

## Value-Based Care, Quality & Health Outcomes for Populations



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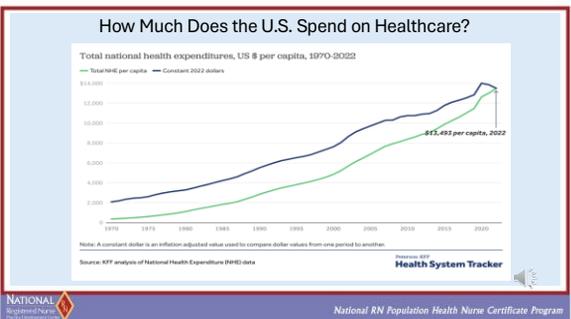
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## Affordability & Access of U.S. Healthcare

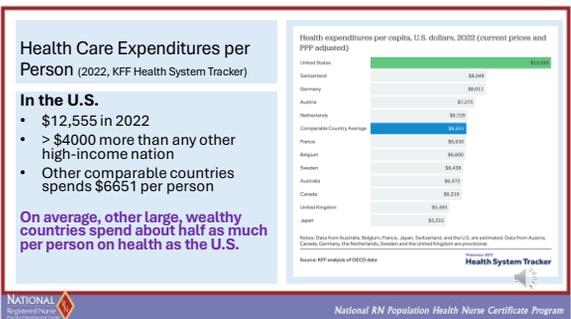
### A Snapshot of Current U.S. Population Outcomes

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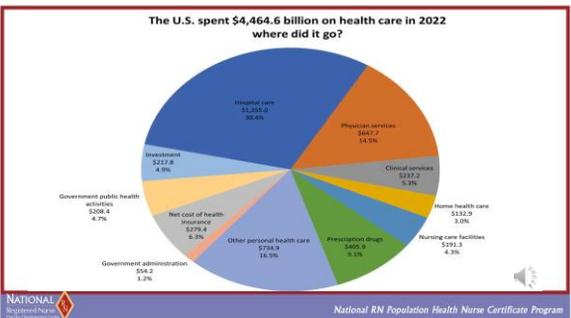
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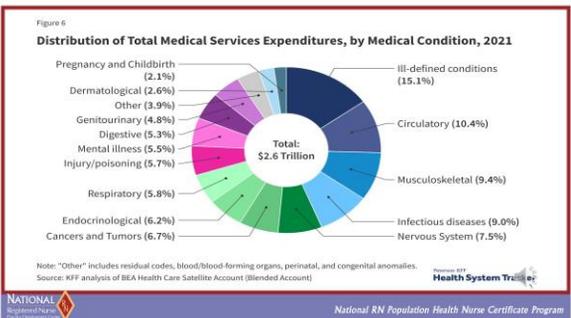
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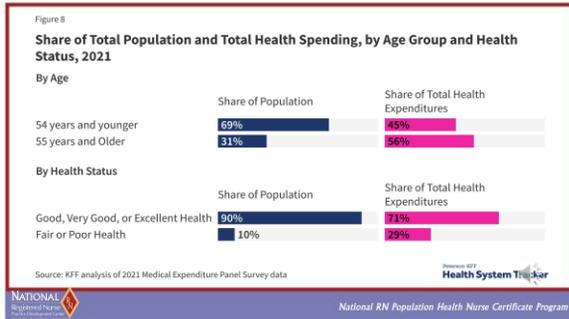
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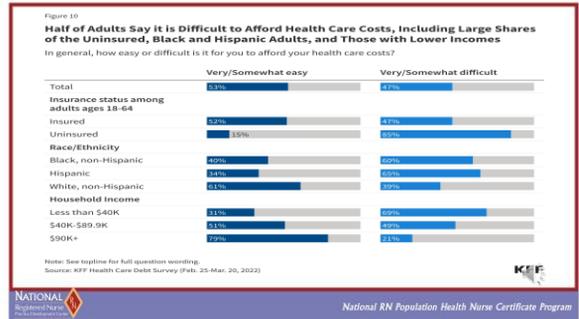
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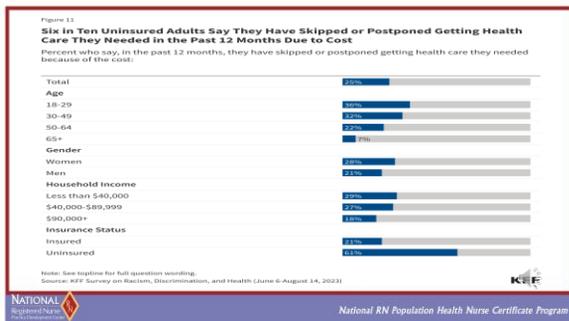
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**Drivers of Healthcare Spending:**

- Utilization (the number of services used)
- Price (the amount charged per service)

• Despite spending nearly twice as much on healthcare per capita, utilization rates in the U.S. do not differ significantly from other wealthy countries (Source: 2022 Health Statistics – Organisation of Economic Co-Operation & Development)

**Price is the main driver of cost in the U.S.**

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**Upstream Solutions for Addressing Spending & Affordability of Healthcare**

Key to Population Health

- Price Transparency Requirements
- Prescription Drug Pricing
- Expansion of Virtual Care
- Provider Payment Reforms
- Medicaid Expansion & Healthcare Marketplace Subsidies
- Value-Based Payment Models

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**Quality of U.S. Healthcare**

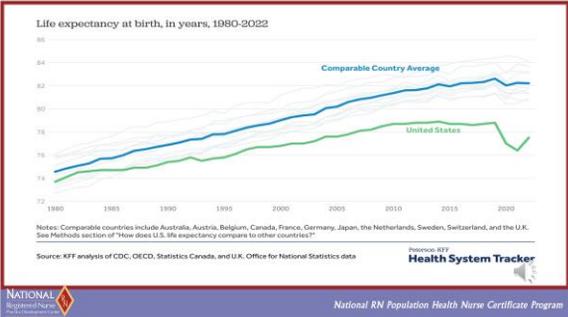
A Current Snapshot of U.S. Population Outcomes

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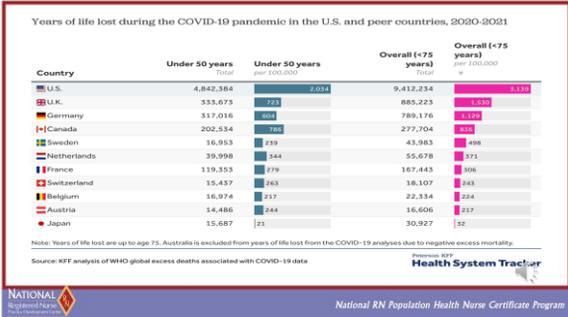
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# Value Based Care, Quality & Health Outcomes for Populations

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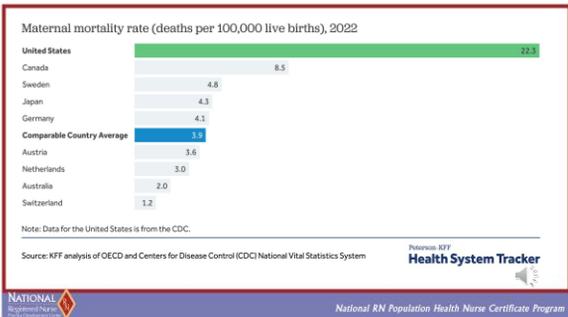
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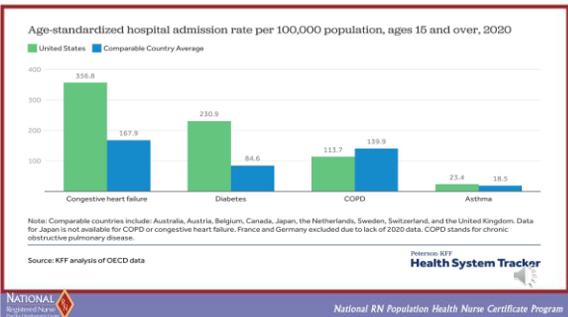
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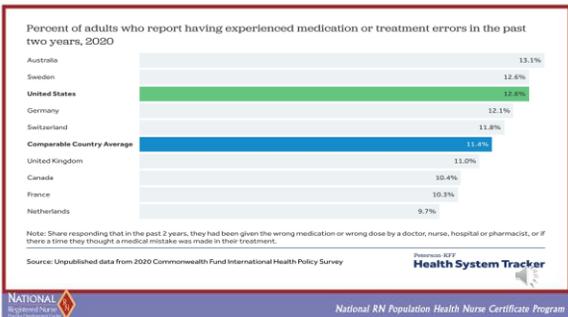
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### The Shift to Quality

Initiatives & Measures to Improve Outcomes

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### The Focus on Quality Healthcare (IOM Committee on Quality Care in America)

IOM Definition of Healthcare Quality:

“The degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

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WHO defines health outcomes as:

“Change in the health of an individual, group of people or population that is attributable to an intervention or series of interventions”

- Clinical measurement
- Self-report
- Observation

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### Six Interrelated Domains of Healthcare Improvement

<p><b>Safe Care</b></p> <ul style="list-style-type: none"> <li>• Avoiding injuries to patients</li> </ul>	<p><b>Timely Care</b></p> <ul style="list-style-type: none"> <li>• Reducing waits for both patients and providers of care</li> </ul>
<p><b>Effective Care</b></p> <ul style="list-style-type: none"> <li>• Providing care based on scientific knowledge</li> </ul>	<p><b>Efficient Care</b></p> <ul style="list-style-type: none"> <li>• Avoiding waste</li> </ul>
<p><b>Patient Centered Care</b></p> <ul style="list-style-type: none"> <li>• Providing respectful and responsive care that ensure patient values guide clinical decisions</li> </ul>	<p><b>Equitable Care</b></p> <ul style="list-style-type: none"> <li>• Ensuring the quality of care does not vary because of characteristics such as gender, race, ethnicity, socioeconomic status or geographic location</li> </ul>

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### The Triple Aim in Healthcare

(IHI - Institute for Healthcare Improvement)

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### The National Quality Strategy (NQS)

- First published in 2011
- Mandated by the Affordable Care Act
- Established a national strategy for quality improvement in healthcare
- Updated annually with progress reports
- Led by the Agency for Healthcare Quality & Research (AHRQ) on behalf of the U.S. Dept of Health and Human Services (HHS)
- Builds on the Institute for Healthcare Improvement (IHI)'s Triple Aim

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### National Quality Strategy

- Guides all HHS quality improvement programs and regulations
- Includes:
  - Centers for Medicare & Medicaid (CMS)
  - Health Resources & Services Administration (HRSA)
  - Substance Abuse & Mental Services Administration (SAMHSA)

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### CMS National Quality Strategy Goals

- Equity**: Advance health equity and whole-person care
- Engagement**: Engage individuals and communities to become partners in their care
- Safety**: Achieve zero preventable harm
- Resiliency**: Enable a responsive and resilient health care system to improve quality
- Outcomes**: Improve quality and health outcomes across the care journey
- Alignment**: Align and coordinate across programs and care settings
- Interoperability**: Accelerate and support the transition to a digital and data-driven health care system
- Scientific Advancement**: Transform health care using science, analytics, and technology

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### Federally Funded Quality Collaboratives

- Perinatal Quality Collaboratives (PQCs)**
  - State or multi-state networks that work to improve the quality of care for mothers and babies.
  - Supported by the CDC's Division of Reproductive Health
  - <https://www.cdc.gov/maternal-infant-health/pqc/index.html>
- Quality Improvement Fund (QIF)**
  - Supports health centers to test new ideas to improve primary care
  - Health centers can propose solutions, learn from each other, and share solutions
  - <https://bphc.hrsa.gov/technical-assistance/quality-improvement-fund>
- Quality Improvement Organizations (QIO Programs)**
  - Brings stakeholders together to improve behavioral health outcomes, chronic disease management
  - <https://www.cms.gov/medicare/quality/quality-improvement-organizations>

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### Outcome Measures

<https://www.ahrq.gov/talkingquality/measures/measure-questions.html>

- The quality and cost targets healthcare organizations are trying to improve
  - Defined and prioritized by national organizations
    - CMS
    - The Joint Commission
    - National Association for Healthcare Quality (NAHQ)
    - National Quality Forum
    - National Committee for Quality Assurance (NCQ)
- Health systems target outcome measures based on:
  - State and federal government mandates
  - Accreditation requirements
  - Financial incentives

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### Top Seven Outcome Measures

- Mortality (22%)
- Safety of care (22%)
- Readmissions (22%)
- Patient experience (PROMs) (22%)
- Effectiveness of Care (4%)
- Timeliness of care (4%)
- Efficient use of medical imaging (4%)

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### Other Examples

- HEDIS – Health Effectiveness Data and Information Set (NCQA)
- CAPHs – Consumer Assessment of Health Providers & Systems (AHRQ)
- OASIS – Outcome Assessment Information Set (Home Health - CMS)
- MDS – Minimum Data Set (Nursing Homes – CMS)

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**Improving Health Outcomes for Populations**  
Innovative Practice & Payment Models

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**Value-Based Care**

- Links payment to outcomes
- Compensation is based on health outcomes vs amount of services provided

**Providers are rewarded for helping patients improve their health, prevent or manage chronic conditions and live healthier lives.**  
(NEJM Catalyst, 2017)

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**VBC relies on:**

- New Patient Centered Models of Care
  - Accountable Care Organizations (ACOs)
  - Patient Centered Medical Homes (PCMHs)
  - Integrated Healthcare Delivery Systems & Provider Sponsored Health Plans
- Alternative Models of Payment
  - Pay for Performance & Bundled Payment
  - Shared Savings & Shared Risk
  - Population-Based Global Payment



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**Population Health Management Strategies**



- Care Management
- Chronic Care Management
- Annual Wellness Visit
- Transitional Care Management
- Enhanced Case Management
- Care Navigation
- Care Planning
- Social Needs/SDoH Assessment
- Referrals
- Wellness & Prevention
- Health Education
- Real-time Alerts
- Telehealth
- Remote Patient Monitoring
- Patient Portal
- Community Support/Resources

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**Key Features of High Performing Population Health Interventions**

- Integrated team-based, person-centered approach that addresses physical, behavioral and social issues
- Proactive patient engagement and services
- Addressing social determinants of health and facilitating access to care and resources
- Coordinating care across patients' health care continuum including community resources and providers
- Providing support with self-care management and risk reduction

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**Goals of Value Based Care**



- Improve effectiveness and quality of care across the care continuum
- Adopt and integrate technology to improve processes and outcomes
- Address health equity and reduce disparities of care
- Minimize fragmentation and improve transitions of care
- Expand access to evidence-based care
- Enhance patient and provider experience with care

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### Goals of Value Based Care a Match for Population Health

- Patient centered philosophy and operations
- Coordinated and integrated population health models
- Effective processes for risk stratification, patient engagement and care coordination
- Robust technology for advanced analytics, data integration and reporting
- Identification of targeted populations and opportunities
- Continuous quality improvement mindset

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### Examples of High Performing Population Health Outcomes

- Reduction of inpatient readmissions, unnecessary ED utilization
- Improvement in access to evidence-based care
- Positive impacts on HEDIS scores, STAR rating results
- Improved patient satisfaction and population health outcomes including health, quality of life and satisfaction

**These types of outcomes directly impact population health and deliver significant value**

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### Final Thought: If It Seems Like There's A Lot of Moving Parts, There Are!



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### Next Steps

- Watch the posted Triple Aim video and review the VBC links
- Review the posted Resources.
- Download any you would like to keep.
- Take the Test Your Knowledge Self-Assessment Quiz
- When you're ready move onto the next topic

- Questions? Let me know:
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