Value Based Purchasing and Quality of Care

Prof. A.F. Al-Assaf, MD, MPH
Executive Director, AIHQ
Professor Emeritus, University of Oklahoma
ala@aihq.com
www.aihq.com
What is Value Based Purchasing?

• A program established by the US Government (cms.gov) to provide incentives for acute care hospitals to deliver quality health care for their patients.

• It is a “Demand” based strategy that measures, reports and rewards care quality. It involves decisions related to access, price, efficiency, effectiveness and incentives.
Quantity based payment vs. Quality based payment
“FORM FOLLOWS FUNCTION”

Louis Sullivan, 2015
The US NQ strategy is to concurrently pursue three aims:
The Strategy’s aims and priorities are supported by the nine National Quality Strategy “levers”: organizations’ core business functions that serve as a means for improving health and health care quality.
Measurement and Feedback

Provide performance feedback to plans and providers to improve care.

A long-term care provider may implement a strategy that includes the use of Quality Assurance and Performance Improvement data to populate measurement dashboards for purposes of identifying and addressing areas requiring quality improvement.
Public Reporting

A regional collaborative may ask member hospitals and medical practices to align public reports to the National Quality Strategy aims or priorities.

Compare treatment results, costs, and patient experience for consumers.
Learning and Technical Assistance

Foster learning environments that offer training, resources, tools, and guidance to help organizations achieve quality improvement goals.

A Quality Improvement Organization may disseminate evidence-based best practices in quality improvement with physicians, hospitals, nursing homes, and home health agencies.
Certification, Accreditation, and Regulation

Adopt or adhere to approaches to meet safety and quality standards.

The National Quality Strategy aims and priorities may be incorporated into continuing education requirements or certification maintenance.
Help consumers adopt healthy behaviors and make informed decisions.

Employers may implement workforce wellness programs that promote prevention and provide incentives for employees to improve their health.
Health Information Technology

Improve communication, transparency, and efficiency for better coordinated health and health care

A hospital or medical practice may adopt an electronic health record system to improve communication and care coordination
Innovation and Diffusion

Foster innovation in health care quality improvement, and facilitate rapid adoption within and across organizations and communities.

Center for Medicare & Medicaid Innovation tests various payment and service delivery models and shares successful models across the Nation.
Workforce Development

Investing in people to prepare the next generation of health care professionals and support lifelong learning for providers

A medical leadership institution may incorporate quality improvement principles in their training
Reward and incentivize providers to deliver high-quality, patient-centered care.

Join a coalition of purchasers that are pursuing value-based strategies.
VBP is based on...

Purchasing care by evaluating:

• Quality (outcomes)
• Service
• Cost

Providing desired (and necessary) services that are high quality at the lowest possible cost!
It is all about appropriately measuring performance

• Performance of **all players**; employers, purchasers, providers, regulators AND consumer behaviors (including employee health and productivity).
• **Measuring performance** is to acquire data!
• Based on accurate, accessible and relevant data; claims, clinical and patient surveys.
• Collecting, measuring, reporting, comparing, acting.
Elements of VBP

1. Standardized **Performance Measurement**
2. Transparency and Public **Reporting**
3. Payment Innovation
4. Informed consumer choice
Transparency

- Data should be converted to useful information (to consumers and purchasers)
- Quality and price indices should become public
- Cost conscious purchasers (actual out-of-pocket expenses)
- Benefit designs = high value providers (for both consumer and purchasers)
Payment Innovations

Re-design payment methods:

• P4P
• Payment for “bundles” of care services or for episodes of care and always based on outcomes (towards good/better health)
• “New design” Capitation payment (based on population health improvement)
• Good health = clinical plus “other” determinants of health (e.g. social)
• Payment should not only be for “treating” sick people but to continuously keeping people healthy.
Informed Consumer Choice

• Life style decisions (preventive and clinical care)
• Treatment choices (personal preferences, compliance rates, and evidence based outcomes)
• Choice for Healthcare Provider/plans (high value – price and STEEEEP quality)
• Enablers: incentives, accessible information, coaching/counseling, health and productivity programs, value-based insurance designs, etc.
<table>
<thead>
<tr>
<th>FY</th>
<th>Domains and weights</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>Clinical Process of Care (10%)</td>
</tr>
<tr>
<td></td>
<td>Patient Experience of Care (25%)</td>
</tr>
<tr>
<td></td>
<td>Outcome (40%)</td>
</tr>
<tr>
<td></td>
<td>Efficiency (25%)</td>
</tr>
<tr>
<td>2017</td>
<td>Patient and Caregiver-Centered Experience of Care/Care Coordination (25%)</td>
</tr>
<tr>
<td></td>
<td>Safety (20%)</td>
</tr>
<tr>
<td></td>
<td>Clinical Care (30%)</td>
</tr>
<tr>
<td></td>
<td>• Clinical Care – Outcomes (25%)</td>
</tr>
<tr>
<td></td>
<td>• Clinical Care – Process (5%)</td>
</tr>
<tr>
<td></td>
<td>Efficiency and Cost Reduction (25%)</td>
</tr>
<tr>
<td>2018</td>
<td>Patient and Caregiver-Centered Experience of Care/Care Coordination (25%)</td>
</tr>
<tr>
<td></td>
<td>Safety (25%)</td>
</tr>
<tr>
<td></td>
<td>Clinical Care (25%)</td>
</tr>
<tr>
<td></td>
<td>Efficiency and Cost Reduction (25%)</td>
</tr>
<tr>
<td>Measure ID</td>
<td>Measure/Dimension Description</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>AMI-7a</td>
<td>Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival</td>
</tr>
<tr>
<td>IMM-2</td>
<td>Influenza Immunization Clinical Process of Care PN-6 Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients</td>
</tr>
<tr>
<td>SCIP-Inf-2</td>
<td>Prophylactic Antibiotic Selection for Surgical Patients</td>
</tr>
<tr>
<td>SCIP-Inf-3</td>
<td>Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time</td>
</tr>
<tr>
<td>SCIP-Inf-9</td>
<td>Urinary Catheter Removal on Postoperative Day 1 or Postoperative Day 2</td>
</tr>
<tr>
<td>SCIP-Card-2</td>
<td>Surgery Patients on a Beta-Blocker Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period</td>
</tr>
<tr>
<td>SCIP-VTE-2</td>
<td>Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery</td>
</tr>
<tr>
<td>CAUTI</td>
<td>Catheter-Associated Urinary Tract Infection</td>
</tr>
<tr>
<td>CLABSI</td>
<td>Central Line-Associated Blood Stream Infection</td>
</tr>
<tr>
<td>MORT-30-AMI</td>
<td>Acute Myocardial Infarction (AMI) 30-Day Mortality Rate</td>
</tr>
<tr>
<td>MORT-30-HF</td>
<td>Heart Failure (HF) 30-Day Mortality Rate</td>
</tr>
<tr>
<td>MORT-30-PN</td>
<td>Pneumonia (PN) 30-Day Mortality Rate</td>
</tr>
<tr>
<td>AHRQ PSI-90</td>
<td>composite Complication/Patient Safety for Selected Indicators (composite)</td>
</tr>
<tr>
<td>SSI</td>
<td>Surgical Site Infection: • Colon • Abdominal Hysterectomy</td>
</tr>
<tr>
<td>MSPB-1</td>
<td>Medicare Spending per Beneficiary (MSPB)</td>
</tr>
</tbody>
</table>

How Is Hospital Performance Scored?

CMS assesses each hospital’s total performance by comparing its Achievement and Improvement scores for each applicable Hospital VBP measure.

CMS uses a threshold (50th percentile) and benchmark (mean of the top decile) to determine how many points to award for the **Achievement** and **Improvement** scores. CMS compares the Achievement and Improvement scores and uses whichever is greater.

To determine the domain scores, CMS adds points across all measures.
Achievement points are awarded by comparing an individual hospital’s rates during the performance period to all hospitals’ rates from the baseline period:

- Hospital rates at or above benchmark = 10 Achievement points
- Hospital rates below the Achievement threshold = 0 Achievement points
- Hospital’s rate is equal to or greater than the Achievement threshold and less than the benchmark = 1–10 Achievement points
Improvement points are awarded by comparing an individual hospital’s rates during the performance period to that same individual hospital’s rates from the baseline period:

- Hospital rates at or above benchmark = 9 Improvement points
- Hospital rates at or below baseline period rate = 0 Improvement points
- Hospital’s rate is between the baseline period rate and the benchmark = 0–9 Improvement points
Consistency points are awarded by comparing a hospital’s Patient Experience of Care dimension rates during the performance period to all hospitals’ Patient Experience of Care rates from a baseline period:

- If all dimension rates are at or above Achievement threshold = 20 Consistency points
- If any dimension rate is at or below the worst-performing hospital dimension baseline period rate = 0 Consistency points
- If the lowest dimension rate is greater than the worst-performing hospital’s rate but less than the Achievement threshold = 0–20 Consistency points

The Patient Experience of Care domain score is the sum of a hospital’s HCAHPS base score and that hospital’s HCAHPS Consistency score.
CMS calculates a hospital’s **Total Performance Score (TPS)** by:

1. Combining the greater of either the hospital’s Achievement or Improvement points for each measure to determine a score for each domain;
2. Then multiplying each domain score by a specified “weight” (percentage); and
3. Then adding together the weighted domain scores.

Priority 1: Making care safer by reducing harm caused in the delivery of care
Priority 2: Ensuring that each person and family members are engaged as partners in their care
Priority 3: Promoting effective communication and coordination of care
Priority 4: Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease
Priority 5: Working with communities to promote wide use of best practices to enable healthy living
Priority 6: Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models
Any Q’s?

Thank you for your attention!