

# Laying a Foundation for Success in the Medicare Hospital Value-Based Purchasing Program

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The Centers for Medicare & Medicaid Services (CMS) is seeking to transform Medicare by purchasing “value” from health care providers and physicians. At Vidant Medical Center, we have begun to link the requirements of the CMS Value-Based Purchasing Program to the goals and objectives embedded within our quality improvement initiatives.

**T**he Patient Protection and Affordable Care Act of 2010 (ACA) contains many provisions that are intended to help support the long-term financial viability of the Medicare program. These changes were enacted to improve quality of care, reduce unnecessary costs, promote accountability among physicians and other providers for the quality and cost of care, ensure equitable access to care, foster the use of electronic health records to coordinate care, and require greater transparency regarding the safety and effectiveness of care. Many of those aims are furthered by the ACA’s establishment of the Hospital Value-Based Purchasing (VBP) Program [1], which is part of a larger effort by the Centers for Medicare & Medicaid Services (CMS) to link the Medicare payment system to improved health care quality. The program builds on the infrastructure that was developed for the hospital inpatient quality-reporting program authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [2]. Based on the premise that competition among hospitals will improve performance on key measures of quality, the VBP program gives the provider community (beginning with hospitals) incentives to eliminate the occurrence of adverse events that result in harm to patients, to adopt evidence-based care standards and protocols, and to reengineer hospital processes to improve the patient experience.

The incentive structure for the program compensates hospitals for their relative performance on clinical process of care measures and on patient experience of care scores [3]; the latter are obtained through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, which asks patients about their recent hospital stay [4]. Table 1 lists the clinical process and patient experience measures that the VBP program will use in Federal Fiscal Year 2013. The value points a hospital accumulates are multiplied by domain-specific weights; in 2013, the weighted values are 70% for clinical process of care and 30% for

patient experience of care. Incentive payments are based on each individual performance measure and use either relative achievement (ie, performance compared to similar hospitals nationwide) or degree of improvement, whichever is greater. In this way, hospitals can earn incentives by competing successfully against high-performing organizations, or they can be rewarded for improvement if they are among the low-performing organizations.

The ACA specifies that the program be funded with reimbursement withhold—*that is, reductions in the base operating diagnosis-related group payment amount.* There is a 1% withhold in 2013, which increases by 0.25% each year until it reaches 2% in 2017. High-performing organizations can earn back the money withheld and also qualify for additional payments based on their relative performance. The intended consequence of the program is a level of competition that accelerates improvements in quality and patient experience.

## Improving Performance at Vidant Medical Center

Vidant Medical Center began using several methods and practices designed to improve performance before the ACA became law. These methods and practices drive performance on each of the VBP metrics. To promote transparency, Vidant has been actively sharing performance data on VBP quality measures using standard scorecards since 2007. These metrics are now displayed in specific operating units throughout the hospital where they are visible to patients, families, and visitors. The same information is also posted on the medical center’s Web site. In recent years, similar information has been made available for specific measures of physician performance. Transparent reporting is now leading to studies of variability among providers. The goals of these studies are to enhance standardization among providers and to improve quality.

As part of its journey in creating a more robust quality improvement program, Vidant adopted a practice of set-

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Electronically published August 1, 2013.

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**N C Med J. 2013;74(4):338-342.** ©2013 by the North Carolina Institute of Medicine and The Duke Endowment. All rights reserved. 0029-2559/2013/74413

**TABLE 1.**  
**Hospital Value-Based Purchasing Program: Performance Measures for Federal Fiscal Year 2013**

|                                                                                                                              |
|------------------------------------------------------------------------------------------------------------------------------|
| <b>Patient experience of care measures</b>                                                                                   |
| Communication with nurses                                                                                                    |
| Communication with doctors                                                                                                   |
| Responsiveness of hospital staff                                                                                             |
| Pain management                                                                                                              |
| Communication about medicines                                                                                                |
| Cleanliness and quietness of hospital environment                                                                            |
| Discharge information                                                                                                        |
| Overall hospital rating                                                                                                      |
| <b>Clinical process of care measures</b>                                                                                     |
| <i>Acute myocardial infarction</i>                                                                                           |
| Fibrinolytic therapy received within 30 minutes of hospital arrival                                                          |
| Primary percutaneous coronary intervention received within 90 minutes of hospital arrival                                    |
| <i>Heart failure</i>                                                                                                         |
| Discharge instructions                                                                                                       |
| <i>Pneumonia</i>                                                                                                             |
| Blood cultures performed in emergency department prior to receiving initial antibiotic                                       |
| Initial antibiotic selection for community-acquired pneumonia in immunocompetent patients                                    |
| <i>Surgical care improvement project</i>                                                                                     |
| Health care-associated infections                                                                                            |
| Prophylactic antibiotic received within 1 hour prior to surgical incision                                                    |
| Prophylactic antibiotic selection for surgical patients                                                                      |
| Prophylactic antibiotics discontinued within 24 hours after surgery                                                          |
| Cardiac surgery patients with controlled 6 AM postoperative serum glucose                                                    |
| <i>Cardiology</i>                                                                                                            |
| Surgery patients receiving beta-blocker therapy prior to arrival who received a beta blocker during the perioperative period |
| <i>Venous thromboembolism</i>                                                                                                |
| Surgery patients with recommended venous thromboembolism prophylaxis ordered                                                 |
| Surgery patients who received appropriated venous thromboembolism prophylaxis within 24 hours                                |

Source of data: Centers for Medicare & Medicaid Services [3].

ting board-approved stretch targets in the areas covered by VBP quality metrics. In some instances, the medical center advanced to setting targets based on all-or-nothing metrics for core measures and harmful events. For example, heart failure discharge instructions are measured this way. The measure states: "Heart failure patients discharged home with written instructions or educational material given to patient or caregiver at discharge or during the hospital stay addressing *all* of the following: activity level, diet, discharge medications, follow-up appointment, weight monitoring, and what to do if symptoms worsen." To help us reach this goal, a statement was developed that was placed in the discharge instructions given to heart failure patients. Targets are set based on the percentage of patients who receive all required core measures; if even a single measure is missed

for a patient, then the score for that patient is zero. Setting stretch goals, such as a 50% reduction in patient harm, has resulted in sustained and continuous improvements in performance. For example, medication errors that caused harm were decreased by 86% from 2011 to 2012. The same has been true for patient experience. The organization's goal was to be in the top decile of performers nationally for patient experience. Vidant Medical Center achieved that goal in 2012, at which time it was also recognized as a top-decile performer in equity of care.

Another key component of Vidant's journey has been leveraging leadership accountability for performance on quality measures. Many tactics are used to drive consistent behaviors among leaders and to maintain accountability for quality outcomes and financial performance. One such tactic is the requirement for service line leaders to report their quality performance in weekly group meetings attended by the hospital president. Physician leaders and administrators are present for a discussion of the previous week's performance, including every event of harm during the week. Performance variance data are reviewed and discussed in the group meetings among hospital leaders, and these data are used to identify quality projects that are adopted by an administrator and a physician partner. Each quality measurement is owned by a physician and an executive sponsor who is responsible for leading performance improvement teams, removing barriers, championing the improvement effort, and reporting on progress. Leaders are expected to conduct their own daily rounds with their staff in order to maintain a focus on the expectations and processes that drive performance.

As leadership accountability increases, the capabilities of the teams led by these individuals must also increase. As we increase transparency and share tactics of accountability, deploying Lean methods and other tools of quality improvement among teams becomes increasingly important. As Vidant's frontline teams and physicians came to appreciate and understand the use of statistical analytics and Lean methodology, they began to focus on the process of care rather than outcomes, and Vidant experienced improvements in performance, employee retention, and employee satisfaction. Without a focus on team capabilities, the organization would have seen its valuable people become disengaged, and quality performance would likely have declined.

Vidant Medical Center has been a leader in engaging patients and families in the work of improvement. Each service line within the medical center has a Patient and Advisory Council made up of former patients and family members. These patient advisers are directly involved in the quality work. They attend rounds on hospital units, participate in design and construction projects, serve as members of performance improvement teams, and even serve on the organization's board of trustees. Having patients play an advisory role has accelerated improvements in patient experience and has been a true differentiator in the quality work,

# The Bundled Payments for Care Improvement Initiative at FirstHealth Moore Regional Hospital

Cindy McDonald

Since passage of the Patient Protection and Affordable Care Act of 2010, the health care industry has been developing payment models for Medicare beneficiaries that move beyond fee-for-service programs. One of the latest models offers hospitals and physicians incentives to improve the quality of care provided to Medicare beneficiaries while decreasing costs, by standardizing care to avoid unnecessary readmissions, tests, and procedures. The Bundled Payments for Care Improvement (BPCI) Initiative was recently launched by the Center for Medicare & Medicaid Innovation, which was created by the Affordable Care Act. The initiative provides 4 different payment models (4 different ways of bundling payments), all of which are designed to encourage doctors, hospitals, and other health care providers to work together to better coordinate care for Medicare patients. If these providers meet certain quality standards and save money, they are eligible to share these savings with the federal government. These BPCI initiatives include retrospective acute care (hospital stay only), retrospective acute and post-acute care episodes, retrospective post-acute care only, and prospective hospital care only [1].

Under a fee-for-service reimbursement system, providers of health care services receive a set fee for each unit of service provided to a patient. There is no incentive to decrease costs, because the more services a provider delivers, the more reimbursement that provider receives. New payment models will focus on outcomes and cost rather than volume. With payment bundling, providers receive their customary payment under the current reimbursement methodologies, but there is an annual reconciliation of payments and costs to the program against the established bundle fee for an episode of care. Based on this reconciliation, the hospital assumes the financial risk for the costs of care and is eligible to share any extra savings with its providers. Participating providers can choose among 48 episodes of care and decide the types of episodes of care for which they want to receive bundled payments [1].

FirstHealth Moore Regional Hospital, a 395-bed, not-for-profit hospital in Pinehurst, North Carolina, is participating in this BPCI beginning in January 2014. FirstHealth chose coronary artery bypass grafting (CABG), cardiac valve replacement, hip replacement, and knee replacement as the types of episodes for which they would accept bundled payments. Although FirstHealth and its cardiac and orthopedic surgeons have worked collaboratively in service lines for years, they applied for the BPCI because they wanted an opportunity to work more closely together and to share the savings generated by their cost-reduction efforts. The BPCI provided a framework for aligning incentives.

A set of metrics and standardized order sets for each type of episode for which payments would be bundled was developed collaboratively by FirstHealth and the participating surgeons and staff members. For example, the standardized order set of tests and procedures for CABG and valve-replacement procedures will follow evidence-based practices. Patients who are selected for these procedures must be cleared for surgery based on cardiac and medical condition risk assessments and physician recommendations. Care Maps created by the Centers for Medicare & Medicaid Services (CMS) will be used to standardize the processes of care for each bundle. Computerized provider order entry will be used to track adherence to the Care Maps. All patients in both groups will be followed to ensure that the order set is adhered to; patients will be monitored for risk assessments, complications, readmissions, and emergency department visits, and follow-up phone calls will be made up to 30 days after hospital discharge. A similar process has been developed with orthopedic surgeons for hip-replacement and knee-replacement patients.

As the costs for complete episodes of care were studied, it became apparent that maximizing quality and efficiency of care would require aligning incentives across the continuum of care, including post-acute care. Accordingly, providers of post-acute care were added to the organiza-

both compared with our past performance and compared with other hospitals.

Vidant Medical Center's performance on VBP measures is depicted in Table 2. As a result of its performance on each of these measures, the medical center is in a good position to earn back incentives in the VBP program. In fact, Vidant Medical Center ranks among the top 25 in North Carolina for number of VBP points earned.

The disciplined and proactive approach to improvement

that Vidant Medical Center has taken since 2007 has paid off in terms of better quality and positive financial results. Increasing transparency, reporting outcomes and process information, setting stretch targets, instilling greater leadership accountability, and engaging patients and families have proved effective in elevating the performance of this academic medical center with more than 900 beds. The quality methods used are scalable and can be effective in organizations of any size. **NCMJ**

tions participating in the bundled payment. FirstHealth and its surgeons have also been working closely with acute rehabilitation facilities, skilled nursing facilities, and home health providers to develop discharge protocols that achieve the best outcomes for patients.

Improving care transitions across settings is a critical component of the care redesign effort. Challenges include ineffective communication, medication errors, lack of physician follow-up, and poor coordination of services. These challenges often lead to rehospitalization and reduced quality of life. Building on the Institute for Healthcare Improvement's Triple Aim initiative, FirstHealth developed an innovative transitional care model that addresses these challenges. The core philosophy of this model is to provide patients with the tools, skills, and support to effectively manage their care as they move from one setting to another, particularly after hospital discharge. Based on its experience with this method, FirstHealth plans to establish a position for a transitions nurse at FirstHealth Moore Regional Hospital; this individual will address patient needs during an acute hospitalization episode, ease transitions, and coordinate care across the continuum.

Beneficiary and caregiver engagement are also key elements of the BPCI, and encouragement of such engagement is embedded throughout the care redesign model. FirstHealth will use Insignia Health's Patient Activation Measure (PAM), which assesses a patient's skills, knowledge, and confidence in managing his or her own health care. PAM assessments will allow physicians and practitioners to develop individualized care plans that provide a patient-centric approach to care while efficiently applying resources.

All participating providers will enter into a contractual agreement with the CMS that defines the terms and conditions for participation, including roles and responsibilities of all parties, eligibility requirements, and specific criteria and methods for determining shared saving payments. Finally, clear language indicating voluntary participation will be included, along with a description of the conditions under which participation can be terminated.

As the parties have moved through the development and pilot phases of the BPCI, key lessons have been learned. Primary among these are the need for communication and transparency and a willingness to make changes based on historical cost data and evidence-based outcome measures. **NCMJ**

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#### Acknowledgment

Potential conflicts of interest. C.M. is an employee of FirstHealth of the Carolinas.

#### Reference

1. Center for Medicare & Medicaid Innovations. Centers for Medicare & Medicaid Services. Bundled Payments for Care Improvement (BPCI) Initiative: General Information. <http://innovation.cms.gov/initiatives/Bundled-Payments/index.html>. Accessed May 5, 2013.

Electronically published August 1, 2013.

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**N C Med J.** 2013;74(4):340-341. ©2013 by the North Carolina Institute of Medicine and The Duke Endowment. All rights reserved. 0029-2559/2013/74414

**TABLE 2.**  
**Vidant Medical Center's Scores and State and National Rankings on Hospital Value-Based Purchasing Program Measures**

| Variable                            | December 2011 update <sup>a</sup> | May 2012 update <sup>b</sup> | July 2012 update <sup>c</sup> |
|-------------------------------------|-----------------------------------|------------------------------|-------------------------------|
| Clinical process of care measures   |                                   |                              |                               |
| Score                               | 47.47%                            | 55.45%                       | 65.45%                        |
| Rank within state                   | 43rd of 84                        | 40th of 85                   | 31st of 85                    |
| Rank within nation                  | 1,312th of 3,044                  | 1,136th of 3,061             | 821st of 3,069                |
| Patient experience of care measures |                                   |                              |                               |
| Score                               | 66.00%                            | 65.00%                       | 64.00%                        |
| Rank within state                   | 8th of 84                         | 9th of 85                    | 13th of 85                    |
| Rank within nation                  | 255th of 3,044                    | 284th of 3,061               | 328th of 3,069                |
| Total performance score             |                                   |                              |                               |
| Score                               | 52.89%                            | 58.32%                       | 65.02%                        |
| Rank within state                   | 33rd of 84                        | 27th of 85                   | 23rd of 85                    |
| Rank within nation                  | 728th of 3,044                    | 612th of 3,061               | 448th of 3,069                |

<sup>a</sup>The December 2011 update was for the fourth quarter of Federal Fiscal Year (FFY) 2011; data collection dates were April 2010 through March 2011.

<sup>b</sup>The May 2012 update was for the first quarter of FFY 2012; data collection dates were July 2010 through June 2011.

<sup>c</sup>The July 2012 update was for the second quarter of FFY 2012; data collection dates were October 2010 through September 2011.

Source: Internal hospital data provided in a quarterly report from the North Carolina Hospital Association.

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### Acknowledgments

Potential conflicts of interest. S.L. and B.F. are employees of Vidant Medical Center.

### References

1. Patient Protection and Affordable Care Act. Pub L No. 111-148, § 3001 (2010), 42 U.S.C. § 1395ww(o) (2010).
2. Medicare Prescription Drug, Improvement, and Modernization Act.

Pub L No. 108-173 § 501B, 42 U.S.C. § 1395ww(b)(3)(B) (2003).

3. Centers for Medicare & Medicaid Services (CMS). National Provider Call: Hospital Value-Based Purchasing. FY2013 Actual Percentage Payment Summary Report. CMS Web site. <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/Downloads/HospVBNPC100412.pdf>. Published October 4, 2012. Accessed April 23, 2013.
4. Hospital Consumer Assessment of Healthcare Providers and Systems. Centers for Medicare & Medicaid Services Web site. <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS.html>. Last modified April 10, 2013. Accessed May 1, 2012.



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