Evidence Based Practice to Value Based Purchasing

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Building Bridges
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Why this topic?

Value based Purchasing is here and not going away. It will grow by leaps and bounds.

The greatest impact on Healthcare is yet to come.

Is value based purchasing based on evidence based practice?

Where is research in VBP?
Objectives for this session

At the end of this session the participant will be able to;
1. State an understanding of Healthcare reform as it relates to Value Based Purchasing (VBP)

2. State how Evidence Based Practice (EBP) is being used to drive Value based Purchasing….or is it?

3. State an understanding of the different roles in organizational success related to VBP

4. Understand the need for research related to this approach.
Value Based Purchasing?

• On January 7, 2011, the Centers for Medicare & Medicaid Services (CMS) released a proposed rule to implement a hospital value-based purchasing (VBP) program as mandated by the Affordable Care Act (ACA).

• The program applies to payments for discharges occurring on or after October 1, 2012. It impacts Federal Fiscal Year payments. The Federal Fiscal year is October through September.
Value-Based Purchasing Program

• Acute care hospitals’ performance on measures of clinical care and measures of patient satisfaction determines how the government distributes dollars.

• The money will be a reward to hospitals for the quality of the care they provide to Medicare beneficiaries.

• The total performance score for a hospital will be based on its achievement or improvement score for each measure of the clinical process of care, achievement or improvement score for each dimension in the measure of the patient-rated experience of care, and the consistency score within the measure on patients’ experience.

www.cms.gov/hospital-value-based-purchasing
### Value-Based Purchasing Timeline

#### Implement VBP for Inpatient Acute Care Hospitals

**FY 2013 VBP Timeline**

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline period begins</td>
<td>July 1, 2009</td>
</tr>
<tr>
<td>Baseline period ends</td>
<td>March 31, 2010</td>
</tr>
<tr>
<td>CMS announces performance standards</td>
<td>April 29, 2011</td>
</tr>
<tr>
<td>Performance period begins</td>
<td>July 1, 2011</td>
</tr>
<tr>
<td>Performance period ends</td>
<td>March 31, 2012</td>
</tr>
<tr>
<td>CMS notifies hospitals of estimated scores</td>
<td>Aug. 2, 2012</td>
</tr>
<tr>
<td>VBP program begins</td>
<td>Oct. 1, 2012</td>
</tr>
<tr>
<td>CMS notifies hospitals of actual scores</td>
<td>Nov. 1, 2012</td>
</tr>
</tbody>
</table>
Value-Based Purchasing Program

- Funding for the program will be generated by reducing base operating DRG payments by 1 percent began in FY 2013.
- All hospitals will have a reduction in the base payment rate for all DRGs to fund the incentive pool.
- The payment reductions will occur irrespective of whether or not a hospital receives an incentive payment.
- The schedule for the reductions is as follows:
  - FY 2013 (1 percent),
  - FY 2014 (1.25 percent),
  - FY 2015 (1.5 percent),
  - FY 2016 (1.75 percent) and
  - FY 2017 and beyond (2 percent).
## Value-Based Purchasing

<table>
<thead>
<tr>
<th>Domain</th>
<th>FY 2013 Weighting</th>
<th>FY 2014 Weighting</th>
<th>FY 2015 Weighting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Process of Care</td>
<td>70%</td>
<td>45%</td>
<td>20%</td>
</tr>
<tr>
<td>Patient Experience of Care</td>
<td>30%</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Outcome</td>
<td>(N/A)</td>
<td>25%</td>
<td>30%</td>
</tr>
<tr>
<td>Efficiency</td>
<td>(N/A)</td>
<td>(N/A)</td>
<td>20%</td>
</tr>
</tbody>
</table>
Timeline

- FY 13 Performance Period is done
- FY 14 Performance Period is done
- FY 15 is currently in Performance Period
## FY 2015 Proposed Performance Periods and Baseline Periods for VBP Program

<table>
<thead>
<tr>
<th>Domain</th>
<th>Measure</th>
<th>Performance period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Process of Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CLABSI</td>
<td>Jan 26, 2013 – Dec 31, 2013</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Medicare Spending Per Beneficiary</td>
<td>May 1, 2013 – Dec 31, 2013</td>
</tr>
</tbody>
</table>
Overview of VBP
Domain Scoring for Clinical care Process and HCAHPS

• Each measure or dimension has a benchmark, which is the mean of the performance of the top 10% of hospitals for that measure or dimension during the baseline period.
Overview of Scoring Methodology

**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
Overview of Scoring Methodology

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
EBP to VBP?

• The current 12 Clinical Process measures are all related to EBP
• Indicators that are part of the AHRQ PSI 90 composite measure are related to EBP
• CLABSI is related to EVB
• Mortality is and is not related to EBP
• Efficiency is and is not related to EBP
• HCAHPS results can be related to EBP
Clinical Process of Care Domain

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

- AMI - Fibrinolytic within 30 min
- AMI - PCI in 90 min of arrival
- HF - Discharge instructions
- PN - Blood Cultures in ED prior to initial antibx
- Antibx selection

- SCIP - timing
- SCIP - selection
- SCIP - discontinuation
- SCIP - post-op glucose cardiac patients
- SCIP - Beta Blocker
- SCIP - VTE ordered
- SCIP - VTE prophylaxis provided
Mortality

Outcome Measures

• Acute Myocardial Infarction (AMI)
• Heart Failure
• Pneumonia (PN)
• “…the 30-day mortality measures
• assess deaths that occur within 30 days after admission.”
Outcome Domain

Agency for Healthcare Research and Quality (AHRQ)

Patient Safety Indicator

Composite Measure
AHRQ PSI-90

Patient Safety indicators
• Pressure Ulcer
• Iatrogenic Pneumothorax
• Central Venous Catheter-related Bloodstream Infections
• Post-op Hip Fracture
• Post-op Hemorrhage or Hematoma

Patient Safety Indicators
• Post-op Physiologic and Metabolic Derangements
• Post-op respiratory Failure
• Post-op PE or DVT
• Post-op Sepsis
• Post-op Wound Dehiscence
• Accidental Puncture or Laceration

http://www.qualityindicators.ahrq.gov
Outcomes Domain

- Catheter Associated Blood Stream Infections (CLABSI)
• For CLABSI, the standardized infection ratio (SIR) will be used and for Medicare Spending per Beneficiary, the minimum is 25 cases.

• National Health Safety Network (NHSN) is the source for this data.
CLABSI

• To its credit, CMS responded to the recommendations of experts in the field (see SHEA FY 2011 IPPS Comments June 2010) and based the rule upon reporting to the CDC National Healthcare Safety Network (NHSN). This system uses a set of standardized definitions across all acute care settings and data is collected by individuals trained in infection prevention and control.
Efficiency Measure

• Medicare Spending per Beneficiary (MSPB) Episode – captures total Medicare spending per beneficiary, relative to a hospital stay, bundling hospital services (Part A) with post-acute care (Part B). It bundles the cost of care delivered to a beneficiary for an episode of care across the continuum.
HCAHPS - Hospital Consumer Assessment of Health Providers and Systems

- A government survey for measuring patient satisfaction at hospitals across the country
- The categories focus on communication with doctors and nurses, responsiveness of hospital staff, pain management, cleanliness and quietness of the hospital environment, and instructions about medications and discharge.
- EVP as part of the patient experience for front line staff? Rounding, Bedside Verbal Reports...etc.
- Does the APN have a role in the Patient experience?..... How can you assist the front line RNs with HACAHPS outcomes?......
HCAHPS

Patient Experience %

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

Patient Care Domain

- 1. Communication with RN
- 2. Communication with MD
- 3. Responsiveness of Staff
- 4. Pain Management
- 5. Communication about Medicines
- 6. Cleanliness and Quietness of Hospital Environment
- 7. Discharge Information
- 8. Overall Rating of Hospital
## HCAHPS Measure Highlights

<table>
<thead>
<tr>
<th>Composite measure</th>
<th>Patient Experience of Care Measures (HCAHPS) for VBP Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Communication with nurses (40% “Always”)</td>
</tr>
<tr>
<td>2</td>
<td>Doctor communication (40% “Always”)</td>
</tr>
<tr>
<td>3</td>
<td>Cleanliness and quietness (40% “Always”)</td>
</tr>
<tr>
<td>4</td>
<td>Responsiveness of hospital staff (40% “Always”)</td>
</tr>
<tr>
<td>5</td>
<td>Pain management (40% “Always”)</td>
</tr>
<tr>
<td>6</td>
<td>Communication about medications (40% “Always”)</td>
</tr>
<tr>
<td>7</td>
<td>Discharge information (40% “Yes”)</td>
</tr>
<tr>
<td>8</td>
<td>Overall hospital rating (40% “9 or 10”)</td>
</tr>
</tbody>
</table>

### Composite Measures:
- **Communication with nurses**
  - Nurse-Courtesy/Respect
  - Nurse-Listen
  - Nurse-Explain

- **Doctor communication**
  - Doctor-Courtesy/Respect
  - Doctor-Listen
  - Doctor-Explain

- **Cleanliness and quietness**
  - Cleanliness
  - Quietness

- **Responsiveness of hospital staff**
  - Bathroom Help
  - Call Button

- **Pain management**
  - Pain Control
  - Help with Pain

- **Communication about medications**
  - New Medicine-Reason
  - New Medicine-Side Effects

- **Discharge information**
  - Discharge-Help
  - Discharge-Systems

- **Overall hospital rating**
  - Overall Rating
What is Medicare doing to improve the quality of care in hospitals?

Through the Hospital Value-Based Purchasing Program, CMS is changing the way it pays hospitals, rewarding hospitals for the quality of care they provide to Medicare patients, not just the quantity of procedures they perform. Hospitals are rewarded based on how closely they follow best clinical practices and how well hospitals enhance patients’ experiences of care. When hospitals follow proven best practices, patients receive higher quality care and see better outcomes. Hospital VBP is just one initiative CMS is undertaking to improve the quality of care Medicare beneficiaries receive.
When hospitals follow proven best practices, patients receive higher quality care and see better outcomes.

- NQF-endorsed consensus standards for nursing-sensitive care, including 15 evidence-based nursing-sensitive performance measures, a framework for measuring nursing-sensitive care, and related research recommendations.

- This is the first-ever set of national standardized performance measures to assess the extent to which nurses in acute care hospitals contribute to patient safety, healthcare quality, and a professional work environment.
NQF Nurse Sensitive Measures

- Death Among surgical patients with treatable serious complications
- Pressure Ulcer Prevalence
- Central Line catheter-associated blood stream infections
- Ventilator Associated Pneumonia in ICU
The 1996 IOM report *Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?* concluded that although nursing services are central to the provision of hospital care, “little empirical evidence is available to support the anecdotal and other informal information that hospital quality of care is being adversely affected by hospital restructuring and changes in [nurse] staffing patterns.”

Since then…..

Since that report, and in part in response to it, the number of studies examining the association of staffing and quality in hospitals has exploded. Major studies demonstrating the association of nurse staffing and patient outcomes, including lengths-of-stay, mortality, pressure ulcers, deep vein thromboses, and hospital-acquired pneumonia have been published in first-tier journals, and several major literature reviews, syntheses, and meta-analyses have been published confirming the association of nurse staffing with patient outcomes.

More support….

When the IOM revisited the issue of nurse staffing and patient care in 2004, it concluded: “Research is now beginning to document what physicians, patients, other health care providers, and nurses themselves have long known: how well we are cared for by nurses affects our health, and sometimes can be a matter of life or death.”

More Research…..

Research on these issues is continuing. Indeed, its scope has expanded through programs such as the Robert Wood Johnson Foundation (RWJF) Interdisciplinary Nursing Quality Research Initiative (INQRI), whose projects are examining how specific processes of care, such as care coordination, medication administration, or introduction of evidence-based protocols, are associated with nursing care and patient outcomes.
Despite this research, the nature of nurses’ work in hospitals is not well understood by the public or policymakers. In a recent survey, 88 percent of the public agreed that making sure there are enough nurses to monitor patient conditions, coordinate care, and educate patients should be a part of efforts to improve quality, but focus groups find that the public is confused about what nurses do, the kind of training they receive, and what distinguishes them from nurse aides and other less trained personnel.

And more......

The public understands that nurses’ work is physically and emotionally demanding but may view this work as delivering care as ordered and providing physical and emotional comfort to patients and their families. Nurses do far more, and the work entails both substantial intellectual and organizational competence.
Among the critical tasks carried out by nurses are:

1. ongoing monitoring and assessment of their patients and, as necessary, initiating interventions to address complications or reduce risk;
2. coordinating care delivered by other providers;
3. educating patients and family members for discharge, which can reduce the risk of post-hospital complications and readmission.
Cost of Nursing?

Much work has examined the association of nursing and quality; less has examined nursing’s impact on costs. A number of studies have assessed whether there is a business case for increasing nurse staffing in hospitals—that is, whether simply increasing staffing would pay for itself in reduced complications and lengths-of-stay. One key finding of this work is that improving nurse staffing does not completely pay for itself, although recent efforts to reduce hospital payment for poor quality may change this conclusion.

Nurses develop substantial knowledge of the strengths and weaknesses of hospital systems and how they fail. Their ability to create workarounds to broken or dysfunctional systems is legendary in health care. As hospitals focus on increasing safety and reliability, patient-centeredness, and efficiency, nurses’ knowledge and commitment to their patients and institutions needs to be effectively mobilized.

P.R. Ebright et al., “Understanding the Complexity of Registered Nurse Work in Acute Care Settings,” Journal of Nursing Administration 33, no. 12
Role of front line nurses

To accomplish this, nurses’ perspectives must be represented at the highest levels of hospital leadership and integrated into hospital decision making.

In addition, consistent with process-improvement research that identifies the active involvement of front-line staff as a critical factor in making and sustaining change, processes for engaging nurses and other front-line staff also need to be expanded.
Role of front line nurses

• Everything we have spoken about is captured by documentation and the bulk of it nursing documentation

• It is about the care provided and the complete and accurate documentation of that care.

• In the end it is only measurable if it is documented.

• Front line staff put hands on care first and now we are dependent on them documenting it all accurately.
The role of the APN in VBP

• Opportunity exists for the APN in hands on care and education of patients and staff.
• Leadership of key nurse sensitive outcome teams; CAUTI, CLABSI, Skin Care, VAP
• Leadership of core measure teams; AMI, PN, HF, SCIP, CVA
• Voice of the front line staff in leadership
• Drive, promote, facilitate…NURSING RESEARCH!
It is not just VBP……

Upcoming Penalties Will Greatly Increase Your Revenue at Risk

Hospital Medicare Payment at Risk, Year by Year

<table>
<thead>
<tr>
<th>Year</th>
<th>Value-Based Purchasing</th>
<th>30-Day Readmissions</th>
<th>Hospital-Acquired Conditions</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>1%</td>
<td>1%</td>
<td></td>
<td>2%</td>
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<tr>
<td>2011</td>
<td>2%</td>
<td>2%</td>
<td></td>
<td>3%</td>
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<tr>
<td>2012</td>
<td></td>
<td>3%</td>
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<td>6%</td>
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<td>2013</td>
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<td>2014</td>
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<td>2019</td>
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<tr>
<td>2020</td>
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## Hospital Readmission Reduction Program Timeline

**Implement HRRP for Inpatient Acute Care Hospitals**

### FY 2013 HRRP Timeline

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</thead>
<tbody>
<tr>
<td>Performance period begins</td>
<td>Performance period ends</td>
<td>Hospitals receive hospital specific reports and discharge level data with results for the FY 2013 program</td>
<td>Deadline for hospitals to notify CMS of any concerns about their excess readmission ratio calculation</td>
<td>CMS publishes excess readmission ratio results in FY 2013 IPPS Final Rule</td>
<td>HRRP program begins; FY 2013 readmission adjustment goes into effect</td>
<td>CMS reports FY 2013 excess readmission ratio results on Hospital Compare</td>
</tr>
</tbody>
</table>
Hospital Readmission Reduction Program (HRRP)

- CMS is implementing a Readmissions Reduction Program beginning in FY 2013.
- The program will penalize acute care hospitals with higher than expected risk-adjusted readmission rates for heart failure, acute myocardial infarction, and/or pneumonia patients who are readmitted to any hospital within 30 days of discharge.
- Positive performance in one of the three conditions does not mitigate negative in another.
- All Wheaton markets currently have initiatives underway to reduce readmissions.
- Analysis has been completed to assess the impact of the penalties that CMS will implement in FY13 for hospitals with high readmission rates.
WHY readmissions?

The final rule also finalizes the methodology and payment adjustment factors to account for excess hospital readmissions for three conditions: heart attack, heart failure and pneumonia. CMS estimates that the readmissions program will result in an approximately $280 million decrease -- .3 percent -- in overall hospital payments.
Hospital Readmission Reduction Program (HRRP)

- Hospitals will receive reduced Medicare payments starting in FY 2013 capped at a maximum of 1% of inpatient payments.
- In FY 2014 the largest potential reduction for a hospital would be 2 percent and 3 percent in FY 2015 and beyond.
- This reduction will apply to all Medicare discharges.
Hospital Acquired Conditions (HACs)

- The HAC provision, together with Present On Admission (POA) indicator reporting, are two hospital-related VBP initiatives that CMS is using to promote increased quality and efficiency of care.
- For discharges occurring on or after October 1, 2008, Inpatient Prospective Payment System (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.
- Per CMS definition, a HAC must meet the following conditions:
  - high cost, high volume, or both;
  - is assigned to a higher-paying MS-DRG when present as a secondary diagnosis; and
  - could reasonably have been prevented through the application of evidence-based guidelines.
Hospital Acquired Conditions (HACs)

The 10 categories of HACs include:

• Foreign Object Retained After Surgery
• Air Embolism
• Blood Incompatibility
• Stage III and IV Pressure Ulcers
• Falls and Trauma
• Manifestations of Poor Glycemic Control
• Catheter-Associated Urinary Tract Infection (UTI)
• Vascular Catheter-Associated Infection
• Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG):
  • Surgical Site Infection Following Bariatric Surgery for Obesity
  • Surgical Site Infection Following Certain Orthopedic Procedures
• Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures:
Hospital-Wide Readmission Rates

- CMS recently added a *Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)* to the Inpatient Quality Reporting (IQR) program.
- CMS recently produced a dry run of this measure on September 4th, 2012.
- Beginning in late 2013, this measure will be publicly reported on the *Hospital Compare* website as part of the Inpatient Quality Reporting (IQR) Program.
  - The *baseline period* is January – December 2010.
  - The *performance period* will be January 1, 2013 – December 31, 2013.
- This measure *may* be used for payment determinations in FY 2015 for either the VBP program *or* the Hospital Readmission Reduction program.
Hospital-Wide Readmission Rates

Data source
• The measure is based on administrative claims data.

Measure population
• The measure includes Medicare Fee-for-Service beneficiaries aged 65 years and older who were discharged from the hospital during the 2010 calendar year.

Outcome
• This measure counts unplanned readmissions within 30 days of discharge for any condition. Readmissions that are scheduled as part of a patient’s plan of care are not included in this measure.

Risk adjustment
• The measure adjusts for differences in hospitals’ patient case mix, so that hospitals that treat older, sicker patients are on a “level playing field” with hospitals serving healthier patients. The measure also adjusts for service mix (discharge diagnosis category) to account for differences in the types of conditions and procedures cared for by hospitals.
Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Measures

- CMS added two outcome measures to the Inpatient Quality Reporting program:
  - Hospital-Level 30-Day All-Cause Risk-Standardized Readmission Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)
  - Hospital-Level Risk-Standardized Complication Rate Following Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)
- CMS recently produced a dry run of these measures on September 4th, 2012.
- Beginning in late 2013, these measures will be publicly reported on the Hospital Compare website as part of the Inpatient Quality Reporting (IQR) Program.
- The baseline period is January 2008 – December 2010.
- The performance period will be January 1, 2013 – December 31, 2013.
- These measures may be used for payment determinations in FY 2015 for either the VBP program or the Hospital Readmission Reduction program.
Meaningful Use

Meaningful use is the set of standards defined by the Centers for Medicare & Medicaid Services (CMS) Incentive Programs that governs the use of electronic health records and allows eligible providers and hospitals to earn incentive payments by meeting specific criteria.
## Physician Value-Based Payment Modifier (VM) Timeline

### Implement VM

### FY 2015 VM Timeline

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<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>CMS Finalizes VM Policies</td>
<td>CMS selects a PQRS reporting method</td>
<td>CMS releases 2012 Performance and how VM would apply based On 2012 data. Retrieve Physician Feedback</td>
<td>CMS determines “Quality Tiering” Calculation Approach for VM</td>
<td>Completed Submission of 2013 Information for PQRS</td>
<td>CMS releases 2013 Performance and how VM applies starting 1/1/2015</td>
<td>VM applies to payment for items and services provided by Physicians in groups of 25 or more eligible professionals</td>
</tr>
</tbody>
</table>
FY 16 Proposed VBP Domains

<table>
<thead>
<tr>
<th>Domain</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Care</td>
<td>TBD</td>
</tr>
<tr>
<td>Person and Caregiver Centered Experience &amp; Outcomes</td>
<td>TBD</td>
</tr>
<tr>
<td>Safety</td>
<td>TBD</td>
</tr>
<tr>
<td>Efficiency &amp; Cost Reduction</td>
<td>TBD</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>TBD</td>
</tr>
<tr>
<td>Community/Population Health</td>
<td>TBD</td>
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</tbody>
</table>
More Coming?

- Out Patient Measures, ED, radiology
- Global immunization measures
- ACC
- STS
- STROKE
VALUE BASED PURCHASING IS HERE TO STAY

Ideas on how to professionally react to this?
How can we get more research in the areas Nursing needs it?
Don’t we want to be the drivers of our practice as it relates to VBP….and Healthcare Reform?