Hospital Pay for Performance: Strategies for Success Under the CMS Value-Based Purchasing Program

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Service Line VP, Premier, Inc.
The National Pay for Performance Summit
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Hyatt Regency San Francisco, CA
Premier is the nation’s largest healthcare alliance

Our mission: To improve the health of communities

- 2.5 MILLION real-time clinical transactions daily
- Owned by healthcare systems
- 90,000+ Alternate sites of care
- $4.2 BILLION savings in 2011
- 2,700+ member hospitals
- Database representing 1 in every 4 U.S. discharges
- Malcolm Baldrige National Quality Award winner
- $40+ BILLION in group purchasing volume
- Five-times named as an Ethisphere most Ethical Company
The Quality Journey – 2003 to Present

**Value-based purchasing:**
- HACs, quality, efficiency, cuts

**Bundled payment**

**Shared savings & Global payment**

**MOVEMENT TO INTEGRATED CARE, NEW PAYMENT MODELS & RISK**

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**Partnership for Patients**

**Medical home**

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**High Performing Hospitals**
- Most efficient supply chain
- Best outcomes in quality, safety
- Waste elimination
- Satisfied patients

**High Value Episodes**
- DRG and episode targeting
- Care models and gainsharing
- Data analytics
- Cost management

**Population Management**
- Population analytics
- Care management
- Financial modeling and management
- Legal
- Physician integration
Reform’s Bending the Curve “Strategic” Plan

Cuts to Existing FFS System
- Market basket reductions
- DSH cuts
- P4P & Nonpayment for anything preventable or unnecessary

Disrupt Existing System
- Bundled Payments
- Innovation Center/demonstrations
- ACOs

Track 1

Track 2

FAILSAFE
Independent Payment Advisory Board

ACOs
The cost of healthcare

The Cost of Health Care
How does it compare?

If other prices had grown as quickly as healthcare costs since 1945...

- A dozen eggs would cost $55
- A gallon of milk would cost $48
- A dozen oranges would cost $134
Medicare’s biggest target

Uses of funds for Medicare expenditures

- 22% MA plans
- 12% Prescription drug benefits
- 6% Outpatient hospital
- 5% SNFs
- 27% Hospitals
- 13% Physician services
- 9% Other Part B covered services
- 6% Hospice and home health

MedPAC Report to the Congress: Medicare Payment Policy, March 2011
### Changes are upon us now!

<table>
<thead>
<tr>
<th>Track 1</th>
<th>Track 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PAYMENT CUTS &amp; COST SHIFT PROVISIONS</strong></td>
<td><strong>TRANSPARENCY PROVISIONS</strong></td>
</tr>
<tr>
<td>2010: 4.9%</td>
<td>Waste, Fraud, and Abuse Provisions for Medicare and Medicaid (RACs &amp; MICs)</td>
</tr>
<tr>
<td>2011: 1.9%</td>
<td>Disclosure of Industry Payments to Physicians and Teaching Hospitals</td>
</tr>
<tr>
<td>2012: 0.1%</td>
<td><strong>COVERAGE EXPANSION PROVISIONS</strong></td>
</tr>
<tr>
<td>2013: 0.1%</td>
<td>Medicaid Expansion</td>
</tr>
<tr>
<td>2014: 0.3%</td>
<td>Insurance Reforms (Pre-existing conditions for adults, premium limits)</td>
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<tr>
<td>2015: 0.2%</td>
<td>Individual Mandate and Employer “Pay or Play”</td>
</tr>
<tr>
<td>CMS Hospital Behavioral Offset relating to IPPS</td>
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<tr>
<td>2016: 0.75%</td>
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<tr>
<td>PhRMA Tax (Ranging from $2.5 B to $4.1 B annually)</td>
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<td>2017: 0.8%</td>
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<tr>
<td>Hospital Productivity Adjustments</td>
<td></td>
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<tr>
<td>2018: 0.5%</td>
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<tr>
<td>Medical Device Tax (2.3 B annually)</td>
<td></td>
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<tr>
<td>2019: 0.8%</td>
<td></td>
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<tr>
<td>Medicare DSH Payment Reduction</td>
<td></td>
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<tr>
<td>2013: 0.5%</td>
<td></td>
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<tr>
<td>Medicaid DSH Payment Reduction</td>
<td></td>
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<tr>
<td>2014: 0.4%</td>
<td></td>
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<tr>
<td>Independent Payment Advisory Board (IPPS hospitals exempt until 2020)</td>
<td></td>
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<tr>
<td>2015: 0.5%</td>
<td></td>
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<tr>
<td>MEASUREMENT PERIOD</td>
<td></td>
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<tr>
<td>2016: 1.5%</td>
<td></td>
</tr>
<tr>
<td>1%</td>
<td>Hospital Value-Based Purchasing</td>
</tr>
<tr>
<td>2017: 1.75%</td>
<td></td>
</tr>
<tr>
<td>1.25%</td>
<td>Hospital Readmission Payment Reductions</td>
</tr>
<tr>
<td>2018: 2%</td>
<td></td>
</tr>
<tr>
<td>RULE MAKING</td>
<td></td>
</tr>
<tr>
<td>2019: 3%</td>
<td></td>
</tr>
<tr>
<td>1%</td>
<td>Hospital-Acquired Conditions Penalties</td>
</tr>
</tbody>
</table>

- **GEOGRAPHIC PAYMENT ADJUSTMENT PROVISIONS**
  - Hospital Wage Index
  - Geographic Variation Bonus

- **DELIVERY SYSTEM PROVISIONS**
  - Accountable Care Organizations
  - Center for Medicare and Medicaid Innovation
  - Bundled Payments Pilot
Estimated Impact to Medicare Payments & Value – Based Purchasing (Blinded Example)

TOTAL ESTIMATED IMPACT 2013 – 2019: ($26,347,998)

VALUE-BASED PURCHASING IMPACT BASED ON CMS FINAL RULE

Percent Reductions vs Overall Average

Total Incentive = $ 0.56

<table>
<thead>
<tr>
<th>Year</th>
<th>Percent Change from Base Payments</th>
<th>Overall Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>-1.6%</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>-4.1%</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>-4.5%</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>-4.6%</td>
<td></td>
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<tr>
<td>2017</td>
<td>-4.6%</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>-4.6%</td>
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</tr>
<tr>
<td>2019</td>
<td>-4.6%</td>
<td></td>
</tr>
</tbody>
</table>

Contribution ($ at risk) = $831.44
Earned Incentive = $832.00
Payment Impact Tab of Inpatient VBP Impact File

Shows Individual Hospital Payments and Percent of Contribution Earned based on Quality Scores – By Domain and Weighted Total Performance Score

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**CMS Inpatient VBP FFY 2013 Payment Model**

**SEE "IMPORTANT NOTES" TAB FOR MORE INFORMATION**

Factors below are set according to FFY 2013 Inpatient VBP finalized policy:

- Contribution factor (operating payments only) 1.00%
- Patient Experience Domain Weight 30%
- Clinical Process of Care Domain Weight 70%

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**Individual Hospital Lookups**

Payments in $ Thousands.

Copy a set of Premier Entity Codes into the yellow column

<table>
<thead>
<tr>
<th></th>
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<td>$51,477</td>
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<td>81.8%</td>
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<td>HCAHPS 18.0</td>
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<td>Weighted Average 32.0</td>
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</table>
Inpatient Value-Based Purchasing ("VBP")

- VBP policies have been included across numerous regulation in the past 1.5 years—VBP, IPPS and OPPS.
- A percent of inpatient operating payments are and will continue to be at stake depending upon quality of outcomes.

<table>
<thead>
<tr>
<th>FY 2013</th>
<th>FY 2014</th>
<th>FY 2015</th>
<th>FY 2016</th>
<th>FY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>1%</td>
<td>1.25%</td>
<td>1.5%</td>
<td>1.75%</td>
<td>2%</td>
</tr>
</tbody>
</table>

- Rewards for achievement or improvement
VBP 2013 measures and weighting

70% Weight: 12 clinical process measures
- Acute myocardial infarction
- Heart failure
- Pneumonia
- Surgery
- Surgical infections

30% Weight: 8 patient experience measures
- Communication with nurses
- Communication with doctors
- Responsiveness of staff
- Pain management
- Communication about medicines
- Cleanliness and quietness of environment
- Discharge information
- Overall rating

Clinical Process & Patient Survey Timeline for FY 2013 Payment
- Baseline July 1, 2009 to March 31, 2010
- Performance July 1, 2011 to March 31, 2012
VBP into the Future

- Expands to include mortality in 2014
- Expands in 2015 to include
  - The “Efficiency Measure”: Medicare Spending per Beneficiary (A/B);
  - AHRQ Patient Safety Indicator composite measure; and
  - Central Line-Associated Blood Stream Infection measure.

<table>
<thead>
<tr>
<th>AHRQ PSI Composite Measure Patient Safety for Selected Indicators (PSI #90)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PSI #03 Pressure Ulcer Rate</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>PSI #06 Iatrogenic Pneumothorax Rate</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>PSI #07 Central Venous Catheter-Related Blood Stream Infection Rate</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>PSI #08 Postoperative Hip Fracture Rate</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>PSI #09 Postoperative Hemorrhage or Hematoma Rate</strong>&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>PSI #10 Postoperative Physiologic and Metabolic Derangement Rate</strong>&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
</tbody>
</table>
Hospital-specific payment adjustment factor has been applied to inpatient claims beginning Oct 1, 2012.

1% 2% 3% 3% 3%

Uses 30-day AMI, HF and PN measures based on 3 years of data (July 1, 2008 - June 30, 2011 for FY 2013).

Applies to wage-adjusted base operating DRG payment amount (includes new tech add-on payment only, no adjustments for DSH, IME, outlier, or low volume).
Readmissions into the Future

Expands in 2015 to include at least:
- Coronary Artery Bypass Graft;
- Chronic Obstructive Pulmonary Disease;
- Percutaneous Coronary Intervention; and
- Other vascular Conditions.

Adds to the Hospital Inpatient Quality Reporting program that are likely to be adopted in the penalty program in the future:
- 30-day Hip/Knee readmissions
- Hospital-Wide All-Cause Unplanned Readmission (HWR)
### Overlapping Medicare HAC policies

<table>
<thead>
<tr>
<th>Hospital-acquired conditions (HACs)</th>
<th>Not eligible higher payment (FY 2008 ongoing)</th>
<th>VBP (rolling in starting FY 2013)</th>
<th>1% Payment Cut - TBD (FY 2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catheter associated UTI</td>
<td>X</td>
<td>X</td>
<td>?</td>
</tr>
<tr>
<td>Surgical Site Infections</td>
<td>X</td>
<td>X</td>
<td>?</td>
</tr>
<tr>
<td>Vascular cath-assoc. infections</td>
<td>X</td>
<td>X</td>
<td>?</td>
</tr>
<tr>
<td>Foreign object retained after surgery</td>
<td>X</td>
<td></td>
<td>?</td>
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<tr>
<td>Air embolism</td>
<td>X</td>
<td></td>
<td>?</td>
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<tr>
<td>Blood incompatibility</td>
<td>X</td>
<td></td>
<td>?</td>
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<tr>
<td>Pressure ulcer stages III or IV</td>
<td>X</td>
<td></td>
<td>?</td>
</tr>
<tr>
<td>Falls and trauma</td>
<td>X</td>
<td></td>
<td>?</td>
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<tr>
<td>DVT/PE after hip/knee replacement</td>
<td>X</td>
<td></td>
<td>?</td>
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<tr>
<td>Manifestations of poor glycemic control</td>
<td>X</td>
<td></td>
<td>?</td>
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<tr>
<td>Ventilator associated pneumonia</td>
<td>X</td>
<td></td>
<td>?</td>
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<tr>
<td>Methicillin resistant Staph. aureus (MRSA)</td>
<td>X</td>
<td></td>
<td>?</td>
</tr>
<tr>
<td>Clostridium difficile (CDAD)</td>
<td>X</td>
<td></td>
<td>?</td>
</tr>
</tbody>
</table>
### Value Based Purchasing across payment silos

<table>
<thead>
<tr>
<th>Payment Models</th>
<th>Physician</th>
<th>Outpatient Hospital and ASCs</th>
<th>Inpatient Acute Care</th>
<th>Long Term Acute Care</th>
<th>Inpatient Rehab</th>
<th>SNFs</th>
<th>Home Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Track One</strong></td>
<td>RBRVS</td>
<td>APC</td>
<td>MS-DRG</td>
<td>MS-DRG</td>
<td>RICs</td>
<td>RUGs</td>
<td>HHRGs</td>
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<tr>
<td>VBP modifier plan</td>
<td></td>
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</tr>
<tr>
<td>published on 11/1/11</td>
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<td></td>
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<tr>
<td>Implement in FY2013 PFS</td>
<td></td>
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<tr>
<td>P4R in FY2013; VBP</td>
<td></td>
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<tr>
<td>implementation plan</td>
<td></td>
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</tr>
<tr>
<td>submitted to Congress on 4/18/11</td>
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<td>VBP commenced 10/1/12</td>
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<tr>
<td>P4R in FY14: VBP test</td>
<td></td>
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<td>pilot by 1/1/16</td>
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<tr>
<td>VBP test pilot by 1/1/2016</td>
<td></td>
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<tr>
<td>VBP impl. plan sent to Congress 6/15/13</td>
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<tr>
<td>VBP impl. plan to Congress overdue (10/1/11 deadline)</td>
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</tbody>
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### Accountable Care Organizations

- **PAC Episode Billing**
- **Acute Care Bundling**
- **Medical Home**

**Track Two**

- PAC Episode Billing
Sustained success requires continuous innovation

Value-based purchasing:
HACs, quality, efficiency, cuts

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Shared savings & Global payment

MOVEMENT TO INTEGRATED CARE, NEW PAYMENT MODELS & RISK

Partnership for Patients

Medical home

High Performing Hospitals
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High Value Episodes
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- Cost management

Population Management
- Population analytics
- Care management
- Financial modeling and management
- Legal
- Physician integration
Measures that closely align with national initiatives

- Evidence-Based Care
  - Evidence-Based Care Performance % “All or Nothing”

- Patient Experience
  - HCAHPS Top Box Global Measures Composite Score

- Mortality
  - Hospital Level Risk Adjusted Mortality (O/E Ratio)

- Harm
  - Composite Harm Index (30 measures)

- Readmissions
  - 30-day all cause readmissions

- Cost of Care
  - Total Inpatient Cost per Case Mix Adjusted Discharge

PFP=Partnership for Patients

VBP = Value Based Purchasing

$ = standalone payment penalty
Premier’s collaborative methodology

ACCELERATING IMPROVEMENT

- **Measure** with defined metrics
- **Report** transparently
- **Share** best practice
- **Execute** collaboratively

“Knowing is not enough; we must apply. Willing is not enough; we must do.”

-Johann Wolfgang von Goethe
HQID: The journey to value based purchasing

If all hospitals in nation achieved this improvement, we estimate annually:

70,000 lives saved and $4.5+ billion in cost savings

How they did it

• “Quality” core value of institution
• Priority of executive team
• Clinician engagement
• Improvement methodology
• Prioritization methodology
• Dedicated resources
• Committed “knowledge transfer”
QUEST: An “Insurance Policy for Reform and VBP”

2008

2013
Sustained improvement over time

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>18 Months</th>
<th>Year 2</th>
<th>30 Months</th>
<th>Year 3</th>
<th>42 Months</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital deaths avoided</td>
<td>8,118</td>
<td>13,285</td>
<td>17,264</td>
<td>20,314</td>
<td>24,820</td>
<td>26,862</td>
<td>29,974</td>
</tr>
<tr>
<td>Dollars saved</td>
<td>$685M</td>
<td>$1.3B</td>
<td>$2.1B</td>
<td>$3.2B</td>
<td>$4.5B</td>
<td>$5.6B</td>
<td>$6.9B</td>
</tr>
<tr>
<td>Patients receiving all EBC</td>
<td>18,359</td>
<td>31,090</td>
<td>44,629</td>
<td>60,247</td>
<td>75,638</td>
<td>90,717</td>
<td>105,494</td>
</tr>
</tbody>
</table>

If all hospitals across the country achieved these gains, an estimated **87,250 lives** and **$34 billion** could be saved each year.

Results based upon the 157 original charter members for years 1 – 3 and for the same group who had data in years 4 and 5 (140); results are cumulative.
Evidence-based care (EBC) improvement – charter member cohort

The biggest improvement has been in primary PCI within 90 minutes of arrival: 12.5% improvement from Year 1 to Year 4.
Mortality improvement – charter member cohort

- Significant reduction in mortality within certain groups (Sepsis)
- Patient and family centered end of life care
- Improved documentation and coding
Harm improvement – charter member cohort

Harm composite trends
4-Quarter Moving Average

Baseline Period

Harm composite

Biggest improvements in Harm: Mediastinitis, Staph sepsis, CLABSI, as well as injuries
Patient experience improvement – charter member cohort

Biggest improvement in nursing communication and communication about medication scores
A higher proportion of QUEST members are earning back more than they contribute to the inpatient VBP program compared to the nation (61% compared to 42%)
## Collaborative engagement activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PremierConnect</strong></td>
<td>Comprehensive online best practices forum</td>
</tr>
<tr>
<td><strong>Benchmarking/Analytics</strong></td>
<td>Access to collaborative-specific, customized comparative reports and benchmarking</td>
</tr>
<tr>
<td><strong>Sprints</strong></td>
<td>A 90 day rapid cycle improvement series to help drive improvement in specific indicators</td>
</tr>
<tr>
<td><strong>Collaboratives</strong></td>
<td>An extended improvement initiative focused on a specific condition, disease state or process</td>
</tr>
<tr>
<td><strong>National Meetings</strong></td>
<td>Two face-to-face meetings per year</td>
</tr>
<tr>
<td><strong>Performance Improvement Support</strong></td>
<td>1:1 coaching for improvement opportunities based on customized improvement plans</td>
</tr>
</tbody>
</table>
Partnership for Patients
Partnership for Patients Program Goals

Goals

• **Reduce harm caused to patients in hospitals.** By the end of 2013, preventable hospital-acquired conditions would **decrease by 40%** compared to 2010.

• **Improve care transitions.** By the end of 2013, preventable complications during a transition from one care setting to another would be decreased such that all hospital readmissions would be **reduced by 20%** compared to 2010.

Focus Areas

• Adverse drug events (ADE) *
• Catheter-associated urinary tract infections (CAUTI) *
• Central line-associated blood stream infections (CLABSI) *
• Injuries from falls and immobility *
• Obstetrical adverse events *

• Pressure ulcers *
• Surgical site infections *
• Venous thromboembolism (VTE) *
• Ventilator-associated pneumonia (VAP) *
• Preventable readmissions *
• Leadership
• Culture

* Denotes an area for measurement: At least one process and one outcomes measure for each area of focus
Impact on Patients and Communities

- 696 Fewer Adverse Drug Events
- 1140 Fewer Catheter Associated Urinary Tract Infections
- 678 Fewer Central Line Associated Blood Stream Infections
- 732 Fewer Falls With Injury
- 317 Fewer Patients with Potentially Preventable Venous Thromboembolism
- 1523 Fewer Obstetrical Traumas during Delivery
- 1844 Fewer Surgical Site Infections
- 394 Patients with Ventilator Associated Pneumonia
- 43,885 Fewer Patients readmitted to hospital
- 338 Fewer Serious Pressure Ulcers
Why do hospitals find Success in Premier Collaboratives?

- **Executive commitment**
  - Support from the top is mandatory, making QUEST everyone’s priority; crystal clear “LOS” (line of sight): Board>C-suite>Associates

- **Sound measurement**
  - Clearly defined and measurable goals

- **Collaboration**
  - Structured approach to measurement, performance gap identification, opportunity analysis, improvement methodology and shared learning

- **Knowledge transfer**
  - Sharing what works & what doesn’t through face-to-face meetings, conference calls, webinars, social media, etc.

- **Transparency**
  - Peer pressure works. Everyone likes being held up as a top performer; no one wants to be at the bottom
Premier’s Supports for Hospital Success in VBP

Your insurance policy for success!
Thank You!

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