Value-Based Purchasing: Improving Healthcare Outcomes Using the Right Incentives

One (1.0) Contact Hour

First Published: 12/10/2013

Course Updated: 1/15/2015

Course Expires: 12/31/2016

Reproduction and distribution of these materials is prohibited without an RN.com content licensing agreement.

Copyright © 2013 by RN.com. All Rights Reserved.

Acknowledgments

RN.com acknowledges the valuable contributions of...

...Marcia Faller, PhD, RN, who serves as Chief Clinical Officer for AMN Healthcare. In this role she is responsible for the clinical quality, competency and continuing education of all clinicians and physicians represented by the company. Dr. Faller has conducted podium and poster presentations on various healthcare staffing topics and published articles on job satisfaction among travel nurses. Her clinical background is in critical care nursing. She earned a bachelor of science in nursing from the University of Arizona, a master of science in nursing and doctorate in nursing from the University of San Diego. Dr. Faller is on the board of directors for the Alliance for Ethical International Recruitment Practices, Community Health Improvement Partners (a San Diego based non-profit organization), and on the Joint Commission advisory board for the Healthcare Staffing Services certification program.

Material protected by Copyright
Conflict of Interest

RN.com strives to present content in a fair and unbiased manner at all times, and has a full and fair disclosure policy that requires course faculty to declare any real or apparent commercial affiliation related to the content of this presentation. Note: Conflict of Interest is defined by ANCC as a situation in which an individual has an opportunity to affect educational content about products or services of a commercial interest with which he/she has a financial relationship.

The author of this course does not have any conflict of interest to declare.

The planners of the educational activity have no conflicts of interest to disclose.

There is no commercial support being used for this course.

Purpose and Objectives

The purpose of this course is to educate nursing professionals about the progression of Value-Based Purchasing (VBP) over the near term and how VBP is influenced by nursing care and actions.

After successful completion of this course, you will be able to:

1. State three reasons why it is important to make changes in America’s healthcare reimbursement programs.
2. Describe the criteria by which hospitals are measured in order to achieve incentive payments.
3. Discuss changes in the reimbursement and incentive payment program since its inception and changes projected for the future.
4. Give three examples of how hospital reimbursements can be impacted by nurses and nursing care under the new payment structure.

Introduction

One of the greatest challenges we face in American healthcare today is our ability to balance healthcare quality with cost. Traditionally, healthcare services have been reimbursed on a fee for service basis: a service was provided and a set fee charged for that service.

With the current changes in healthcare reimbursement, there is a focused effort on moving to value-based purchasing, also known as pay for performance. Under this arrangement, healthcare organizations are rewarded for meeting pre-established goals for delivery of quality healthcare services. As an example, when a patient is hospitalized and Medicare reimburses a hospital for the stay, if the patient is readmitted within 30 days for the same condition, the hospital will not receive reimbursement for the hospital care provided during this return visit.

The quality goal in this example was to prevent readmission, and when that goal is not met, reimbursement will not occur. By placing reimbursement incentives on quality performance rather than volume of activity, American healthcare will benefit from improved patient outcomes. This is a fundamental change from historical forms of reimbursement.

The Hospital Value-Based Purchasing (VBP) Program

Material protected by Copyright
The Hospital VBP program was established by Congress as part of the Affordable Care Act (ACA). This program requires the Centers for Medicare & Medicaid (CMS) to implement a Hospital VBP program that rewards hospitals for the quality of care they provide. Under the Hospital VBP program, CMS will evaluate hospitals' performance during a performance period, based on both achievement and improvement on selected measures.

Hospitals will receive points on each measure based on their highest level of achievement relative to an established standard or their improvement in performance from their performance during a prior baseline period.

Not all hospitals participate in VBP. Only hospitals currently aligned with the Inpatient Prospective Payment System (IPPS) will be required to participate in VBP.

Essentially, this eliminates all children’s hospitals, VA hospitals, long term care facilities, critical access hospitals, psychiatric hospitals and rehabilitation hospitals from the program.

**What is The Inpatient Prospective Payment System (IPPS)?**

Under the IPPS, Medicare payments fund the entire hospitalization. Each hospital case is categorized into a diagnosis-related group (DRG). Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG. The fee amount covers all services, labor and non-labor that a patient receives while in the hospital. It’s actually quite complex, with changes to reimbursements happening annually.

**What is Value-Based Purchasing (VBP)?**

VBP is a strategy used by employers and the government to promote quality and value in healthcare services while controlling costs (National Business Coalition on Health [NBCH], 2013).

VBP is:

- Required by the ACA, which added Section 1886(o) to the Social Security Act.
- A quality incentive program built on the Hospital Inpatient Quality Reporting (IQR) measure reporting infrastructure.
- The next step in promoting higher quality care for Medicare patients.
- A model that pays for care that rewards better value and patient outcomes, instead of just volume of services.
- Funded by increasing reductions from participating hospitals' base operating DRG payments, beginning with a 1% reduction in FY 2013. Each year hospitals' DRG payments are reduced by a greater percentage, increasing annually to reach 2% in FY 2017. In 2014, these reductions totaled $963 million.
- Using measures that have been specified under the Hospital IQR Program and results published on Hospital Compare for at least one year.

(CMS, 2012)

**What is Inpatient Quality Reporting (IQR)?**

Hospitals report data for specific quality measures for many common health conditions. These data are reported on the Hospital Compare website at [www.hospitalcompare.com](http://www.hospitalcompare.com) where consumers can
view any hospital of interest and compare its data to any other hospital. The data are available to help consumers make more informed decisions about where to receive care (CMS, 2012).

**Why Move to a VBP Model of Reimbursement?**
- U.S. spends nearly 18% of GDP on healthcare, more than any other country (World Bank, 2014).
- Yet, U.S. health outcomes are no better than other developed countries.

**IOM Findings**

The Institute of Medicine (IOM) published a report in 2012 entitled “Best Care at Lower Cost: The Path to Continuously Learning Healthcare in America.”

The IOM discussed the rising cost and complexity of healthcare in America and noted the following:
- Less than 50% of elderly patients are current on preventative services.
- Elderly patients with co-morbidities take 19 medication doses every day.
- Every year the average elderly patients sees 7 physicians across 4 practices.
- The average surgical patient is seen by 27 different providers.
- 1 out of every 5 elderly patients is readmitted within 30 days.
  (Smith, 2013)

**Wasted Spending Chronic Diseases**

More emphasis on prevention has potential for reducing spending to treat chronic diseases. For example, obesity leads to many chronic diseases.
- Obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer, some of the leading causes of preventable death.
- Nearly 40% of adult Americans are obese.
- Approximately 17% of children and adolescents aged 2—19 years have obesity.
- The estimated annual medical cost of obesity in the U.S. was $147 billion in 2008 U.S. dollars; the medical costs for people who are obese were $1,429 higher than those of normal weight.
  (CDC, 2014a)

**Prevalence of Self-Reported Obesity Among U.S. Adults by State and Territory, BRFSS, 2013**

Material protected by Copyright

Wasted Spending Chart

When examined in this manner, it becomes clear that American healthcare MUST change.

Test Yourself

According to the Institute of Medicine's 2012 report, most of the healthcare wasted spending is on:

A. Excessive administrative costs
B. Inefficient delivery of care
C. Unnecessary services

The correct answer is C. $210 billion is wasted on unnecessary services annually, compared to $190 billion on excessive administrative costs, and $130 billion on inefficient delivery of care.
The ACA of 2010 Established the Basis for VBP

The aims of the ACA are to increase the quality and affordability of health insurance, reduce the number of uninsured people by expanding public and private health coverage options, and lower the costs of healthcare for both individuals and the government.

The ACA provides for staged implementation of VBP beginning in 2012 and will continue to increase expectations in subsequent years.

Some of the changes that ACA will force are:

- Hospital reimbursement will be based on the quality of outcomes rather than the quantity of services provided.
- Provider and organization behaviors will change in order to produce quality results.
- Overall health and prevention of illness will improve.

“Instead of payment that asks, “How much did you do?” the Affordable Care Act clearly moves us toward payment that asks, “How well did you do?” and more importantly, “How well did the patient do?”

Dr. Donald Berwick, Centers for Medicare & Medicaid Services (CMS) Administrator
April 11, 2011

VBP: Baseline Performance Measurements and Program Implementation

Measures

- Multiple different measures are used. Specific measures may be added or retired from time to time.
- 2 scores are earned for each measure: 1) achievement, 2) improvement. The higher of the two is the final score.
- Points achieved vary based on degree of meeting or exceeding threshold levels and benchmark targets on all measures.
- In addition, consistency points are earned based on the patient experience domain (HCAHPS). Hospitals are rewarded if they have scores above the national 50th percentile in ALL 8 HCAHPS dimensions.

Eligibility & Funding

- The program is not static, instead every year the domains and weighting change. Domains initially included Clinical Process of Care and Patient Experience of Care. Later the domain of Outcomes was added and still later the domain of Efficiency was included.

(CMS, 2013)

Note!

HCAHPS is described in more detail later in this course.
Scoring Progression Over Time

Measures are added gradually with shifting weights. Previous to the implementation of the actual scoring and improvement-based reimbursement, eligible facilities will have established their baseline metrics in all of the measurements.

Each of these measured segments is referred to as a “domain,” for example, Clinical Process of Care is a “domain” that in 2013 included 12 different measures and accounted for 70% of incentive payments.
Fiscal Year 2013 VBP

For the year 2013, hospitals were evaluated on 2 domains:

- The Patient Experience of Care which is measured through the standardized HCAHPS survey.
- The Clinical Process of Care which is a compilation of healthcare categories in which standard evidence-based practice expectations are used to determine if the care expectations were met.

The reimbursements paid are weighted. For 2013, 70% of the reimbursement was based on the Clinical Process of Care domain and 30% on the Patient Experience of Care domain.

Examples of standards, also called Core Measures, in the Clinical Process of Care domain (70% of incentive payments):

- Fibrinolytic agent received within 30 minutes of hospital arrival (AMI 7a)*
- PCI received within 90 minutes of hospital arrival (AMI 8a)*
- Discharge instructions (HF 1)**
- Blood culture before 1st antibiotic received in hospital (PN 3b)***
- Initial antibiotic selection for CAP immunocompetent patient (PN 6)***
- Received prophylactic antibiotic consistent with recommendations (SCIP 2)****
- Controlled 6 AM post-op serum glucose – cardiac surgery (SCIP 4)****

*AMI = Acute Myocardial Infarction Core Measure Set
**HF = Heart Failure Core Measure Set
***PN = Pneumonia Core Measure Set
****SCIP = Surgical Care Improvement Project Core Measure Set

Fiscal Year 2013 VBP

The Patient Experience of Care domain relies on the Healthcare Consumer Assessment of Hospital Performance (HCAHPS), a survey that patients use to rate (30% of incentive payments):

- Communications with nurses
- Communications with doctors
- Responsiveness of hospital staff
- Pain management
- Communication about medications
- Cleanliness and quietness
- Discharge information
- Overall rating of hospital

Fiscal Year 2014 VBP

In 2014, in addition to the 2 domains used in 2013, a new domain was added and the weighting for reimbursement shifted. This 3rd domain is called Outcomes and it measures results related to 30-day
mortality for 3 disease conditions: Acute myocardial infarction (AMI), heart failure (HF) and pneumonia (PN). Twenty-five percent (25%) of reimbursement is based on Outcomes results, 45% going to Clinical Process of Care and the remaining 30% for Patient Experience of Care.

Fiscal Year 2014 VBP

Clinical Process of Care Domain (selected examples) (45% of incentive payments):
- Fibrinolytic agent received within 30 minutes of hospital arrival (AMI 7a)
- PCI received within 90 minutes of hospital arrival (AMI 8a)
- Discharge instructions (HF 1)
- Blood culture before 1st antibiotic received in hospital (PN 3b)
- Initial antibiotic selection for CAP immunocompetent patient (PN 6)
- Received prophylactic antibiotic consistent with recommendations (SCIP 2)
- Controlled 6 AM post-op serum glucose – cardiac surgery (SCIP 4)

Outcome Domain NEW in 2014 (25% of incentive payments):
- 30-day mortality, AMI
- 30-day mortality, HF
- 30-day mortality, PN

Patient Experience of Care Domain (30% of incentive payments):
- Communications with nurses
- Communications with doctors
- Responsiveness of hospital staff
- Pain management
- Communication about medications
- Cleanliness and quietness
- Discharge information
- Overall rating of hospital

Test Yourself
The Outcomes domain measures related to 30-day mortality rates for three disease conditions, including:

A. Heart failure
B. Diabetes
C. Sepsis

The correct answer is: A. This 3rd domain is called Outcome and its measures are related to 30-day mortality in 3 disease conditions: Acute myocardial infarction, heart failure and pneumonia.

Fiscal Year 2015 VBP

In 2015, the weighting shifts again. A 4th domain is added. This domain is called “Efficiency” and the
measurement is Medicare spending per beneficiary. This measure evaluates the cost to Medicare of services performed by hospitals and other healthcare providers during a Medicare spending per beneficiary event. In addition, two new outcomes measures are added: central line associated blood stream infection rate and complication/patient safety for selected indicators.

In 2015, 30% of the incentive payment is based on Patient Experience of Care, another 30% based on Outcomes. Clinical Process of Care and Efficiency measures each represent 20% of the total amount paid as incentive payments.

8 Patient Experience of Care Domain Measures (30% of incentive payments):
- Communications with nurses
- Communications with doctors
- Responsiveness of hospital staff
- Pain management
- Communication about medications
- Cleanliness and quietness
- Discharge information
- Overall rating of hospital

Fiscal Year 2015 VBP

Outcome Domain Measures (30% of incentive payments):
- 30-day mortality, AMI
- 30-day mortality, HF
- 30-day mortality, PN
- Central line associated blood stream infection rate
- Complication/patient safety for selected indicators

Efficiency Domain Measure Added in 2015 (20% of incentive payments):
- Medicare spending per beneficiary

Clinical Process of Care (selected examples) (20% of incentive payments):
- Fibrinolytic agent received within 30 minutes of hospital arrival (AMI 7a)
- PCI received within 90 minutes of hospital arrival (AMI 8a)
- Discharge instructions (HF 1)
- Blood culture before 1st antibiotic received in hospital (PN 3b)
- Initial antibiotic selection for CAP immunocompetent patient (PN 6)
- Received prophylactic antibiotic consistent with recommendations (SCIP 2)
- Controlled 6 AM post-op serum glucose – cardiac surgery (SCIP 4)

VBP 2015
The Future of VBP

In the coming years, CMS will continue moving away from process-of-care measures, placing a greater emphasis on outcomes. In 2017, the process measures (Clinical Process of Care Measures or Core Measures) will constitute only 5% of VBP. Recall that at the beginning of VBP in 2013, Clinical Process of Care Measures was allocated 70% of VBP payments. This shift focuses more sharply on the success of the healthcare team’s effort, rather than whether healthcare professionals followed evidence-based guidelines.

CMS has announced plans to add three care transition measures in HCAHPS to VBP. These measures are already are already part of IQR.

In addition, CMS plans to add additional efficiency measures in the future, such as kidney/urinary tract infection, cellulitis and gastrointestinal hemorrhage, hip replacement/revision; knee replacement/revision, and lumbar spine fusion/refusion.

(Hospital Case Management, 2014)

HCAHPS Measures the Patient Experience of Care

What is HCAHPS?
Hospital Consumer Assessment of Healthcare Providers and Systems AKA “patient satisfaction”

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is a standardized survey instrument and data collection methodology for measuring patients’ perspectives on healthcare. The survey utilizes a core set of questions that can be combined with a set of hospital-specific items to support improvement in internal customer service and quality. National implementation of the survey began in December 2005. Public reporting enhances accountability by
increasing the transparency of quality measures (Quality Net, 2013).

HCAHPS results are reported as the percentage of patients who indicated the highest rating on the scale. The survey results are often talked about in terms of “top box”, “middle box” and “bottom box.”

Top box refers to results of 75% or more – for example, if for an organization, the statement: Patients who reported that their nurses "Always" communicated well shows a result of 80%, this means that 80% of the patients who responded gave the highest rating (Always) to that statement. This is a top box result. If only 25% had selected “Always,” this would be a bottom box result. If 26% to 74% had selected “Always,” this would be a middle box result. Healthcare organizations strive to achieve patient satisfaction responses ALL in the top box, or top 25%.

HCAHPS scores are also reported to Quality Net and therefore published on the Hospital Compare website for consumers to see.

HCAHPS Survey Results

The HCAHPS survey covers a core set of 27 questions in the categories below. Hospitals can customize the survey to add their own specific questions as well.

- Communication with nurses
- Communication with doctors
- Responsiveness of hospital staff
- Pain management
- Communication about medicines
- Discharge information
- Cleanliness of hospital environment
- Quietness of hospital environment
- Overall rating of hospital
- Willingness to recommend hospital

(HCAHPS, 2014)

HCAHPS = 27 questions in all

Medicare Claims and Administrative Data Measure Outcomes

Medicare claims data provides the information about:

- 30-day mortality
- 30-day readmissions
- Selected measures of safety and quality:
  - Patient Safety Indicators and Inpatient Quality Indicators identified by the Agency for Healthcare Research and Quality (AHRQ)
  - Hospital-Acquired Conditions (HACs) which CMS has identified as preventable adverse outcomes

Material protected by Copyright
Medicare Claims and Administrative Data Measure Outcomes

Specifically, the following information is reported:

30-day risk-standardized mortality measures
- Acute Myocardial Infarction
- Heart Failure
- Pneumonia

30-day risk-standardized readmission measures
- Acute Myocardial Infarction
- Heart Failure
- Pneumonia

AHRQ Patient Safety Indicators (PSIs)
- PSI 04 - Death among surgical inpatients with serious treatable complications
- PSI 06 - Iatrogenic pneumothorax
- PSI 11 - Postoperative respiratory failure
- PSI 12 - Postoperative PE or DVT
- PSI 14 - Postoperative wound dehiscence
- PSI 15 - Accidental puncture or laceration
- PSI Composite - Complication/patient safety for selected indicators

AHRQ Inpatient Quality Indicators (IQIs)
- IQI 11 - Abdominal aortic aneurysm (AAA) repair mortality
- IQI 19 - Hip fracture mortality rate
- IQI Composite #2 - Mortality for selected medical conditions

Hospital-Acquired Condition Measures (HACs)
- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Pressure ulcer stages III and IV
- Falls and trauma
- Vascular catheter-associated infection
- Catheter-associated urinary tract infection
- Manifestations of poor glycemic control

Exactly What is a HAC?
Material protected by Copyright

Hospital-Acquired Condition

Certain conditions acquired during hospitalization are defined as “Hospital-Acquired Conditions” (HACs). In order to meet the criteria, the condition must first be occurring in high volume and/or be costly. The condition must also result from the assignment of a case (or patient) to a more intensive DRG; one that has a higher reimbursement amount when present as a secondary diagnosis.

Finally, the condition could reasonably have been prevented through the application of evidence-based guidelines. For discharges occurring on or after October 1, 2008, IPPS hospitals do not receive the higher payment for cases when one of the selected conditions is acquired during hospitalization (i.e., was not present on admission).

The case is paid as though the secondary diagnosis is not present (CMS, 2013). In other words, CMS does not reimburse the cost of treating the HAC.

Core Measure Sets Measure the Clinical Process of Care

What is a Core Measure (Set)?

A Core Measure is an evidence-based, scientifically-researched standard of care which has been shown to result in improved clinical outcomes. Basically, by following the standards of a Core Measure, the right care is delivered every time, resulting in improved patient outcomes.

A Core Measure Set is the group of measures that comprises the evidence-based practices related to a single disease condition. For example, the Venous Thromboembolism Core Measure Set (VTE) contains 6 Core Measures:

- VTE-1 Venous Thromboembolism Prophylaxis
- VTE-2 Intensive Care Unit Venous Thromboembolism Prophylaxis
- VTE-3 Venous Thromboembolism Patients with Anticoagulation Overlap Therapy
- VTE-4 Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol or Nomogram
- VTE-5 Venous Thromboembolism Warfarin Therapy Discharge Instructions
- VTE-6 Hospital Acquired Potentially-Preventable Venous Thromboembolism

Hospitals collect data to address the standards of the Core Measures and report it to Quality Net as part of their IQR requirements. This data is published to the Hospital Compare website for consumer use.

Both TJC and CMS require reporting on Core Measure Sets. The reporting requirements of TJC and CMS vary somewhat in terms of what is mandated and which measures are included in the Core Measure Set. Reporting to TJC is required for Joint Commission accreditation. Reporting to CMS is required in order to receive reimbursement and incentive payments.

Core Measure Sets Measure the Clinical Process of Care

For 2015, TJC identifies 14 Core Measure Sets

http://www.jointcommission.org/core_measure_sets.aspx

Material protected by Copyright
• Surgical Care Improvement Project
• Heart Failure
• Hospital-Based Inpatient Psychiatric Services
• Emergency Department
• Children’s Asthma Care
• Perinatal Care
• Pneumonia Measures
• Acute Myocardial Infarction
• Hospital Outpatient Department
• Immunization
• Substance Use
• Tobacco Treatment
• Venous Thromboembolism
• Stroke

(TJC, 2014)

The complete listing of all Core Measures in each Core Measure Set is available in the form of the Specifications Manual for National Inpatient Hospital Quality Reporting Measures which can be downloaded at http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures.aspx.

Although reporting is not mandated on all Core Measures and all Core Measure Sets, it is important to remember that all Core Measures are evidence-based practices associated with favorable patient outcomes.

**Medicare Claims Data Measures Efficiency**

This measure evaluates the cost to Medicare of services performed by hospitals and other healthcare providers during an episode of illness as Medicare spending per beneficiary event.

**Nursing Implications**

**Core Measures**

Core measures require nursing intervention in many instances including documentation of admission status, assessments during hospitalization and discharge instruction. Documentation is critical especially when patient compliance may often be required to achieve the measure, e.g. influenza vaccination refused by patient.

Timeliness of certain orders and interventions and presence of specific medications in discharge prescriptions affect Core Measure performance. Nurses can proactively influence quick response times and obtain needed orders. Nurses’ work in discharge teaching not only directly addresses certain Core Measures, but also affects readmission and mortality results.
Nursing Implications

HCAHPS
In hospitals, nurses are the primary caregivers 24/7 for patients; therefore, impact on patient satisfaction overall is often directly related to the nursing care delivered. An entire section of the HCAHPS survey is dedicated to questions directly related to the patients’ perception of nursing care received while in the hospital. Many of the HCAHPS items relate to communication. The nurse is in a perfect position to facilitate communication – not only with patients and nursing staff, but with other disciplines as well.

Some HCAHPS items relate to communication about medications and discharge teaching. The nurse has the opportunity to provide information about medications and discharge expectations throughout the hospitalization. To validate the effectiveness of teaching, the nurse uses the teach back method, by asking the patient to state his understanding of the information the nurse has communicated.

HCAHPS measures the patient’s perception of pain management. Certainly the nurse assesses, intervenes, and follows up to evaluate response to pain relief approaches.

Some of the HCAHPS items relate to cleanliness and quietness of the patient care environment. Nurses’ communication with other team members can favorably impact the patient care environment.

Nursing Implications

HACs
Many hospital-acquired conditions are directly influenced by nursing care, such as progression of pressure ulcers that may develop with insufficient turning and repositioning and poor nutrition. Hospitals are no longer reimbursed for treating HACs. It is extremely important that if the condition is present upon admission that fact is well-documented as well as any incidents that occur during the hospitalization. Nurses impact HACs by:

- Adhering to practice bundles designed to prevent catheter associated urinary tract infection (CAUTI) and central line associated blood stream infection (CLABSI)
- Monitoring blood glucose, reporting results, and implementing protocols
- Following policy and procedure for administering blood and blood components
- Assessing fall risk and implementing fall precautions
- Paying careful attention to the procedure for sponge, sharps, and instrument counts in the OR setting

Test Yourself
What nursing responsibility is particularly important in relation to ALL of the Core Measure Sets?
A. Documentation
B. Infection prevention
C. Skin assessment
The correct answer is: A. Core measures require nursing intervention in many instances including documentation of admission status, assessments during hospitalization and discharge instruction. Documentation is critical especially when patient compliance may often be required to achieve the
measure, e.g. influenza vaccination is refused by the patient.

Summary

The ACA passed in 2010 is making substantial changes to the way that hospitals receive funds from CMS. Already, we are seeing reductions in reimbursements to help pay for the new incentive-based system that will help to improve quality outcomes. Financial incentives of the past that rewarded care providers based on volume of care instances are in serious decline and instead incentives are directed toward care that provides clear quality outcomes for patients.

The speed of change of the measurement criteria and weighting is rapid and hospitals must keep up with the changes or risk lower reimbursements and payments. Nurses, too, must stay abreast of the changes as the care that they are giving directly impacts reimbursements and incentive payments that hospitals receive, especially through Core Measures, HCAHPS, and indirectly through discharge teaching that may prevent readmission and increased costs of care.

If the ACA is successful in its mission, Americans will see results in critical measures:

- Healthcare costs will moderate or reduce as a percent of GDP
- Obesity rates and rates of other preventable health risks will decline resulting in lower rates of diabetes, hypertension, heart disease, cancer, and other illnesses
- Overall quality of patient care will improve

Conclusion

By studying this course you have learned about the progression of Value-Based Purchasing (VBP) over the near term and how VBP is influenced by nursing care and actions.

After completing the course, you have learned:

- Three reasons why it is important to make changes in America’s healthcare reimbursement programs
- Criteria by which hospitals are measured in order to achieve incentive payments
- Changes in the reimbursement and incentive payment program since its inception and changes projected for the future
- Three examples of how hospital reimbursements can be impacted by nurses and nursing care under the new payment structure

Online Resources

Keep up-to-date on value based purchasing through the following online resources:

- [http://www.ahrq.gov](http://www.ahrq.gov)
- [http://www.qualitynet.org](http://www.qualitynet.org)
References


Hospital Case Management Staff (2014). Look ahead to succeed under VBP Hospital Case Management, 22(7), pp. 92-93.


Disclaimer

This publication is intended solely for the educational use of healthcare professionals taking this course, for credit, from RN.com, in accordance with RN.com terms of use. It is designed to assist healthcare professionals, including nurses, in addressing many issues associated with healthcare. The guidance provided in this publication is general in nature, and is not designed to address any specific situation. As always, in assessing and responding to specific patient care situations, healthcare professionals must use their judgment, as well as follow the policies of their organization and any applicable law. This publication in no way absolves facilities of their responsibility for the appropriate orientation of healthcare professionals. Healthcare organizations using this publication as a part of their own orientation processes should review the contents of this publication to ensure
accuracy and compliance before using this publication. Healthcare providers, hospitals and facilities that use this publication agree to defend and indemnify, and shall hold RN.com, including its parent(s), subsidiaries, affiliates, officers/directors, and employees from liability resulting from the use of this publication. The contents of this publication may not be reproduced without written permission from RN.com.

Participants are advised that the accredited status of RN.com does not imply endorsement by the provider or ANCC of any products/therapeutics mentioned in this course. The information in the course is for educational purposes only. There is no “off label” usage of drugs or products discussed in this course.

You may find that both generic and trade names are used in courses produced by RN.com. The use of trade names does not indicate any preference of one trade named agent or company over another. Trade names are provided to enhance recognition of agents described in the course.

Note: All dosages given are for adults unless otherwise stated. The information on medications contained in this course is not meant to be prescriptive or all-encompassing. You are encouraged to consult with physicians and pharmacists about all medication issues for your patients.