CMS Reporting and Value-Based Purchasing

Christine Martini-Bailey RN, BSN, CSSGB
Director, Quality Improvement and Patient Safety
Health Services Advisory Group (HSAG)
What Is a CMS Quality Improvement Organization (QIO)?

- Funded by CMS
- Tasked with implementing the National Quality Strategy
  - Safer care
  - Ensure patient and family engagement
  - Support coordination of care
  - Advocate for disease prevention
  - Promote best practices of healthy living
  - Make care affordable
- No-cost services
- Partners in quality improvement
- Confidential

Department of Health and Human Services (HHS)

Centers for Medicare & Medicaid Services (CMS)
Nearly 25 percent of the nation’s Medicare beneficiaries

HSAG is the Medicare QIN-QIO for Arizona, California, Florida, Ohio, and the U.S. Virgin Islands.
The QIN-QIO, BFCC-QIO, and VIQR Programs

**Quality Innovation Network-Quality Improvement Organization (QIN-QIO)**
Coordinate with providers and communities on data-driven quality initiatives.

**Beneficiary and Family-Centered Care Quality Improvement Organization (BFCC-QIO)**
Field quality-of-care complaints and appeals.

**Value, Incentives, and Quality Reporting (VIQR) Support Contractors**
Help providers report quality measure data.
CMS Quality Strategy: The Triple Aim

Better Health

Better Care

Lower Cost

HSAG Quality Improvement Teams

- Chronic Condition team
  - Diabetes self-management
  - Healthcare disparities
- Physician Office team
  - Quality Payment Program (QPP)
  - Improving cardiac health
  - Depression and alcohol misuse screenings
- Hospital Improvement team
  - Healthcare-associated infections
  - Patient safety—Safety across the board
  - Sepsis
- Care Coordination team
  - Readmission reduction
  - Adverse drug events
- Long-term Care team
  - Reducing healthcare-acquired conditions
  - Care coordination
A Business Case for Quality

<table>
<thead>
<tr>
<th>WHAT</th>
<th>Compliance-Based Payments</th>
<th>Penalty-Based Reductions</th>
<th>Incentive-Based Payments</th>
</tr>
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<tbody>
<tr>
<td>Inpatient Quality Reporting</td>
<td>Hospital-Acquired Conditions (HACs)</td>
<td>Readmissions</td>
<td>Value-Based Purchasing (VBP)</td>
</tr>
<tr>
<td>HOW</td>
<td>Hospitals that submit data are eligible for Medicare’s annual payment update (APU).</td>
<td>Lowest quartile of hospitals who fail to avoid preventable conditions (e.g., infections) receive a penalty.</td>
<td>Hospitals with excess readmissions are penalized.</td>
</tr>
<tr>
<td>FINANCIAL IMPACT</td>
<td>1/4 of APU increase reduction</td>
<td>1% reduction</td>
<td>Up to 3% reduction</td>
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</tbody>
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https://www.cms.gov/Medicare/Medicare.html
A Business Case for Quality: Compliance-Based Payments

**WHAT**
- **Compliance-Based Payments**
  - **Inpatient Quality Reporting**
    - Hospitals that submit data are eligible for Medicare’s annual payment update (APU).

**HOW**
- **Penalty-Based Reductions**
  - **Hospital-Acquired Conditions (HACs)**
    - Lowest quartile of hospitals who fail to avoid preventable conditions (e.g., infections) receive a penalty.
  - **Readmissions**
    - Hospitals with excess readmissions are penalized.

**FINANCIAL IMPACT**
- **1/4 of APU increase reduction**

**Incentive-Based Payments**
- **Value-Based Purchasing (VBP)**
  - High-performing hospitals eligible to earn money.

**FINANCIAL IMPACT**
- **1% reduction**
- **Up to 3% reduction**
- **Up to 2% reduction**
- **Earn up to 2+%**

https://www.cms.gov/Medicare/Medicare.html
APU: A Closer Look

- Also called “market basket update”
- Update to payments based on price inflation
- Inpatient Prospective Payment System (IPPS) reporting submission
  - eCQM – electronic Clinical Quality Measure
    • Submitted annually through electronic abstraction
  - Inpatient-abstracted measures
    • Chart abstracted measures
  - Claims-based measures
    • Based on coding submitted for Medicare payment
  - Structural patient safety
    • Attestation measures
  - Person and community engagement
    • Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
## A Business Case for Quality: Penalty-Based Reductions: HACs

<table>
<thead>
<tr>
<th>WHAT</th>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Earn up to 2% reduction</td>
</tr>
</tbody>
</table>

https://www.cms.gov/Medicare/Medicare.html
HAC: A Closer Look

• Based on six Quality Measures
  – Patient Safety Indicators (PSI) 90 Composite
    • PSI 03 – Pressure Ulcer Rate
    • PSI 06 – Iatrogenic Pneumothorax Rate
    • PSI 08 – In-Hospital Fall with Hip Fracture Rate
    • PSI 09 – Perioperative Hemorrhage or Hematoma Rate
    • PSI 10 – Postoperative Acute kidney Injury Requiring Dialysis Rate
    • PSI 11 – Postoperative Respiratory Failure
    • PSI 12 – Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate
    • PSI 13 – Postoperative Sepsis Rate
    • PSI 14 – Postoperative Wound Dehiscence Rate
    • PSI 15 – Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate
  – Central Line-Associated Bloodstream Infection (CLABSI)
  – Catheter-Associated Urinary Tract Infection (CAUTI)
  – Surgical Site Infection (SSI)
    • Colon Surgery
    • Abdominal Hysterectomy
  – Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia
  – Clostridium difficile Infection (CDI)
HAC: Impact of Frontline Staff Members

• Clear, detailed documentation
• Present On Admission (POA)
  – Pressure Ulcers
  – Infections (especially transfers)
• Bundles, protocols, and order sets
  – Preoperative bundles
  – Falls and pressure ulcer prevention
  – Ventilator-associated events/Pneumonia bundles
  – Sepsis bundles
  – Nursing-driven protocols—Urinary catheter removal
  – CDI prevention and timely testing
A Business Case for Quality: Penalty-Based Reductions: Readmissions

**Compliance-Based Payments**
- **Inpatient Quality Reporting**
  - Hospitals that submit data are eligible for Medicare’s annual payment update (APU).

**Penalty-Based Reduction**
- **Hospital-Acquired Conditions (HACs)**
  - Lowest quartile of hospitals who fail to avoid preventable conditions (e.g., infections) receive a penalty.
- **Readmissions**
  - Hospitals with excess readmissions are penalized.

**Incentive-Based Payments**
- **Value-Based Purchasing (VBP)**
  - Low-performing hospitals subject to reductions.
  - High-performing hospitals eligible to earn money.

**Financial Impact**
- **1/4 of APU increase reduction**
- **1% reduction**
- **Up to 3% reduction**
- **Up to 2% reduction**
- **Earn up to 2+%**

[https://www.cms.gov/Medicare/Medicare.html](https://www.cms.gov/Medicare/Medicare.html)
Readmission Reduction Program: A Closer Look

Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate

• Acute myocardial infarction (AMI)
• Pneumonia (PNU)
• Total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)
• Chronic obstructive pulmonary disease (COPD)
• Coronary artery bypass graft (CABG)
• Heart failure (HF)

Source: CMS. Accessed on March 26, 2018. Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html
Readmissions: Impact of Frontline Staff Members

- Discharge planning, discharge planning, discharge planning!
- Chronic condition education
- Patient and family engagement
- Medication reconciliation
- Clear discharge instructions
- Follow-up appointments

Don’t just ask, “What’s the matter?”
Ask “What matters to you!”

http://behavioralscientist.org/dont-just-ask-whats-matter-ask-matters/
A Business Case for Quality: VBP

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<thead>
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https://www.cms.gov/Medicare/Medicare.html
VBP: A Closer Look

• Quality incentive program
• Selects measures under the hospital Inpatient Quality Reporting (IQR) program
• Ties hospital reimbursement to quality of care
• “Budget-neutral” program
  – Funded by a 2 percent reduction from hospital’s base operating fund
  – Disperses dollars based quality outcomes

The History of VBP

Weights not changed for FY 2019 FY 2020

https://www.cms.gov/Medicare/Medicare.html
FY 2020 VBP Domain Weights and Measures

**Safety**
1. CDI: Clostridium difficile Infection
2. CAUTI: Catheter-Associated Urinary Tract Infection
3. CLABSI: Central Line-Associated Bloodstream Infection
4. MRSA: Methicillin-Resistant Staphylococcus aureus Bacteremia
5. SSI: Surgical Site Infection Colon Surgery & Abdominal Hysterectomy
6. PC-01: Elective Delivery Prior to 39 Completed Weeks Gestation

**Clinical Care**
1. MORT-30-AMI: Acute Myocardial Infarction (AMI) 30-Day Mortality Rate
2. MORT-30-HF: Heart Failure (HF) 30-Day Mortality Rate
3. MORT-30-PN: Pneumonia (PN) 30-Day Mortality Rate
4. THA/TKA: Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Complication Rate

**Efficiency and Cost Reduction**
1. MSPB: Medicare Spending per Beneficiary

**Person and Community Engagement**
1. Communication with Nurses
2. Communication with Doctors
3. Responsiveness of Hospital Staff
4. Communication about Medicines
5. Cleanliness and Quietness of Hospital Environment
6. Discharge Information
7. Care Transition
8. Overall Rating of Hospital

Achievement

**Benchmark**
Average (mean) performance of the top ten percent of hospitals

**Achievement Threshold**
Performance at the fiftieth (median) of hospitals during the Baseline Period

# FY 2020 Hospital Value-Based Purchasing Domain Weights

(Payment adjustment effective for discharges from October 1, 2019 to September 30, 2020)


<table>
<thead>
<tr>
<th>Domain</th>
<th>Baseline Period</th>
<th>Performance Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Care</td>
<td>July 1, 2010- June 30, 2013</td>
<td>July 1, 2015–June 30, 2018</td>
</tr>
<tr>
<td>Measures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-Day Mortality, Acute Myocardial Infarction (MORT-30-AKI)</td>
<td>Threshold 0.853715 Benchmark 0.875609</td>
<td></td>
</tr>
<tr>
<td>30-Day Mortality, Heart Failure (MORT-30-HF)</td>
<td>Threshold 0.881080 Benchmark 0.906088</td>
<td></td>
</tr>
<tr>
<td>30-Day Mortality, Pneumonia (MORT-30-PN)</td>
<td>Threshold 0.882266 Benchmark 0.909832</td>
<td></td>
</tr>
<tr>
<td>Measures</td>
<td></td>
<td></td>
</tr>
<tr>
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<td>July 1, 2010- June 30, 2013</td>
<td></td>
</tr>
<tr>
<td>Measures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effective Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Complication Rate (THA/TKA)</td>
<td>Threshold 0.033229 Benchmark 0.033176</td>
<td></td>
</tr>
<tr>
<td>Person and Community Engagement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCAHPS Survey Dimensions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication with Nurses</td>
<td>Floor 51.80% Threshold 70.08% Benchmark 67.12%</td>
<td></td>
</tr>
<tr>
<td>Communication with Doctors</td>
<td>Floor 50.47% Threshold 80.41% Benchmark 88.44%</td>
<td></td>
</tr>
<tr>
<td>Responsiveness of Hospital Staff</td>
<td>Floor 35.74% Threshold 66.67% Benchmark 80.14%</td>
<td></td>
</tr>
<tr>
<td>Communication about Medications</td>
<td>Floor 26.16% Threshold 65.30% Benchmark 73.88%</td>
<td></td>
</tr>
<tr>
<td>Hospital Cleanliness and Quietness</td>
<td>Floor 41.52% Threshold 66.72% Benchmark 79.42%</td>
<td></td>
</tr>
<tr>
<td>Discharge Information</td>
<td>Floor 66.72% Threshold 74.44% Benchmark 82.11%</td>
<td></td>
</tr>
<tr>
<td>Care Transition</td>
<td>Floor 20.53% Threshold 51.14% Benchmark 62.50%</td>
<td></td>
</tr>
<tr>
<td>Overall Rating of Hospital</td>
<td>Floor 32.47% Threshold 71.59% Benchmark 85.12%</td>
<td></td>
</tr>
<tr>
<td>Efficiency and Cost Reduction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSBP Medicare spending per beneficiary</td>
<td>Threshold Median Medicare Spending per Beneficiary across all hospitals during the performance period Benchmark Mean of lowest decile of Medicare Spending per Beneficiary across all hospitals during the performance period</td>
<td></td>
</tr>
<tr>
<td>Safety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthcare-Associated Infections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central Line-Associated Bloodstream Infections (CLABSI)</td>
<td>Threshold 0.784 Benchmark 0.000</td>
<td></td>
</tr>
<tr>
<td>Catheter-Associated Urinary Tract Infections (CAUTI)</td>
<td>Threshold 0.828 Benchmark 0.000</td>
<td></td>
</tr>
<tr>
<td>Surgical Site Infection (SSI): Colon</td>
<td>Threshold 0.781 Benchmark 0.000</td>
<td></td>
</tr>
<tr>
<td>SSI: Abdominal Hysterectomy</td>
<td>Threshold 0.722 Benchmark 0.000</td>
<td></td>
</tr>
<tr>
<td>Methicillin-resistant Staphylococcus aureus (MRSA)</td>
<td>Threshold 0.815 Benchmark 0.000</td>
<td></td>
</tr>
<tr>
<td>C. difficile Infections (CDI)</td>
<td>Threshold 0.652 Benchmark 0.091</td>
<td></td>
</tr>
<tr>
<td>Process</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PC-01 Elective Delivery Prior to 39 Completed Weeks of Gestation</td>
<td>Threshold 0.000000 Benchmark 0.000000</td>
<td></td>
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</table>

Achievement Points

Achievement points are awarded by comparing an individual hospital’s rates during the Performance Period with all hospitals’ rates from the Baseline Period.

- Rate at or above the benchmark (10 points).
- Rate less than the achievement threshold (0 points).
- Rate somewhere at or above the threshold, but less than the benchmark (1–9 points).
Improvement Points

Improvement points are awarded by comparing a hospital’s rates during the Performance Period to that same hospital’s rates from the Baseline Period.

- Rate at or above the benchmark (9 points).*
- Rate less than or equal to the Baseline Period rate (0 points).
- Rate between the Baseline Period rate and the benchmark (0–9 points).

*Hospitals with rates at or better than the benchmark, but do not improve from their Baseline Period rate (i.e., have a Performance Period worse than the Baseline Period rate), will receive 0 improvement points, as no improvement was actually observed.
# Understanding My Value-Based Purchasing Report

This report displays data from the Fiscal Year 2018 Value-Based Purchasing (VBP) Program, which affects payments from October 1, 2017—September 30, 2018. Baseline and Performance Periods vary by domain and are detailed below.

## Clinical Care Measures [5%]

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline</th>
<th>Performance Period-1</th>
<th>Performance Period-2</th>
<th>Incentive Amount</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPH 2014/15</td>
<td>9.8212%</td>
<td>8.7812%</td>
<td>7.7412%</td>
<td>7.7412%</td>
<td></td>
</tr>
<tr>
<td>Targeted Risk of Recurrent MI (M01.41)</td>
<td>8.7812%</td>
<td>7.7412%</td>
<td>6.7012%</td>
<td>6.7012%</td>
<td></td>
</tr>
<tr>
<td>Hospital Readmission Reduction Program (HRP)</td>
<td>7.7412%</td>
<td>6.7012%</td>
<td>5.6612%</td>
<td>5.6612%</td>
<td></td>
</tr>
<tr>
<td>Other Inpatient Measure</td>
<td>6.7012%</td>
<td>5.6612%</td>
<td>4.6212%</td>
<td>4.6212%</td>
<td></td>
</tr>
</tbody>
</table>

**Achievement Threshold:** The 20th percentile of all hospitals’ performance during the baseline period for each measure.

**Benchmark:** The mean of the top decile of all hospitals’ performances during the baseline period for each measure.

**Achievement Points:** Awarded to a hospital by comparing its performance period rates with all hospitals’ baseline period rates. A dash indicates not applicable or that no data were available.

**Improvement Points:** Awarded by comparing its performance on a measure during the performance period with its performance on the same measure during the baseline period. A dash indicates not applicable or that no data were available.

## Efficiency and Cost Reductions [15%]

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<tr>
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<tr>
<td>PPS2014</td>
<td>9.8212%</td>
<td>8.7812%</td>
<td>7.7412%</td>
<td>7.7412%</td>
<td></td>
</tr>
<tr>
<td>PPS2015</td>
<td>8.7812%</td>
<td>7.7412%</td>
<td>6.7012%</td>
<td>6.7012%</td>
<td></td>
</tr>
<tr>
<td>PPS2016</td>
<td>7.7412%</td>
<td>6.7012%</td>
<td>5.6612%</td>
<td>5.6612%</td>
<td></td>
</tr>
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**Measure Score:** Awarded to a hospital or each measure, based on the greater of the improvement or achievement points. A dash indicates the minimums were not met for scoring the domain.

## Unweighted Clinical Care Measures Domain Score:

A hospital’s total earned points for the Clinical Care domain divided by the total possible points, multiplied by 100. A dash indicates the minimums were not met for scoring the domain.

Hospitals have the opportunity to still receive a Total Performance Score (TPS) if one domain is not scored. If your facility did not meet the minimum measure scores in one of the four domains, the domain that did not meet the minimum would have its weight distributed to the other domains. This would make the remaining three domains 33.3 percent instead of 25 percent. The Domain weight for each domain is included on the first page of your hospital percentage payment summary report.

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Source: Understanding My Value-Based Purchasing Report. HSAG. Available at https://www.hsag.com/contentassets/f0730b76658149688af5ae42f8f3551c/understandingmyvbprprt2018508.pdf
Understanding My Fiscal Year (FY) 2018 Value-Based Purchasing Report

Clinical Process of Care Measures
- To receive an improvement score, a measure must have at least 10 eligible cases during the baseline period.
- A measure must also have at least 10 eligible cases during the performance period to either achieve an improvement score.

Patient Experience of Care Consistency Score/HCAHPS:
- A hospital can earn between 0–20 points based on the hospital's lowest HCAHPS dimension score during the performance period.

SSI Scores: At least one of the two SSI strata (abdominal hysterectomy and colon surgery) must have at least one predicted infection.

Combined SSI Score: A weighted average is computed based on the number of predicted infections and the points awarded to each stratum.

Efficiency Measure: Claims-based, includes risk-adjusted and pre-standardized payments for Part A and Part B services provided three days prior to hospital admission through 30 days after hospital discharge.

Total Performance Score: Sum of weighted domain scores; requires scores from at least 3 of 4 domains.

Base Operating DRG Payment Amount Reduction: The percentage by which a hospital's base operating DRG payment will be reduced. This amount is 2 percent for FY2018.

Value-Based Incentive Payment Percentage: Portion of the base operating DRG payment amount a hospital earned back based on its performance in the hospital VBP program.

Net Change in Base Operating DRG Payment Amount: Amount your FY2018 base operating DRG payments will be changed due to the Hospital VBP Program. Amount is equal to value-based incentive payment percentage less base operating DRG payment amount reduction (2 percent).

Value-Based Incentive Payment Adjustment Factor: Value used to translate a hospital’s Total Performance Score into the value-based incentive payment. This is what each claim amount is multiplied by to get the final payment amount.
VBP Program Achievement Thresholds
Safety Domain

<table>
<thead>
<tr>
<th>Measure</th>
<th>VBP FY 2019 Data CY 2017</th>
<th>VBP FY 2020 Data CY 2018</th>
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<tr>
<td>CAUTI</td>
<td>0.822</td>
<td>0.828</td>
</tr>
<tr>
<td>CLABSI</td>
<td>0.860</td>
<td>0.784</td>
</tr>
<tr>
<td>CDI</td>
<td>0.924</td>
<td>0.852</td>
</tr>
<tr>
<td>MRSA</td>
<td>0.854</td>
<td>0.815</td>
</tr>
<tr>
<td>SSI Hysterectomy</td>
<td>0.762</td>
<td>0.722</td>
</tr>
<tr>
<td>SSI Colon</td>
<td>0.783</td>
<td>0.781</td>
</tr>
<tr>
<td>PSI 90</td>
<td>0.774058</td>
<td>(Not part of VBP)</td>
</tr>
</tbody>
</table>

“Your facility has had 3 excess infections based on the VBP achievement threshold”

SIRs can be misleading! Focus on the unit with highest CAD to reduce facility overall SIR

“Target” improvements in the units with the highest CAD

Don’t forget to look for best practices

Mock data is listed in the table.

VBP: Impact of Frontline Staff Members

- Wash your hands!
- Infection prevention
- Nurse-driven protocols for urinary catheters
- Do they need that line?
- CDI prevention and timely testing
- Discharge planning
- Chronic condition education
- Patient and family engagement
- Medication reconciliation
- Clear, concise documentation
What Is the Impact?
Hospital Compare and Star Ratings

- Quality outcomes information for more than 4,000 Medicare certified hospitals
- Allows healthcare consumers to make informed decisions
- Encourages hospitals to improve quality of care
Hospital Star Rating

• Overall Hospital Quality Star ratings
  – An addition to the current public reporting of hospital quality information on the Hospital Compare website

• Summarize information from existing measures

Source: Hospital Overall Ratings. CMS Hospital Compare website. Accessed at March 26, 2018. Available at: https://www.medicare.gov/hospitalcompare/About/Hospital-overall-ratings.html
Hospital Compare

## Comparing Hospitals

**General Information**

- **ST ELIZABETH YOUNGSTOWN HOSPITAL**
  - Address: 1044 BELMONT AVENUE, YOUNGSTOWN, OH 44501
  - Phone: (330) 746-7211
  - Overall rating: 🌟🌟🌟🌟🌟
  - Distance: 1.4 miles

- **ST ELIZABETH BOARDMAN HEALTH CENTER**
  - Address: 8401 MARKET STREET, BOARDMAN, OH 44512
  - Phone: (330) 729-2929
  - Overall rating: 🌟🌟🌟🌟🌟
  - Distance: 9.1 miles

- **ST JOSEPH WARREN HOSPITAL**
  - Address: 667 EASTLAND AVE SE, WARREN, OH 44481
  - Phone: (330) 841-4000
  - Overall rating: 🌟🌟🌟🌟🌟
  - Distance: 14.0 miles

**Survey of Patients' Experiences**

- ST ELIZABETH YOUNGSTOWN HOSPITAL
  - Learn more
  - View rating details

- ST ELIZABETH BOARDMAN HEALTH CENTER
  - Learn more
  - View rating details

- ST JOSEPH WARREN HOSPITAL
  - Learn more
  - View rating details

**Timely & Effective Care**

- ST ELIZABETH YOUNGSTOWN HOSPITAL
  - Add to My Favorites
  - Maps and directions

- ST ELIZABETH BOARDMAN HEALTH CENTER
  - Add to My Favorites
  - Maps and directions

- ST JOSEPH WARREN HOSPITAL
  - Add to My Favorites
  - Maps and directions

**Complications & Deaths**

- ST ELIZABETH YOUNGSTOWN HOSPITAL
  - Add to My Favorites
  - Maps and directions

- ST ELIZABETH BOARDMAN HEALTH CENTER
  - Add to My Favorites
  - Maps and directions

- ST JOSEPH WARREN HOSPITAL
  - Add to My Favorites
  - Maps and directions

**Unplanned Hospital Visits**

- ST ELIZABETH YOUNGSTOWN HOSPITAL
  - Add to My Favorites
  - Maps and directions

- ST ELIZABETH BOARDMAN HEALTH CENTER
  - Add to My Favorites
  - Maps and directions

- ST JOSEPH WARREN HOSPITAL
  - Add to My Favorites
  - Maps and directions

**Use of Medical Imaging**

- ST ELIZABETH YOUNGSTOWN HOSPITAL
  - Add to My Favorites
  - Maps and directions

- ST ELIZABETH BOARDMAN HEALTH CENTER
  - Add to My Favorites
  - Maps and directions

- ST JOSEPH WARREN HOSPITAL
  - Add to My Favorites
  - Maps and directions

**Payment & Value of Care**

- ST ELIZABETH YOUNGSTOWN HOSPITAL
  - Add to My Favorites
  - Maps and directions

- ST ELIZABETH BOARDMAN HEALTH CENTER
  - Add to My Favorites
  - Maps and directions

- ST JOSEPH WARREN HOSPITAL
  - Add to My Favorites
  - Maps and directions

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How It All Adds Up

FY 2018

It Takes a Team to Succeed

Keys to Success:

- Engaged Frontline Staff
- Visible C-Suite Support
- Physician Buy-in
Transparency

- Hospital goals
- Data outcomes at the unit level
- Team huddles
- Real-time feedback
- Unit champions
- Eliminate silos
It’s Not About The $$$

It’s About Patient Care
The Face of HAI

• Father/grandfather/great-grandfather
• Veteran of Army and Air Force
• The family “social event planner”
• Never reached his 62nd birthday
• Never saw his granddaughter marry
• Never meet his great-granddaughters
• Never saw his grandson’s undefeated high school football season
• Never saw his grandson play college football
• Never saw his grandson going to medical school
• Successfully fighting colon cancer
• MRSA introduced into his central line
• Died of MRSA CLABSI May 19, 2008

“Old as she was, she still missed her daddy sometimes.”
—Gloria Naylor
Questions?
Thank you!

Christine Martini-Bailey RN, BSN
HSAG Director, Quality Improvement and Patient Safety

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HSAG uses data to drive improvement, drawing on our strength in measurement, analysis, and reporting to inform improvement activities and validate their impact.

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