

# Medicare Hospital Inpatient Value Based Purchasing Program

Presented by  
Joe Becht



# The Case for Change and Value Based Purchasing

# Health Care Reform

Why?

Where are we?

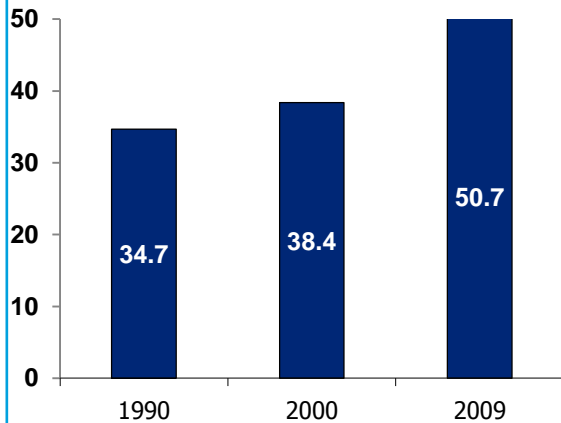
What is ahead?

# Health Care Reform

## Access

The number of Americans without health insurance coverage is high and climbing higher

The Uninsured in America  
1990-2009 (in millions)

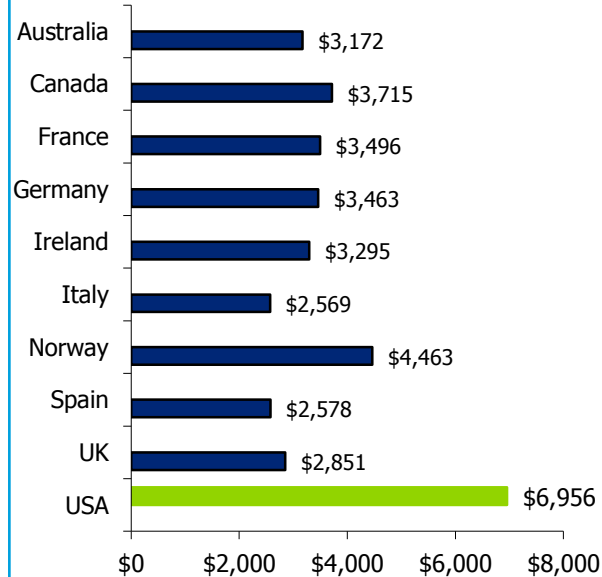


Source: data from U.S. Census Bureau

## Cost

The US spends significantly more per capita on health care than other industrialized nations

Health Care Spending Per Capita, 2007  
Comparison of 10 OECD Countries



Source: Organisation for Economic Co-operation and Development, OECD Health Data 2009

## Quality

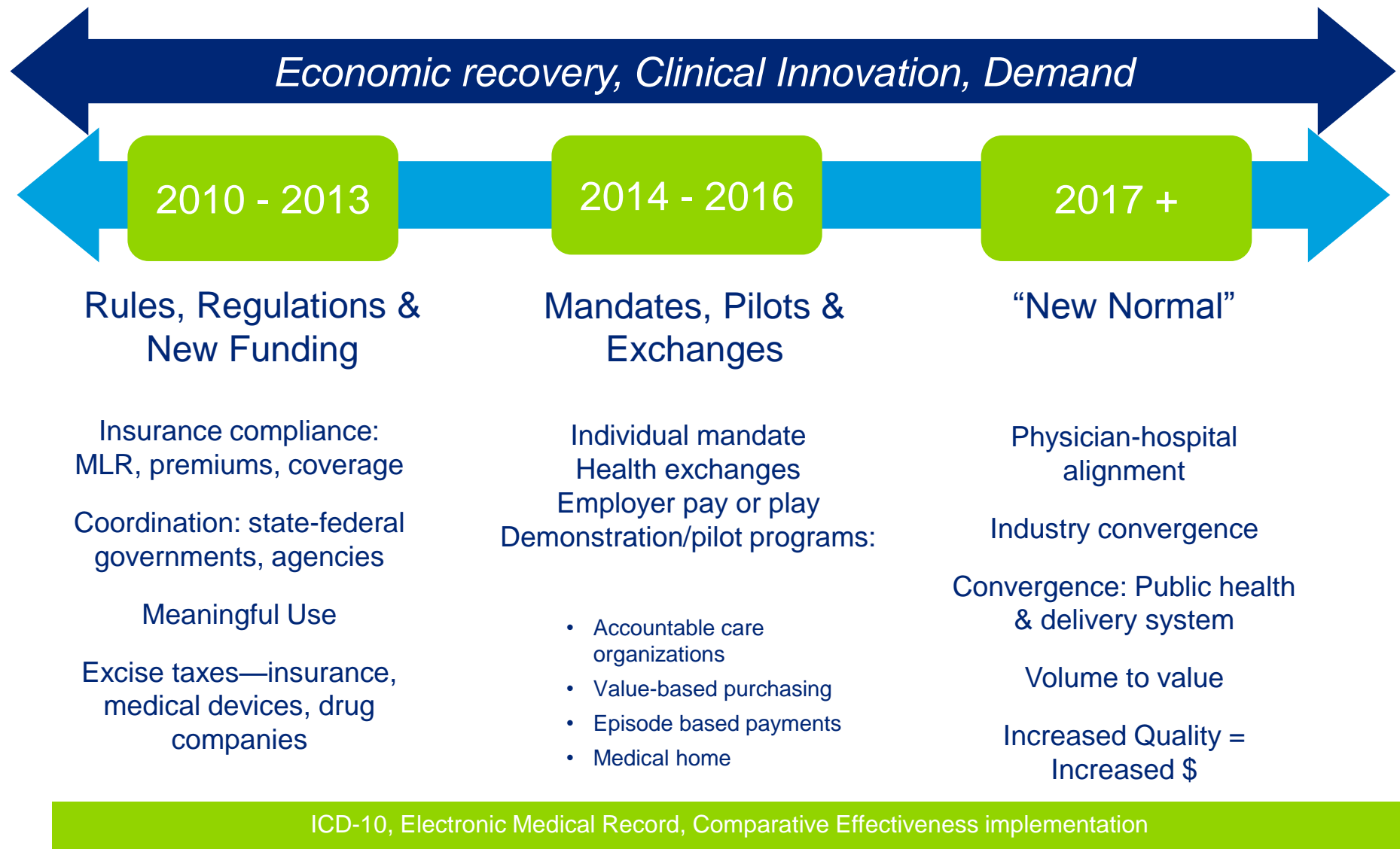
Despite higher US spending, our nation lags behind benchmark countries in measures of health care outcomes

Life Expectancy at Birth, 2004  
Comparison of 10 OECD Countries

	OECD Average	United States	US Ranking (out of 15 countries)
Health Care Expenditure % of GDP*	8.9%	16.0%	15th
Average Life Expectancy at Birth	79.1	78.1	14th
Public Financing % of Health Care	73.0%	45.4%	14th
Prevalence of Diabetes in Adults (aged 20-79)*	6.3%	10.3%	14th
Prevalence of Obesity		34.0%	14th
Rate of Caesarean Deliveries*	25%	31%	12th
# of Asthma Hospital Admission Rates per 100,000 (aged 15+)*	51	120	15th
# of Diabetes Complications Admission Rates per 100,000 (aged 15+)*	21	57	15th

Source: OECD Health Data 2006

# Health Care Reform



# Health Care Reform

## The “five big bets” in PPACA

- **Individual mandate:** Will the uninsured and newly eligible for Medicaid enroll? Will the insured increase by 32 million as targeted? Is risk spread appropriately?
  - **Employer exit:** Will employers drop health benefits after 2016 to facilitate direct consumer engagement and thereby reduce operating costs? Will their employees purchase through the exchanges, or go without? Is PPACA the road to employers exiting health insurance?
  - **State capabilities:** Will states be able to manage their expansion new responsibilities and obligations? Can states manage population-based health (Medicaid, CHIP, workers comp) & insurance risk effectively?
  - **Delivery system costs:** Will delivery system reforms-accountable care organizations, value-based purchasing, medical homes, bundled payments, comparative effectiveness – reduce costs over time?
  - **Quality:** Are Americans ready for limits based on cost and comparative effectiveness?
-

# What is Medicare Value Based Purchasing?

- In healthcare, value is viewed to be a function of quality, efficiency, safety, and costs.
- Under VBP, providers are held accountable for quality and cost of health care services they provide.
- There are rewards and consequences
- There are specific performance measures
- VBP is expected to reduce Medicare spending by approximately \$200B over the next 10 years

# Paying for Value

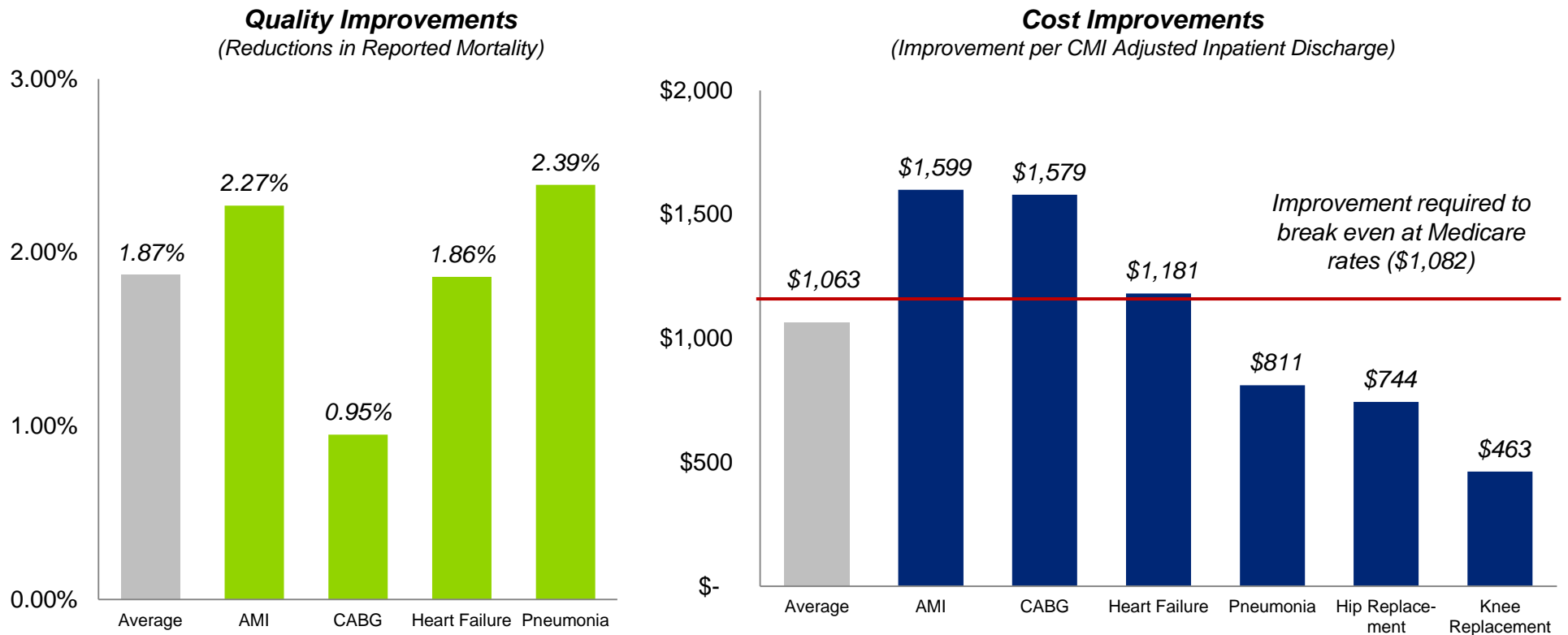
CMS' VBP Program is reflective of the shift in payment from transactional to outcome based

Program	CMS and Medicaid	Commercial
Pay for Performance	VBP -2% to +2%	Incentive basis "tiering" requirement for rate increases
HAC and Never Events	1% Reimbursement at Risk	Numerous programs by payer
Re-admissions	1% Reimbursement at Risk due to excessive re- admissions for pneumonia, heart failure, and heart attack	Numerous programs by payer
Global Prepayment	ACO's	Integrated payer/provider (Kaiser)

# The Value Proposition

Gains observed in Premier’s Hospital Quality Incentive Demonstration (HQID) project show the potential for providers who are able to push the “value frontier.”

## Reported Quality and Cost Improvements



If all hospitals in the nation were to achieve this improvement, the estimated cost savings would be greater than **\$4.5 billion annually** with estimated **70,000 lives saved per year**.

# CMS Will Begin Paying for Value

On April 29, 2011, CMS published the final regulations establishing the value-based purchasing (VBP) program for acute care hospitals paid under the Medicare Inpatient Prospective Payment System (IPPS), as required by PPACA Section 2013.

	FY2013
<b>Measures</b>	2 Domains: <ul style="list-style-type: none"> <li>▪ Process of Care (12 measures) – <i>70% weighted</i></li> <li>▪ Patient Experience (8 HCAHPS dimensions) – <i>30% weighted</i></li> </ul>
<b>Baseline Time Period</b>	July 1, 2009 to March 31, 2010*
<b>Performance Time Period</b>	July 1, 2011 to March 31, 2012*

**Total hospital VBP payments across all hospitals will be funded through a reduction in base operating diagnostic-related group (DRG) payments for each discharge, beginning at 1% in FY2013 and reaching 2% in FY2017.**

The overarching goal of VBP is to transform Medicare from a passive payer of claims to an active purchaser of quality health care for its beneficiaries

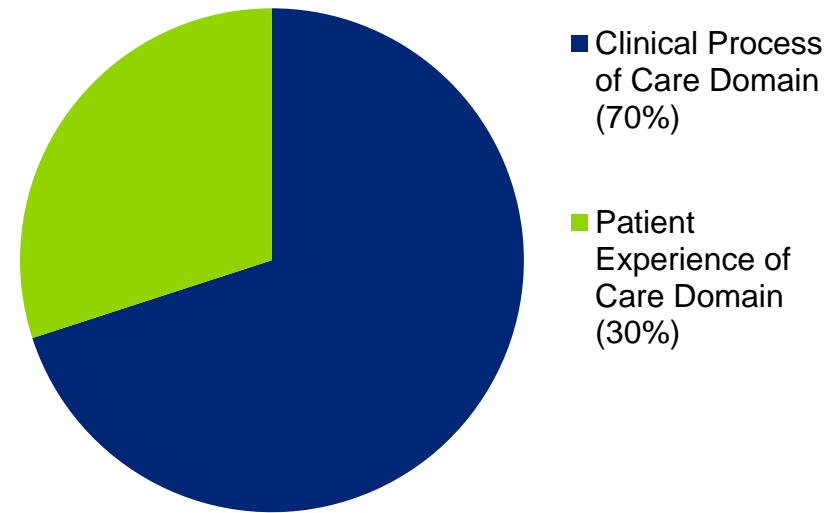
Plan to initially use ¾ of a year because CMS needs time to calculate total performance scores, value-based incentive payments, notify hospitals regarding their payment adjustments, and implement the payment adjustments.

# Final Hospital VBP Domains

## 12 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 6AM Postoperative Serum Glucose
10. SCIP-Card-2 Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period
11. SCIP-VTE-1 Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered
12. SCIP-VTE-2 Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis within 24 Hours

# Weighted Value of Each Domain



## 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 & Quietness
7. Discharge Information
8. Overall Hospital Rating

# Hospital Value-Based Purchasing: Measure Explanations

Measure Title	Brief Explanation
Percent of Heart Attack Patients Given Fibrinolytic Medication Within 30 Minutes Of Arrival	Blood clots can cause heart attacks. Doctors may give this medicine, or perform a procedure to open the blockage, and in some cases, may do both.
Percent of Heart Attack Patients Given PCI Within 90 Minutes Of Arrival	The procedures called Percutaneous Coronary Interventions (PCI) are among those that are the most effective for opening blocked blood vessels that cause heart attacks. Doctors may perform PCI, or give medicine to open the blockage, and in some cases, may do both.
Percent of Heart Failure Patients Given Discharge Instructions	The staff at the hospital should provide you with information to help you manage your heart failure symptoms when you are discharged.
Percent of Pneumonia Patients Whose Initial Emergency Room Blood Culture Was Performed Prior To The Administration Of The First Hospital Dose Of Antibiotics	A blood culture tells what kind of medicine will work best to treat your pneumonia.
Initial Antibiotic Selection for CAP in Immunocompetent Patient	Antibiotics are medicines that treat infection, and each one is different. Hospitals should choose the antibiotics that best treat the infection type for each pneumonia patient.
Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision	Getting an antibiotic within one hour before surgery reduces the risk of wound infections. This measure shows how often hospital staff make sure surgery patients get antibiotics at the right time.
Prophylactic Antibiotic Selection for Surgical Patients	Some antibiotics work better than others to prevent wound infections for certain types of surgery. This measure shows how often hospital staff make sure patients get the right kind of preventive antibiotic medication for their surgery.
Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	Taking preventive antibiotics for more than 24 hours after routine surgery is usually not necessary. This measure shows how often hospitals stopped giving antibiotics to surgery patients when they were no longer needed to prevent surgical infection.

# Hospital Value-Based Purchasing: Measure Explanations continued...

Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose	All heart surgery patients get their blood sugar checked after surgery. Any patient who has high blood sugar after heart surgery has a greater chance of getting an infection. This measure tells how often the blood sugar of heart surgery patients was kept under good control in the days right after their surgery.
Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period	Many people who have heart problems or are at risk for heart problems take drugs called beta blockers to reduce the risk of future heart problems. This measure shows whether surgery patients who were already taking beta blockers before coming to the hospital were given beta blockers during the time period just before and after their surgery.
Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered	Certain types of surgery can increase patients' risk of having blood clots after surgery. For these types of surgery, this measure tells how often treatment to help prevent blood clots was ordered by the doctor.
Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery	This measure tells how often patients having certain types of surgery received treatment to prevent blood clots in the period from 24 hours before surgery to 24 hours after surgery.

# Hospital Value-Based Purchasing: Measure Explanations continued...

<p>Patient Experience of Care</p>	<p>A random sample of patients discharged from hospitals across the country are surveyed and asked questions about their feelings and perceptions about their hospital stay. This measure combines hospital performance on questions that asked patients their levels of satisfaction with some of the following elements of their stay:</p> <ul style="list-style-type: none"><li>•How well nurses communicated with patients</li><li>•How well doctors communicated with patients</li><li>•How responsive hospital staff were to patients' needs</li><li>•How well caregivers managed patients' pain</li><li>•How well caregivers explained patients' medications to them</li><li>•How clean and quiet the hospital was</li><li>•How well caregivers explained the steps patients and families need to take to care for themselves outside of the hospital (i.e., discharge instructions)</li></ul> <p>The survey also asks patients to give an overall satisfaction rating to their hospital stay.</p>
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# Clinical Process of Care Measures 2013

Measure ID	Measure Description	Threshold	Benchmark
AMI-7a	Fibrinolytic Therapy Received within 30 Minutes of Hospital Arrival	0.6548	0.9191
AMI-8a	Primary PCI Received within 90 Minutes of Hospital Arrival	0.9186	1.00
HF-1	Discharge Instructions	0.9077	1.00
PN-3b	Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital	0.9643	1.00
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient	0.9277	0.9958
SCIP-Inf-1	Prophylactic Antibiotic Received within One Hour Prior to Surgical Incision	0.9735	0.9998
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients	0.9766	1.00
SCIP-Inf-3	Prophylactic Antibiotic Discontinued within 24 Hour After Surgery End Time	0.9507	0.9968
SCIP-Inf-4	Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose	0.9428	0.9963
SCIP-Inf-9	Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2	0.9286	0.9989
SCIP-VTE-1	Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered	0.95	1.00
SCIP-VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis within 24 Hour Prior to Surgery to 24 Hours After Surgery	0.9307	0.9985
SCIP-Card-2	Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period	0.9399	1.00

# Patient Experience of Care Measure

Measure ID	Measure Description	Performance Standard (Achievement Threshold)	Benchmark
HCAHPS	Communication with Nurses	75.18%	84.70%
	Communication with Doctors	79.42%	88.95%
	Responsiveness to Hospital Staff	61.82%	77.69%
	Pain Management	68.75%	77.90%
	Communication About Medicine	59.28%	70.42%
	Cleanliness and Quietness of Hospital Environment	62.80%	77.64%
	Discharge Information	81.93%	89.09%
	Overall Rating of Hospital	66.02%	82.52%

# Additional FY 2014 Hospital VBP Program Proposals

- Included in the proposed Outpatient Prospective Payment System (OPPS) rule, published in the Federal Register on July 18, 2011 and available online at:  
<http://www.gpo.gov/fdsys/pkg/FR-2011-07-18/pdf/2011-16949.pdf>
- The public comment period is currently open and continues until August 30, 2011.
- The proposals include:
  - An additional clinical process measure for FY 2014
  - A minimum number of cases and measures for all FY 2014 domains, except efficiency
  - Performance and baseline periods for all FY 2014 domains (except mortality measures, which were already finalized)
  - Performance standards for all FY 2014 domains (except mortality measures, which were already finalized, and efficiency measures, which were outlined in the FY 2012 Inpatient Prospective Payment System rule)
  - FY 2014 domain weighting

# CMS Will Begin Paying for Value

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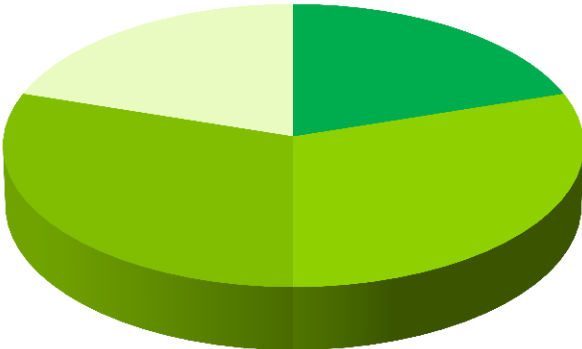
	FY2014
<b>Measures</b>	3 Domains (weights TBD): <ul style="list-style-type: none"> <li>▪ Process of Care (45%)</li> <li>▪ Patient Experience (30%)</li> <li>▪ Outcomes (25%)               <ul style="list-style-type: none"> <li>– 3 mortality</li> <li>– 8 Hospital Acquired Conditions</li> <li>– 2 AHRQ Patient Safety Composites</li> </ul> </li> </ul>
<b>Baseline Time Period</b>	<ul style="list-style-type: none"> <li>▪ Process of Care and Patient Experience: April 1, 2010 – December 31, 2010</li> <li>▪ Outcomes: Mortality – July 1, 2009 – June 30, 2010; HAC &amp; AHRQ – March 3, 2010 – September 30, 2010</li> </ul>
<b>Performance Time Period</b>	<ul style="list-style-type: none"> <li>▪ Process of Care and Patient Experience: April 1, 2012 – December 31, 2012</li> <li>▪ Outcomes:               <ul style="list-style-type: none"> <li>– Mortality: July 1, 2011 to June 30, 2012</li> <li>– HACs &amp; AHRQ Measures: begins March 3, 2012 – September 31, 2012</li> </ul> </li> </ul>

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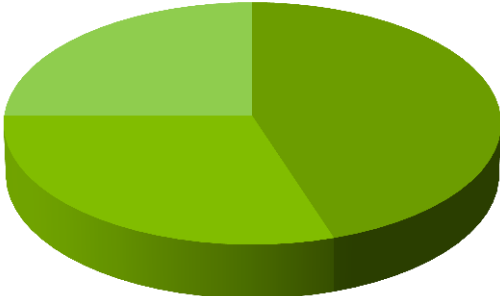
# VBP Weighting in FY 2014

### Proposed



- Clinical Processes (20%)
- Patient Experience (30%)
- Clinical Outcomes (30%)
- Medical Efficiency (20%)

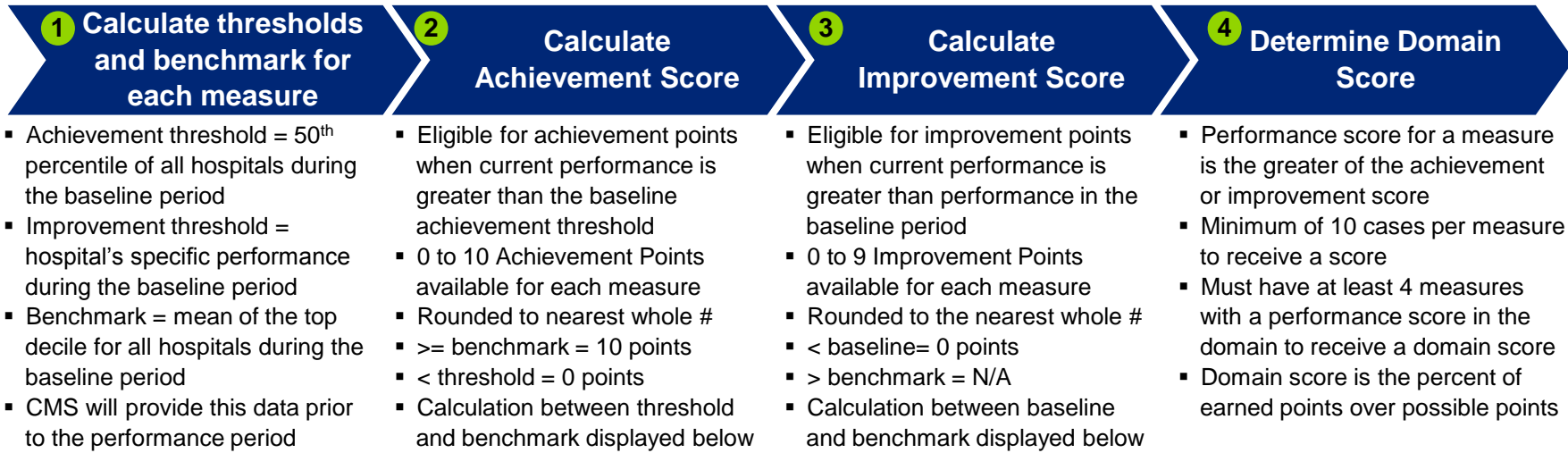
### Final



- Clinical Processes (45%)
- Patient Experience (30%)
- Clinical Outcomes (25%)
- Medical Efficiency (0%)

# Methodology: Scoring Process of Care & Outcomes

**Process of Care and Outcomes** domains receive performance scores based on the greater of achievement and improvement scores, which encourages lower performing hospitals to continue improvement efforts.



## Sample Calculations

**1 Sample Thresholds and Benchmark**

Achievement Threshold	0.47
Improvement Threshold	0.21
Benchmark	0.87

**2 Sample Achievement Scores**

Baseline Achievement	0.47
Baseline Benchmark	0.87
Current Performance	0.70

**Calculation:**  
 $[ 9 * ((0.70 - 0.47) / (0.87 - 0.47))] + 0.5 = 5.675$

*Rounded up to an Achievement Score of 6*

**3 Sample Improvement Scores**

Baseline Performance (i.e. Improvement Threshold)	0.21
Baseline Benchmark	0.87
Current Performance	0.70

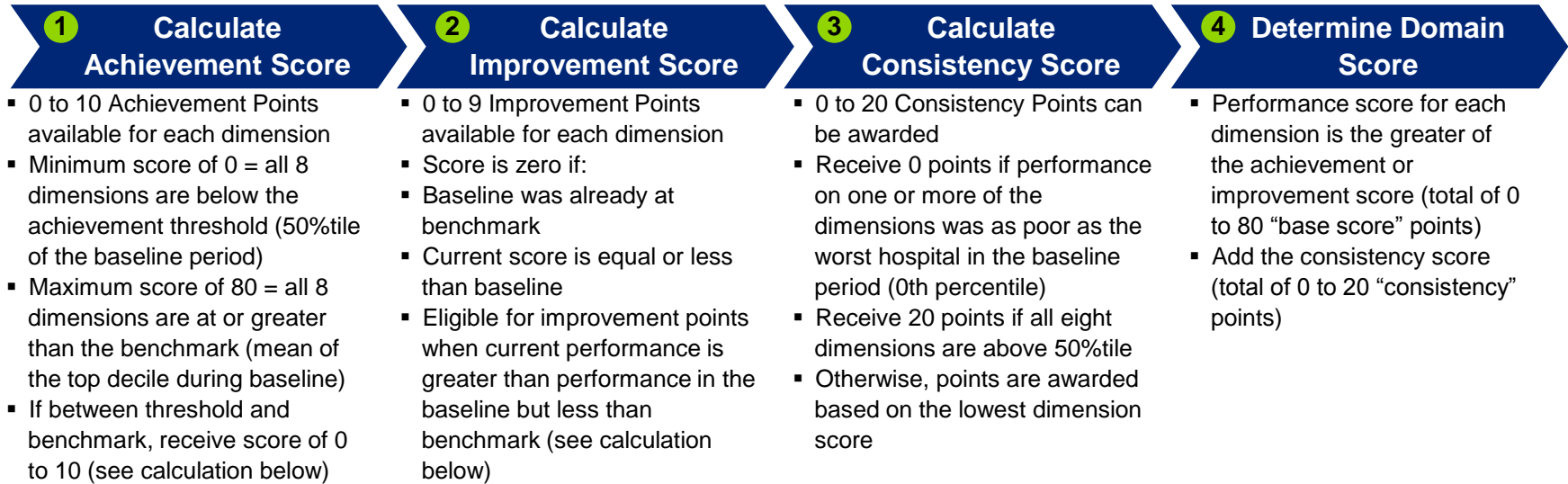
**Calculation:**  
 $[ 10 * ((0.70 - 0.21) / (0.87 - 0.21))] - 0.5 = 6.92$

*Rounded up to an Achievement Score of 7*

**4 Calculation:**  
 Domain score = (total earned points) / (total possible points) \* 100%

# Methodology: Scoring Patient Experience

The *Patient Experience* domain also utilizes achievement and improvement scores but incorporates a consistency score as well to promote uniform focus across all HCAHPS dimensions.



## Sample Calculations

**1 Sample Achievement Scores**

Achievement Threshold	0.79
Benchmark	0.89
Current Performance	0.82

**Calculation:**  
 $[9((0.82 - 0.79) / (0.89 - 0.79))] + 0.5 = 3.2$

*Rounded to nearest integer for an Achievement Score of 3*

**2 Sample Improvement Scores**

Baseline Score	0.77
Baseline Benchmark	0.89
Current Performance	0.82

**Calculation:**  
 $[10 * ((0.82 - 0.77) / (0.89 - 0.77))] - 0.5 = 3.67$

*Rounded up to an Improvement Score of 4*

**3 Calculation:**  
 $[20 * (\text{lowest dimension score}) - 0.5]$   
 Rounded to the nearest integer

*Lowest dimension score = (Hospital performance score - floor) / (Achievement Threshold - floor)*

*Floor = 0th percentile*

**4 Calculation:**  
 Patient Experience Domain Score = “Base Score” + “Consistency Score”

# Incentive Payment Methodology

Four mathematical exchange function options were considered (straight line - linear; concave curve - cube root function; convex curve - cube function; and S shape - logistic function) when deciding the methodology for distributing VBP payments. Ultimately, the linear exchange function was proposed in the rule.

Payment Reduction to Base Operating DRG by Year		Slope	Breakeven VBP Performance Score
FY2013	1.0%	1.5	67%
FY2014	1.25%	1.6	63%
FY2015	1.5%	1.7	59%
FY2016	1.75%	1.8	56%
FY2017	2.0%	1.9	53%
		2.0	50%
		2.1	48%
		2.2	45%
		2.3	43%
		2.4	42%
		2.5	40%

## Key Takeaways

- Linear function provides all hospitals the same marginal incentive to continually improve
- Function's intercept is zero, meaning hospitals with scores of zero will not receive an incentive payment
- Payment for each hospital with a score above zero will be determined by the slope of the linear exchange function, which will be set to meet the budget neutrality (Hospital Incentive Payment = Slope \* Hospital Total Performance Score)
- Roughly half of hospitals will receive a net increase in payments and half will receive a net decrease in payments
- Among the 3,092 hospitals that will be participating in the Hospital VBP program, CMS used 2009 data to estimate that the incentive payments (i.e., the percentage of the base operating DRG withhold earned back) will range from 2.36% for the lowest-scoring hospital to 181.7% for the highest-scoring hospital
- Overall, the distributive impact of this rule is estimated at \$850 million for FY 2013 (reflected in 2010 dollars)
- The slope of the linear exchange function is determined by the highest VBP incentive payment divided by the highest VBP total performance score (if the best score in the CMS estimate were 100% then the slope would equal 1.817).

# Timing and Communications

Hospitals must rapidly prepare for the VBP legislation as the performance period for Process of Care and Patient Experience measures included in the FY2013 program begins on July 1, 2011.

Timing	Communication
January 13, 2011	Publication of Proposed Rule
March 8, 2011	Last day to submit comments on Proposed Rule
April 29, 2011	Publication of the Final Rule
July 1, 2011 to March 31, 2012	Performance Period for FY2013 for Process of Care and Patient Experience Domains ( <i>Baseline Period for FY2013: July 1, 2009 to March 31, 2010</i> )
TBD	Performance Period for FY2014 for Outcomes Domain ( <i>Baseline Period: 12 months TBD</i> )
August 2, 2012 (60 days prior to start of FY2013)	Hospitals will be informed, through their QualityNet account, of the estimated amount of their value-based incentive payment adjustment for FY2013 discharges, derived from the most recently available data
October 1, 2012	1% reduction applies to discharges occurring on or after this date for the FY2013 VBP Program
November 1, 2012	Notification of the exact amount of the value-based incentive payment adjustment for FY 2013 discharges, including VBP performance measure score, condition-specific score, domain-specific score, and total performance score
December 1, 2012	Deadline to submit corrections related to performance measure scores, condition-specific scores, domain-specific scores and total performance scores
January 2013	Value-based incentive payment adjustment incorporated into claims processing system, and applied to all FY2013 discharges (including those that occurred beginning October 1, 2012)

The Secretary may choose measures that have been included on the Hospital Compare website for at least one year prior to the beginning of the performance period.

## The Fine Print: Additional VBP Details

- **Topped out measures** – when the overall 75<sup>th</sup> %tile and 90<sup>th</sup> %tile of a measure is statistically indistinguishable, it will be excluded because measuring would have no meaningful effect on a hospital's performance score
- **Future measures** – the Secretary must ensure that the selected measures include measures on six specified conditions or topics: Acute Myocardial Infarction (AMI); Heart Failure (HF); Pneumonia (PN); Surgeries, as measured by the Surgical Care Improvement Project (SCIP); Healthcare-Associated Infections (HAI); and, the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS)
- **Retiring measures** - a sub-regulatory process will also be proposed to retire Hospital VBP measures
- **Distinguishing providers** – payment adjustments to hospitals will be distinguished by provider number in hospital cost reports
- **Missing data during the baseline period** - these hospitals will be included in the Hospital VBP program, but that they will be scored based only on achievement
- **On-going communication** - Secretary will periodically post on the Hospital Compare website aggregate information on the Hospital VBP program, including: (1) the number of hospitals receiving value-based incentive payments under the program as well as the range and total amount of such value-based incentive payments; and (2) the number of hospitals receiving less than the maximum value-based incentive payment available for the fiscal year involved and the range and amount of such payments

# An Increasing Impact of Quality on Reimbursement

Between 2013 and 2017, the amount of a Provider's Medicare Inpatient payments that will be at risk or available for bonus payments through the HAC and VBP programs will increase from 1.8% to 4.6%.

	FY2013	FY2014	FY2015	FY2016	FY2017
Hospital Acquired Conditions			1.0%	1.0%	1.0%
Hospital Readmission Rates	-1.0%	-2.0%	-3.0%	-3.0%	-3.0%
Value Based Purchasing (At Risk)	1.0%	1.25%	1.5%	1.75%	2.0%
Value Based Purchasing (Bonus)*	0.8%	1.0%	1.2%	1.4%	1.6%
<b>Range of Impact</b>	<b>2.8%</b>	<b>4.25%</b>	<b>6.7%</b>	<b>7.15%</b>	<b>7.6%</b>

A hospital, with \$50M in Annual Medicare Inpatient Payments has an estimated **\$8.25M** risk/opportunity in the 5 years between 2013 and 2017 from PPACA quality related reimbursement

	FY2013	FY2014	FY2015	FY2016	FY2017	5-year Total
Hospital Acquired Conditions			\$.5M	\$.5M	\$.5M	<b>\$1.5M</b>
Hospital Readmission Rates	-\$0.5M	-\$1.0M	-\$1.5M	-\$1.5M	-\$1.5M	<b>-\$6.0M</b>
Value Based Purchasing (At Risk)	\$.5M	\$.625M	\$.75M	\$.875M	\$1.0M	<b>\$3.75M</b>
Value Based Purchasing (Bonus)*	\$.4M	\$.5M	\$.6M	\$.7M	\$.8M	<b>\$3.0M</b>
<b>Range of Impact</b>	<b>\$1.4M</b>	<b>\$2.125M</b>	<b>\$3.35M</b>	<b>\$3.575M</b>	<b>\$3.8M</b>	<b>\$14.25M</b>

# Leading Practices in Quality Metrics

Key Activity	Leading Practice
Prioritize Metrics	<ul style="list-style-type: none"> <li>•Focus attention on a manageable number of metrics</li> <li>•Use a combination of system and hospital metrics</li> <li>•Frame scorecard around key organizational priorities for quality improvement</li> <li>•Track individual metrics, while incentivizing improvement on composites and outcomes</li> <li>•Assess performance and monitor emerging metrics before they become incentivized metrics</li> </ul>
Establish “Buy-In”	<ul style="list-style-type: none"> <li>•Align business and physician leadership</li> <li>•Promote performance transparency across organization</li> <li>•Incentivize down to the staff level based on system, hospital, and individual performance</li> <li>•Enable the highest levels of leadership to be active participants in quality governance</li> </ul>
Enable Process Improvement	<ul style="list-style-type: none"> <li>•Use combination of system and hospital support teams to implement process changes</li> <li>•Develop and share action plans to drive improvement</li> <li>•Learn from episodes with poor outcomes through the sharing of case studies</li> <li>•Engage health information technology resources in process improvement efforts</li> </ul>



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