The Market Force Course
12 Tools for Translating Market Forces into Frontline Terms
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Available Within Your Nursing Executive Center Membership

In recent years, the Nursing Executive Center has developed numerous resources to help nursing leaders improve nurse engagement. Select resources are shown here. All resources are available in unlimited quantities through the Nursing Executive Center.

Improving Nurse Engagement

**National Prescription for Nurse Engagement**
- Most powerful strategies for driving engagement in today’s rapidly transforming market
- Rationalize the flow of change to prevent frontline stress and burnout
- Build meaningful frontline recognition that values professional impact into leaders’ workflow
- Broaden access to nontraditional professional development opportunities

**Instilling Frontline Accountability**
*Best Practices for Enhancing Individual Investment in Organizational Goals*
- Simple strategies for making performance data meaningful and actionable for frontline staff
- Reward and recognition strategies that ensure frontline staff members remain motivated to achieve key organizational goals
- Improve frequency and effectiveness of peer-to-peer nurse feedback

**Onsite Presentation of Prescription for Nurse Engagement**
*Best Practices for Enfranchising Frontline Staff in Organizational Transformation*
- Translate market forces into frontline terms
- Build meaningful recognition into leaders’ workflow
- Broaden access to nontraditional development opportunities

**Engaging the Nurse Workforce**
*Best Practices for Promoting Exceptional Staff Performance*
- Develop check-ins to keep an eye on staff and consistently engage them in performance-related discussion
- Customize interventions by developing a comprehensive action plan
- Maximize desirable turnover rates from disengaged or disobedient staff

**To Access These Resources**
To access these and other Nursing Executive Center resources, please visit our website: [advisory.com/nec](http://advisory.com/nec) and enter the publication title into the search engine.
Executive Summary

Why It’s a Problem if Frontline Staff Don’t Understand Health Care Market Forces

There are at least two consequences if frontline staff don’t understand the market forces challenging their organization. First, frontline staff who don’t understand market forces are less engaged. Data shows that staff who don’t see the link between executive actions and their organization’s mission become alienated and disengaged. Second, many market forces require health systems to adopt new strategies—and if frontline staff don’t understand the reason behind the new strategies, they won’t perform at the highest level.

How This Toolkit Equips Nurse Leaders to Translate Market Forces into Frontline Terms

This toolkit is designed to equip nurse leaders to translate market forces into frontline terms. What sets it apart from other resources is that it is written with frontline caregivers in mind. Every resource within this toolkit uses everyday language and is brief, scannable, and interactive.

This toolkit has two parts:

• The first part contains one-page "cheat sheets" that equip nurse leaders to explain market forces to frontline staff. These cheat sheets are designed so a busy leader can quickly review them before a staff meeting and find answers to three primary questions: "What is the market force?", "Why should you care?", and "How can nursing help?" Each cheat sheet also contains brief, ready-to-use talking points leaders can use during huddles or unit meetings.

• The second part contains interactive resources nurse leaders can use to help frontline staff gain deeper understanding of the market forces. These resources include: short videos to post on organizational intranets or share at staff meetings; ready-to-use posters that distill complex concepts into concrete actions for frontline staff; and interactive exercises that help frontline staff understand the scope of the challenge—and brainstorm potential solutions.

How to Use This Toolkit

This toolkit’s cheat sheets and interactive resources equip nurse leaders to explain 12 market forces to frontline staff. While some interactive resources complement cheat sheets, leaders can use any resource in this toolkit independently and in any order—each has stand alone value.

Decide which market force is the greatest challenge for your organization, review the cheat sheet, share the talking points with frontline staff, and then cement understanding by sharing a video or exercise.
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Section I
Reinforcing Nurse Leader Knowledge

- Tool #1: Nurse Manager Cheat Sheets
Tool #1: Nurse Manager Cheat Sheets

How to Use This Tool

Overview

This tool contains a series of one-page “cheat sheets” that equip nurse leaders to explain market forces to frontline staff. These cheat sheets are designed so a busy leader can quickly review them before a staff meeting and find answers to three primary questions: "What is the market force?", "Why should you care?", and "How can nursing help?" Each cheat sheet also contains brief, ready-to-use talking points leaders can use during huddles or unit meetings.

Intended Audience

Nurse directors, nurse managers, nurse educators, and other nursing leaders

Topics Covered

• Accountable Care Organization
• Bundled Payments
• Care Coordination
• HCAHPS
• Hospital-Acquired Conditions
• Meaningful Use
• Pay-for-Performance
• Patient-Centered Medical Home
• Population Health Management
• Readmission Penalty
• Value-Based Care
• Value-Based Purchasing

Available Online

To access this tool online, please visit advisory.com/nec/marketforcestoolkit
Accountable Care Organization

What is an accountable care organization?
An accountable care organization (ACO) is a provider-led organization that takes on full responsibility for the overall cost and quality of care delivered to a defined patient population. Not only do ACOs deliver care in new ways, they also receive payment from the government (or other payers) based on new payment models. ACOs create financial incentives for providers to reduce unnecessary patient utilization and improve quality. If the providers in an ACO successfully deliver high-quality care at lower cost, then they all share a portion of the cost savings.

Almost any group of providers can form an ACO, but most ACOs include primary care providers. An ACO doesn’t necessarily have to include a hospital.

Why should you care about accountable care organizations?
ACOs have the potential to improve care quality by creating incentives to keep patients healthy and out of the hospital. (In other words, they create incentives for providers to work together to treat patients in the lowest-cost, clinically appropriate setting).

If your hospital is part of an ACO, it could earn a financial bonus for providing lower-cost, high quality care.

If you work in a hospital that isn’t part of an ACO, there’s a chance your may see your volumes decline since patients may be treated in lower acuity settings.

How can nursing help?
Since a key goal of ACOs is preventing avoidable hospitalizations, many of nursing’s responsibilities extend beyond the acute-care setting. These often include:

• Coordinating care for patients with chronic conditions (e.g., oversee care plan, medications, transitions from sites of care)
• Managing visits with low-acuity patients
• Equipping patients to manage their own care via online portals, educational materials, and community resources
• Calling patients to follow up at home, ensure they are taking medication, and following their care plan

ACOs will also create new roles for nurses, including those of “transition manager” and “health coach.” This will give nurses the opportunity to work with patients and providers beyond the acute care setting.
Nurse Manager Cheat Sheets

What Else Should You Know?

What should you be telling your staff?

- An accountable care organization, or ACO, is a provider-led organization that takes on full responsibility for the overall cost and quality of care delivered to a defined patient population.
- ACOs provide financial incentives for the participating providers to reduce unnecessary patient utilization and improve quality. If the providers in an ACO successfully deliver high-quality care at lower cost, then they all share a portion of the cost savings.
- ACOs rely on nursing to successfully coordinate patient care and manage disease registries.
- To help your organization succeed as part of an ACO, nurses should: communicate with providers across different sites of care to ensure care is coordinated, provide clear and actionable patient education so patients can manage their own care, and document all patient care to avoid duplicating tests or procedures.

How different is an accountable care organization from other payment programs?

This chart shows how the ACOs compare to other payment programs. Compared to more traditional models, the biggest differences are that ACOs give providers an incentive to reduce patient utilization and put providers at risk of losing money if they aren’t high-quality or efficient.

<table>
<thead>
<tr>
<th>Does the program...</th>
<th>Pay-for-Performance</th>
<th>Bundled Payment Contract</th>
<th>Accountable Care Organization</th>
<th>Capitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create an incentive to reduce patient utilization?</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Create an incentive for providers to improve quality?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Limit the patient’s choice of provider?</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Shift risk to the providers. If so—how much risk? (e.g., Could the providers lose money if they perform poorly).</td>
<td>Low</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>

Questions to ask your CNO

1. Is our organization part of an accountable care organization?
2. If yes, what population is covered in our ACO?
3. Who are our key partners in the ACO?
Bundled Payments

What are bundled payments?

A bundled payment is a single, lump-sum payment that’s shared by all providers who care for a patient during a single episode of care. This is different from the traditional way providers are paid (called “fee-for-service”). Under the traditional system, every provider who cares for a patient (hospital, ambulatory clinic, nursing home, etc.) is paid individually for their services.

Bundled payments are supposed to encourage different providers to work together and give more efficient, better coordinated care. The way it works is: a bundled payment is smaller than the sum of the individual payments for the primary care clinic, hospital, and post-acute provider. So for providers to make money, they’ll need to share the single payment—and deliver care more efficiently.

Why should you care about bundled payments?

Bundled payments can lead to better care and lowered costs. Under bundled payments, all providers will have to work together to deliver care more efficiently. This should reduce the amount of work that is duplicated across settings and also eliminate gaps in care between settings. If all providers work together to treat the patient, and do so without spending the entire lump-sum, they get to share the extra dollars, which means more resources for your organization.

How can nursing help?

Nursing must work with providers within the hospital and across care settings to improve coordination of care. Specifically, nursing should provide all patients with clear discharge and medication instructions, and follow up with patients post-discharge to ensure compliance. Additionally, nurses should consistently and accurately document patient information to reduce duplication and avoid errors.
What Else Should You Know?

What should you be telling your staff?

- A bundled payment is a single, lump-sum payment shared by all providers who care for a patient during an episode of care. (This could be our hospital, a SNF, and a primary care clinic).

- Bundled payments are supposed to encourage different providers to work together to give more efficient, better coordinated care.

- The reason why is: the lump sum payment is less than the amount that would be paid out to each individual provider. So to make money, we’ll need to share the single payment and deliver care more efficiently.

- You can help our organization earn our share of the bundled payment by: discharging patients to the appropriate care setting, giving patients clear discharge and medication instructions, following up with “high-risk” patients post-discharge, and consistently documenting patient information.

Questions to ask your CNO

1. Is our organization participating in a bundled payment?
2. If so, what other providers are we working with to share the bundled payment?
3. Which patient population falls under our bundled payment program?
What is care coordination?

The phrase “care coordination” describes when caregivers in different disciplines and different settings communicate fully, share the same goals for a patient, and have complementary plans of care.

What does care coordination look like?

- Patients not having to repeat personal information to different caregivers
- Patients receiving consistent instruction and education from all caregivers
- Caregivers in one setting being well informed about the care a patient received in another
- Patients experiencing seamless transitions between care settings

Many of the terms in this toolkit are used to define specific government payment programs. Care coordination is different. It’s the end goal many government payment programs are trying to achieve. It isn’t a specific payment program.

Why should you care about care coordination?

Care coordination will improve care quality, improve patient transitions, reduce duplication of care, and reduce gaps in care. As a result, it should also improve efficiency and reduce costs. Because of its potential impact on cost and quality, it is a critical part of most hospitals’ and health system’s future strategy.

How can nursing help?

Care coordination efforts will rely heavily on the nursing team. To improve care coordination you should:

- **Hardwire use of risk assessments**: Build risk assessment into nurses’ workflow in order to identify patients at greatest risk for readmissions, falls, pressure ulcers, and other avoidable conditions.
- **Communicate shared goals and responsibilities** across the care team: Gather all members of the care team together in-person (or using remote technology) to clearly communicate shared goals and responsibilities.
- **Review patient medications**: Identify gaps, inconsistencies, or challenges with patients’ medication regimens; inform care team of any necessary changes.
- **Empower patients to engage in their care**: Educate patients about their care and discharge plan so that they are equipped to manage their own care at home.
- **Partner with post-acute providers**: Work with post-acute care providers to facilitate seamless transitions across the continuum.

Source: Nursing Executive Center.
What Else Should You Know?

What should you be telling your staff?

- The phrase “care coordination” describes when caregivers in different disciplines and different settings communicate fully, share the same goals for a patient, and have complementary plans of care.
- You’ll know care is coordinated when: patients don’t have to repeat information to different caregivers in different settings, patients receive consistent instructions and education from all caregivers, caregivers in one setting are informed about a patient’s care in another setting, and patients experience seamless transitions across setting.
- Care coordination should improve care quality, smooth patient transitions, reduce duplication of care, and reduce gaps in care. As a result, it should also improve efficiency and reduce costs.
- This means it’s a critical part of most hospitals’ and health systems’ future strategy.
- As a nurse you can help coordinate care by: facilitating ongoing conversations between physicians, therapists, case managers, patients, and families to keep everyone working toward the same goals; documenting accurately and providing clear discharge planning; and providing patient education to engage patients and families.

What are some of the ways to improve care coordination?

<table>
<thead>
<tr>
<th>Project</th>
<th>Description</th>
<th>Learn More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Transitions Intervention</td>
<td>Four-week program targeting patients 65 or older; teaches patients self-management skills, provides timely follow-up, and educates about red flags.</td>
<td><a href="http://www.caretransitions.org">www.caretransitions.org</a></td>
</tr>
<tr>
<td>Hospital to Home (H2H)</td>
<td>National quality improvement campaign for patients with cardiovascular-related illness; aims to reduce readmissions and improve transition from inpatient to outpatient setting.</td>
<td><a href="http://www.h2hquality.org">www.h2hquality.org</a></td>
</tr>
<tr>
<td>Project BOOST (Better Outcomes for Older Adults Through Safe Transitions)</td>
<td>National initiative to help improve patient care in the transition from hospital to home includes: preparation for patient discharge, medication reconciliation, telephone contact within 72 hours, teach back, and direct communication with principal outpatient provider upon discharge.</td>
<td><a href="http://www.hospitalmedicine.org/boost/">http://www.hospitalmedicine.org/boost/</a></td>
</tr>
<tr>
<td>Project Re-Engineered Discharge (RED)</td>
<td>Group at Boston University Medical College develops and tests strategies to improve hospital discharge process to promote patient safety and reduce readmissions.</td>
<td><a href="http://www.bu.edu/fammed/projectred/">http://www.bu.edu/fammed/projectred/</a></td>
</tr>
<tr>
<td>Transitional Care Model</td>
<td>Provides comprehensive in-hospital planning and home follow-up for chronically ill, high-risk older adults. Key component is transitional care nurse who follows patient from hospital to home.</td>
<td>www-transitionalcare.info</td>
</tr>
</tbody>
</table>

Questions to ask your CNO

1. What care coordination pilots is our organization participating in?
2. What are your top priorities for improving care coordination at our organization?
3. Who are our key partners across the health system and community to improve care coordination?
HCAHPS

What is HCAHPS?

HCAHPS is a national survey that asks patients to rate their experience in the hospital across eight categories, which include communication with nurses, pain management, and responsiveness of hospital staff. The survey is sent to randomly selected patients between 48 hours and 6 weeks after they are discharged. The results are collected by the government and shared with consumers.

A hospital’s performance on the HCAHPS survey directly impacts its finances. HCAHPS scores are one metric used to determine if an organization can earn a financial bonus or will receive a financial penalty.

HCAHPS is commonly pronounced “H-caps.” The full name of the survey is “The Hospital Consumer Assessment of Healthcare Providers and Systems.”

A hospital’s performance on the HCAHPS survey may also impact its reputation. The survey results are widely available and patients have the ability to compare the performance of different hospitals.

Why should you care about HCAHPS?

HCAHPS may help improve the patient experience. Not only does the program give hospitals a financial incentive to improve the patient experience, the survey results can help diagnose specific improvement opportunities.

How can nursing help?

The way nurses deliver care and interact with patients directly impact their hospital’s HCAHPS score. The survey specifically asks patients to rate the following areas of their inpatient stay: communication with nurses, responsiveness of hospital staff, pain management, discharge information, hospital environment, and overall hospital rating.

To improve their hospital’s HCAHPS performance, nurses should: reduce noise at night, anticipate patient needs (particularly around pain management), involve patients and family members in the care process, and clearly communicate discharge and medication instructions.

What should you be telling your staff?

- HCAHPS is a national survey that asks patients to rate their experience in the hospital across eight categories. (These include communication with nurses, pain management, and responsiveness of hospital staff).
- How well our hospital performs on HCAHPS directly impacts its finances. If we do well, our hospital will earn a bonus. If we do poorly, we may lose a portion of our reimbursement for Medicare patients.
- HCAHPS survey results may impact our hospital’s reputation. The survey results are widely available and patients can compare the performance of different hospitals.
- To improve performance on HCAHPS you should: anticipate patient needs (particularly around pain management), involve patients and family members in care, and clearly communicate discharge and medication instructions.
What Else Should You Know?

What does HCAHPS measure?
The HCAHPS survey has eight categories (which are called “domains”). They are listed below.

Summary of Eight HCAHPS Domains

1. Communication with nurses
2. Communication with doctors
3. Responsiveness of hospital staff
4. Pain management
5. Communication about medicines
6. Discharge information
7. Hospital environment (quiet, noise)
8. Overall hospital rating

Resources to improve HCAHPS performance

If you are trying to improve your unit’s HCAHPS performance, the resources below can help.

<table>
<thead>
<tr>
<th>Title</th>
<th>Description</th>
<th>Where to Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhancing the Patient Experience</td>
<td>Twenty best practices for implementing a holistic patient experience strategy.</td>
<td>advisory.com/PatientExperience</td>
</tr>
<tr>
<td>The Patient Experience Toolkit</td>
<td>Seven implementation tools to help improve your unit’s HCAHPS scores.</td>
<td>advisory.com/PEToolkit</td>
</tr>
<tr>
<td>HCAHPS Crosswalk</td>
<td>Interactive tool that maps best practices and tools to each HCAHPS domain.</td>
<td>advisory.com/Research/Nursing-Executive-Center/Tools/2013/HCAHPS-Crosswalk</td>
</tr>
</tbody>
</table>

Questions to ask your CNO

1. What are our top strategies for improving our HCAHPS performance?
2. What are our hospital’s biggest barriers to achieving excellent patient satisfaction?
3. What are our top areas for improvement?
Hospital-Acquired Conditions

What are hospital-acquired conditions?
Hospital-acquired conditions occur when a patient receiving care in the hospital experiences an unrelated condition. As an example, if a patient was admitted to the hospital for a hip replacement and during her time in the hospital, acquired a catheter-associated urinary tract infection (CAUTI), this infection is a hospital-acquired condition (HAC). Some common HACs include MRSA,1 C-Difficile,2 and CLABSI.3 Certain HACs are also referred to as “never events”—since they should never occur.

HACs are very common. One out of every 10 hospitalized patients experience a hospital-acquired condition.

Why should you care about hospital-acquired conditions?
HACs cause our patients a lot of unnecessary pain and suffering. And in the future, patients will be even more vulnerable to HACs because they will be older and sicker.

HACs also cost a lot of money. Every year, the U.S. health care system spends $45 billion on hospital-acquired conditions. This is money that could be spent on other patient care priorities if HACs are reduced.

HACs also cost hospitals money. Starting in 2015, hospitals will be penalized by losing a portion of their reimbursement if their rates of HACs are among the worst in the nation.

If your hospital is penalized, it means it may have fewer resources available for other priorities.

How can nursing help?
Nurses should follow every step of every clinical protocol, every time. In addition, nurses should proactively manage older and sicker patients to avoid complications and adverse events.

It’s also vital to accurately document each patient’s condition at admission. The goal is to record any conditions that are present when a patient is admitted, to ensure that a condition isn’t counted as “hospital-acquired”—when in fact, a patient was admitted with it.

What should you be telling your staff?

- Hospital-acquired conditions are secondary conditions (such as infections or pressure ulcers) that occur while patients are being treated in the hospital for another reason. You’ll sometimes hear them called “HACs.”
- They’re also sometimes called “never events,” because we never want them to occur.
- HACs cause our patients a lot of unnecessary pain and suffering.
- They also cost a lot of money. Every year, the U.S. spends $45 billion on hospital-acquired conditions.
- To encourage hospitals to reduce HACs, starting in 2015 the government will financially penalize hospitals with high rates of HACs.
- One of the most important ways you can help reduce our hospital’s rates of HACs is to follow every step of every protocol, every time.
- Another way to ensure our hospital isn’t financially penalized under the HAC program is to document all patient conditions upon arrival. This will ensure conditions discovered later on are not counted as HACs.
- You should pay particular attention to patients who are older and have many comorbidities, since they are at higher risk for experiencing HACs or never-events such as: falls, pressure ulcers, and catheter-associated UTIs.

How is your hospital’s performance on HACs calculated?

Your hospital’s performance will be measured in two categories: patient safety measures and rates of major infections. The specific metrics in each category are shown below.

### Patient Safety Measures
1. Pressure Ulcer Rate
2. Iatrogenic Pneumothorax Rate
3. Central Venous CRBSI Rate
4. Postoperative Hip Fracture Rate
5. Perioperative PE DVT Rate
6. Postoperative Sepsis Rate
7. Postoperative Wound Dehiscence Rate
8. Accidental Puncture or Laceration Rate

### Rates of Major Infections

<table>
<thead>
<tr>
<th>Metric</th>
<th>FY 2015</th>
<th>FY 2016</th>
<th>FY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>CAUTI</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>SSI – Colon</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>SSI – Abdominal Hysterectomy</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>MRSA</td>
<td>✔️</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. difficile</td>
<td></td>
<td></td>
<td>✔️</td>
</tr>
</tbody>
</table>

Which hospitals will be penalized?

Hospitals performing in the bottom 25% nationally (measured on the two categories shown above, patient safety measures and rates of major infections) will have a portion of their reimbursement withheld.

### Questions to ask your CNO

1. How does our hospital-acquired condition rate compare to other hospitals?
2. Which HACs is our organization most concerned about reducing?
3. Which programs, processes, or technologies are we using to reduce hospital-acquired conditions?
Meaningful Use

What is Meaningful Use?

Meaningful Use (MU) is a government program that encourages hospitals and physicians to adopt and “meaningfully use” electronic health records (EHR).

To participate in MU, a hospital (or physician) must use an electronic health record that meets certain technical requirements and meets a set of system performance measures, such as transmitting a certain percentage of patient data electronically and providing patients’ access to their own health records. There are financial incentives for hospitals to participate. Hospitals that do not participate face financial penalties. The financial penalties will start in 2015 and will take the form of lower Medicare reimbursement rates.

Meaningful Use is divided into three stages. Each stage has a different focus and set of measures that providers must meet. For example, Stage 1 focuses on the ability of a provider to capture and share basic clinical data. Stage 2 focuses on a provider’s ability to share clinical information with patients and across sites of care. Stage 3 will focus on improving patient outcomes. While there are currently only three stages of Meaningful Use, there may be more in the future. The program is currently scheduled to continue until at least 2021.

Why should you care about Meaningful Use?

Meaningful Use requires physicians and providers to adopt electronic health records. In theory, these should: improve communication between providers, improve communication between providers and patients, reduce the number of unnecessary lab tests, prevent adverse drug events, decrease order turnaround time, and even reduce length-of-stay.

MU also directly impacts a hospital’s bottom line. There are big financial rewards for participating. There are also financial penalties if a hospital doesn’t meet the program’s standards. Once a hospital begins MU, it must participate year-over-year or risk receiving a penalty.

How can nursing help?

Even the most sophisticated EHR is only as good as the data within it. And since nurses are entering most of the patient data into the EHR, it is important that they consistently and accurately document patient data.

Having accurate data is important to both patient care and MU. For a hospital to comply with MU, it will need to meet certain performance requirements—such as providing patient-specific educational materials and creating a disease registry of patients with specific conditions to target quality improvement efforts. These hinge on having accurate data. This means frontline staff will need to continue to document accurately, even if the EHR interface (and their workflow) are changing.

Nurses should also encourage patients to use a portal since this will make it more likely that patients will log in. (And patient use of portals is important to Stage 2).
What should you be telling your staff?

- Meaningful Use is a government program that encourages hospitals to adopt and “meaningfully use” electronic health records.
- The goal is to encourage providers to adopt electronic health records. Supporters believe these will improve care quality and safety, improve care coordination, and also increase efficiency.
- The Meaningful Use program is divided into three stages. Each stage has a specific focus. Stage 1 is about data capture. Stage 2 is about advanced clinical processes. Stage 3 is about using data to improve outcomes.
- There are only three stages right now. There may be more in the future.
- As a nurse, you can help support Meaningful Use by consistently and accurately documenting patient data and encouraging patients to use portals or personal health records.

Three Stages of Meaningful Use

The boxes below show the main objectives for each stage of Meaningful Use and deadlines for implementation.

Stage 1 (2011-2012)
Data Capturing & Sharing

- Increase implementation and adoption of EHR systems
- Capture structured data
- Enhance reporting on clinical quality metrics

Stage 2 (2014)
Advanced Clinical Processes

- Increase exchange of health information
- Demonstrate care coordination across sites of care
- Empower patients with health information

Stage 3 (2017)
Improved Outcomes

- Drive use of real-time data at the point of care
- Use outcomes-focused clinical quality measures
- Utilize clinical decision support for prevention, disease management, and safety
- Provide access to patient self-management tools

Questions to ask your CNO

1. What are our hospital’s priorities around Meaningful Use right now?
2. How are we planning for the next phase of Meaningful Use implementation?
3. How are we incorporating frontline nurse feedback into Meaningful Use implementation?
Pay-for-Performance

What is pay-for-performance?

Pay-for-Performance is a blanket term describing three payment programs that link reimbursement to hospital quality. The three programs are: Value-Based Purchasing, Hospital-Acquired Conditions Reduction, and Readmissions Reduction. Pay-for-Performance is often abbreviated as “P4P.”

Each P4P program measures hospital performance on quality metrics. In all three programs, hospitals performing poorly will receive a reduced reimbursement. Of the three P4P programs, only Value-Based Purchasing offers a potential bonus.

Why should you care about pay-for-performance?

P4P has the potential to drive a greater emphasis on care quality. The programs provide hospitals with added incentives to reduce avoidable readmissions, eliminate hospital-acquired conditions, and perform well on patient experience and outcomes measures.

P4P will also impact how much money your hospital earns. If your hospital performs well on P4P metrics it will avoid being penalized and might even earn a bonus. This could mean your hospital will have more resources to invest in staff and patients.

How can nursing help?

P4P aims to drive improvements in care quality. The best way nursing can help is by delivering high-quality care. Specifically, nurses should:

- Look for processes to deliver more efficient care (e.g., hold care team huddles at the start of each day to review patients’ care plans).
- Anticipate patient needs to improve patient experience.
- Follow up with most vulnerable patients post-discharge to reduce readmissions.

Source: Nursing Executive Center.
What Else Should You Know?

What should you be telling your staff?

• Pay-for-performance is a blanket term describing three payment programs that link reimbursement to quality. You might hear it abbreviated as P4P.
• The goal of P4P is to encourage hospitals to improve quality.
• The three payment programs included in P4P are: Value-Based Purchasing, Hospital-Acquired Conditions Reduction, and Readmissions Reduction.
• If our hospital performs poorly on the metrics in these programs, there will be a financial penalty. If our hospital performs well on all three programs, it will won’t lose any money and may even earn a bonus.
• In order to minimize our hospital’s chance of receiving reduced reimbursement, the most important thing we can do is to deliver high-quality care. We should: follow every step of every protocol to avoid hospital-acquired conditions, follow up with most vulnerable patients post-discharge to reduce readmissions, anticipate patient needs, and eliminate never-events.

“Pay-for-Performance” Describes Three Different Mandatory Payment Programs

Additional details on each program are provided below.

<table>
<thead>
<tr>
<th>Program</th>
<th>Capsule Description</th>
<th>Reward or Penalty?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Value-Based Purchasing Program</td>
<td>Hospitals can receive a financial bonus for strong performance across four different categories of metrics.</td>
<td>Reward and Penalty</td>
</tr>
<tr>
<td>Hospital-Acquired Conditions Reduction Program (HAC)</td>
<td>Tracks specific hospital-acquired conditions; organizations performing in the bottom quartile nationally are subject to reimbursement penalties.</td>
<td>Penalty Only</td>
</tr>
<tr>
<td>Readmissions Reduction Program</td>
<td>Tracks avoidable readmissions; organizations that fall below the national average are subject to reimbursement penalties.</td>
<td>Penalty Only</td>
</tr>
</tbody>
</table>

Questions to ask your CNO

1. Which P4P metric(s) is our hospital most focused on improving?
2. In which area(s) is our hospital already performing well?
3. Has our hospital been rewarded or penalized this year under any of the P4P programs? If so, which ones?
Patient-Centered Medical Home

What is a patient-centered medical home?

The patient-centered medical home is a new primary care model. It is intended to be more patient-centered, team-based, and deliver more coordinated care than the traditional primary care model.

The phrase “patient-centered medical home” can be confusing because it can be used at least two different ways. Sometimes people use the term to describe the general concept of patient-centered, team-based, and well-coordinated primary care. Other times people use it to describe a specific primary care delivery model that not only has those characteristics but also meets specific standards set by a third party, The National Committee for Quality Assurance (NCQA).

Why should you care about patient-centered medical homes?

Most experts believe shifting from traditional primary care to a patient-centered medical home will require clinics to hire more nurses and expand their responsibilities. Not only will more nurses work in primary care in the future—their responsibilities will include: care management, equipping patients to manage their own care via online portals, and following up with patients at home.

If you work in the inpatient setting, medical homes will have little impact on your day-to-day work, though many of your patients may receive primary care in a patient-centered medical home.

Outside of the impact on nurse staffing, patient-centered medical homes should improve care quality by improving preventative care, chronic care, and helping patients to remain healthy (and outside the hospital).

How can nursing help?

Nurses working in a patient-centered medical home will be responsible for assessing and treating complex patients and helping patients manage chronic illnesses.

What should you be telling your staff?

- The patient-centered medical home is a new primary care model. It’s intended to be more patient-centered and team-based, and to deliver more coordinated care than traditional primary care.
- Nurses working in a patient-centered medical home will be responsible for assessing and treating complex patients and managing chronic illnesses.
- Most experts believe clinics that become patient-centered medical homes will need to hire more nurses and expand their responsibilities.
- If you work in the inpatient setting, medical homes will have little impact on your role, though many of your patients may receive care in a medical home.
What standards does a patient centered medical home have to meet to be recognized by the NCQA?

The NCQA requires patient-centered medical homes to meet the seven standards listed in this table.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Physician</td>
<td>Each patient has an ongoing relationship with a personal physician trained to provide continuous, comprehensive care.</td>
</tr>
<tr>
<td>Physician-Led Medical Practice</td>
<td>Personal physician leads care team responsible for ongoing care patient care.</td>
</tr>
<tr>
<td>Patient-Centered</td>
<td>Care team is responsible for addressing all patient’s health needs, coordinating with necessary professionals at every stage, acute care, post-acute, preventative care, etc.</td>
</tr>
<tr>
<td>Coordinated Care</td>
<td>Care is integrated across the health care system and with the patient’s community.</td>
</tr>
<tr>
<td>Quality and Safety</td>
<td>Care team practices evidence-based medicine and uses of an EMR.</td>
</tr>
<tr>
<td>Enhanced Access</td>
<td>There is expanded access to care through after-hours, open scheduling, and online portals.</td>
</tr>
<tr>
<td>Payment</td>
<td>Payment recognizes added value of care provided in medical home, costs less compared to ED and hospital.</td>
</tr>
</tbody>
</table>

How many patient-centered medical homes are there?

Patient centered medical homes are exploding in popularity. This chart shows the increase in patient centered medical homes officially recognized by the NCQA—and this is only a partial count. There are many more primary care clinics that consider themselves to be patient-centered medical homes but are not formally recognized by the NCQA.

Number of NCQA Medical Homes

300% increase in the number of medical homes in three years

<table>
<thead>
<tr>
<th>Number of NCQA Medical Homes</th>
<th>2010</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1,500</td>
<td>&gt;6,000</td>
</tr>
</tbody>
</table>

Questions to ask your CNO

1. Are any of the primary care clinics in our system a PCMH?
2. How can we identify which of our patients are in a PCMH?
3. How do you think the PCMHs in our community might impact our patients?
Population Health Management

What is population health management?

The phrase “population health management” describes when a health care provider is responsible for delivering care to a predefined group of people. Proponents of population health management hope that because a single health care provider is meeting all a patient’s needs, there will be less duplication, better coordination, and lower costs.

To successfully meet an entire population’s health care needs—and deliver high-quality care without going bankrupt—providers will need to make two big changes.

First, they’ll need to change how they are paid. They’ll need to enter into risk-based contracts—in which a provider’s financial health hinges on how efficiently they deliver care. The best known example of risk-based contracts is when providers receive a flat fee for delivering care to each individual, regardless of how much care an individual receives. This is known as “capitation.”

Second, providers will need to change their care delivery model. Current care models are too focused on inpatient care and aren’t focused on keeping patients healthy and out of the hospital. The goal of future care models will be to equip providers to care for patients in the lowest-cost, lowest-acuity (and clinically appropriate) setting.

Why should you care about population health management?

Population health management has the potential to reduce waste in health care delivery and help patients remain healthier and out of the hospital. Population health managers will have strong incentives to reduce duplication in care, reduce readmissions, improve care coordination, and improve the care received by chronically ill patients.

Population health management will also increase the demand for nurses. Nurses will likely be hired into new cross-continuum roles including: care navigators, care managers, and transitional care coordinators.

How can nursing help?

Nurses working for a population health manager will be asked to care for patients in the lowest acuity, clinically appropriate setting. Specifically, nurses should:

• Use clinical and psychosocial tools to assess patients for their level of utilization risk
• Assign a care navigator or care manager to high-risk patients
• Provide clear, actionable education materials to patients
• Establish relationships with community-based organizations to match patients with long-term support and resources

Source: Nursing Executive Center.
What Else Should You Know?

What should you be telling your staff?

- The phrase “population health management” describes when a health care provider is responsible for delivering care to a predefined group of people.
- Proponents of population health management hope that because a single healthcare provider is meeting all of a patient’s needs, there will be less duplication, better coordination, and lower costs.
- The way successful population health managers have delivered high-quality (and cost-effective) care is by dividing their patients into three groups: low-risk, rising-risk, and high-risk. (The “risk” refers to a patient’s likelihood of needing to receive extensive care in the future).
- Population health is probably good news for nurse employment. There will probably be a lot of organizations that want to hire nurses as care managers, transition coaches, and primary care nurses.
- [If your organization is serving as a population health manager] We will want to provide clear and actionable patient education, use clinical and psychosocial tools to assess patients for their level of utilization risk, and assign a care navigator or care manager to high-risk patients.

Successful population health management requires treating three distinct patient populations

To deliver high-quality and cost effective care to a large population, population health managers divide their patient population into three groups: low-risk, rising-risk, or high-risk. (The “risk” refers to a patient’s likelihood of needing to receive extensive care in the future). Health care providers will deliver the most care (and spend the most money) on patients who are “high-risk.”

The chart below shows the typical breakdown of a patient population into the three groups. It also shows the recommended strategy for safely and cost-effectively caring for patients within each group.

Three Distinct Patient Populations

- **High-Risk Patients**
  5% of patients; usually with complex disease(s), comorbidities
  - Provide extensive, hands-on support to high-risk patients.

- **Rising-Risk Patients**
  20% of patients; may have conditions not under control
  - Proactively address needs of rising-risk patients to prevent their conditions from worsening.

- **Low-Risk Patients**
  75% of patients; any minor conditions are easily managed
  - Engage patients to keep them healthy and connected to health system.

Questions to ask your CNO

1. Is our organization participating in population health management?
2. If yes, which patient population(s) fall under our population health care plan?
3. How are we supporting our highest risk patients?

Source: Nursing Executive Center.
Readmission Penalty

What is the Readmissions Reduction Program?
The Readmissions Reduction Program is a government payment program that began in 2013. It incentivizes hospitals to reduce readmissions rates by creating financial consequences for those with high readmission rates. Under the program, hospitals don’t earn their full reimbursement if certain patients are readmitted more often than the national average.

This raises a question: How does the government measure readmissions? The government currently isn’t focusing on all patients. Instead, this program is currently focused on Medicare patients and only those with AMI, heart failure, pneumonia, or hip or knee arthroplasty. In addition, the program looks only at readmissions that happen within 30 days of discharge.

The Readmissions Reduction Program can be confusing because it has many different names. It is sometimes called the “readmissions penalty.” And because it is one of three reimbursement programs which are collectively called “pay for performance,” sometimes it is called “pay for performance.”

Why should you care about readmissions?
Avoidable readmissions impact almost a million patients every year. Currently one out of every five Medicare patients is readmitted within 30 days of discharge. And experts believe 75% of these readmissions could be avoided. These avoidable readmissions cause needless pain and suffering for patients and their families.

The Readmissions Reduction Program has the potential to reduce readmissions by creating financial incentives for hospitals to ensure their readmission rate is at—or better—than the national average. This creates incentives to improve discharge planning and care coordination to ensure patients receive the care they need after discharge.

How can nursing help?
Nursing can help reduce readmissions by providing high-quality discharge planning and post-discharge follow-up. Specifically, nursing (or nurse leaders) should:

• Build risk-assessment into nurses’ workflow in order to identify patients at risk for readmissions regardless of condition. Equip nurses with training and tools to match patients to the most appropriate care setting.
• Incorporate the teach-back model1 into patient education.
• Space out patient education across several days so patients have time to process and ask questions before discharge.
• Provide a timely follow-up visit for most vulnerable patients


1) In the “teach back” model, the nurse educates the patient and then asks the patient to restate the most important points in their own words.
What Else Should You Know?

What should you be telling your staff?

- The Readmissions Reduction Program is a government payment program that began in 2013.
- Its goal is to encourage hospitals to reduce readmissions rates by financially penalizing hospitals with readmission rates worse than the national average for certain conditions.
- The program is focused on Medicare patients—and those with AMI, heart failure, pneumonia, or hip or knee arthroplasty. Hospitals are scored on their overall performance on readmissions within 30 days of discharge, rather than receiving a penalty each time someone is readmitted.
- One reason the program was created is that there’s a big national opportunity to improve care by reducing readmissions. Currently one out of every five patients is readmitted within 30 days. Experts believe 75% of these readmissions could be avoided.
- We can reduce our readmission rates by: providing user-friendly discharge instructions, following up with patients post-discharge to verify medications, and conducting a risk assessment in order to tailor interventions to specific risk factors for readmission.

What conditions are included in the Readmissions Reduction Program?

These lists show the conditions that are currently included through 2015. It is likely more will be added.

- **Cardiac**
  - Acute myocardial infarction
  - Heart failure
  - Coronary artery bypass graft (2017)

- **Pulmonary**
  - Pneumonia
  - COPD (2015)

- **Orthopedic**
  - Total hip arthroplasty (2015)
  - Total knee arthroplasty (2015)

Which readmissions should my hospital try to reduce?

As the table below shows, not all readmissions are the same. Some are planned; others are not. Some are related to the initial admission; others are not.

The Readmission Reduction Program measures only “unplanned” and “related” readmissions (those shown in the dashed outline in the table). These are the readmissions your hospital should focus on reducing.

<table>
<thead>
<tr>
<th>Planned</th>
<th>Unplanned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related</td>
<td>A woman is admitted with preterm labor; physician stops the labor and schedules her to return the following week to deliver the baby.</td>
</tr>
<tr>
<td>Unrelated</td>
<td>A man admitted for heart failure and received a Foley catheter; he is readmitted four days later after discharge with a urinary tract infection.</td>
</tr>
<tr>
<td></td>
<td>A man is admitted for AMI; physician discovers a lung tumor and schedules surgery to remove tumor for the following week.</td>
</tr>
<tr>
<td></td>
<td>A child comes to the ED and needs an emergency appendectomy, returns two weeks later after falling down the stairs and needs stitches.</td>
</tr>
</tbody>
</table>

Questions to ask your CNO

1. Which conditions have the highest readmission rates in our hospital?
2. What are our hospital’s biggest barriers to reducing readmissions?
3. How does our hospital’s performance compare to the national average for readmissions?

Value-Based Care

**What is value-based care?**

Value-based care describes a group of payment programs that are designed to reduce government spending on health care and encourage hospitals to improve care quality.

The payment programs give hospitals financial incentives to deliver high-quality, efficient, and coordinated care. While all the payment programs share the same goals, there are two different types of programs. Additional details on each are shown below.

<table>
<thead>
<tr>
<th>Payment Model</th>
<th>Capsule Description</th>
<th>Sample Programs</th>
<th>Mandatory?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay-for-Performance¹</td>
<td>Pay-for-performance is a blanket term describing three payment programs that link reimbursement to hospital quality.</td>
<td>Value-Based Purchasing Program¹</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hospital-Acquired Conditions Reduction Program¹</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Readmissions Reduction Program¹</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk-Based Contracts</td>
<td>Under these programs a group of providers are accountable for the total cost and quality of care for a population of patients over a period of time.</td>
<td>Bundled Payment Contracts¹</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shared Savings Program</td>
<td>No</td>
</tr>
</tbody>
</table>

**Why should you care about value-based care?**

Value-based care programs help health care providers improve quality and efficiency of care—specifically on metrics such as readmissions rates, hospital-acquired infections, and patient satisfaction. Successfully implementing value-based care programs will mean that patients receive better, more coordinated care that costs less.

Additionally, since value-based care programs use financial incentives to encourage high-quality, efficient care, there are dollars on the line that your organization can earn or lose based on performance.

Be careful not to confuse value-based care with the value-based purchasing program. Value-based care is a broad term that describes an entire category of payment programs. The value-based purchasing program refers to a specific payment program (shown in the table above).

¹) Additional information on these programs is included in this toolkit.

Source: Nursing Executive Center.
What Else Should You Know?

How can nursing help?

To **improve care quality** nurses should:
- Use clinical and psychosocial tools to assess patients for level of risk in order to design an individualized care plan
- Compile medication information and follow up with patients or home health provider post-discharge to ensure compliance

To **deliver more efficient care** nurses should:
- Collaborate with providers within and across care settings to coordinate care
- Document all patient care to avoid duplicating efforts

To **achieve better outcomes** nurses should:
- Space out patient education across several days so patients have time to process and ask questions before discharge
- Activate patients (and family members) to ensure the patient can own their self-care after discharge

What should I be telling my staff?

- Value-based care describes a group of payment programs designed to reduce government spending on health care and encourage hospitals to improve care quality and efficiency.
- Value-based care has the potential to improve care quality and efficiency. Value-based care will encourage hospitals to improve performance on specific quality measures, including: reducing avoidable readmissions, reducing hospital-acquired infections, and improving patient satisfaction.
- Value-based care will impact how much money our hospital earns. If we perform well on value-based care programs, we will avoid being penalized and might even earn a bonus. This could mean the hospital will have more resources to invest in staff and patients.
- As a nurse you can help our hospital perform well on value-based care by: conducting clinical and psychosocial assessment to identify high-risk patients; capturing complete patient histories (including pre-existing conditions); documenting all tests, procedures, and medications to avoid duplication; and following-up with patients post-discharge.

Questions to ask your CNO

1. Is our organization operating under any of the new risk-based payment models? If so, which ones?
2. Which pay-for-performance program is our organization most focused on?
3. Has our organization earned a bonus or received a reimbursement penalty under any of the value-based care programs so far? Do you expect that we will in the coming year?
Value-Based Purchasing

What is Value-Based Purchasing?

Widely known as VBP, this government program creates a financial incentive for hospitals to improve their quality. Hospitals that perform well on quality metrics can earn a bonus. Hospitals that don’t, will lose a portion of their inpatient reimbursement.

The question is: How does the government measure a hospital’s quality? Under VBP, the government considers a hospital’s performance in key categories (called “domains”). At the time this report was written, the VBP program included four domains: process of care, experience of care, outcomes of care, and efficiency of care. A fifth domain, safety, is scheduled to be added in FY 2017.¹ Your hospital can receive a strong overall score by showing that you perform better than national benchmarks OR by demonstrating improvement over time (even if your current performance is below national benchmarks).

Why should you care about Value-Based Purchasing?

High quality care has always been important to nurses. VBP now provides a financial incentive for delivering high-quality care. Nurses can have a significant impact on VBP metrics, specifically in the categories of patient experience and outcomes. In addition, your hospital’s performance on VBP metrics determines if it will earn a bonus, lose money, or break even.

Be careful not to confuse the Value-Based Purchasing program with value-based care. The Value-Based Purchasing program refers to a specific payment program (discussed here). Value-based care is a broad term which describes an entire category of payment programs. (A more detailed description is included on page 33 of this toolkit.)

How can nursing help?

Engaging patients and families in their care, translating clinical information into patient-friendly terms, and minimizing avoidable patient disruptions will help improve performance on patient experience metrics.

Establishing evidence-based protocols, coordinating care among interdisciplinary team members, and proactively managing high-risk patients will help improve performance on outcomes metrics.

What should you be telling your staff?

• Value-Based Purchasing, widely known as VBP, is a mandatory payment program that will impact our hospital’s bottom line.
• The goal of the program is to create a financial incentive for hospitals to improve their quality by rewarding quality of care over quantity of care.
• The VBP program measures hospital performance on specific quality metrics.
• If we perform well on VBP metrics, our hospital can earn a bonus. On the other hand, if our hospital performs poorly or if we don’t demonstrate improvement, our hospital could be financially penalized.
• Our performance is measured across different categories such as: process of care, patient experience, outcomes, cost, and safety.
• As nurses, we can play an integral role inflecting all categories of metrics. We can most directly impact the metrics measured in the patient experience and outcome categories. We should: provide clear discharge instructions to patients and families, communicate openly with all members of the care team, and follow every step of clinical protocols every time.

¹) Safety metrics are already being collected, however reimbursement rates will not reflect safety metrics until FY 2017.

Source: Nursing Executive Center.
What Else Should You Know?

Sample metrics tracked under Value-Based Purchasing by category

Below are sample metrics included in the VBP program, organized by domain. A complete list of metrics is included on the following page. (Domains and metrics are subject to change).

<table>
<thead>
<tr>
<th>Domain</th>
<th>Sample Metrics Included</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process of Care</td>
<td>• Fibrinolytic therapy received within 30 min of hospital arrival</td>
</tr>
<tr>
<td></td>
<td>• Influenza immunization</td>
</tr>
<tr>
<td>Experience of Care</td>
<td>• HCAHPS scores (e.g., communication with nurses, communication with doctors,</td>
</tr>
<tr>
<td></td>
<td>responsiveness of hospital staff, pain management)</td>
</tr>
<tr>
<td>Outcomes of Care</td>
<td>• 30-day mortality rate for acute myocardial infarction, heart failure, and pneumonia</td>
</tr>
<tr>
<td>Efficiency of Care</td>
<td>• Medicare part A and B spending per beneficiary</td>
</tr>
<tr>
<td>Safety¹</td>
<td>• Catheter-associated urinary tract infection</td>
</tr>
<tr>
<td></td>
<td>• Colon surgical site infections</td>
</tr>
<tr>
<td></td>
<td>• PSI-90 (Composite score for patient safety for select indicators)</td>
</tr>
</tbody>
</table>

Category weightings

When the government calculates VBP performance, it doesn’t give all domains equal weight. This chart shows how the domain weights will change over time.²

VBP Domain Weighting

(with year of starting consideration)

![Domain Weighting Chart]

Questions to ask your CNO

1. Which VBP metric(s) is our organization most focused on improving?
2. In which area(s) is our organization already performing well?
3. How is our organization performing relative to national benchmarks? Compared to our own benchmarks?

1) Finalized category to be added starting in FY 2017.
2) Proposed category weightings not yet finalized.

Source: CMS, Nursing Executive Center.
The following is a complete list of metrics included in the VBP program by year. 
(Note the categories and metrics are subject to change over time.)

<table>
<thead>
<tr>
<th>Category</th>
<th>Metric</th>
<th>FY 2015</th>
<th>FY 2016</th>
<th>FY 2017</th>
<th>FY 2018</th>
<th>FY 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process of Care</strong></td>
<td>AMI-7a (Fibrinolytic therapy received within 30 minutes of hospital arrival)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>IMM-2 (Influenza immunization)</td>
<td>-</td>
<td>✓</td>
<td>✓</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>PC-01 (Elective delivery prior to 39 weeks)</td>
<td>-</td>
<td>-</td>
<td>✓</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td><strong>Experience of Care</strong></td>
<td>HCAHPS Scores (Patient satisfaction measures)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td><strong>Outcomes of Care</strong></td>
<td>MORT-30-AMI (Acute myocardial infarction 30-day mortality rate)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>MORT-30-HF (Heart failure 30-day mortality rate)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>MORT-30-PN (Pneumonia 30-day mortality rate)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Efficiency of Care</strong></td>
<td>MSPB-1 (Medicare spending per beneficiary)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td><strong>Safety</strong></td>
<td>CAUTI (Catheter-associated urinary tract infection)</td>
<td>-</td>
<td>✓</td>
<td>✓</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>CLABSI (Central line-associated blood stream infection)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>SSI–Colon (Colon surgical site infection rate)</td>
<td>-</td>
<td>✓</td>
<td>✓</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>SSI–Abdo Hyst (Abdominal hysterectomy surgical site infection rate)</td>
<td>-</td>
<td>✓</td>
<td>✓</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>C. diff. (Clostridium difficile infection rate)</td>
<td>-</td>
<td>-</td>
<td>✓</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>MRSA (Methicillin-resistant Staph. aureas infection rate)</td>
<td>-</td>
<td>-</td>
<td>✓</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>PSI-90 (Composite of select patient safety indicators)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>THA/TKA Complication (Hip and Knee Arthroplasty Complication Rate)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>✓</td>
</tr>
</tbody>
</table>

✓ = Included in VBP program  
P = Pending final rule; likely to be included

1) Proposed categories and metrics, not yet finalized.
2) Finalized category to be added starting in FY 2017.

Source: CMS, Nursing Executive Center
Section II
Translating Market Forces into Frontline Terms

Plug-and-Play Videos
• Tool #2: Bundled Payments Plug-and-Play Video
• Tool #3: Care Coordination Plug-and-Play Video
• Tool #4: Hospital-Acquired Conditions Plug-and-Play Video
• Tool #5: Meaningful Use Plug-and-Play Video

Ready-to-Use Posters
• Tool #6: Ready-to-Use Patient Experience Posters
• Tool #7: Ready-to-Use Population Health Poster

Customizable Slides and Scripting
• Tool #8: A Primer on Pay-for-Performance

Interactive Exercises
• Tool #9: Care Coordination Awareness Workshop
• Tool #10: Preventable Readmissions Awareness Workshop
• Tool #11: A “Doomsday” Exercise
• Tool #12: Value-Based Purchasing Reality Check
Bundled Payments

Tool #2: Bundled Payments Plug-and-Play Video

How to Use This Tool

Overview
This tool is a brief video nurse leaders can play for frontline staff to help further their understanding about changing payment systems. The goal of this tool is to help frontline staff understand how new payment models, such as bundled payment contracts, can lead to more efficient and more coordinated care.

Intended Audience
The video is intended for all frontline caregivers who work directly with patients.

Key Takeaways
• Organizations participating in a bundled payment program have incentives to better coordinate care, which will help improve the quality of care delivered to patients.
• Bundled payments also encourage providers to improve efficiency, since participating providers can share in the savings if they can reduce the overall cost of care.
• Frontline staff can help their organization succeed under bundled payment contracts by working more closely with other caregivers within and across care settings to improve care coordination.

Available Online
To access this tool online, please visit advisory.com/nec/marketforcestoolkit

What are bundled payments?
Tool #3: Care Coordination Plug-and-Play Video

How to Use This Tool

Overview
This tool is a brief video which nurse leaders can play for frontline staff to help further their understanding about changing payment systems. The goal of this tool is to help frontline staff understand how new payment models, such as bundled payment contracts, can lead to more efficient and more coordinated care.

Intended Audience
The video is intended for all frontline caregivers who work directly with patients.

Key Takeaways
• Studies show that more coordinated care leads to better patient outcomes. So why have we always worked separately? Part of the reason is the way in which organizations traditionally get paid: fee-for-service models reward individual effort without holding anyone responsible for coordinating care across settings.
• This video explains how new payment models are unifying the efforts of frontline caregivers across settings and improving the quality of the care they provide.

Available Online
To access this tool online, please visit advisory.com/nec/marketforcestoolkit

Why it pays to better coordinate care

Dave Willis
Managing Director
The Advisory Board Company
Hospital-Acquired Conditions

Tool #4: Hospital-Acquired Conditions Plug-and-Play Video

How to Use This Tool

Overview
This tool is a brief video which nurse leaders can play for frontline staff to help further their understanding about the impact of hospital-acquired conditions. The goal of this tool is to help nurses and other frontline caregivers understand why it is important to prevent hospital-acquired conditions and the concrete action steps they can take to help prevent them.

Intended Audience
The video is intended for all frontline caregivers who work directly with patients.

Key Takeaways
• Hospital-acquired conditions are secondary conditions (such as infections or pressure ulcers) that occur while patients are being treated in the hospital for another reason. They’re also sometimes called “never events,” because we never want them to occur.

• Hospital-acquired conditions occur frequently. Studies show that on average, one in ten hospitalized patients develops a hospital-acquired condition. They’re also costly to treat. Nationally, hospitals and health systems spend $45 billion per year caring for patients who develop a hospital-acquired condition.

• Nurses and other caregivers play a critical role in preventing hospital-acquired conditions. One of the most important ways nurses can help prevent never events is to follow every step of every protocol, every time.

Available Online
To access this tool online, please visit advisory.com/nec/marketforces-toolkit

How you can help prevent “never events”
Meaningful Use

Tool #5: Meaningful Use Plug-and-Play Video

How to Use This Tool

Overview
This tool is a brief video which nurse leaders can play for frontline staff to help further their understanding about Meaningful Use. The goal of this tool is to help nurses and other frontline caregivers understand what Meaningful Use is, how it will impact their daily workflow, and how it can lead to improved care quality, coordination, and efficiency.

Intended Audience
The video is intended for all frontline caregivers who work directly with patients.

Key Takeaways
• Meaningful Use is a government program that encourages hospitals to adopt and “meaningfully use” electronic health records. The goal is to encourage providers to adopt electronic health records.
• Meaningful Use has the potential to improve care quality and safety, improve care coordination, and increase efficiency.
• As a nurse, you are an end-user of the electronic health record (EHR). You can help support Meaningful Use by consistently and accurately documenting patient data and providing feedback about how changes impact your daily workflow.

Available Online
To access this tool online, please visit advisory.com/nec/marketforcestoolkit

Can Meaningful Use improve patient care?
Tool #6: Ready-to-Use Patient Experience Posters

How to Use This Tool

Overview
This tool includes three ready-to-use posters that can help nurse leaders further frontline understanding about the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). The goal of this tool is to help frontline staff understand the scope of the challenge and the concrete actions they should take to improve HCAHPS scores and patients’ overall experience.

Intended Audience
The posters are intended for all frontline caregivers who work directly with patients.

Key Takeaways
• The most effective way to achieve lasting improvements in patient experience scores is to take a holistic approach. Rather than just focusing on discrete HCAHPS measures, frontline caregivers should focus on addressing patients’ overall experience.

• Many nurses don’t have enough time to spend connecting with individual patients. Even the most empathetic caregivers can focus too narrowly on a patient’s condition and miss valuable information that could impact the patient’s hospital experience and their plan of care.

• Care processes can create needless uncertainty for many patients and families. Frontline staff can play a critical role in improving their patients’ experience by simply keeping them informed.

Available Online
To access this tool online, please visit advisory.com/nec/marketforcetoolkit
Expanding Our Focus Beyond HCAHPS

**What is HCAHPS?**
- HCAHPS is a national survey that assesses hospital performance on patient satisfaction in eight areas.
- To provide truly patient-centered care, caregivers must consider patients’ overall experience, not just discrete HCAHPS measures.

**What can you do?**
- Anticipate Patient Needs
- Involve Family Members in Patient Care
- Provide Clear, Actionable Patient Education

**Patient Experience**
- Ongoing Emotional Support
- Family Involvement and Care Team Integration
- Avoidable Disruptions Minimized
- Compassionate, Empathetic Caregivers
- Clear, Actionable Patient Education
- Up-to-Date and Thorough Information
- Physical and Emotional Needs Anticipated

**HCAHPS**
- Communication with Nurses
- Communication with Doctors
- Quiet at Night
- Information About Medications
- Discharge Information
- Cleanliness
- Responsiveness
- Pain Management
If you’re not taking care of the whole person...
...you’re not taking care of the patient

**Nurse Perception of Patient**
- Patient in room 182 admitted two days ago
- Diagnosed with ventilator-associated pneumonia
- Scheduled for diagnostic imaging, blood work
- Acting irritable today; requested additional pain medication twice

**Patient Perception of Experience**
- Patient has never been admitted to hospital before; anxious about inpatient stay
- Concerned about long-term impact of surgery on ability to work physically demanding job
- Worried about missing daughter’s upcoming wedding
A Powerful Case for Keeping Patients Informed

Emergency Department Patient Satisfaction and Information on Wait Times

$n=1,524,726$

Well-informed patients are more satisfied, even with a dramatically longer wait.

4+ Hour Wait

- 96.6% of Patients Well-Informed
- 47.2% of Patients Not Well-Informed

<1 Hour Wait

- 97.4% of Patients Well-Informed
- 42.7% of Patients Not Well-Informed

Tool #7: Ready-to-Use Population Health Poster

How to Use This Tool

Overview
This tool includes a ready-to-use poster, which can help nurse leaders further frontline staff understanding of how their organization may be managing the health of a predetermined population. The goal of this tool is to help frontline staff understand the role nurses will play in population health management.

Intended Audience
The posters are intended for all frontline caregivers who work directly with patients.

Key Takeaways
- The way successful population health managers have delivered high-quality (and cost-effective) care is by dividing their patients into three groups: low-risk, rising-risk, or high-risk. (The “risk” refers to a patient’s likelihood of needing to receive extensive care in the future).
- Population health is probably good news for nurse employment. There will likely be a lot of organizations wanting to hire nurses as care managers, transition coaches, and primary care nurses.
- If your organization is serving as a population health manager, it will be helpful to provide clear and actionable patient education, use clinical and psychosocial tools to assess patients for their level of utilization risk, and assign care navigator or care manager to high-risk patients.

Available Online
To access this tool online, please visit advisory.com/nec/marketforcestoolkit
Tool #8: A Primer on Pay-for-Performance

How to Use This Tool

Overview

This tool includes customizable PowerPoint slides with corresponding scripting to help a nurse executive or other leader further frontline staff understanding about Pay-for-Performance (P4P). The goal of this tool is to help nurses and other frontline caregivers learn about the three P4P programs that impact their hospital’s reimbursement and the concrete actions they should take to help their organization succeed.

The PowerPoint slides and script points are available in a customizable format so presenters can tailor their message. The slides and scripting can be used for a stand-alone session about pay-for-performance or embedded into an existing presentation. We recommend keeping your primer on P4P brief (no more than 20 minutes).

Intended Audience

This primer is intended for all frontline caregivers who work directly with patients.

What’s required?

As the facilitator, you should allocate 20 minutes to prepare, 20 minutes for didactic presentation, and 10-20 minutes for discussion and Q&A.

Materials:

• Laptop or computer to access slides
• Projector/screen to display slides

Available Online

Thumbnails of the slides and corresponding scripting are shown on the following pages. To access customizable versions of the slides and script online, please visit advisory.com/nec/marketforcestoolkit
Meet the **Three Patient Populations in Our Community**

**MANAGING POPULATION HEALTH** can help patients remain healthier (in and out of the hospital) and can prevent unnecessary health care utilization. Successful population health managers divide patients into three groups:

1. **HIGH-RISK** 9% of population
2. **RISING-RISK** 20% of population
3. **LOW-RISK** 75% of population

### The high-risk patient

These patients have **at least** one complex illness, multiple comorbidities, and psychosocial problems.

**THE IDEAL CARE TEAM**

The typical high-risk patient should have a **one-on-one relationship** with the health system, principally through a high-risk care manager.

**PROVIDERS SHOULD AIM TO:**

1. Deliver intensive, comprehensive, and proactive management
2. Trade high-cost services for low-cost management

### The rising-risk patient

These patients typically represent 20% of the population and have multiple risk factors that could push them into the high-cost category if left unaddressed, such as a diabetic patient who is also obese and smokes.

**THE IDEAL CARE TEAM**

The typical rising-risk patient should be managed in the **medical home**

**PROVIDERS SHOULD AIM TO:**

1. Avoid unnecessary spending and keep these patients from becoming high-risk
2. Manage these patients in enhanced primary care, such as the medical home

### The low-risk patient

Roughly 75% of patients fall into this category. They’re either healthy or have a well-managed chronic condition. This patient type is typically looking for convenient access to the services they need most.

**THE IDEAL CARE TEAM**

The low-risk patient’s principal means of interacting with the system should be through a **patient portal**

**PROVIDERS SHOULD AIM TO:**

1. Keep the patient healthy
2. Maintain their loyalty to the system
3. Collect data on the patient so they can treat them more effectively when they do need care


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Pay-for-Performance

Tool #8: A Primer on Pay-for-Performance

Why are we talking about Pay-for-Performance?

It’s All About Quality

Sample Hospital Payment Systems

Fee-for-Service (Older Payment System)
Rewards high-volume hospitals, receives larger payment for treating more patients

Pay-for-Performance (Newer Payment System)
Rewards higher care quality; hospitals receive larger payment for providing better quality of care

Three Pay-for-Performance Programs

<table>
<thead>
<tr>
<th>Program</th>
<th>Capsule Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value-Based Purchasing</td>
<td>Hospitals receive a financial bonus for strong performance across four different categories of metrics.</td>
</tr>
<tr>
<td>Readmissions Reduction Program</td>
<td>Tracks avoidable readmissions; organizations that fall below the national average subject to reimbursement penalties.</td>
</tr>
<tr>
<td>Hospital-Acquired Conditions (HAC) Reduction Program</td>
<td>Tracks specific hospital-acquired conditions; organizations performing in the bottom quartile nationally are subject to reimbursement penalties.</td>
</tr>
</tbody>
</table>

Program #1: Value-Based Purchasing

Value-Based Purchasing Program’s Three-Step Process

1. Percentage of reimbursement withheld
2. Performance assessed on specific metrics
3. Hospital receives bonus, or penalty, or breaks even

Program #2: Readmissions Reduction Program

Readmissions Reduction Program

Conditions Subject to Reduced Reimbursement

- Cardiac: Acute myocardial infarction
- Pulmonary: Pneumonia, COPD (2015)
- Orthopedic: Total hip arthroplasty (2015)

1 in 5 Patients are readmitted within 30 days of discharge
75% Of hospital readmissions are avoidable

Program #3: Hospital-Acquired Conditions Reduction Program

Hospital-Acquired Conditions Reduction Program

Representative Hospital-Acquired Condition Rate National Distribution

1 in 10 Hospitalized patients develop a hospital-acquired condition

$45 Billion Annual cost of hospital-acquired conditions

What can you do to help?

Frontline Caregiver Action Steps to improve Pay-for-Performance

- Document all patient conditions on arrival
- Identify specific risk factors for adverse events
- Follow every step of clinical protocols
- Involve patients and families in their care

Communicate openly with all members of the care team
Space out patient education across multiple days
Provide user-friendly discharge instructions
Follow-up post-discharge to verify medications
Pay-for-Performance

Tool #8: Primer on Pay-for-Performance

Customizable Script Points for Nurse Leaders

Title slide: Primer on Pay-for-Performance

- You may be hearing some new terms thrown around: readmissions penalty, value-based purchasing, pay-for-performance, and never events. Or worse, you’re hearing things that sound more like code: “P4P,” “VBP,” and “HACs.” Do any of these sound familiar?
- My aim today is to help demystify these terms. But more importantly, to help you understand why we’re talking about pay-for-performance in the first place—and why you should care.

Slide 2: Why are we talking about Pay-for-Performance?

- The way our hospital gets paid is changing. And the good news is: it’s all about quality.
- On the left, the way we have always been paid under the system we call “fee-for-service.” Our hospital simply got paid for the care we provide based on volume. In other words, the more patients, the more tests, the more procedures—the more money our hospital received.
- But on the right, that’s beginning to change. A newer payment system, called “pay-for-performance,” is now rewarding not volume, but better care quality.

Slide 3: Three Pay-for-Performance Programs

- Pay-for-performance is a term describing three mandatory payment programs that were created by the government to link reimbursement to hospital quality. Some people shorten pay-for-performance to “P4P.”
- You can see brief descriptions of the three programs here. They are:
  - Value-Based Purchasing
  - The Hospital-Acquired Conditions Reduction Program
  - Readmissions Reduction Program
- I’ve shared brief descriptions for you here, but I want to double-click on each of these to help you understand how each program is different and the types of quality metrics they track.

Slide 4: Value-Based Purchasing

- The first pay-for-performance program is called “Value-Based Purchasing.” You may hear this referred to as “VBP.” VBP was created to give hospitals a financial incentive to improve care quality. Instead of being rewarded for the quantity of care we deliver, we can be rewarded for the level of quality we provide.
- I’ve shared a simplified overview of how it works in three steps. First, the government withholds a portion of our hospital’s reimbursement. Next, we report our outcomes on specific metrics and the government assesses our performance compared to a national average. And on the right, how our hospital gets paid.
- Let me go into Step 3. If our hospital is above average, we can earn back everything the government withheld, plus an additional bonus. On the other hand, if our performance is below average, we receive a penalty and don’t get fully reimbursed for the care we deliver. If we are in the middle of the pack, we just break even—no penalty, but no bonus either.
- Any questions about how this works?
- VBP assesses our performance on a long list of metrics in the five categories you see listed in the table here. These include things like how closely we follow protocols, our patient satisfaction scores, and specific quality outcomes. This table shows only some metrics included in VBP, but if you’re interested in seeing the complete list, I’d be happy to share that with you.¹

¹ A complete list of VBP metrics can be found on page 37 of this toolkit.

Source: Nursing Executive Center.

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advisory.com
Tool #8: Primer on Pay-for-Performance

Customizable Script Points for Nurse Leaders (cont.)

Slide 5: Readmission Reduction Program
• Let’s now turn to the second P4P program, the Readmissions Reduction Program. You may hear people refer to this as the “readmission penalty.” The reason it’s often called a penalty is because (unlike VBP) there’s no opportunity to earn a bonus—only a penalty. In other words, there’s no carrot, just a stick.
• The goal of the readmission penalty is pretty straightforward: to encourage hospitals to reduce readmissions within 30 days. Our hospital will receive a financial penalty if our overall performance on 30-day readmissions is below average (or put another way, if our readmission rates are higher than average).
• For now, the penalty doesn’t apply to all patients: it only applies to patients with the specific conditions you see here. We aren’t penalized currently for conditions listed with a future date, but we will be, so we should get to work on preventing them now.
• At the bottom of the slide, one reason this program was created is there’s a big opportunity to improve care by preventing readmissions. On the left, about a fifth of patients get readmitted to the hospital within 30 days of discharge, and on the right, 75% of those readmissions could have been avoided.

Slide 6: Hospital-Acquired Conditions Reduction Program
• The third P4P program is the Hospital-Acquired Conditions Reduction Program. You’ve all heard of hospital-acquired conditions. I’m talking about things like pressure ulcers, patient falls, catheter-associated UTIs, ventilator associated pneumonia, and so on. Sometimes you hear them called “never events.” Why? Well, because they should never occur.
• Like the readmissions penalty, this program offers no bonus—just a penalty. Looking at the graphic on the slide, only the lowest-performing 25% of hospitals receive a penalty. In other words, the hospitals with HAC rates in the top 25th percentile. So there’s a higher bar for receiving a penalty than the readmissions reduction program.
• But the real reason to focus on preventing these conditions isn’t whether or not we receive a penalty. I’d argue that our driving motivation should be the quality of care we provide for our patients. If staying in our hospital means getting a never event, then we haven’t served our patients as well as we could have. Our aim shouldn’t be just staying above the fray to avoid a penalty, it should be to get our HAC rates down to zero, and keep them there.

Slide 7: What can you do to help?
• So what can we do to improve our performance on P4P? Well I’ve jotted a few specific things down on this last slide. Take a look. As you scan through these, note that almost all of them are driven by nurses and other frontline caregivers. Just to name a few:
  - Identifying specific risk factors for adverse events
  - Involving patients and families in their care
  - Spacing out patient education across multiple days
• Put simply, we’re relying on you to help us make a difference. I’m curious—as you look at the action steps on this slide:
  - Can you think of any others?
  - What do you think are our best opportunities to improve performance on P4P?

[Note to presenter: Depending on the time allotted and the size of the group, you may decide to either wrap up the conversation here or invite questions about any of the P4P programs discussed.]
Care Coordination

Tool #9: Care Coordination Awareness Workshop

Facilitator Guide

Overview
This guide prepares facilitators to lead frontline caregivers through a workshop that will help them better understand the barriers to coordinated care on their unit or in their primary work site, how uncoordinated care can affect care quality, and the role bedside caregivers can play in improving coordination.

The exercise may surface innovative action ideas, but the primary aim is not process improvement. Rather, it's to raise frontline caregivers’ awareness of the important role they play in delivering coordinated, high-quality care.

Who should attend?
Frontline caregivers who work together on a given unit, across multiple units, or across care settings. Attendees may include nurses, physicians, respiratory therapists, patient care assistants, technicians, medical assistants, etc. We recommend limiting attendance to approximately 25 participants.

What's required?
As the facilitator, you should allocate 30 minutes to prepare and 90 minutes for the workshop (limit the total session to two hours).

Materials:
- Three flip charts and markers
- Copy of worksheet (How Can We Improve Care Coordination?) for each staff member printed on 11 x 17 inch paper (see pages 71 and 72)
- Dot stickers

Set Up:
- Distribute the following to each participant:
  - 5 dot stickers (any color)
  - 1 worksheet

What is the facilitator's role?
As a workshop facilitator, you will manage time during the session and guide participants through the exercise. The workshop is most effective when you help participants arrive at their own conclusions without giving away the answers.

To do this, make sure you are familiar with potential challenges to coordinated care so you can ask probing questions (e.g., Why do your patients often have to repeat themselves?) This will help you keep discussion on the right track while spurring participants to think critically about challenges and potential solutions.

Recommended agenda (see the following pages for facilitation details)
- Introduction: 5 minutes
- Group brainstorm: 15 minutes
- Dots exercise: 10 minutes
- Break out into groups: 5 minutes
- Worksheet Part I: Identify the Top Opportunity: 20 minutes
- Report back to the larger group on Part I: 10 minutes
- Worksheet Part II: Take Action: 15 minutes
- Closing discussion: 10 minutes

Available Online: To access this tool online please visit advisory.com/nec/marketforcetoolkit

Source: Nursing Executive Center.
Care Coordination

Tool #9: Care Coordination Awareness Workshop

How to Run the Workshop

1. **Introduce the goal of the session (5 minutes)**
   At the start of the workshop, explain the goal and structure of the workshop.
   
   Key points to include:
   
   - **The goal of the workshop**: To ensure all frontline caregivers understand the opportunities they have to improve coordination and the specific role they can play.
   
   - **How the workshop will run**:
     - Participants will begin with a brainstorming exercise and vote (using dot stickers) on the greatest challenges they experience in their own practice.
     - The facilitator will break attendees into smaller groups, assigning each group a specific challenge to tackle.
     - Each group will report back with the improvement opportunities they identified and potential action steps.

2. **Ask participants to brainstorm what uncoordinated care looks like (15 minutes)**
   
   Ask the question, “What does uncoordinated care look like?”
   
   - Provide one or two examples:
     - Patients have to repeat themselves.
     - Patients do not receive care when they need it.
   
   - **Write each answer on a flip chart** until the group feels they have an exhaustive list (15-20 answers). If the group seems stuck, use the list in the box below and ask probing questions to stimulate ideas.

---

**Sample Attributes of Uncoordinated Care**

- Information is lost between units or sites of care.
- Patients don’t understand their instructions.
- Caregivers in one setting don’t know what care was delivered in another setting.
- Patients receive conflicting information.
- Patients are missing key information.
- Caregivers are missing key information.
- Caregivers duplicate tests or procedures.
- Patients don’t have adequate support needed to follow their instructions.
- Patients do not feel empowered to provide input about their care.
- Patients don’t know who to contact for help.
- Caregivers don’t know about socioeconomic factors that impact their patients’ care.
- Caregivers don’t communicate with family members.
- Patients receive care in the wrong setting.
- Patients wait until their care is acute to seek care.
- Tests and procedures are performed unnecessarily.
- Patients feel overwhelmed by too much information.
- Patients receive post-discharge calls from multiple people.
- Caregivers in different units or sites have different patient goals.

---

Source: Nursing Executive Center.
Tool #9: Care Coordination Awareness Workshop

3 Vote on the specific problems participants see in their own practice (10 minutes)

Ask each participant to walk up to the flip charts and place a dot next to the five attributes of uncoordinated care they believe are the biggest problems in their own practice.

After participants have finished voting, circle the attributes that receive the greatest number of dots. Do a “gut-check” to confirm that they are the right challenges to tackle. If an attribute seems to be beyond frontline staff control (for example, limitations of the EMR), consider setting it aside and circle the attribute receiving the next largest number of dots.

4 Break into small groups (5 minutes)

Break into groups of no more than five people per group. Assign each group one of the challenges circled on the flip charts.

5 Conduct worksheet exercise part I: Identify the Top Opportunity (20 minutes)

Provide an overview of Part I: Identify the Top Opportunity. Ask participants to review the worksheet. Use the example shown in the first row to and walk through each step.

   • Step 1: Write the problem your group has been asked to address on the line above the table.

   • Step 2: In the first column, describe the current state. What do we currently assume or do that leads to this problem?

   • Step 3: In the second column, describe the desired state. What do we need to think or do differently to prevent this problem?

   • Step 4: In the third column, describe any evidence that this problem exists and potential impact on care quality.

   • Step 5: Using a scale of 1-10, assign each row a problem rating (how big of a problem this is) and difficulty rating (how difficult it will be to change the current state).

   • Step 6: Place a star next to the current state with the highest problem rating and lowest difficulty rating. This is your top opportunity.

6 Report back (10 minutes)

Ask each group to report back to the larger group with their top opportunity by describing the current state, desired state, and evidence of impact.
Tool #9: Care Coordination Awareness Workshop

7 Conduct worksheet exercise part II: Take Action (15 minutes)

Provide an overview of Part II: Take Action. Ask participants to review the worksheet. Use the example shown in the first row to walk through each step:

- **Step 1:** Write your team’s top opportunity from Part I on the line above the table.
- **Step 2:** In the first column, identify three things we can do to change the current state.
- **Step 3:** In the second column, identify potential barriers to changing the current state.
- **Step 4:** In the third column, identify individuals who need to be involved for change to occur.
- **Step 5:** In the fourth column, identify the necessary steps to make the change.

8 Closing discussion (10 minutes)

Instead of asking groups to report back with the action steps from Part II of the worksheet, use this time to invite discussion about what they learned during the exercise. The prompts listed below can help you get the discussion started.

### Closing Discussion Prompts

- Based on some of the issues you raised, why do you think care coordination is so important?
- Did this exercise open your eyes to any issues you didn’t realize we had?
- Can anyone share an opportunity they have in their own role to better coordinate care?
- What was the best idea you heard today that we should think about sharing with other leaders at our organization?
- What are some of the resources available to help us deal with the challenges we’ve discussed today?
How Can We Improve Care Coordination?

Part I. Identify the Top Opportunity

**Step 1:**
Write the problem your group has been asked to address on the following line.
One challenge my unit faces trying to coordinate care is: 

*For example:* Patients have to repeat themselves multiple times.

**Step 2:**
In the first column, **describe the current state.** What do we currently assume or do that leads to this problem?

**Step 3:**
In the second column, **describe the desired state.** What do we need to think or do differently to prevent this problem?

**Step 4:**
In the third column, **describe any evidence** that this problem exists and potential **impact.**

**Step 5:**
Using a scale of 1-10, assign a **problem rating** (how big of a problem this is) and **difficulty rating** (how difficult it will be to change the current state).

<table>
<thead>
<tr>
<th>Current State</th>
<th>Desired State</th>
<th>Evidence and Impact</th>
<th>Problem Rating¹</th>
<th>Difficulty Rating²</th>
</tr>
</thead>
<tbody>
<tr>
<td>We don't know if another caregiver has already asked a question, so we ask to make sure we get the information we need.</td>
<td>We know what questions our patients have already answered and we only have to ask once.</td>
<td>Patients get frustrated and that may impact our HCAHPS scores. We waste our time duplicating work.</td>
<td>8</td>
<td>7</td>
</tr>
</tbody>
</table>

**Step 6:**
**Place a star** next to the current state with the highest problem rating and lowest difficulty rating. This is your **top opportunity.**

1) A rating of “1” means the problem is small, and a rating of “10” means it is large.
2) A rating of “1” means the current state is easy to change and “10” means it is difficult to change.

Source: Nursing Executive Center.
## How Can We Improve Care Coordination?

### Part II. Take Action

**Step 1:**
Write your team’s **top opportunity** from Part I on the following line.

Our **top opportunity** is:

---

### Step 2:
In the first column, identify **three things we can do** to change the current state.

### Step 3:
In the second column, identify **potential barriers** to changing the current state.

### Step 4:
In the third column, identify **individuals** who need to be involved for change to occur.

### Step 5:
For each change idea, identify **specific action steps** needed to begin the process.

<table>
<thead>
<tr>
<th>Things We Can Do to Change The Current State</th>
<th>Potential Barriers to Change</th>
<th>Who Should Be Involved?</th>
<th>Action Steps</th>
</tr>
</thead>
</table>
| Remove redundant questions found on multiple assessment forms. | • It will take time to review all the assessments  
• Can’t change the assessment forms without approval | • Clinical quality director  
• Managers/directors/staff from nursing and other departments (ED, PT/OT, Respiratory Therapy, etc.) | 1) Present improvement opportunity to clinical quality director  
2) Gather frontline interdisciplinary team to review assessments and identify redundant questions |
Tool #10: Preventable Readmissions Awareness Workshop

Facilitator Guide

Overview:
This guide prepares facilitators to lead a frontline caregiver workshop on opportunities to reduce avoidable readmissions. The goal of the workshop is to help frontline staff understand the reasons readmissions occur, the impact of readmissions on care quality, and the critical role they can play in preventing avoidable readmissions.

The exercise may surface innovative ideas for reducing readmissions, but the primary goal is not process improvement. Rather, it’s to raise frontline caregivers’ awareness of the important role they play in preventing avoidable readmissions.

Who should attend?
Frontline caregivers who work together on a given unit, across multiple units, or across care settings. Attendees may include nurses, physicians, respiratory therapists, patient care assistants, technicians, medical assistants, etc. We recommend limiting attendance to approximately 25 participants.

What’s Required?
As the facilitator, you should allocate 30 minutes to prepare and 90 minutes for the workshop (limit the total session to two hours).

<table>
<thead>
<tr>
<th>Materials:</th>
<th>Setup:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Three flip charts and markers</td>
<td>• Distribute the following to each participant:</td>
</tr>
<tr>
<td>• Copy of worksheet for each staff member</td>
<td>• 5 dot stickers (any color)</td>
</tr>
<tr>
<td>• Dot stickers</td>
<td>• 1 worksheet (printed on 11x17 inch paper)</td>
</tr>
</tbody>
</table>

Recommended Agenda (see the following pages for facilitation details)

• Introduction: 5 minutes
• Group brainstorm: 15 minutes
• Dots exercise: 10 minutes
• Break out into groups of no more than 5 participants per group: 5 minutes
• Worksheet Part I: Identify the Top Opportunity: 20 minutes
• Report back to the larger group on Part I: 10 minutes
• Worksheet Part II: Take Action: 15 minutes
• Closing discussion: 10 minutes

Available Online: To access this tool online please visit www.advisory.com/nec/marketforcostoolkit
Tool #10: Preventable Readmissions Awareness Workshop

How to Run the Workshop

1. **Introduce the goal of the workshop**
   - At the start of the workshop, explain the goal and structure of the workshop.
   
   **Key points to include:**
   - The goal of the workshop is to ensure all frontline caregivers understand the reasons patients get readmitted and what they can do to help prevent avoidable readmissions.
   - How the workshop will run:
     - Participants will begin with a brainstorming exercise and vote (using dot stickers) on the greatest challenges they experience in their own practice.
     - The facilitator will break attendees into smaller groups, assigning each group a specific challenge to tackle.
     - Each group will report back with the improvement opportunities they identified and then brainstorm potential action steps.

2. **Ask participants to brainstorm potential reasons for readmissions**
   - Ask the question, “What are all of the reasons that patients get readmitted?”
   
   **Some examples include:**
   - Patients do not understand discharge instructions.
   - Patients do not have someone at home to help them get to the pharmacy to fill a prescription.
   - Caregivers do not follow up with patients within 72 hours of discharge.
   
   **Note:** We are looking only for potentially preventable readmissions. This excludes readmissions that are planned or unrelated to the patient’s initial condition. See page 32 of this toolkit for further description of different types of readmissions.

<table>
<thead>
<tr>
<th>Sample Reasons for Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients do not understand discharge instructions.</td>
</tr>
<tr>
<td>Patients do not have someone at home to help them get to the pharmacy to fill a prescription.</td>
</tr>
<tr>
<td>Caregivers do not follow up with patient within 72 hours of discharge.</td>
</tr>
<tr>
<td>Providers in the hospital do not communicate with providers in the post-acute setting.</td>
</tr>
<tr>
<td>Providers do not recognize patients that are at high-risk for readmission.</td>
</tr>
<tr>
<td>Patients do not attend a follow-up visit after their hospital stay.</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
Tool #10: Preventable Readmissions Awareness Workshop

3 Vote on the specific problems participants see in their own practice
   Ask each participant to walk up to the flip charts place a dot next to the five reasons for readmission they believe are the biggest problems in their own practice.

   After participants have finished voting, circle the items receiving the greatest number of dots.

4 Break into small groups
   Break into groups of no more than five people per group. Assign each group one of the challenges circled on the flip charts.

5 Conduct worksheet exercise part I: Identify the Top Opportunity
   Provide an overview of Part I: Identify the Top Opportunity. Ask participants to review the worksheet. Use the example shown in the first row to walk through each step.

   - **Step 1:** Write the problem your group has been asked to address on the line above the table.
   - **Step 2:** In the first column, describe the current state. What do we currently assume or do that leads to this problem?
   - **Step 3:** In the second column, describe the desired state. What do we need to think or do differently to prevent this problem?
   - **Step 4:** In the third column, describe any evidence that this problem exists and potential impact on care quality.
   - **Step 5:** Using a scale of 1-10, assign each row a problem rating (how big of a problem this is) and difficulty rating (how difficult it will be to change the current state).
   - **Step 6:** Place a star next to the current state with the highest problem rating and lowest difficulty rating. This is your top opportunity.

6 Report back
   Ask each group to report back to the larger group with their top opportunity by describing the current state, desired state, and evidence of impact.

Source: Nursing Executive Center.
Tool #10: Preventable Readmissions Awareness Workshop

7 Conduct worksheet exercise part II: Take Action

Provide an overview of Part II: Take Action. Ask participants to review the worksheet. Use the example shown in the first row to and walk through each step:

• **Step 1**: Write your team’s **top opportunity** from Part I on the line above the table.
• **Step 2**: In the first column, identify **three things we can do** to change the current state.
• **Step 3**: In the second column, identify **potential barriers** to changing the current state.
• **Step 4**: In the third column, identify **individuals** who need to be involved for change to occur.
• **Step 5**: In the fourth column, identify the **necessary steps** to make the change.

8 Closing discussion

Instead of asking groups to report back with the action steps from Part II of the worksheet, use this time to invite discussion about what they learned during the exercise. The prompts listed below can help you get the discussion started.

**Closing Discussion Prompts**

• Based on some of the issues you raised, why do you think reducing readmissions is so important?
• Did this exercise open your eyes to any issues you didn’t realize we had?
• Can anyone share an opportunity they have in their own role to prevent avoidable readmissions?
• What was the best idea you heard today that we should think about sharing with other leaders at our organization?
• What are some of the resources available to help us deal with the challenges we’ve discussed today?
# How Can We Prevent Readmissions?

## Part I. Identify the Top Opportunity

**Step 1:**
Write the problem your group has been asked to address on the following line.

One reason patients are readmitted is: ___

*For example: Patients do not understand their discharge instructions.

**Step 2:**
In the first column, **describe the current state.** What do we currently assume or do that leads to this problem?

**Step 3:**
In the second column, **describe the desired state.** What do we need to think or do differently to prevent this problem?

**Step 4:**
In the third column, **describe any evidence** that this problem exists and potential **impact.**

**Step 5:**
Using a scale of 1-10, assign a **problem rating** (how big of a problem this is) and **difficulty rating** (how difficult it will be to change the current state).

<table>
<thead>
<tr>
<th>Current State</th>
<th>Desired State</th>
<th>Evidence and Impact</th>
<th>Problem Rating</th>
<th>Difficulty Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Even though we explain discharge instructions to patients, the family member caring for the patient after discharge is not present.</td>
<td>Family members caring for patients after discharge are always present for patient education sessions.</td>
<td>A patient is readmitted because he didn’t understand how to take his medications correctly.</td>
<td>9</td>
<td>6</td>
</tr>
</tbody>
</table>

**Step 6:**
**Place a star** next to the current state with the highest problem rating and lowest difficulty rating. This is your **top opportunity.**

---

1) A rating of "1" means the problem is small, and a rating of "10" means it is large.
2) A rating of "1" means the current state is easy to change and "10" means it is difficult to change.

Source: Nursing Executive Center.
How Can We Prevent Readmissions?

Part II. Take Action

Step 1:
Write your team’s **top opportunity** from Part I on the following line

**Our top opportunity** is:

For example: Even though we explain discharge instructions to patients, the family member caring for the patient after discharge is not present.

<table>
<thead>
<tr>
<th>Step 2:</th>
<th>Step 3:</th>
<th>Step 4:</th>
<th>Step 5:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In the first column, identify three things we can do to change the current state.</strong></td>
<td><strong>In the second column, identify potential barriers to changing the current state.</strong></td>
<td><strong>In the third column, identify individuals who need to be involved for change to occur.</strong></td>
<td><strong>For each change idea, identify specific action steps needed to begin the process.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Things We Can Do to Change The Current State</th>
<th>Potential Barriers to Change</th>
<th>Who Should Be Involved?</th>
<th>Action Steps</th>
</tr>
</thead>
</table>
| Identify the person (other than the patient) who should always be present for patient education and/or teach-back sessions. | • It isn’t always apparent who will be caring for the patient at home after discharge  
• The person who needs to learn key information isn’t always available when we need them to be | • Nurses, physicians, care managers, patient-care assistants  
• Patients and family members who will care for the patient after discharge | 1) Draft proposal for a protocol to identify a “key learner”, who will present proposal to governance council  
2) Develop a process to ensure “key learners” can be present for all education and/or teach-back sessions. |

Source: Nursing Executive Center.
Tool #11: A “Doomsday” Exercise

Facilitator Guide

Overview
This guide prepares leaders to facilitate an interactive exercise for frontline staff on the impact of hospital-acquired conditions by reviewing a fictional “doomsday” scenario. The goal is to demonstrate the cost of common adverse events and help frontline staff understand how adverse events often require leaders to make difficult budgetary trade-offs.

Who should attend?
Frontline caregivers who work together on a given unit or care setting. Attendees may include nurses, physicians, respiratory therapists, patient care assistants, technicians, medical assistants, etc. We recommend limiting attendance to approximately 25 participants.

What’s required?
The first time you prepare for this session, you should allocate 2-3 hours to prepare the laminated poster and removable cost items. Since these items are reusable, preparation for additional sessions will require only 10-15 minutes (to review the scenario and print handouts). You should allocate one hour for each workshop.

Materials:
• Digital camera
• Laminator and laminating sheets
• Velcro dots (purchased at a craft store)
• Scissors
• Pencils (one per participant)

Handouts:
• “Doomsday” Scenario Fictional Case Study found on page 83 of this toolkit
• “Doomsday” Worksheet, found on page 84 of this toolkit
• “Doomsday” Exercise Cost List, found on page 85 of this toolkit

Setup
• Take a digital photo of an empty unit and/or administrative office (see the Sample “Doomsday” Laminated Unit Poster on the following page). Have the photo enlarged to fit on a 3 ft. by 5 ft. poster paper and laminated.

• Take digital photos of the items listed in the table of the Doomsday Exercise Cost List. An editable version can be found by visiting advisory.com/nec/marketforcestoolkit. Print photos of each item on card stock. Cut images out and laminate them. Apply Velcro dots to the back of each image. Affix each item to the laminated poster in advance of the session. (Select images of items included in the cost list can be found by visiting advisory.com/nec/marketforcestoolkit.)

• Familiarize yourself with the “Doomsday” scenario.
• Distribute the “Doomsday” Scenario Fictional Case Study, “Doomsday” Worksheet, and pencils.

Recommended agenda (see following pages for facilitation details)
• Introduce the goal of the session: 5 minutes
• Review the “Doomsday” scenario: 15 minutes
• Reveal the actual cost of specific adverse events: 15 minutes
• Make difficult trade-offs: 10 minutes
• Discussion: 15 minutes

Available Online
To access this tool online please visit advisory.com/nec/marketforcestoolkit

Source: Nursing Executive Center.
Sample “Doomsday” Laminated Unit Poster

The following image is a sample “doomsday” laminated unit poster with moveable Velcro pieces, shared by MedStar Montgomery Medical Center. You may choose to combine a unit photo with an administrative office (as shown here), or simply take a photo of an empty unit for your “doomsday” exercise magnetic board. We recommend printing the photo on 3 ft. by 5 ft. poster paper and laminating it to enable repeated use.
Tool #11: A “Doomsday” Exercise

How to Run the Workshop

1. **Introduce the goal of the session (5 minutes)**
   Key points to include:
   - The goal of this exercise is to understand the impact of hospital-acquired conditions on our patients and the financial health of our organization.
   - The case we are about to review is a fictional scenario. You’ll note that it’s an extreme example. While the events in the example wouldn’t normally happen to a single patient, the events happen to different patients in our hospital on a regular basis.

2. **Review the “Doomsday” Scenario (15 minutes)**
   Review the “Doomsday” Scenario Fictional Case Study with the group. As the facilitator, you can either read the case study aloud or have participants take turns reading different sections of the scenario.
   - Note that the cost of each event may not match the cost for your specific organization. The values provided are meant to represent the costs incurred by common hospital-acquired conditions. These values are for teaching purposes only.
   - Instruct participants to follow along as the group reviews the case. Each time an event occurs in the case study (indicated by bold formatting and a number), participants should estimate how much they think the event costs their hospital. Ask them to write their estimate in the boxes corresponding with the numbers in the scenario on the worksheet provided. Do not stop to discuss each adverse event. Rather, ask participants to write down their estimates silently.

3. **Reveal the actual cost of adverse events (15 minutes)**
   **Ask participants:** Does anyone want to guess what they think a _________ costs?

   After hearing responses from one or two participants, reveal the actual cost of the event to the group. Estimated costs are shown in the box below. Ask participants to write the correct cost values in their worksheet. Repeat this step for each of the six events in the scenario.

<table>
<thead>
<tr>
<th>Avoidable Event</th>
<th>Observation Unit Admission</th>
<th>Patient Fall</th>
<th>Central Line Infection</th>
<th>Pressure Ulcer</th>
<th>Urinary Tract Infection</th>
<th>Clostridium Difficile Infection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost</td>
<td>$3,000</td>
<td>$10,000</td>
<td>$54,000</td>
<td>$3,000</td>
<td>$44,000</td>
<td>$7,000</td>
</tr>
</tbody>
</table>

Source: Nursing Executive Center.
Hospital-Acquired Condition

Tool #11: A “Doomsday” Exercise

4 Make difficult budgetary trade-offs (10 minutes)

Ask participants to turn their attention to the laminated unit poster, populated with removable cost items normally found on the unit (and/or administrative office).

- Explain that as a result of the hospital-acquired conditions that Laura experienced in the “doomsday” scenario, we’ll have to cut the additional costs from the unit’s budget.
- Distribute the “Doomsday” Exercise Cost List and briefly explain that it shows the costs of common items normally included in their unit’s budget.

Ask participants: What would you cut?

Remind participants that this is an exercise, and clarify that you are not asking them to propose actual changes to your unit’s budget.

- Starting with the first event on the worksheet, ask a participant to volunteer to remove the items from the unit poster they would choose to cut from the budget that equals the cost of the avoidable event.
- Repeat this step for each of the six events.

Closing Discussion Prompts

Ask participants to consider the trade-offs they made. Invite discussion by asking probing questions:

- Did you find it difficult to choose which items we should cut?
- What are some of the things you can do to prevent hospital-acquired conditions?
- What do you think are our best opportunities to reduce our hospital’s rates of hospital-acquired conditions?
- What are some of the resources available to help us address these opportunities?
A “Doomsday” Scenario Fictional Case Study

Listed on this page is a fictional “doomsday” scenario, in which a patient experiences multiple hospital-acquired conditions during her hospital stay. Review the scenario together with your workshop facilitator. Each time a preventable event occurs, estimate what you think this event costs.

- On Tuesday, Laura, a 60-year-old female visits the blood transfusion center as follow-up treatment for ovarian cancer. She experiences a syncopal episode with a near fall. The rapid response team is called. Laura is stabilized and taken to the ED.

- Laura’s port site post-fall tubing is pulled and dressing dislodged with port exposed. The port site is not redressed.

- The care team decides to place Laura in the observation unit (1) for further evaluation. Clinicians on the observation unit are not aware of her previous near fall in the infusion center and allow Laura to opt out of using the bed alarm.

- Laura subsequently falls (2) during the late evening on evaluation and suffers a crack of the femoral head. She is transferred to an inpatient unit and scheduled for an open reduction internal fixation (ORIF); physicians are unable to operate until her cardiac condition is stable.

- Laura has several other comorbidities to consider. She is very thin, with fragile skin, diabetic, has high blood pressure, and is malnourished. It is difficult to turn Laura to the side due to pain when she is moved. She is maintained on Accumax mattress, rather than the P500 (a special surface to prevent pressure ulcers).

- Day 3: Laura goes to the OR. A Foley catheter is inserted. Laura’s temperature is elevated to 101°F post-op. Blood cultures are drawn and later report pseudomonas. Laura has a central-line associated blood stream infection (CLABSI) (3).

- Day 5: Laura is seen during the prevalence survey and has a pressure ulcer on her sacrum (4). There is no documentation on Laura’s chart as to padding during the OR or PACU time. Staff report that she is difficult to turn due to pain and would not stay on her side. The Foley catheter is noted and discontinued at this time.

- Day 8: Laura’s fever spikes again to 103°F with chills and slight confusion. Urine and wound cultures are collected. She is placed on broad-spectrum antibiotics. Culture results show klebsiella in urine, a catheter-associated urinary tract infection (CAUTI) (5).

- Day 11: Laura experiences multiple episodes of foul smelling diarrhea. Clostridium difficile (C-diff) of stool is ordered. C-diff results are positive (6).

- Day 13: Laura is transferred to inpatient rehab. The report from the rehab facility says that she has a stage III pressure wound with 50% slough.

Source: MedStar Montgomery Medical Center, Olney, MD. Nursing Executive Center.
Hospital-Acquired Conditions

A “Doomsday” Scenario Worksheet

Laura’s 13-Day Length-of-Stay

1. Observation Unit
   Admission

2. Patient
   Fall

3. Central Line
   Infection

4. Pressure
   Ulcer

5. Urinary Tract
   Infection

6. Clostridium
   Difficile Infection

Source: Nursing Executive Center.
## A “Doomsday” Exercise Cost List

### Medical Surgical Unit Cost List

<table>
<thead>
<tr>
<th>Item</th>
<th>Estimated Cost for Each</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foot/ankle pumps</td>
<td>$10,000</td>
</tr>
<tr>
<td>Small copier</td>
<td>$3,500</td>
</tr>
<tr>
<td>Office chairs</td>
<td>$540</td>
</tr>
<tr>
<td>Waiting room furniture</td>
<td>$6,000</td>
</tr>
<tr>
<td>Nurses’ station computers</td>
<td>$1,000</td>
</tr>
<tr>
<td>Bedside computers</td>
<td>$5,000</td>
</tr>
<tr>
<td>Stretchers</td>
<td>$6,000</td>
</tr>
<tr>
<td>IV pumps</td>
<td>$3,000</td>
</tr>
<tr>
<td>Large printer</td>
<td>$1,500 + $1,000 per year</td>
</tr>
<tr>
<td>Large copier</td>
<td>$6,000</td>
</tr>
<tr>
<td>Cold therapy machines</td>
<td>$3,800</td>
</tr>
<tr>
<td>Bedside commodes</td>
<td>$100</td>
</tr>
<tr>
<td>Vital signs monitor</td>
<td>$3,500</td>
</tr>
<tr>
<td>Recliners</td>
<td>$1,800</td>
</tr>
<tr>
<td>Bladder scanner</td>
<td>$17,000</td>
</tr>
<tr>
<td>Line cart</td>
<td>$1,400</td>
</tr>
<tr>
<td>Isolation cart</td>
<td>$100</td>
</tr>
<tr>
<td>Fax machine</td>
<td>$250</td>
</tr>
<tr>
<td>Doppler</td>
<td>$600</td>
</tr>
<tr>
<td>Thermometer</td>
<td>$650</td>
</tr>
<tr>
<td>Vocera accessories (replacing one per day)</td>
<td>$525</td>
</tr>
<tr>
<td>Full-time RN</td>
<td>$68,000</td>
</tr>
<tr>
<td>Nurse technician</td>
<td>$30,000</td>
</tr>
</tbody>
</table>

Source: MedStar Montgomery Medical Center, Olney, MD.
Tool #12: Value-Based Purchasing Reality Check

Facilitator Guide

Overview
This guide prepares facilitators to lead a conversation with frontline staff about value-based purchasing (VBP) by sharing your own organization’s performance data. The goal of the conversation is to help frontline staff understand the value-based purchasing program, how it impacts their hospital, and the role they can play in improving their hospital’s performance.

Who should attend?
Frontline caregivers who work together on a single unit or care setting. Attendees may include nurses, physicians, respiratory therapists, patient care assistants, technicians, medical assistants, etc. We recommend limiting attendance to approximately 25 participants.

What's required?
As the facilitator, you should allocate 30 minutes to prepare and 60 minutes for the session.

Materials:
- Copy of Value-Based Purchasing Template¹
- Your hospital-specific VBP performance data (detailed instructions for retrieving your data are provided on the following page)
- White board (for larger groups) and large, red marker

Handouts:
- “What Is Value-Based Purchasing” one-pager, found on page 92 of this toolkit

What’s the facilitator’s role?
As facilitator, you will manage time during the session and guide participants through the session. Familiarize yourself with the Value-Based Purchasing Program Nurse Manager Cheat Sheet, found on page 35-37 of this toolkit. This will help you keep discussion on the right track while spurring participants to think critically.

¹ Before January 2015, only four domains are included in the program; After January 2015, a fifth domain—Safety—will be included.
Tool #12: Value-Based Purchasing Reality Check

Facilitator Guide (cont.)

Setup

• Before the session, access and print your organization’s specific data on value-based purchasing, available at advisory.com/marketforcestoolkit. The following page describes how to retrieve this information in four easy steps.

• Print a copy of the “gas gauge” template on 11x17 inch paper. The template can be found on page 93 of this toolkit. A black and white photocopy is sufficient. If you prefer, a color version of this template is also available as a downloadable PDF at advisory.com/marketforcestoolkit.

  – For smaller groups (less than 10 people), tape the template to a white board or wall at the front of the room, where participants can see it easily.

  – For larger groups (more than 10 people), we recommend drawing the template by hand on a whiteboard prior to the session. Make your hand-drawn template large enough so all participants can see it easily.

• Make copies of the handout on page 92 of the toolkit called, “What Is Value-Based Purchasing?” Print one copy per attendee. Do not share the handout until after you have completed Step 3.

Recommended agenda (see following pages for facilitation details)

• Introduce the goal of the session: 5 minutes

• Define value-based purchasing: 5 minutes

• Report your hospital’s TPS and national percentile rank: 10 minutes

• Introduce the domains that comprise the TPS: 10 minutes

• Report your hospital’s performance on each domain: 10 minutes

• Closing discussion: 20 minutes

Available Online:

To access this tool online please visit advisory.com/nec/marketforcestoolkit
Value-Based Purchasing

Tool #12: Value-Based Purchasing Reality Check

Retrieving Your Hospital-Specific VBP Data

**Step 1:** Visit advisory.com/marketforcestoolkit

**Step 2:** Access the Customized Medicare Value-Based Purchasing Impact Assessment for the upcoming fiscal year.

**Step 3:** Click the red button to view your organization’s data.

**Step 4:** Click on the OVERVIEW tab to view your organization’s Total Performance Score (TPS). Right click on the page and print. A sample screenshot of this page is shown below.

Click on the DOMAINS tab to view your organization’s performance on each domain. Right click on the page and print. A sample screenshot of this page is shown below.

The first tab in the tool shows the OVERVIEW of your hospital’s performance.

The second tab in the tool shows how your organization is performing in each of the four DOMAINS.

Beginning in January 2015 there will be a fifth domain: safety.

Source: Nursing Executive Center.
Tool #12: Value-Based Purchasing Reality Check

How to Run the Workshop

1 Introduce the goal of the session (5 minutes)
   Begin with a few probing questions to gauge how much attendees already know about value-based purchasing:
   - Raise your hand if you have heard of “value-based purchasing” or “VBP.”
     [It’s okay if nobody raises their hand. If some attendees do raise their hands, ask the following question.]
   - Would anyone like to describe what VBP is (to the best of your knowledge)?
   - Why do you think it’s important?
   Explain the goal of the session: to help frontline staff understand the value-based purchasing program, how it impacts their hospital, and the role they can play in improving their hospital’s performance.

2 Define value-based purchasing (5 minutes)
   Key points to include:
   - Value based purchasing, often called VBP, is a government payment program that will impact our hospital's finances. It’s designed to give all hospitals an extra financial incentive to improve their quality.
   - Under this program, our hospital can earn financial rewards for having strong quality outcomes. On the other hand, we can be penalized (paid less for Medicare patients) if we don’t have strong quality outcomes.

3 Report your hospital’s Total Performance Score and national percentile rank (10 minutes)
   Introduce the Total Performance Score (TPS).
   Key points to include:
   - The VBP program assigns a performance score to every hospital, based on its outcomes.
   - The best possible score a hospital can receive is 100.
   Ask participants to estimate what they think their hospital’s performance score might be. Aim to draw out different answers and ask participants to explain why they believe the score is high or low.
   Reveal your actual performance score. (This is located in the red circle on the “overview” page you printed during the setup. It is labeled, “Total Provider Score” on your printout.) Write your hospital’s score in the circle at the top of your preprinted or hand-drawn gas gauge template.

   Introduce the national percentile.
   - In addition to a raw score your hospital is also given a percentile ranking based on how it compares to other hospitals in the country.
   Ask participants to estimate how your hospital compares to other hospitals nationally. Allow the group to guess and share ideas about why they believe the percentile rank is high or low.
   Reveal your hospital’s percentile rank. (This number is right above the gas gauge on the “overview” page, labeled percentile rank.) Using a large, red marker draw an arrow to indicate your hospital’s percentile rank at the top of your preprinted or hand-drawn gas gauge template.

Source: Nursing Executive Center.
Value-Based Purchasing

Tool #12: Value-Based Purchasing Reality Check

4 Introduce the domains that comprise the Total Performance Score (10 minutes)

Distribute the one-page handout called “What Is Value-Based Purchasing?” to all participants.

- Explain that there are different categories, called domains, that comprise the TPS:
  - Process of care measures whether or not we complete the correct clinical processes to treat specific types of patients. For example, whether pneumonia patients receive the correct antibiotics and when surgery patients had their catheters removed.
  - Experience of care measures patient satisfaction scores. For example, how well we respond to patient needs and if we keep the hospital quiet enough at night.
  - Outcomes of care measures specific patient outcomes, such as the mortality rates for heart attack, heart failure, and pneumonia patients; hospital-acquired infection rates; and many other quality indicators.
  - Efficiency of care measures how much it costs our hospital to care for each Medicare patient.
  - Safety measures rates of common infections such as central line-associated blood stream infections, catheter-associated UTIs, and surgical site infections.

5 Report your hospital’s performance on each domain (10 minutes)

- Ask participants to estimate which domains they think are high or low. Aim to draw out different answers and ask participants to explain why.
- Reveal your hospital’s percentile rank for each domain. (This is located in each of the four gas gauge graphics on the “domains” page you printed during the setup. It is labeled. Draw arrows to indicate your hospital’s percentile rank in each domain on your preprinted or hand-drawn gas gauge template.

6 Closing discussion (20 minutes)

Ask participants to consider the lower-performing domains. Invite discussion by asking probing questions, for example:

- Does anything surprise you? Why or why not?
- Do you think it’s a good thing or a bad thing that hospitals now receive rewards or penalties based on the level of care quality they provide?
- How can VBP help our patients?
- What are some specific opportunities we have to improve our hospital’s performance?
- What are some of the resources available to help us address these opportunities?
What Is Value-Based Purchasing?

- Value Based Purchasing, often called VBP, is a mandatory government payment program that will impact our hospital's finances.
- The program is designed to give hospitals an extra financial incentive to improve their quality.
- It will reward hospitals that have strong quality by giving them a bonus. It will penalize hospitals that don't have good quality by paying them less for the care they give Medicare patients.
- VBP measures performance on metrics in five categories (called “domains”): process, outcomes, patient experience, efficiency, and safety.

Value-Based Purchasing Domains

Process of care
This domain measures how often caregivers complete the correct clinical processes to treat specific types of patients, including:
- Heart attack patients given PCI within 90 minutes of arrival to hospital
- Influenza immunization

Experience of care
This domain measures patient satisfaction scores, including:
- Communication with nurses
- Discharge information
- Hospital cleanliness and quietness

Outcomes of care
This domain measures outcomes for specific conditions and rates of hospital-acquired conditions, including:
- Heart attack mortality rate
- Heart failure mortality rate
- Pneumonia mortality rate

Efficiency of care
This domain measures how much money hospitals spend to take care of each Medicare patient, per episode of care.

Safety
This domain measures if providers are delivering high-quality clinical care by tracking rates of common infections, including:
- Central line-associated blood stream infection
- Catheter-associated UTI
- Surgical site infections

Source: Nursing Executive Center.
Value-Based Purchasing Reality Check

1) Before January 2015, only four domains are included in the program; after January 2015, a fifth domain—“Safety”—will be included.