with reporting tied to reimbursement. Along with the obvious benefit of avoiding financial penalties, the data that is reported through these programs is publicly available for patients to access, giving hospitals a way to stand out from their competitors.

But value-based programs come with a host of challenges that hospitals need to understand. "These programs and the reporting process are very complex, so I think that's a barrier," says **Holly Moore**, MSN, CCRN-K, a Clinical Director within HealthTrust Clinical Services. "They require commitment from the hospital executive suite, physicians, service line leaders and hospital staff. Hospital executives are particularly crucial, as they make strategic and financial decisions that impact the institution's focus and allocation of resources."

programs

STEP 2

UNDERSTAND THE METRICS

Each program has its own set of metrics, and it's important for quality departments and hospital leaders to understand what each is measuring because, as Moore points out, "if you don't know what's being measured, you can't improve your metrics."

Understanding that nuance will also draw attention to issues such as the overlap between some of the programs, where hospitals can be penalized twice on similar metrics. For example, the Hospital-Acquired Condition (HAC) Reduction Program focuses on preventing avoidable complications—such as bloodstream infections from IVs and surgical site infections—but hospitals are also being scored on those in the safety domain of the Hospital Value-based Purchasing (VBP) Program. So hospitals violating both can be doubly penalized.

Differences also exist within each model. HAC and the Hospital Readmission Reduction Program (HRRP), for example, use a penalty model with hospitals judged against a benchmark, while VBP includes both a penalty and an incentive. "CMS is penalizing the poorly performing hospitals and incentivizing the top performers," says Moore, "using a carrot-and-stick approach as a way to get everybody to elevate their care." (See page 34 for more details on these models.)

Performance periods and payment periods also vary between programs. Adding to the complexity is the timing of the penalty or payment: Because penalties

are all done in arrears, hospitals are being penalized or incentivized based on care they delivered up to five years ago, depending upon the program.

For example, the penalty for HRRP is assessed using a three-year average and occurs a year later. This means a hospital receiving a penalty in 2020 is actually being penalized for its readmissions from 2015 to 2018. "That really affects how soon a hospital is going to see the financial impact of any kind of quality-improvement initiatives they do today," says Moore.

She explains that foresight is needed. "We want to see the results of our efforts immediately, and it's easy to lose sight of the long game when you're focused on the short game."

STEP 3

TAKE IMMEDIATE ACTION ON DATA

By tracking their own on-site, real-time data, hospitals don't have to wait out the performance period to take action and see results. "Hospitals have to tackle value-based care by acting on data now, knowing that it is projecting what kind of payment or penalty they're going to have in the future," says Moore.

Real-time data also provides ongoing results to share with executive teams, which is helpful in encouraging them to grasp the problem and find meaningful solutions. "You often see hospitals that want to throw 10 darts at a dartboard and hope one of them sticks, rather than targeting their response to the real problem they can find by looking into the data," says Bush.

Bush recommends using the data to look at individual cases as well as general trends. "With HRRP, for example, part of the assessment should include trending data for the prior discharge location of the readmitted patients," she explains. "If the trend is showing many of them are returning back from home, a more detailed, patient-level assessment can look at education and resources the patient was provided at discharge, such as follow-up appointments, education using teach-back or medication reconciliation. If they are returning from skilled facilities, a detailed assessment can include evaluation of the transition at discharge, standardized information flow, warm hand-off or other coordinated efforts."

There are a variety of ways to look at and use this data. HealthTrust members have access to the All Payers Claims Data (APCD). This dataset provides a more complete picture of the population that a member serves because it includes information on all patients discharged in a particular time frame. This is in contrast to the Medicare claims dataset, which only provides information on patients aged 65 or older.

"While no perfect dataset exists, APCD is a rich source of information for our members and provides a way to evaluate performance by trending risk-adjusted outcomes," says Moore.

As value-based care grows, CMS and other payers continue to introduce programs such as bundled payment arrangements. With the wide array of regulations and policies that go along with this shift to pay-for-performance, hospitals need to stay informed of the complexities in order to minimize penalties and improve patient outcomes and satisfaction. "Understanding what you're going to be graded on, what the performance periods are in relation to the payment periods, and where you're going to be penalized or incentivized is key," says Moore. "And then, keep your finger on the pulse of those metrics in your facility in real-time so that you can impact future payments."

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TO LEARN MORE about maximizing your value-based care program, contact Kimberly Wright, RN, AVP, Clinical Consulting/Clinical Data Solutions at HealthTrust, at kimberly.wright@healthtrustpg.com

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OVERVIEW OF VALUE-BASED CARE PROGRAMS

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HOSPITAL-ACQUIRED CONDITION (HAC) REDUCTION PROGRAM

Overview: The HAC Reduction Program aims to **increase patient safety by reducing the number of preventable hospital-acquired conditions**, such as pressure ulcers and central line-associated bloodstream infections. The worst-performing quartile of hospitals receive a 1% deduction in their Medicare payments.

How it works: Hospitals are rated using the CMS Patient Safety Indicator (PSI) 90 and the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) Healthcare-Associated Infection (HAI) measures. Medicare reimbursements are based on a discharge diagnosis-related group (DRG), with different levels to account for the severity of illness for sicker patients. For example, an otherwise healthy cardiac patient who has a stent inserted will be discharged at a lower DRG than a cardiac patient who also has chronic kidney disease and high blood pressure.

HOSPITAL VALUE-BASED PURCHASING PROGRAM (VBP)

Overview: The Hospital VBP program aims to **improve the quality of care for hospital patients and improve the patient experience**. Hospitals are assessed in four categories:

- clinical outcomes
- person and community engagement
- safety
- efficiency
- cost reduction

How it works: The VBP program uses both penalties and incentives to motivate hospitals to provide quality care. Each hospital is graded on the VBP metrics and then compared to each other, with the poorest-performing hospitals penalized up to 2% of their reimbursements and the top-performing hospitals receiving a bonus.

HOSPITAL READMISSIONS REDUCTION PROGRAM (HRRP)

Overview: The HRRP **reduces payments to hospitals with excess 30-day readmissions** in the areas of:

- heart failure
- chronic obstructive pulmonary disease
- acute myocardial infarction
- pneumonia
- coronary artery bypass graft
- elective total hip replacement and/or total knee replacement

A readmission occurs when a patient is admitted and discharged with one of the targeted diagnoses (index admission) then is readmitted to any hospital for any unplanned readmission in the 30 days following the index admission.

How it works: The HRRP is a unique hospital value-based program in that it includes the 30-day period following discharge. Because of this, hospitals need to work with key players from across the community in order to reduce readmissions, including team members working inside the hospital (e.g., nurses, hospitalists, surgeons), as well as outside (e.g., home health care, EMS, primary care physicians).

"HRRP is bringing to the table a multidisciplinary team from across the care continuum to talk about what is necessary to safely transition patients out of the hospital," says Bush. "This is a system problem, so the solution has to go across your organization—rather than remain within the walls of your hospital." **HT**