



Dashing through the Data: Understanding How Nursing Drives Hospital Performance Measures and Resources

NOVEMBER 11, 2014

THIS SESSION

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- 1. Health Care Reform and the Patient Protection & Affordable Care Act
- 2. Value-Based Purchasing
- 3. Readmission Penalties
- 4. Hospital-Acquired Conditions Penalties
- 5. Delivery System Reform Incentive Payment (DSRIP)
- 6. Nurses' role
- 7. Labor/Management Collaboration



CONVERGING TRENDS ARE DRIVING THE SHIFT TO PRIMARY CARE AND OTHER REFORMS

- Current system:
 - ➤ Reactive, fragmented, disease-oriented, feefor-service driven
 - Soaring health care costs combined with budgetary crises, especially at the State level
 - ➤ Rising epidemic of chronic illness



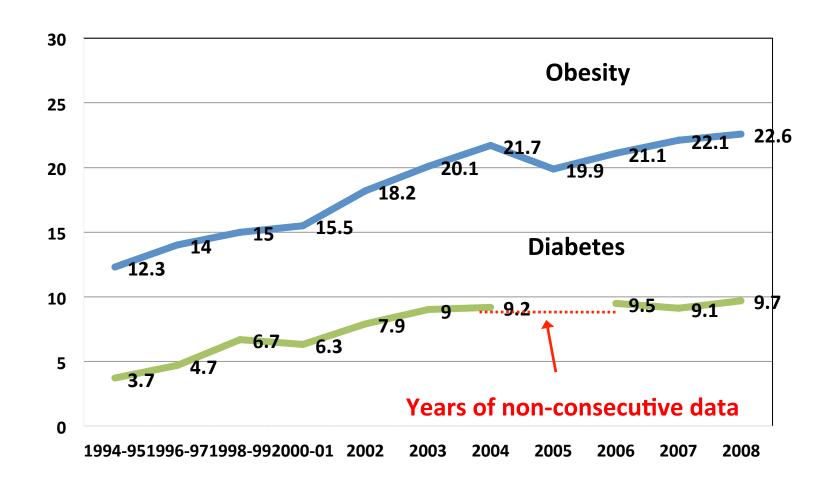
CHRONIC DISEASES

- Chronic diseases are a major contributor to health care costs
- The costs of medical care for people with chronic diseases represent 75 percent of the \$2 trillion in U.S. annual health care spending.
- Institute of Medicine Report, January 2012





ADULT OBESITY AND DIABETES ON STEADY RISE IN NEW YORK CITY



INSTITUTE OF MEDICINE REPORT 2010



LEADING CHANGE ADVANCING HEALTH

The nursing profession has the capacity to implement wide-reaching changes in the health care system

WITH MORE THAN 3 MILLION MEMBERS

NURSES REPRESENT THE LARGEST SEGMENT OF

THE U.S. HEALTH CARE WORKFORCE

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WHY IS DATA IMPORTANT?

Data is critical to achieving the Triple Aim:



Data is driving health care reforms



FLORENCE NIGHTINGALE - STATISTICIAN!



- Collected data on soldier mortality in military hospitals
- ☐ In 1855, the mortality rate was 42.7%!
- Her analysis showed that the principal reason was unsanitary conditions
- After improving hygiene and sanitation among the soldiers, the mortality rate significantly dropped
- ☐ She developed techniques to present data to make a strong argument for health care reform!



PAYMENT REFORM

- Value Based Purchasing (Pay-for-Performance)
 - Hospital Consumer Assessment of Healthcare Providers & Survey (HCAHPS)
 - Core Measures
 - Outcomes
- Elimination of Payments
 - Select re-admissions
 - Healthcare-Acquired Conditions
 - Disproportionate share hospitals (DSH)



HOSPITAL PAYMENT ELEMENTS OF PPACA*

1. Value Based Purchasing (VBP)
Program

2. Hospital
Readmissions
Reduction Program

3. Hospital Acquired Condition (HAC) Reduction Program



1. VALUE-BASED PURCHASING PROGRAM

- Links hospitals' Medicare payment to quality performance
- Quality measures include:
 - ☐ Clinical Process of Care (FY2013)
 - ☐ Patient Experience of Care (FY2013)
 - ☐ Patient Outcomes (FY2014)
 - ☐ Efficiency (FY2015)



How Does VBP Work?

- Base operating Payments are reduced for all hospitals, creating a pool of funds for re-distribution ("Budget neutral")
- The percent reduction increases from 1% in FY 2012 to 2% in FY 2017
- Hospitals can gain or lose, based on their performance on
 established measures





VBP Domains and Weights

VBP Fiscal Year	2013	2014	2015	2016
Process of Care	70%	40%	20%	10%
Patient Experience (HCAHPS)	30%	30%	30%	25%
Outcome (Mortality, patient safety, HACs, HAIs)		25%	30%	40%
Efficiency (Medicare spending per Beneficiary)			20%	25%

CMS Shift for Quality Measurement:



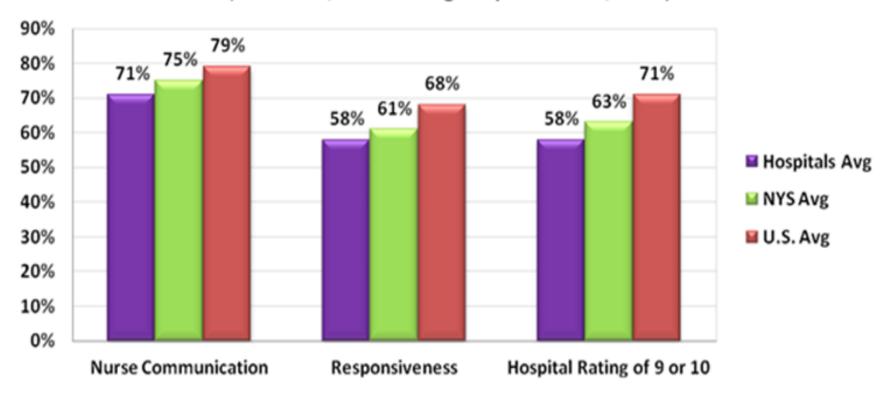
Clinical Process Measures (not risk-adjusted)



Outcomes and Efficiency Measures (risk-adjusted)

HCAHPS Scores (14 Hospitals)

(October 1, 2012 through September 30, 2013)



How DID WE DO? 2014*

Percent of Hospitals Receiving a Bonus	Average 2014 VBP Bonuses	Percent of Hospitals Receiving a Penalty	Average 2013 VBP Penalties
43%	\$ 169,227	57%	(\$93,155)

BONUS RANGE: \$1,016 - \$649,902

PENALTY RANGE: \$5,917 - \$222,719



FY 2015 OUTCOME MEASURES (30% OF VBP SCORE)

Outcome Measure

Acute Myocardial Infarction (AMI) 30-Day Mortality Rate

Heart Failure (HF) 30-Day Mortality Rate

Pneumonia (PN) 30-Day Mortality Rate





Central Line-Associated Bloodstream Infection (CLABSI)



AHRQ* PATIENT SAFETY INDICATOR COMPOSITE

PSI 03 - Pressure Ulcer Rate

PSI 06 - latrogenic Pneumothorax Rate

PSI 07 - Central Venous Catheter-Related Bloodstream Infection Rate

PSI 08 - Postoperative Hip Fracture Rate

PSI 12 - Postoperative Pulmonary Embolism or Deep Vein Thrombosis Rate

PSI 13 - Postoperative Sepsis Rate

PSI 14 - Postoperative Wound Dehiscence Rate

PSI 15 - Accidental Puncture or Laceration Rate



2. READMISSION PENALTIES BEGAN IN FY 2013

- Hospitals with higher-than-average 30-day riskadjusted readmission rates for heart failure, acute myocardial infarction, and pneumonia receive reduced Medicare payments, capped at a maximum of 1% of inpatient payments.
- Penalties increase to a maximum of 2% of inpatient payments in FY 2014 and 3% from FY 2015 onwards.
- FY 2015 will add COPD, and elective knee and hip replacement





How did we do? 2014*

Average Readmissions Penalties Hospitals 2014	Penalty Range 2014
\$345,888	\$4,966 to \$1,433,264

TOTAL REVENUE LOST:

= \$ 6.4 Million



* 14 Hospitals

3. HAC REDUCTION PROGRAM

 In FY 2015, hospitals with HAC incidence rates in top quartile (e.g. worst performers) will receive a 1% reduction in payment

 This HAC program is in addition to the HAC Non-Payment Program that began in 2009



HAC PROGRAM DOMAINS AND MEASURES

Domain 1

(AHRQ Measure)

Weighted 35%

AHRQ PSI-90 Composite

This measure consists of:

PSI-3: pressure Ulcer

PSI-6: latrogenic pneumothorax

PSI-7: central venous catheter-related blood

stream infection rate.

PSI-8: hip fracture rate

PSI-12: postoperative PE/DVT rate

PSI-13: sepsis rate

PSI-14: wound dehiscence rate

PSI-15: accidental puncture

Domain 2

(CDC Measures)

Weighted 65%

2015 (2 measures):

CAUTI

2016 (1 additional measure):

Surgical Site Infection (Colon Surgery and Abdominal Hysterectomy)

2017 (2 additional measures):

MRSA C Diff

How Many Deaths Per Day Occur in US Hospitals Due to Hospital Acquired Infections?

A. 25

B. 50

C. 100

D. 200

721,800 INFECTIONS 75,000 DEATHS Per Year

HAC TRIPLE WHAMMY

- 1. Non-payment 10 conditions (2009)
- 2. VBP (2015)
- 3. HAC Reduction Program (2015)



UP TO 8% OF CMS PAYMENT "AT RISK" BY FY 2017

	FY14	FY15	FY16	FY17
Hospital Inpatient Quality Reporting	2% reduction for failure to report	2% reduction for failure to report	2% reduction for failure to report	2% reduction for failure to report
Hospital Acquired Conditions	No additional payment for 10 HACs	1% reduction in payment if HAC incidence is in top Quartile	1% reduction in payment if HAC incidence is in top Quartile	1% reduction in payment if HAC incidence is in top Quartile
Hospital Readmissions	2% reduction, AMI, HF, PN	3% reduction , AMI, HF, PN, COPD	3% reduction , AMI, HF, PN, COPD	3% reduction , AMI, HF, PN, COPD
Value Based Purchasing	Up to 1.25% reduction or addition	Up to 1.5% reduction or addition	Up to 1.75% reduction or addition	Up to 2% reduction or addition
TOTAL CMS Payment At Risk	5.25%	7.5%	7.75%	8%

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NYS – DELIVERY SYSTEM REFORM INCENTIVE PROGRAM (DSRIP)

- Federal waiver reinvestment of \$6.42 billion in federal savings generated by Medicaid Redesign Team (MRT) reforms.
- Statewide initiative open to safety-net providers.
- Payments based on performance on process and outcome milestones.
- Collaboration among community providers required
- Focus on sustainable health care system transformation

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DSRIP's GOALS

- Increase access to primary care and care coordination
- Improve health outcomes for Medicaid patients
- Prevent avoidable hospitalizations (25% over five years)
- Long-term systemic transformation



DISCUSSION

- What Role Do or Can Nurses Play in:
 - Improving process and outcome measures and their associated penalties? (VBP, Readmissions, HAC)
 - 2) Improving staff understanding of data?

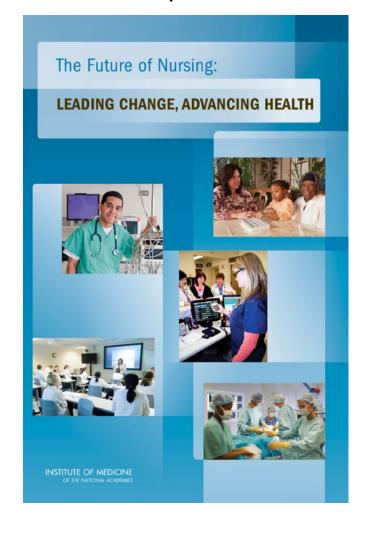




WHY IS DATA IMPORTANT? It's role in performance improvement

"Being a full partner involves taking responsibility for identifying problems and areas of system waste, devising and implementing improvement plans, tracking improvement over time, and making necessary adjustments to realize established goals."

IOM Report - 2010





WHAT CAN WE Do?

Labor and management have successfully worked together to address and improve infection control, patient experience, HCAHPS, and other measures affecting quality of care and quality of work





LMI RESEARCH RESOURCES



What Exactly Does



LABOR MANAGEMENT PROJECT Research Bulletin

Patient Centered Care

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Hospital-Acquired Conditions and Infections Rougital Acquired Conditions (RACs) are complications not prevent at the time of hospital adminsion that develop while marketing medical important. They include a large of potential patient harms, including hospital acquired infections. (ANA) and threats to patient salely such as precious ulcon and femigraphy objects related after surgery.

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Research Bulletin

What are the Consequences

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What's at Risk for Hospitals?

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THE TAKE AWAY...

- Reforms are underway affecting hospital payments and how we organize and deliver services
- Payment reform includes value-based purchasing, readmissions penalties, penalties for hospital acquired conditions (and DSRIP)
- Union and management can work together to increase VALUE of health care services: maximizing quality, reducing cost and waste, and improving the overall patient experience

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