Health Care Systems - A National Perspective

Erica Preston-Roedder, MSPH PhD
• Quality Overview
• Overview and discussion of CMS programs
  • Increasing transparency
  • Move from P4R to P4P
  • Expanding beyond the hospital
  • Expanding beyond CMS
  • Move to outcome measures
  • Accountability measures versus improvement measures
• NCQC’s statewide experience
Why healthcare quality?

US spends 16% of GDP on healthcare, but...

- More than 100,000 Americans get the wrong care and are injured as a result (IOM 1999)
- More than 1.5 million medication errors are made each year (IOM 2006)
- Americans receive appropriate, evidence-based care when they need it only 55 percent of the time (McGlynn 2003)
What is healthcare quality?

AHRQ: “doing the right thing for the right patient, at the right time, in the right way to achieve the best possible results.”

IOM: “safe, effective, patient-centered, timely, efficient and equitable.”
IHI’s Triple Aim for healthcare

IHI says: “includes both quality and patient satisfaction”
What is ‘quality’ in healthcare?

“Quality” in national discussions often refers to all aspects of the triple aim

• This is especially true around ‘quality measurement.’

• More quality measures are bringing in affordability

  • Ex: Medicare spending per beneficiary

  • Ex: Targeted NQF area for development
WHOSE quality?

Measures of hospital quality (VBP, HIQR, HCAHPS)
Measures of health plan quality (HEDIS)
Measures of physician quality (Physician value-based modifier)
Measures of quality at other sites of care (Nursing Home Quality, Am Surg, etc.)
Overview & Discussion of CMS Hospital Programs
Current CMS programs for hospitals

CMS mandated quality reporting from hospitals in 2003.

- RHQDAPU, now HIQR

Data from that program is used for three pay for performance hospital programs, beginning 2010:

- Hospital Value-Based Purchase (HVBP)
- Hospital Readmission Reductions Program
- HAC Reduction Program
HIQR overview

What is it?
• Over 60 quality measures collected from hospitals
• PLUS roughly 35 claims-based measure calculated by CMS

Why does it exist?
• Focuses national attention on known quality of care issues
• Public reporting places pressure on hospitals to improve
• Allowed CMS to build a pay-for-performance program
What kind of measures are included?

- Many process measures (AMI, HF, ED performance, PN, Stroke, Surgical Care, VTE, Perinatal Care)
- HCAHPS—patient satisfaction survey data
- Infection data
- Some structural measures
- Mortality measures
- Readmission measures
- Safety measures (ARHQ PSI, HACs)
- Cost measures
Patients who reported that their doctors "Always" communicated well

Why is this important?

Hide Graph

U.S. national death rate for heart attack patients = 15.2%
Hospital Value-Based Purchasing

- Authorized in 2010
- Structure changes each year
- Hospitals can make or lose money
FY 2014 Finalized Domains and Measures/Dimensions

13 Clinical Process of Care Measures

1. AMI-7a Fibrinolytic Therapy Received within 30 Minutes of Hospital Arrival
2. AMI-8 Primary PCI Received within 90 Minutes of Hospital Arrival
3. HF-1 Discharge Instructions
4. PN-3b Blood Cultures Performed in the ED Prior to Initial Antibiotic Received in Hospital
5. PN-6 Initial Antibiotic Selection for CAP in Immunocompetent Patient
6. SCIP-Inf-1 Prophylactic Antibiotic Received within One Hour Prior to Surgical Incision
7. SCIP-Inf-2 Prophylactic Antibiotic Selection for Surgical Patients
8. SCIP-Inf-3 Prophylactic Antibiotics Discontinued within 24 Hours After Surgery
9. SCIP-Inf-4 Cardiac Surgery Patients with Controlled 6 a.m. Postoperative Serum Glucose
10. SCIP-Inf-9 Postoperative Urinary Catheter Removal on Postoperative Day 1 or 2.
11. SCIP-Card-2 Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period
12. SCIP-VTE-1 Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered
13. SCIP-VTE-2 Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis within 24 Hours

Domain Weights

- Clinical Process of Care Domain (45%)
- Outcome Domain (25%)
- Patient Experience of Care Domain (30%)

8 Patient Experience of Care Dimensions

1. Nurse Communication
2. Doctor Communication
3. Hospital Staff Responsiveness
4. Pain Management
5. Medicine Communication
6. Hospital Cleanliness and Quietness
7. Discharge Information
8. Overall Hospital Rating

3 Mortality Measures

1. MORT-30-AMI Acute Myocardial Infarction (AMI) 30-day mortality rate
2. MORT-30-HF Heart Failure (HF) 30-day mortality rate
3. MORT-30-PN Pneumonia (PN) 30-day mortality rate

* Represents a new measure for the FY 2014 Program not in the FY 2013 Program.
How Will Hospitals Be Evaluated?
Achievement vs. Improvement

**Achievement Points:**
Awarded by comparing an individual hospital’s rates during the Performance Period with all hospitals’ rates from the Baseline Period
- Rate at or above the Benchmark: 10 points
- Rate less than the Achievement Threshold: 0 points
- Rate equal to or greater than the Achievement
- Threshold and less than the Benchmark: 1–10 points

**Improvement Points:**
Awarded by comparing a hospital’s rates during the Performance Period to that same hospital’s rates from the Baseline Period
- Rate at or above the Benchmark: 9 points
- Rate less than or equal to Baseline Period Rate: 0 points
- Rate between the Baseline Period Rate and the Benchmark: 0–9 points
Challenges…

- Does VBP reward hospitals for meaningful differences in care?
- For process measures, many measures are topped out
- Assigning weights to domains
Are these meaningful differences in care?

**AMI 30-Day Mortality Survival Rate**

**Threshold**
84.77%

**Outcome Domain:**
July 1, 2009 – June 30, 2010

**Benchmark**
86.73%
Mortality rates are tightly grouped

<table>
<thead>
<tr>
<th></th>
<th>AMI</th>
<th>Heart Failure</th>
<th>Pneumonia</th>
</tr>
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<tbody>
<tr>
<td>Maximum</td>
<td>21.0</td>
<td>17.9</td>
<td>24.5</td>
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<tr>
<td>90%</td>
<td>16.9</td>
<td>13.8</td>
<td>14.5</td>
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<tr>
<td>75%</td>
<td>16.1</td>
<td>12.7</td>
<td>13.1</td>
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<tr>
<td>Median (50%)</td>
<td>15.1</td>
<td>11.7</td>
<td>11.8</td>
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<tr>
<td>25%</td>
<td>14.2</td>
<td>10.7</td>
<td>10.7</td>
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<tr>
<td>10%</td>
<td>13.3</td>
<td>9.9</td>
<td>9.9</td>
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<tr>
<td>Minimum</td>
<td>9.4</td>
<td>6.4</td>
<td>6.5</td>
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<tr>
<td>Measure ID</td>
<td>Measure Description</td>
<td>Performance Standard (Achievement Threshold)</td>
<td>Benchmark</td>
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<td>------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------</td>
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<tr>
<td>AMI-7a</td>
<td>Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival</td>
<td>0.6548</td>
<td>0.9191</td>
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<tr>
<td>AMI-8a</td>
<td>Primary Percutaneous Coronary Intervention (PCI) Received Within 90 Minutes of Hospital Arrival</td>
<td>0.9186</td>
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<tr>
<td>HF-1</td>
<td>Discharge Instructions</td>
<td>0.9077</td>
<td>1.0</td>
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<tr>
<td>PN-3b</td>
<td>Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital</td>
<td>0.9643</td>
<td>1.0</td>
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<tr>
<td>PN-6</td>
<td>Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patient</td>
<td>0.9277</td>
<td>0.9958</td>
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<tr>
<td>SCIP-Inf-1</td>
<td>Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision</td>
<td>0.9735</td>
<td>0.9998</td>
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<tr>
<td>SCIP-Inf-2</td>
<td>Prophylactic Antibiotic Selection for Surgical Patients</td>
<td>0.9766</td>
<td>1.0</td>
</tr>
<tr>
<td>SCIP-Inf-3</td>
<td>Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time</td>
<td>0.9507</td>
<td>0.9968</td>
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<tr>
<td>SCIP-Inf-4</td>
<td>Cardiac Surgery Patients with Controlled 6:00 a.m. Postoperative Serum Glucose</td>
<td>0.9428</td>
<td>0.9963</td>
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<td>SCIP-VTE-1</td>
<td>Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered</td>
<td>0.9500</td>
<td>1.0</td>
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<tr>
<td>SCIP-VTE-2</td>
<td>Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery</td>
<td>0.9307</td>
<td>0.9985</td>
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<tr>
<td>SCIP-Card-2</td>
<td>Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period.</td>
<td>0.9399</td>
<td>1.0</td>
</tr>
</tbody>
</table>
How should domains be weighted?

- Should patient experience be worth 30%?
- Patients: We want more outcomes!
- (Some) hospitals: We can’t control outcomes!

<table>
<thead>
<tr>
<th>Measure Domain</th>
<th>FY 2013 Final</th>
<th>FY 2014 Final</th>
<th>FY 2015 Final</th>
<th>FY 2016 Proposed</th>
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<tr>
<td>Process</td>
<td>70%</td>
<td>45%</td>
<td>20%</td>
<td>10%</td>
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<tr>
<td>Patient Experience</td>
<td>30%</td>
<td>30%</td>
<td>30%</td>
<td>25%</td>
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<tr>
<td>Outcomes</td>
<td>0%</td>
<td>25%</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td>Efficiency</td>
<td>0%</td>
<td>0%</td>
<td>20%</td>
<td>25%</td>
</tr>
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</table>
Readmissions Reduction Program

• Why readmissions?
• What is it? Readmissions penalty of up to 3% (FY 2015) for having readmissions in excess of expected values.

• Challenges:
  • Based on old data (e.g., FY 2013 based on Jul 2008-Jun 2011)
  • How much of readmission is in hospital control, e.g. PCP behavior and patient behavior?
  • Disproportionate penalty on hospitals serving disadvantaged?
HAC Reduction Program

- Penalizes hospitals in bottom 25th percentile on various quality measures (HACs, infections) with 1% payment cut

- Challenges
  - Discourages active surveillance
Major Themes in Quality Reporting
Themes…

1. Accountability measures versus improvement measures
2. Increasing transparency
3. Move from P4R to P4P
4. Expanding beyond the hospital
5. Expanding beyond CMS
6. Patient perspective in quality measurement
7. Proliferation of quality measures
8. Has there been progress?
“Currently, there is a great deal of pressure for public accountability of health care organizations, especially for managed care plans and even for medical groups and individual clinicians. Purchasers, legislators, and consumer advocates are all calling for public disclosure of patient satisfaction and other health care outcomes, on the theory that the comparative information will be used in choosing providers and thereby will force attention to quality issues…”
...Although accountability measures may identify areas and organizations that need improvement, **these results are necessarily so far downstream that they are rarely of much help to the process of improving the delivery of health care.** Knowing for example, that your health plan or medical group has, for example, below-average rates of providing mammograms* does not tell you anything useful about **why that is so** or **where to begin efforts to change that rate.**"

Solberg, Mosser & McDonald (1997)
Examples of Measures for Accountability

Accountability Measure: Measure used for public reporting, used for payment, or used in some other way to ‘hold the organization accountable’ for quality.

Examples:
HIQR: CMS Hospital Compare
Value-based purchasing
Measuring for accountability versus improvement

<table>
<thead>
<tr>
<th>Accountability</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmissions Excess readmit ratio</td>
<td>% of patients seen by PCP within 7 days of discharge</td>
</tr>
<tr>
<td>CAUTI infection rate</td>
<td>% of patients whose catheter is daily reviewed for necessity</td>
</tr>
<tr>
<td>30-day HF mortality ratio</td>
<td>% of patients with a scale at home</td>
</tr>
</tbody>
</table>
Themes...

1. Accountability measures versus improvement measures
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Transparency has increased over time

Mid-1980s to 1990s:
- Mid-1980’s HCFA (now CMS) publishes hospital-specific mortality data
- State efforts in 1990s
- AHRQ’s development of CAHPS

Late 1990’s/early 2000s:
- Compare websites, 2000 NQF starts, To Err is Human (1999), TJC uses Perf. Measurement, Leapfrog

2010 and beyond:
- Plans to roll out transparent reporting of physician quality measures on CMS Physician Compare
Themes…

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Move from P4R to P4P

- Recent proliferation of pay for performance programs at CMS
- Pay for performance programs are increasing in size, i.e. constitute a larger part of hospitals’ budgets each year

![Percent of Medicare Payment At Risk In Quality](chart)

<table>
<thead>
<tr>
<th>Year</th>
<th>Medicare Payment At Risk In Quality</th>
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<tbody>
<tr>
<td>FY 2013</td>
<td>2%</td>
</tr>
<tr>
<td>FY 2014</td>
<td>3%</td>
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<tr>
<td>FY 2015</td>
<td>5%</td>
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<tr>
<td>FY 2016</td>
<td>6%</td>
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<tr>
<td>FY 2017</td>
<td>7%</td>
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Themes...

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Expanding Beyond the Hospital

Physician quality reporting... moving to P4R Non-hospital facilities?

- Outpatient settings
- Ambulatory surgery
- Long-term care hospitals
- Inpatient psychiatric facilities
- End-stage renal disease facility
- PPS-Exempt cancer hospitals
Examples of P4P outside the hospital...

- Physician value-based modifier begins CY 2015.
  - CY 2015 starts with groups of 100+ EP practitioners
  - Future expansion to smaller groups of physicians
    (10+ EPs in CY 2016, all physicians CY 2017)
- VBP for SNFs required by ACA
Themes…

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Expanding beyond CMS…

BCBSNC
• Quality indicators included in contract negotiations
• ‘Tiers’ hospitals based (in part) on quality of care indicators

NC Medicaid
• Quality measurement as part of ACO models?
• 3% Medicaid ‘shared savings’ (including quality measures) passed last year
Themes…

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Bringing the patient perspective to quality measures

What do patients care about?
• “Where should I go for my hip surgery?”

Patient-reported outcomes (PROs), e.g. quality of life after depression treatment

How do we measure patient-family centered care?
Constant challenge of presenting info in a patient-friendly way
Do we have the right measures in the pipeline for patients?

Exhibit 1. NQF-endorsed Quality Measure Growth by Type, 2005-2010

NQF-endorsed measures over time

Source: Data provided by National Quality Forum, March 2012
Themes...

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Proliferation of measures!

• Too many measures! (Or too few…?)
• Burden of data collection
• Hospitals feel pulled in many directions at once
• More measures = less patient-friendly
• Efforts to harmonize are sometimes successful, but subject to special interests
Themes…

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Has there been progress?

Aggregate Optimal Care Trends for N.C. Hospitals

Optimal Care measures derived from the CMS/HQA Hospital Inpatient Process Measures.

Pneumonia: The optimal care score does not include influenza vaccination during Q2 and Q3 (non flu season).

Heart Attack: Statin at Discharge was an added 8th measure beginning with Jan 2011 discharges.

Data Source: The Carolinas Center for Medical Excellence
It is harder to show change in outcomes...

FIGURE A.1.1. Trend in the Median Hospital’s One-Year RSMR for AMI, Heart Failure, and Pneumonia, July 2009 – June 2012.
FIGURE A.1.3. Trend in the Median Hospital’s One-Year RSRR for AMI, Heart Failure, Pneumonia, and Hip/Knee Arthroplasty, July 2009 – June 2012.
NCQC state experience
North Carolina Quality Center (NCQC)

Vision
North Carolina delivers the best healthcare

Mission
The North Carolina Quality Center partners with providers and communities on their improvement journey to provide safe, quality healthcare

Values
Leadership, collaboration, integrity, transparency, patient-centered, excellence and responsiveness
How do we do our work?

Educational learning programs
Collaborative learning programs
Partnership for Patients Hospital Engagement Network
Patient Safety Organization
Analysis & transparent publication of quality and patient safety data
### Vidant Medical Center dashboard

<table>
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<tr>
<th>HCAHPS Patient Perceptions Survey</th>
<th>4/12-3/13</th>
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<tbody>
<tr>
<td>Rate 9 or 10 Overall</td>
<td>75.0%</td>
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<tr>
<td>Always Clean and Quiet</td>
<td>65.5%</td>
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<th>Conditions</th>
<th>Optimal Care Score</th>
<th>Mortality Rate</th>
<th>Readmission Rate</th>
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<td>1/13-6/13</td>
<td>7/09-6/12</td>
<td>7/09-6/12</td>
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<tr>
<td>Heart Attack (HA) (^a)</td>
<td>99.8%</td>
<td>13.5%</td>
<td>19.2%</td>
</tr>
<tr>
<td>Heart Failure (HF) (^a)</td>
<td>97.6%</td>
<td>12.9%</td>
<td>23.7%</td>
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<tr>
<td>Pneumonia (PN)</td>
<td>96.1%</td>
<td>12.2%</td>
<td>18.6%</td>
</tr>
<tr>
<td>Surgical Care (SCIP10)</td>
<td>99.6%</td>
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Color Coding:
- Top Quartile
- 2nd Quartile
- 3rd Quartile
- Lowest Quartile
- No Data
Recent successes - EED

JC PC-01: Early Elective Deliveries (NC Hospitals)

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<td>1.9%</td>
<td>1.0%</td>
<td>1.3%</td>
<td>0.9%</td>
<td>1.3%</td>
<td>1.7%</td>
<td>1.1%</td>
<td>1.1%</td>
<td>1.0%</td>
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<td>1.0%</td>
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<td>PforP Goal</td>
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<td>77</td>
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Recent successes - CLABSI

### CLABSI Standardized Infection Ratio (NC Hospitals)

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<tr>
<th>Year</th>
<th>Measure</th>
<th>PforP Goal</th>
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<tbody>
<tr>
<td>2010 Q3/Q4</td>
<td>0.74</td>
<td>0.46</td>
</tr>
<tr>
<td>Jan-11</td>
<td>0.55</td>
<td>0.46</td>
</tr>
<tr>
<td>Apr-11</td>
<td>0.57</td>
<td>0.46</td>
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<tr>
<td>Jul-11</td>
<td>0.45</td>
<td>0.46</td>
</tr>
<tr>
<td>Oct-11</td>
<td>0.60</td>
<td>0.46</td>
</tr>
<tr>
<td>Jan-12</td>
<td>0.42</td>
<td>0.46</td>
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<tr>
<td>Apr-12</td>
<td>0.58</td>
<td>0.46</td>
</tr>
<tr>
<td>Jul-12</td>
<td>0.46</td>
<td>0.46</td>
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<tr>
<td>Oct-12</td>
<td>0.52</td>
<td>0.46</td>
</tr>
<tr>
<td>Jan-13</td>
<td>0.54</td>
<td>0.46</td>
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<tr>
<td>Apr-13</td>
<td>0.49</td>
<td>0.46</td>
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<tr>
<td>Jul-13</td>
<td>0.49</td>
<td>0.46</td>
</tr>
<tr>
<td>Oct-13</td>
<td>0.47</td>
<td>0.46</td>
</tr>
<tr>
<td>Jan-14</td>
<td>0.50</td>
<td>0.46</td>
</tr>
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| # Hospitals | 69   | 90 | 91 | 89 | 88 | 92 | 92 | 94 | 94 | 94 | 92 | 91 | 92 | 68 |
Harness the power of networks
Transparency is a key leverage point
The HOW takes real training/knowledge
Large-scale policy levers = more interest in our programs (both by senior leaders & staff)
• Large-scale policy levers sometimes make it hard to encourage interest in other important areas.
How do you keep ‘quality’ from being seen as neither ‘regulatory box-checking’ nor a payment program… as the core work of providing patient care?
Takeaways

• Quality data includes process, outcome, patient satisfaction
• Data used for pay-for-performance programs: HVBP, Readmissions Reduction, HAC reduction
• Quality expanding—more transparency, more settings, more P4P, more measures, more patient-centered.
• Quality can be improved by encouraging sharing best practices across stakeholders and transparently sharing data.