Value Based Payments: Implications for All Members of the Healthcare Team Webinar

April 28, 2016

Laurie Fink: Good afternoon everyone. The Quality Insights, Quality Innovation Network team welcomes you to today's webinar, Value Based Payments: Implications for All Members of the Healthcare Team. My name is Laurie Fink and I am a Communications Specialist for the Improving Care Coordination and Medication Safety initiative.

Before we get the presentation started I would like to take a moment to review a few housekeeping items. First, all participant lines have been muted and will remain in a listen only mode throughout today's presentation. There will be a question and answer session following the presentation so if a question comes to mind at any time during this session please feel free to type it in the chat or the Q & A boxes which can be found on the right of your screen and it will be addressed during the Q & A at the end of the formal presentation. If your chat box is not currently open please look at the upper right hand corner of your screen for an icon that contains what looks like a speech bubble and click on that to open your chat. For those of you using a Mac, the chat icon is located at the bottom right hand corner or your screen.

Please note that this webinar is being recorded and the recording will be posted on the Quality Insights website at www.qualityinsights-qin.org later this afternoon. It can found under the events tab as an archived event, the recording will also be posted on My Quality Insights. The slide deck for today's presentation was emailed to all participants earlier this morning. If for some reason your didn't receive a copy of the slides via email the slide deck is also now posted on the Quality Insights website and that would also be found on the events tab as an archived event.

I would like to now introduce you to today's speaker, Julie Volz. Julie has been a project coordinator with Quality Insights since 2002. She's been a registered nurse in the Philadelphia area for over 40 years and has more than 25 years of experience in quality improvement, case management, and infection prevention. Without further ado I will now hand the presentation over to Julie.

Julie Volz: Thanks Laurie. I just want to make sure, I am off mute. Okay. Great. Welcome everyone, I have to say that in my tenure at Quality Insights this has to be the biggest audience I've ever had and I've done hundreds of presentations so I'm excited.

Today, we're going to talk about the business case for quality. That's actually what this is when we're talking about Value Based Payments. If you are not from a hospital and so you're not getting paid with Value Based Payments right now this is also pertinent to you because you're part of their payment system so we all need to work together on this. If you're not part of Value Based Payments now like nursing homes you will be in the future, shortly in the future I might add.

There are many references on the internet about building a business case based on the added costs that unconventional, unintentional events have on your company's bottom line and they use those by analyzing the cost of individual cases with and without adverse events. My presentation has a

different take, ever since the onset of Medicare Value Based Incentive programs the impact of unintended events takes a more global effect. Rather just effecting the individual case, poor outcomes now effect the entire reimbursement system. Medicare is now moving from payment for [ep-to-so-dic 00:03:56] hospital care into reimbursement encompassing multiple pre and post hospital settings.

Let's take a look at the programs that drive the change in reimbursement and discuss some of the implications and ways to improve the quality of care as well as the bottom line for your facility. We're going to start with a poll just to see who's in the audience but while you're answering that, in the 25 seconds that you get to answer that, we're going to look at this volume to value shift and that's for the Medicare reimbursement. Let's start at the very beginning, one of my favorite songs, 'Let's start at the very beginning ...'it all started with hospitals. There was the Medicare Modernization Act of 2003 and that started the pay for reporting for hospitals. There was only 10 measures at the time and, now, there's over 100.

After that, 2 years later, came the Deficit Reduction Act of 2005 and that expanded the measure set, it also started public reporting, and it introduced value based performance into the mix. Also, HCAHPS started at the time, the patient experience where just as importantly as the quality measures the patient's perception of the care that they received became vitally important. Then we have the Affordable Care Act, or ACA, of 2010 which most people refer to as Obamacare. Let's see, it looks like we have mostly nurses. Good. Administrators in there also and then a bunch of other. Ah, a physician too or 2 of them. Let's get back to Obamacare, I have to cringe every time someone says, "Obamacare," because most people think that it only has to do with providing insurance to the uninsured but there was so much more in the Affordable Care Act.

Around that time Don Berwick moved from the Institute for Healthcare Improvement to CMS and brought with him the triple aim which was the better health, better care, and lower costs. Everything that Medicare's doing now involves those 3 items and tying it all together. The Affordable Care Act is what supported the development of most value based initiatives. They started with [HAIs 00:06:42] and they gradually increased it. They started with [CLABSI 00:06:47] in 2011 and then in 2012 added [CAUTI 00:06:51]. CLABSI, in case you don't know, is the Central Line Associated Blood Stream Infections. CAUTI, the Catheter Associated Urinary Tract Infections and SSI which is the Surgical Site Infections. In 2013, MRSA, or methicillin-resistant Staph aureus, and CDI, claus tritium difficile infections were added.

There are annual updates to all these things. A proposed rule for hospitals comes out in the Spring, we just had one released, and it's open for comment now, and it'll be finalized on August 1 so we have those. Just recently, MACRA came out which is the Medicare Access and Chip Re-authorization Act and that's what introduced Value Based Payments to the [SNF 00:07:44] world. Even more recent, today, MACRA came out with proposals for physician reimbursement which is before they just needed to report and they had some meaningful use and that ties that all together. It starts in 2017 and the payments will begin in 2019 and they call it MIPS, is what they're calling that one. It's Merit based Incentive Payment System.

That includes, clinical measures, meaningful use, costs, and also any performance improvement activities that the physicians undertake. Now, we have MIPS thrown into the program. The reason why I bring that up is because we talk about VBP and I have seen it as Value Based Purchasing, Value Based Performance, there's so many different things that it can be, Value Based Payment is

another one. I'm wondering whether they're going to be having everything to this merit based incentive as for the value based.

We're going to talk about some of the CMS value-based initiatives - this is just a brief overview. I'm going to go into all these in depth. The Value-Based Purchasing Program, as I said, was established by the ACA and this begins to look at that volume to value shift. It's designed to improve the outcomes in concert with the triple aim. We also have the Hospital Acquired Conditions Program which looks at complications arising in the hospital. We have a Readmission Reduction Program for hospital readmissions. Then we have, most recently, the SNF Value Based Purchasing which came out just with this MACRA and that's going to look at all [cause 00:10:02] readmissions for skilled nursing facilities. I think, April wants to launch another poll question at this point in time.

As I said, we're going to talk about each of these programs individually and see how the whole thing ties together. Believe me, although there's lots of information here, it will all tie together in the end. First, is the Hospital Readmission Reduction Program and this is with the hospitals. We're currently in fiscal year 16 for hospitals and that started in October 2015, they run on a fiscal year from October through September. The current payments are based on readmissions that occurred from July 2011 through June 2014, so you can see, there's a bit of a data lag when that happens which causes a problem. If you're not working on it then you could stay with readmission penalties for periods of years until you catch up to the data period where you started working on that. Currently, they look at readmissions for patients who are originally admitted for AMI, acute myocardial infarction, congestive heart failure, pneumonia, chronic obstructive lung disease, or pulmonary disease, and elective joint replacements. If they had any of those conditions on their first hospital stay then readmissions in those cases would be counted against the facility, the hospital.

CABG surgery is also going to be added next year and the interesting thing about CABG surgery is that a lot of those patients are originally admitted for AMI, or acute myocardial infarction so there could be a double whammy for those patients that are readmitted because they would be counted both as an AMI and as a CABG surgery. Penalties are assigned if the hospital exceeds the readmission ratios. New readmission results are distributed to hospitals each June so in June you will be getting your new numbers but in the current year we had almost 26,000 hospitals receiving a penalty and all but 209 of those were also on the list for the prior year so you can see where the effect of that data lag comes. The average penalty was .61% and the maximum penalty is 3% and it's based on, as I said, a ratio where it's risk adjusted and the penalty's based on the difference between the projected rate of unplanned readmissions and the actual rates.

Oh good, it looks like a lot of people have heard a lot of these programs so that's really exciting. Since we're dealing with our Quality Insights which is the Quality Improvement Network for 5 states, being Delaware, Louisiana, New Jersey, Pennsylvania, and West Virginia let's look at the percent of the hospitals that are currently, in this year, dealing with readmission penalties. Now, the national rate for hospitals in a state is 54% so you can see where our states are not doing well with readmission penalties. We have a lot of room for improvement. Now, the amount varies by hospital in these states though with Delaware having only .35% of a penalty, that's their average, up to West Virginia which has a .99, or about 1%, .99% being the average penalty. If you remember I said that, the national rate was .61 so we do have some work to do with the readmission penalties for hospitals.

Now, the SNF Value Based Purchasing Program, as I said, is just brand new beginning with October 1, 2018 2% of your Medicare reimbursement for skilled nursing facilities will be withheld. The reason for that is they want these things to be budget-neutral, they don't want an additional burden on the Medicare system so they want to make it budget neutral. They take out these 2% and then you have the ability to earn it back or get more so there is some incentive to this. The nursing homes with the low admission rates can get more than the 2% withheld so they could actually make some money on this. Nursing homes with the highest readmission rates will not receive any incentive payments so if you have a high readmission rate in your skilled facility then that's 2% of your total Medicare reimbursement. High admission rates you can kiss that 2% goodbye. That's the SNF Value Based Purchasing Program, kind of simple just plain readmissions.

We have the Hospital Value Based Program and that is similar to that SNF one except it's much much more complex. It starts out, like the others, with 2% held back and then the hospitals can earn some back, or get more back, or lose everything. That means it is budget neutral, it doesn't add anything to the Medicare stresses on that fund, it is a rewards and incentives program although most people think it's a punishment but you can make money on this. It deals with all Medicare patients and that's traditional Medicare not your HMOs. We're going to go into the Value-Based Purchasing Program now and we're going to talk about the specifics.

Here you see how complex the Value Based Purchasing Program is for hospitals. There are 4 domains and you can see them all in the circle there. Now, for all of these measures the performance period is the most recent data that we have which is 2015 and baseline, which is what it's compared to, in most cases is 2013 data. Mortality and this AHRQ PSI 90 they have longer periods so they may have 18 months, I think, they're trying to get it up to 3 years for the baseline and then the performance period. We're going to look at the different aspects of the Value Based Purchasing Program. I do want to point out though when this first started, the Value Based Purchasing, there were only 2 domains and 70% was the core measures, if you will, and then 30% was HCAHPS or the patient's perception.

Now, you can see here, the clinical care is, now, 5% for the process because the process measures where are those core measures? The process measures, now, are just down to 3 which is giving thrombolytics timely in the face of an acute MI, which is rarely done these days I might add, the immunizations, and the pregnancy complications. As I said, there were a ton of process measures but they've topped out. There was no room for improvement so they gradually delete them from the program. We have 30% being on clinical care but the majority of that is on outcomes which is mortality. Then we have the HCAHPS which is this 25% in the orange and that's the patient perception of care, that's the surveys that are sent after the patient leaves the hospital. Safety, safety is this green 20% and you can see down here the safety includes [CLABSI 00:19:24] the central line infections, CAUTI the urinary tract infections, SSI, MRSA, the C-difficile infections, and then this AHRQ PSI 90 score, and I'm going to talk about that later.

The important thing to look at here is that all of these infections are counted individually in the calculation of the Value Based Purchasing Reimbursement, as I said, we're going to talk about that in a minute. The last domain is the efficiency and cost reduction which is 25% of the score and that is one measure which is this Medicare Spending Per Beneficiary. We will spend a lot of time on that because that is the one thing that is impacted by all aspects of the healthcare system whether it be hospice, home care, DME, physicians, inpatients, SNF it all impacts that efficiency and cost reduction domain or the Medicare Spending Per Beneficiary.

Okay. A couple things that you need to know in how Value Based Purchasing is scored. First benchmark, the benchmark is the top 10% of all hospitals. In most cases, all those measures that we talked about the benchmark is 100% compliance that's because people have been working on this for such a long time that the top 10% are achieving that 100%. The other term is achievement threshold and that's the 50th percentile oF all hospital performance. The important about the achievement threshold, that 50th percentile, is that if you don't hit average, you get no points towards your score. The less points you get, the less money you get, or you lose money. They're the 2 things that are really important here.

There's 2 ways to score points in Value Based Purchasing, the first is the achievement points. That's where the hospital's performance is scored against all other hospitals and, as I said, the closer you get to benchmark you get the full amount of 10 points. If you're lower than the achievement threshold you get nothing so there is a goal to get to, at least, that achievement threshold so you can try to get some points. The other way to score points is through improvement points and that looks at how you compare to your original performance. If you're worse than you were in the baseline, 2 years before that, then you get no points and the closer you are to benchmark you can get 9 points.

Just looking at HAIs because this presentation actually did start out as a business case for HAI reduction but we do have active HAI prevention projects in all 5 of our states so I wanted to look at where we are. Now, when you look at SIR, which is the Standardized Infection Ratio, that's how these are measured. It's a CDC program, things are entered into NHSN, which I can't remember what it's for but, believe me it's a program that they enter into it. It compares the number of HAIs to the number that are expected and the lower the SIR the better so we're looking for low numbers here.

Now, as I said, the Value Based Purchasing achievement threshold which is the red column here that's where you need to be to get some points so we need to be below that in order to get points. When you look at this as a whole state, not individual hospitals but as a whole state, you can see that for CLABSI, let's say, only Delaware and West Virginia fall below that achievement threshold so that they're doing better than the national average. For CAUTI all 5 states are below the national average for the SIR. We're all doing poorly in the SSIs. Unfortunately, that was never part of the QIN contract so we weren't charged to improve those so there's currently, unless they're working with another program, hospitals are not getting assistance from us on those measures. As we promote good hospital hygiene and good antibiotic stewardship, hopefully, that'll impact some of these SSIs.

Only Louisiana is slightly low for CDI so we all really need to work for that and I'm talking slightly low, just below the Value Based threshold. You can see where some improvement needs to be made in order for us to help our hospitals get the most bang for their buck in the Value Based Purchasing reimbursement system.

The next Value Based Incentive Program is the Hospital Acquired Conditions. This is separate and apart from the Value Based Purchasing, this is another total reimbursement issue. For Hospital Acquired Conditions there's 2 components to the score for this. 1, is 25% of the score and that is the AHRQ PS 90 composite score and, remember I said, that was part of Value Based Purchasing well it's also part of the Hospital Acquired Conditions Program, as I said, totally separate. I happen to think, the term double dipping seems appropriate here but because Hospital Acquired

Conditions and avoiding them is so important they do put a special emphasis on this.

The other thing is, is that in domain 2 which is 75% of the score look what's included in domain 2 which is CLABSI, CAUTI, and SSI which were all part of Value Based Purchasing also. We have 2 things here that are really important because they impact reimbursement in 2 different ways. The other thing was the composite score, the AHRQ composite score, that has things in it like pressure ulcers, post-operative hip fractures, [DVTs 00:26:37], sepsis which could also come from the SSIs so you can see that there might be a problem with that too, accidental punctures and lacerations. One of the things that, up until this year, was also included in that composite score was the CLABSI. Not only did you have CLABSI as part of the Value Based Purchasing Program but you had CLABSI as part of domain 2 of the Hospital Acquired Conditions and you had CLABSI impacting the AHRQ composite score. Now, I think that they finally realized that having CLABSI impact this 3 different times might be a little ridiculous and so the most recent proposed rule came out that they would delete that from the composite score.

Another value initiative to talk about is the Medicare Spending Per Beneficiary. Now, this is part of the Value Based Purchasing Program so we did skip around a little bit but I wanted to really talk about this in depth. Medicare Spending Per Beneficiary it's a hospital measure, right now, it only impacts the hospital. It's average Medicare Spending Per Beneficiary per hospital divided by the mean for all hospitals, median, I'm sorry, for all hospitals. It's a claims based data it doesn't need to be abstracted or anything it just needs to be just pooled from the Medicare claims. It impacts the entire, not just the episode of the admission but the entire [peri 00:28:38] admission period. They look at parts A and part B spending for 3 days prior to hospital admission, the hospital admission itself, and then for 30 days post discharge. Now, remember this is 25% of the hospital Value Based Purchasing score so we're talking about something that looks at a really big picture impacting many partners and stake holders in the healthcare system but impacting the hospitals. It really makes you look at what's best for the patient and not just the hospital.

Now, this is just strictly the regular Medicare, no HMOs, transfers, deaths, and really significant statistical outliers are not included in this and it is risk adjusted. Let's look at this Medicare Spending Per Beneficiary in detail. Now, I like this measure in that it really focuses on the entire healthcare system, it doesn't just focus on what's done in the hospital. Many times we talk about the hospital costs which is very difficult to figure out because what a hospital charges, what it really costs them, and what they're reimbursed are 3 totally separate entities and it's very difficult to figure it out, what's really going on.

You hear these stories all the time about somebody charging $400 for a band-aid but what did it cost the hospital? 5 cents. What does the hospital get paid for that? Nothing if it's an inpatient so you have to look at all these pieces. With this, this is actual Medicare claims. I told you, we have those 3 periods of time and when the hospital gets these reports they breakout from these 3 periods of time what was the average cost per case, or the average spending per case, for home health, for hospice, outpatient, inpatient, skilled nursing facilities, [DME 00:30:59], and then carrier and what carrier is is the physician claims. I don't know why they call it carrier but we'll go along with it.

This is hospital A, I just picked this hospital out of our database. This has hospital A and you look at, if we start with the green and work our way left, the average spending per episode of care for the nation for this last year, that we're currently in, was $20,025. For the state, for Pennsylvania, which

this is in, is $20,323 slightly higher, realizing that in the nation there's a lot more rural states and Pennsylvania has 2 big urban areas some would say 4 big urban areas but, at least, 2 huge ones. Then we have this hospital, which is hospital A, and the average spending per episode of care for this hospital is 21,853 so it's higher than what's expected. When these reports come out the hospitals have the ability to look at these reports and determine exactly what contributed to that higher than expected spending episode. May not seem a lot but this is the average per episode and when you think of the number of Medicare patients that were treated during that time frame it turns out to be a lot of money.

We're going to look first at the 1 to 3 days prior to admission and this is the first period. There's not much variation in this, there's a slight bump in the inpatient but it doesn't count transferred patients so since the claims for the patients that are transferred aren't included in this we can assume that this is patients that were readmitted within 3 days prior to the index admission, that's the only way you could have inpatient in the 3 days prior to the admission so that's one thing to look at. We have less than average for outpatient spending so one would have to look at that to see if, maybe, they could have done more outpatient testing before the patient was admitted to the hospital, it's just something to look at. You can see where, as you would expect, in the 3 days prior to coming in the hospital the most spending is done on the physician side where they're evaluating to determine if they should come in.

Then we look at the second period, this is the actual hospital stay and we can see here that during this hospital stay there were fewer dollars spent than average across their state and the nation. Other than physician fees, the other categories should be around zero but when you look at this because the spending for this hospital was lower than expected so we know that that's not what's driving the higher Medicare Spending Per Beneficiary. We would see a huge spike in that blue one if that was the case but that's not the case.

Then, we look at the 3rd period which this last period is the one that usually has the most impact for those hospitals with a high Medicare Spending Per Beneficiary and this is the care coordination piece. What are the costs once the patient leaves the hospital? We'll look at these individually. For home health, on the left, it's lower than the state national average so that's not a reason for the higher than average Medicare Spending Per Beneficiary. It's not hospice, and it's not DME either so the big bumps in the dollars are seen in inpatient, SNF, and physicians. We'll look at SNF first.

Hospitals that send a lot of their patients to skilled facilities that's not a bad thing and if they're sending them there because they're still not stable enough to be in a home environment and they don't get readmitted because you send them there then that's a good thing and that's wisely spent money. As you can see here in the 30 days after discharge not only are you seeing a high SNF rate spending but you're also seeing a high physician spending because look at how high the inpatient dollars are after the patient leaves the first time. This indicates that this facility itself, its inpatient claims are over $2,000 above the national spending per episode of care. It's a serious a problem with readmissions here so sending patients to the SNF hasn't helped, it hasn't prevented them from coming back in. One of the things you want to look at here is because of these readmissions, because you have a lot of patients go into the SNF ... so let's look at the SNFs that are close to this facility.

Now, these are the SNF readmission rates for 10 SNFs that hospital A's patients are sent to. Now, you can see in the last column the state average for skilled readmissions is 19.41%, if you can't see

that, that's what it says. Not one of the skilled facilities that this hospital refers to is below the state average so all of these skilled facilities are readmitting patients to the hospital. One of them is over 40% readmission rate for patients going back, and believe me, I've had years in case management, I know the pressure there is to get the people out of the hospital. I know that you look for the first available bed and just ship them there.

I think, that the time for that happening is now over because you have to be aware of these measures and these rates. If you're sending somebody to a SNF that readmits 40% of their patients then that's not really helping you at all. Not only that, it's going to affect your reimbursements down the line, there's just so many issues that can come because of this. SNF readmission rates are, now, being reported so everybody really needs to pay attention to them.

My recommendation for hospital A would be to work with their partners in the healthcare community, especially the skilled facilities to reduce the readmissions. Maybe, the hospital could provide some education for the staff at the SNF, or develop programs for better communication between the facilities, something to help the both the hospital to reduce their readmission rate and the skilled facility to reduce their admission rates because that's going to impact them in the next year. Coordination and collaboration are going to be the key for both hospitals and SNFs if they're going to survive in this environment.

Let's look at the Medicare Spending Per Beneficiary for hospital B and this is just going to show you how interconnected the financial success of hospitals and SNFs need to be as we move from volume to value. We have 2 more examples. We have hospital B and you can see where their spending is not that high, it's about $600 per case more than the national average but still it's higher and so that's going to impact their Value Based Purchasing payment.

We're going to look at that crucial period, that 30 days post discharge period. This is the one that's impacted by care coordination. The hospital is spending lots of their dollars sending the patient to the SNF but, as I said before, if you're spending a lot of money sending patients to SNFs and it's not decreasing your readmission rate then you really need to work on that. Here the inpatient dollars are not significantly lower than, well certainly, state but they're higher than the national average. We still see here that although a lot of patients are being sent out to SNFs they are still coming back and that's also reflected here where the physician fees are up because they come back to the hospital and need to be seen daily in the hospital.

Now, what I'm going to do is, I have the same group here that we just talked about, with hospital B we're going to look at the SNFs that this hospital is using. Again, state 19.41 and here's a skilled facility that is 55% readmission rate, 27 or almost 28, and 33 and a third so although, this facility is sending patients to SNFs because, maybe, they need more care and they're not ready to go to a stable home environment the fact that the patients are being readmitted doesn't help their bottom line, it doesn't help anybody's bottom line at this point in time. Again, this hospital and their referring facilities really need to work together to try to decrease that readmission rate.

We're going to look at hospital C and this one you can see where their average spending per episode is much lower. Now, I want to tell you that hospital C is located 5 miles West of hospital B and look at the difference in the average spending per episode of care. When you look at the breakdown of this, the analysis of it this is exactly what I was talking about before, they spent a lot of money on skilled facilities and they send their patients to SNFs but look how much lower than

expected, they're over a $1,000 less per episode of average spending per episode of care than the national or state average, look at the big gap here. This is a hospital that, you saw it here, you saw it in their Medicare Spending Per Beneficiary is low that's exactly where you want it to be. Then, lots of money being spent on SNFs but the hospital's getting a benefit from it. You can see because there's less readmissions there's less money being spent on physician charges, physician claims.

Now, if we look at the readmission patterns of the skilled facilities that are associated with this facility, these referral patterns, we have the state average 19.41 but the 3 biggest SNFs that they refer to right near their facility are all below the state average for readmission rates and that reflects both these skilled facilities are going to do well when it comes to the reimbursement for the Value Based Purchasing for SNFs in the years to come and this hospital does well because they work together and they do partner well together. I promise to tie that all together.

I also want to tie together the potential impact for these value based initiatives on hospitals alone. If you look at the 2% the hospitals lose right off the bat and they have the potential to get it back but what if they don't? What if they don't do well? Then, they lose 2%. If they have a high readmission rate they lose 3% and they can lose 1% for the Hospital Acquire Conditions. Remember the Hospital Acquired Conditions are really tied to a lot of the measures in Value Based Purchasing so they do have the potential to lose 6% of their Medicare reimbursement. That's a lot to tie together, 6%, here working with the SNFs, the SNFs' potential for losing money so it's all intertwined.

The last thing that I wasn't to do to tie this all together is I want to look at a case study and this is a HAI case study, HAIs are near and dear to my heart. SNF readmissions aside we're going to look at this and we're going to see what are the value metrics that are affected by these hospital events. In your mind just think, how many do you think there are? Count them as we go along. We have Benjamin Poor, which is my little take on Benjamin Franklin and Poor Richard, he's a 66 year old Medicare patient admitted for pneumonia. Comes in the hospital, and he develops a CLABSI, and the organism was MRSA so he was in the ICU for sepsis for 14 days. Now, when you're in the ICU everybody wants to put a [foley 00:45:41] in you because they want to monitor your urinary output so, of course, he developed a CAUTI. Eventually, he gets better, he's discharged to a SNF. Now, he gets into the SNF he develops diarrhea and was admitted 2 days later for treatment of [CDIF 00:45:57].

He gets better from that, he goes back to the SNF but he was dehydrated when he was in the hospital, they never restarted his diuretics before he left, he goes back to the skilled facility not on his diuretics, he goes into congestive heart failure, has to go back to the hospital, and then he dies during that hospital stay. In addition to looking at the cost of the care provided how many other financial impacts are occurring? I know you can't answer that but, I'm going to tell you, I counted 15 and I may have missed a few. First of all there's the [DRG 00:46:45] payment for the hospital. The hospital gets one set payment for pneumonia admission, now, out of that payment if they just treat the patients for pneumonia and he goes home then that's the money spent and they might make a little money on that or they just might break even. When you count in all the antibiotics that this guy had to have during this stay for the CLABSI, being treated for MRSA [Vanco 00:47:14] is not a cheap drug, all the extra ICU care.

Then he develops a CAUTI, there's more antibiotic costs being associated to that, and he's in the hospital for a long period of time so the [DRG 00:47:28] payment got eaten away in the first 3 days

of this guy's stay so he loses money on the [DRG 00:47:34] payment. Then, he has [CLABSI 00:47:38] that effects the Value Based Purchasing, it did effect the AHRQ 90 it doesn't any longer but it does effect the Hospital Acquired Conditions. The organism is MRSA so there you have MRSA being counted for Value Based Purchasing. Develops a CAUTI, CAUTI being counted for Value Based Purchasing. He goes to the SNF and he's readmission and so there's a readmission right there for pneumonia and he develops CDI which is a Hospital Acquired Condition, or a hospital acquired infection because he was only out of the hospital 2 days so we know it was something that was initiated in the hospital so we have a CDI.

Then we have the readmission for pneumonia, so we have a pneumonia readmission. The guy eventually died within 30 days of that pneumonia admission so we have mortality for the pneumonia admission. He died within a few days of CHS admission so we have the mortality for CHS. Now, you have that family who is totally mad at you now because this guy has been bouncing back and forth from hospital to nursing home to hospital to SNF and back and dies and it's all due to complications. If that family received an HCAHPS survey then they're going to be mighty ticked and they're not going to give you a good rating which would effect your Value Based Purchasing.

Then you have the other things. Here's this guy who stays all these days in the ICU so that backs up people getting in the ICU which leads to filled beds in the hospital and in the ICU, the emergency department gets over crowded. Once the emergency department gets over crowded then you have to go on divert status and you lose the money for those admissions that you missed because these patients went elsewhere. Then when you look at all of this, all these returns, all these costs, all these readmissions just think of what that's doing to your Value Based Purchasing as far as Medicare Spending Per Beneficiary. You can see that this is a guy who had the CLABSI been prevented, maybe, he never would have had these [sequelae 00:50:12]. Had a med reconciliation been done prior to the guy leaving, maybe, somebody would've picked up on the fact that he needed his diuretics attended to and he would've developed the congestive heart failure.

All these processes need to be included to make sure that we look at the whole big picture and not just our little bit. Yeah, we discharged the patient back to the SNF but no med reconciliation was done so we need to make sure that everybody's working together, make sure everybody's covering everybody's back all for the betterment not only of the patient but of your facility's bottom line. As I said, Benjamin Franklin, "A penny saved is a penny earned." Just spending a couple more cents on the right equipment to put that CLABSI in really could've saved not only the patient's life but also the bottom line for your facility.

With that we're going to go for questions. If we don't get time to answer your question or if you have other questions later I would be really happy to answer them, anything about the value based initiatives or any of the value based incentive programs. Laurie?

Laurie Fink: Thanks so much Julie. Yes, at this time we will begin the question/answer portion of the webinar. If you have any questions for Julie please type them in either the chat or the Q & A box on the right of your screen. If you have already submitted a question during the presentation it will be addressed, now, as time permits. We did have our first question submitted and it asks, where can we find the readmit rate for the SNF in our area?

Julie Volz: If you're participating with us, those reports are uploaded to your My Quality Insights, through My Quality Insights the Reports page you can download it from there.

Laurie Fink: Okay. The next question asks, where can you obtain data that you demonstrated for Medicare Spending Per Beneficiary?

Julie Volz: The individual reports are distributed to all the hospitals with a preview period usually around the June to July period but there is also a medicare.gov data site that's in conjunction with the Medicare Compare. There's a data portion of that where can actually look at the breakdown of the data if you don't have available the actual report that was distributed the prior year.

Laurie Fink: Okay. What kinds of programs are available for hospitals to participate in for quality improvement in these areas?

Julie Volz: We have 2 programs. 1, HAI reduction we work with hospitals in all 5 states to decrease the Hospital Acquired Infections specifically CAUTI, CLABSI, and CDI. Also, we have another program where we work with hospitals to improve their Value Based Purchasing scores whether it be through HAI improvement or through improvement in HCAHPS scores. Then, certainly, in the care coordination piece we have a big chance to help improve that Medicare Spending Per Beneficiary and decrease that readmission rates.

Laurie Fink: Okay. Our question asks, is there any future plan that you are aware of where readmissions for behavioral health services will be factored into Value Based Payments?

Julie Volz: I don't know specifically but I can tell you that there were changes in the discharge planning measures for psych. It appears that the way they changed it, because they discontinued the HBIPS 5 and 6, and 7, I think, or 5 and 6 they discontinued those beginning January 1 this year and beginning in July there are new measures. They really are looking in depth at that care coordination piece of discharging the patient with the appropriate follow-up so it appears that they're putting the same emphasis that they would on SNF with readmissions. Like I said, they're moving quickly now, I didn't expect them to bundle the physicians into a big Value Based Purchasing type program but they did really quickly.

Laurie Fink: Okay. Our next question is, a hospital has lower than average for all components of Medicare Spending Beneficiary except for the SNF care category. Both the hospital and the most frequently used SNFs work together and have lowered readmission rates. Do you have any thoughts on other causes for the high SNF cost?

Julie Volz: No. I think it's totally appropriate that you're sending patients to SNFs. I think that with my case management background one of the big drives was to get the patient out of the hospital as quickly as you can. Let's face it, the elderly these days they're much more elderly than they ever were before and they need that added time to get physical therapy, to improve their [ADLs 00:56:20] so that they can function in a home environment. If you're doing well and your Medicare Spending Per Beneficiary, that average cost per episode and you're spending a lot in SNFs, I think, that's a great thing. It helps the patient, like I said, I can't say enough knowing that SNFs are necessary, they're vital, they've been left to not to be part of this for a long time and so, now, with everybody working together to benefit the patient, I think, it's a great thing.

Laurie Fink: Okay. We have another question that asks, how can volunteers help?

Julie Volz: Great question. I have to think for that a second. One of the things that volunteers can do is help with making sure that they're following the procedures such as are you washing your hands appropriately when you're going in and out of the rooms whether it be in a nursing facility or whether it be in the hospital? Making sure that you're not being a transmitter of infection. Sometimes, volunteers will sit with patients or residents and tell them things that they would never tell a nurse. They might admit to you that they don't have enough support at home and they need more support where they wouldn't want to admit that to their doctor, that they can't function alone at home. You might become their advocate and get more support for them, or get [DME 00:58:15] ordered, or something by passing that along to the care team. There's a lot of room for volunteers.

We are also looking at the Quality Insights for Medicare beneficiaries and their caregivers to be part of our team to lead us ... if you're a Medicare beneficiary of the elderly with Medicare to lead us to make sure that we're doing things appropriate for patients that are really thinking about the patient side of things and not just the facility side of things. We're always looking for people to join our patient family engagement activities.

Laurie Fink: I think we have time for one more question, how does patient choice play into hospitals selecting preferred providers?

Julie Volz: I think that, first of all, encouraging patients to use Nursing Home Compare when these readmission rates are going to be on there they're going to see who has high readmission rates. Certainly, we need to let the patient make a choice and, like I said before, so many times we forced them into taking the first available bed and don't allow them enough time. I think, that's because we make a decision in the morning, "Oh, you need to leave today," and so we don't give them that much time to pick an appropriate place that may have a lower readmission rate. By being a [whole care 00:59:59] team and coordinating the care, I can tell you, my father was in the hospital recently and we knew 3 days ahead of time what day they were planning on sending him home so that we knew how to get things lined up. That had to be altered, they came into us one day and said, "Oh, we're no longer at Tuesday, we're looking at Wednesday now." We were always part of the conversation and that meant a lot, that we knew what was going on at all times.

Including the patient, including the family, allowing them to be part of that decision making process so that they can be prepared to pick an appropriate place to go.

Laurie Fink: All right. Thanks so much Julie. We are out of time so we'll get things wrapped up for today. If you did submit a question that we did not get to we will definitely compile all of those and provide answers to them, arrange them on a document, and we'll post them on the website along with the Power Point presentation, and the recording of today's session.

Thank you everyone for joining us today. I want to remind you that there will be a very brief evaluation at the close of this session. If you could please take a minute to complete it, your input really does help us to plan future programs. With that, I'd like to thank you again for taking time out of your day to join us for this session and have a great day. This session has now concluded.