NEXT WAVE

"We Understand Health Care"

Implementing Value Based Purchasing:

Policy Questions, Practical Solutions

January, 2007

This White Paper was prepared in response to a request by the Centers for Medicare and Medicaid Services (CMS) for input into their Plan for Medicare Hospital Value Based Purchasing. Portions of this paper were presented orally by John D. Shaw, Next Wave's President at the Listening Session held on January 17, 2007 at CMS offices in Baltimore.

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Implementing Value Based Purchasing: *Policy Questions, Practical Solutions*

Value Based Purchasing (VBP), a refinement of Pay for Performance (P4P), is a major focus of efforts to improve effectiveness, patient experiences, and efficiency in the U.S. Healthcare delivery system. The target of these efforts is to better align incentives for all stakeholders, and thereby remove existing barriers to implementing necessary improvements.

The Deficit Reduction Act (DRA) of 2005 specifies that the Centers for Medicare and Medicaid Services (CMS) develop a plan to implement VBP for Medicare hospital payments for Federal Fiscal Year 2009 (FFY09 – beginning October 1, 2008.) On January 17, 2007 CMS held a Listening Session in Baltimore, Maryland to solicit oral testimony on a range of design questions for implementing the VBP plan. Written comments are due by January 24, 2007.[1] These comments will be evaluated when preparing the draft plan, scheduled to be issued March 22, 2007. A second Listening Session at CMS is scheduled for April 12, 2007 to solicit feedback on the draft plan. These efforts are focused in four major design areas:

1. Measures of Value (Quality, Patient Experience, Efficiency)
2. Data Infrastructure & Validation (How data for the measures are collected and audited)
3. Incentive Structure (Timing, Amounts, and Mechanisms for VBP payments)
4. Public Reporting (Transparency for all Stakeholders – in a useful format)

Next Wave (NWI) is a health services research and policy consulting firm located in Albany, New York. NWI staff spent over 30 years in the design, implementation, and evaluation of local, state, national, and international payment and quality measurement systems. Solutions recommended in this white paper are based on comprehensive project experience, spanning a broad range of stakeholder groups and delivery settings.

This expansion of our comments on hospital VBP payments are organized as follows:

A. <u>Cross-Cutting/System-Wide Trends and Context</u>
Issues that have broad implications for the successful implementation of VBP across all design areas are presented in this section.

B. <u>Major/High Impact Comments on Each of the Four Design Areas</u>
Issues likely to have significant impact in each of the four design areas are discussed in this section. Note that many of these issues were presented in oral testimony at the January 17, 2007 Listening Session.

C. **<u>Evidence and Experience References</u>**
Evidence supporting our comments and recommendations from the research literature are presented. In addition, since many aspects of policy development and implementation are not routinely studied in formal research literature, we present the basis of our comments, using examples from our professional experience. In these cases, we outline to the extent feasible the explicit and implicit assumptions, context, and scope for the issue illustrated. We also note unintended consequences observed and mechanisms apparently responsible for them (e.g. invalid implicit assumptions, unanticipated stakeholder reactions, etc.)

<u>Attachment A – Formatted Transcript of 1/17/07 Oral Comments</u>

A. Cross-Cutting/System-Wide Trends and Context

Since publication of To Err is Human in 1999,[2] the Institute of Medicine released a series of reports addressing various major gaps in the delivery of health care in the U.S. – and blueprints to fix them. Any substantive health care policy change should be consistent with these blueprints – or explicitly justify any inconsistency. In our judgment, the following represent major priorities to achieve the greatest improvement in value, in the shortest time, while avoiding major unanticipated outcomes.

Priority Focus 1 – It's The System that Needs Attention – Not Just the Individual Silos

Our healthcare system is faced with continually rising costs and an outmoded delivery system that is organized in 'silos' for each delivery setting (hospital, inpatient rehab facility, nursing home, home care, formal outpatient care, primary care, physician specialists, etc.) Healthcare services are currently delivered, paid, and regulated within the boundaries of each provider type. This discontinuous service delivery model promotes ineffective communication, sub-optimal coordination – particularly "hand-offs" between providers, duplicate services, lack of accessibility to care, and less than optimal outcomes. An alternative healthcare delivery system would be integrated across the continuum of care (INCLUDING the patient in those areas where they are their own caregiver), with overlapping provider responsibilities and aligned interests.

- ***We strongly recommend that any proposal that claims to promote Value, in hospitals and each and every other setting silo, must explicitly recognize and address overall system improvements and interactions with other setting silos. Regional cooperation (and aligned vs. competitive incentives) would enable all providers to put the focus on patient centered care, with an emphasis on quality, safety, and efficiency.***
- ***A potential strategy would be that any "efficiency" measures be limited to broad measures across episodes and across time. In effect move away from the current focus on making "efficient silos" – which has the unintended consequence of encouraging each silo to simply shift costs:***
    - ***From providers to providers in other settings***
    - ***From payors to other payors***
    - ***From employers to employees***

Priority Focus 2 – Evaluate Proposal Priorities – How Well Do They Address Identified Gaps

Major issues that are frequently overlooked in promoting change are the human factors resisting the change. These include inertia, resistance to the time and expense of implementing changes, fear of the unknown (what will THEIR role be after the change), and frequently a mistrust that proposed changes would actually improve things vs. make them worse. Those already involved in care delivery are aware of current problems – they live with them every day. They implicitly assess whether they believe that the proposed changes will fix THEIR daily headaches. People will get behind and support changes that will make their jobs easier after the change. On the other hand, they will fight implementation of changes that do not address current problems – and may make it worse. "Selling 101" teaches the need to "identify objections" and show how the proposals will address THEIR concerns. Recommendations to facilitate implementation of any VBP proposals include:

- ***Do a formal evaluation and listing of CURRENT problems and gaps, and next to each one, list IF/HOW the proposals solve problems/close gaps, and identify which specific stakeholders are affected. This will quickly show:***
    - ***Risks of change resistance (blank solutions to existing problems)***
    - ***Targeting for which stakeholders need to understand which aspects of the proposals positively affect THEM. This can form the basis of efforts to educate specific stakeholder groups with issues targeted to their specific concerns.***
- ***"Face Validity" for all stakeholders will align willingness to support recommended change.***

Priority Focus 3 – Use Caution with "Tournament" Competition (If I Win, You Must Lose)

If incentives are structured so that facilities either win or lose, then VBP becomes a "tournament competition." Those at the top hold onto their edge of providing quality care, and those at the bottom have few resources to improve. Winners become reluctant to share their best practices in order to maintain their competitive edge, and losers become entwined in a "doom loop" - unable to achieve even the minimum expected level of performance. It is neither the facility that wins or loses; instead it is the patient who loses when this becomes another barrier to improving the quality of care within our healthcare system. Focus needs to be on engaging the entire spectrum.

- ***VBP payments can be approached using a tiered approach – e.g. benchmark small and rural hospitals different from major urban teaching centers.***
- ***A fixed payment amount plus a variable payment amount based on volume (e.g. for a particular Tier: $50,000 plus $x plus y%) would be one equitable approach. The fixed payment amount would help address fixed and infrastructure costs, and the variable payment amount could address performance and hospital volume.***
- ***In addition, it is important to keep ALL stakeholders engaged. Some portion of the VBP payments should be earmarked for Improving vs. not improving.***
- ***Consider shifting the tournament competition so that the success strategy to "win" is no longer "do best and hide the secrets to your success" to pay for "do best and SHARE the secrets to your success."***

Priority Focus 4 – Patient Centeredness is More than a Goal – It's also a Strategy

Patient-Centered Care (incorporating desires, values, cultural beliefs, and needs viewed through the patient's lens) is a major outcome goal for reforming the health care system. It should also be a strategy promoted within each health care encounter and with all health care providers - incorporate opportunities for patient responsibility and self-management. The patient (and family member/friend) is a major provider of their own care in what we recognize to be high cost/high impact areas of chronic care, end of life care, and post hospital recovery.

- ***Incorporate where possible explicit measures of patient engagement (e.g. HCAHPS.)***

Priority Focus 5 - Major Opportunities in Care Coordination Across Settings and Time

In moving towards a cost effective system, one of the biggest areas of waste and inefficiency that currently exists is coordinating care across an episode and over time.

- ***VBP money needs to be earmarked for improving communication, disseminating best practices, preventive care, to fund sharing, and best practice dissemination, and working***

together between different settings to come up with a good system wide process.

Priority Focus 6 - Long Term Investment/Return vs. Short Term Budget Neutrality

Budget Neutrality is a common principle in regulatory change – the pie remains the same, while the size of each slice may differ. This is an attempt in part to assure that predictability of budgets. Our society is now accustomed to immediate responsiveness – the next quarterly earning statement, the next annual budget cycle, the next election, etc. Health reforms need to acknowledge that the long term fiscal viability of the Medicare program in the face of our aging population cannot be completed in a single budget cycle. Fundamental restructuring requires an investment strategy to cover extra up-front efforts, with returns not expected for 3-5 years to cover learning curve and other implementation time frames. This is a standard model for business, and also has examples in health care, such as restructuring long term care in Ohio as decade ago[3] and comprehensive re-structuring care delivery in New York last summer.[4]

- ***We strongly recommend that any "budget neutrality" investment/return calculations envisioned for VBP be performed over a 5 year period rather than annually.***

Priority Focus 7 - Improve Outcomes – Not Just Indicators

We observe an overwhelming skepticism that VBP based on outcomes can be meaningful - across all stakeholders we work with. There is a concern whether current outcome measures actually address "face validity" and "risk adjustment" concerns. For example, several current widely used measures do not measure what many believe they measure in the Orthopedic population. E.g. both of the examples below are in the AHRQ Patient Safety Indicators – PSIs), which are more and more frequently used by themselves or as part of "complication composites":

- Reported rates for Venous Thromboembolism (VTE) i.e. Pulmonary Embolism (PE) and Deep Vein Thrombosis (DVT) in many cases are actually measuring commitment to research and hospital specific screening test policies. The variation in these two controllable areas have an impact on raw rates that is ten times greater than differences in actual clinical approaches. We can design research, coding, and screening policies to yield any value between 1% and 15% for hip and knee replacement populations – without actually changing any real patient outcomes.[5]
- Reported rates for "Accidental Puncture or Laceration" are based upon an ICD-9-CM code 998.2 - Accidental Puncture or Laceration During a Procedure. It is used for a variety of situations – cutting an artery or bowel by mistake during surgery, etc. In the Spine Surgery population, most of these cases are "incidental durotomies." a minor nick to the dura membrane surrounding the spinal column, which may cause a small leakage of spinal fluid, and might in turn cause headaches and/or a small increase in length of stay. They are fairly common, ranging in frequency of 1% or less for simple laminectomy explorations or disk removal to 15% or higher for complicated spinal fusion revisions, multi-level spine surgery, and removal of adhesions from the dura itself from prior spinal surgery. Because it is common, many physicians never code it as a complication (e.g. half of hospitals and surgeons in New York State in a study performed by Next Wave several years ago.) Other surgeons always code it, while others will only code it if and how they repair the "leak." We can also design patient selection admission, documentation, and coding policies to yield any desired value between 1 and 10% for the spine surgery population – again without actually changing any real patient outcomes.

This illustrates a major concern expressed by many – that VBP will improve indicators, but may not improve actual outcomes. As we indicated above, we can easily identify policies to manipulate the above "outcome measures" by an order of magnitude – in large patient populations – spine surgery and hip and knee replacements represent a significant portion of the Medicare beneficiary population. We have worked on ways to understand, document, and improve these measures for the last decade to eliminate the potential to manipulate them and move toward specifications that will actually improve care.[6] The solution is further work and focus:

- ***All proposed measures for VBP (and Public Reporting) should be vetted through the NQF consensus process. This will assure the opportunity for all stakeholders to express concerns, with further evidence and study for important, yet controversial measures to resolve concerns.***
- ***All proposed measures to be evaluated and tested with both the real world measures themselves and in the clinical literature with controlled populations. Any discrepancy MUST be reconciled to avoid inappropriate measures.***

B. Major/High Impact Comments on Each of the Four Design Areas

Please refer to our Oral Comments in Attachment A for major discussions of these points. Below are further clarifications an references for issues and recommendations raised.

1. Measures of Value (Quality, Patient Experience, Efficiency)

The ultimate goal is to Improve Outcomes of Care – Reduce Risk of Patient Harm, Improve Patient Experience and Engagement in their own care, Improve Total System Efficiency – across settings and time, not just for current hospital admission.

The roadmap to get there is progressing from Process Measures Currently in Use (Interim Tools) -> Outcome Measures, with appropriate Risk Adjustment -> High Value efficient and effective care across settings and over time.

Several commenters suggested that **Structural Measures** should also be used, since they are implicitly part of the Structure/Process/Outcome quality framework. This is implicitly appealing, but raises challenges for how to measure appropriate structures.

- ***We recommend that Structural Measures should focus on Broad Concepts, such as:***
  - ***Commitment to Culture of Safety (several tools could be refined for use)***
  - ***Formal Commitment to Ongoing Process Improvement in a provider's management structure (e.g. FOCUS-PDSA)[7]***
  - ***Commitment to and Participation in Broad Initiatives – RHQDAPU, IHI-100,000 lives, Drug Safety, etc.***
  - ***Recognizing Nursing and other front line staff contributions***
    - ***Magnet Nursing is one way, but only 225 hospitals have been certified. This could be used as one of the criteria for sharing best practices, since Magnet hospitals have been evaluated on many of the above dimensions.***

2. Data Infrastructure & Validation (How data for the measures are collected and audited)

Note that several key factors need to be addressed in addition to those we presented orally:

- ***Any potential use of "complications" for Payment, VBP, or Public Reporting MUST utilize the "Present on Admission" concept to exclude issues that arose prior to the current hospital stay. There is a new indicator that will be available in Administrative data later this year. Analysis and measure validation can utilize data from California and New York – which have several year's data available.***
- ***Note that even measures such as Patient Experience of Care (HCAHPS) may require risk adjustment for appropriate benchmark comparisons. For example, malpractice claims are statistically related to MD-Patient interactions, and vary widely across patient types (e.g. Surgery patients, particularly Trauma and Orthopedic, have significantly higher claims than Internal Medicine.)***

3. Incentive Structure (Timing, Amounts, and Mechanisms for VBP payments)

The incentive structure is the Design feature to align rewards with desired actions. Ideally, the structure will clearly align incentive payments with the largest potential reform opportunities, remove major perceived barriers to the desired change, and provide immediate reinforcement for the desired behavior so that it becomes a habit.

a. Encourage Health Care Value – NOT Just More Efficient Hospital Silos.

The incentive structures presented in the Issues Paper appeared limited to isolated add-ons or bonuses for individual hospital efforts. This ignores a huge opportunity to encourage hospitals to help fix one of the largest problems with the current delivery system – the lack of good communication and coordination across settings for a patient episode and over time for patients with chronic conditions. Failure to include incentives for broader efforts could have unintended consequences of reinforcing the current "silo" mentality and inhibit needed reform action.

- ***Earmark a specific (and significant) portion of any hospital VBP funding to System-wide coordination efforts that are within the control of hospitals. This should apply to VBP efforts in all other settings as well.***

b. **"Front Load" Investments for Infrastructure, with an Explicitly Stated Plan to Move Toward Outcomes**

This concept is already a part of the VBP efforts - current initiatives are "Pay for Reporting" to encourage investment in data infrastructure and validation. Progress could be accelerated with more investments in Health Information Technology up-front, with returns from these investments occurring in later years. This investment would move the agenda forward as work continues to devise acceptable risk adjustment methodology for developing meaningful non-biased outcome measures.

- ***Invest higher VBP amounts in early years to accelerate implementation and overcome barriers.***
- ***Periodically publish updated "roadmap" plans for incentive structures, similar to current efforts to keep all stakeholders aware of planned HQA measure refinement.***

c. **Fixed and Variable Rewards to Align with Fixed/Variable Implementation Costs**
One of the major concerns raised is how to overcome the limited influence of incentive payments for small and/or rural hospitals due to low inpatient volumes[8] since the best VBP reward may not even cover implementation costs. Any VBP structure that ignores this issue will not be viable in the political and regulatory arena – numerous examples exist in the current hospital reimbursement formula.[9]

- ***Each desired action should be explicitly evaluated for implementation costs, with appropriate fixed/variable reward formulas to assure small and large stakeholders that their implementation costs are covered first AND in addition, they will see a reward for desired reform actions.***

d. **Facilitate and Reward Best Practice Transfer and Implementation**
There will be both highly performing hospitals and those that need help (lack of knowledge and/or resources) in implementing desired reforms. Top performers will have the knowledge and resources to achieve their success, and possess hands-on expertise in best practices and procedures. A small investment in technology transfer from Top Performers to those who need help can help rapidly implement reforms.

- ***Pay facilities to have their staff share best practices***
- ***Regional focus for efforts target stakeholders already aligned with interests in providing quality health care value for their community***
- ***Some form of accreditation to assure quality (Magnet Status for Nursing, Certified Curriculum, Certified Trainers, etc.)[10]***

C. Evidence and Experience References

In addition to cited evidence in the literature, references below also include relevant experience gained by Next Wave staff throughout their professional careers in policy development, provider and regulatory implementation, and evaluation of expected and unexpected outcomes.

Translating research into practice is slow, frequently taking 17 years from research hypothesis to broad implementation.[11] Overall performance does not achieve a passing grade in the U.S. health care system, where we routinely only implement half of proven best practices.[12] Health Policy requires a short turnaround, frequently 6 months or less for a particular issue, due to the rapidly changing priorities driven by demands of annual Legislative sessions and elections.[13] Because of this, policy researchers and analysts often must rely on their own knowledge and experience, unpublished reports and data shared by colleagues, personal contacts and experiences gleaned from others at professional meetings, and involvement on relevant Advisory Committees and Boards. For these examples, we outline the basis for our professional judgment - WHY a particular approach is likely applicable/transferable to Medicare Hospital VBP. We address to the extent feasible the explicit and implicit assumptions, context, and scope for the issue illustrated. We particularly note unintended consequences observed and the mechanisms apparently responsible for them (e.g. invalid implicit assumptions, unanticipated stakeholder reactions, etc.) We have observed that the ability to describe the mechanisms responsible for counter-intuitive results is critical to achieving face validity of findings. Few policies that lack face validity are ever successfully implemented.

We recognize that the scope of this paper precludes being able to present all of the nuances of the projects supporting our experiences – some details of which are proprietary to a particular stakeholder and cannot be shared without their consent. We therefore encourage readers to contact us for further details that can be shared to assess transferability at:

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[1] **Federal Register** / Vol. 71, No. 226 / Friday, November 24, 2006 / Notices, p. 67876-67877.

[2] Institute of Medicine (1999) *To Err is Human: Building a Safer Health System.* Linda T. Koh, Janet M. Corrigan, Molla S. Donaldson (Eds.). Washington, DC: National Academy Press.

[3] The State of Ohio implemented new nursing home payments in a 6 month time frame rather than many years other states required. In part this was driven by an increase in payments in the first years to compensate for the increased cost of implementation – removing potential objections about "unfounded mandates." The enabling legislation required recovery of this investment by year 5. The Ohio project director for these efforts, Sheila Lambowitz, currently leads several CMS reform efforts in the Office of Institutional Post Acute Care Policy.

[4] The $ 1.5 billion Federal-State Health Reform Partnership (F-SHRP) Medicaid Waiver granted to New York State in September, 2006 requires demonstrated program savings in total over the 5-year waiver period. There is planned investment in action areas to overcome current barriers to change – lack of funding for HIT, closure/consolidation costs, implementing infrastructure for optimizing setting for care delivery, etc.

[5] Next Wave. "When a Quality Measure Doesn't Measure Quality: A Case Study." Albany, NY. 1999. download at: http://www.nextwave.info/whitepapers/beware4.pdf

[6] Next Wave has worked on refining these measures over the past decade:

- Initial evaluation of variability in composite "complication" scores in 1997-1998 triggered by hospitals affected by unexpectedly high rates
- Case study (above) prepared in 1999 highlighting
    - Discrepancy between rates reported in clinical studies for Best Practices and those reported in administrative data (like MEDPAR)
    - Strong correlation between high hospital reported DVT rates and clinical research into best prophylaxis practices (25% of overall reported DVT rate variability was explained by a simple predictor representing Yes/no for recent DVT research found in MEDLINE.)
        - We found that the mechanism is screening, prophylaxis, and documentation practices. Most hospitals do not do screening tests for DVT. Underlying rates are high (50-60%) for hip and knee replacements (as well as cancer and trauma patients) without any prophylaxis. Hospitals therefore routinely prophylax these patients since the prophylaxis is fairly low risk for the patient. Coders are only allowed to code confirmed or suspected DVT, NOT "possible or at risk for DVT." If no screening test is done, no DVT code can be entered on the Administrative record.
        - Hospitals doing research to improve prophylaxis routinely screen 100% of patients because they need to know actual rates. Coders then have documented DVT rates in the record that they must code. "Best" DVT rates for Hip and Knee replacement are improving from 20-30% in the clinical literature in 1999 to 10-20% today. The reported rate in administrative data is only 1%, an order of magnitude lower than actual rates.
- We brought this finding to the attention of a number of researchers, including several involved with the creation of the AHRQ Patient Safety Indicators. Early descriptions of the PSIs incorporated references about this screening bias as a caution. In addition, the PSIs were consciously termed "Indicators" rather than "Measures" to indicate that they are important things to look at for improvement, but may NOT be appropriate for comparative use and public reporting.
- Also in 1999, we brought concerns over where to code Incidental Durotomies to the attention of the Editorial Advisory Board on ICD9-CM (EAB-Coding Clinic). They responded that either 997.01-Central Nervous System Complications or 998.2-Accidental puncture or laceration during procedure could be used, with

CDC-National Center for Health Statistics indicating a preference for 997.01.

- In 2003, we provided input to the ICD9-CM Coordination and Maintenance Committee for creation of two new DVT codes (453.41-Proximal and 453.42-Distal) to differentiate WHERE the clot exists. Distal clots, usually in the calf veins are not considered clinically meaningful by many MDs, who typically do not code them. These codes were implemented in October, 2004 and are becoming available in administrative data to do further analysis.
- In 2005, we requested that the EAB re-examine how Incidental Durotomies should be coded, resulting in a decision effective May 12, 2006 to code them to 998.2 along with lacerations of blood vessels, nerves, organs, etc.
- In 2006, we requested that ICD9-CM code 998.2 be further subdivided to explicitly identify Incidental Durotomies by adding a fifth digit. This request is still pending.
- We are preparing formal comments and requests to AHRQ to refine PSI definitions to reduce the existing bias in VTE and Incidental Durotomy measures. We expect to file these requests by March 2007.
- We stated a concern in our 1999 White Paper that: *There is an old saying that goes "Everything looks like a nail if your only tool is a hammer." Unfortunately, this saying is all too familiar in today's world of "report card" measures for hospitals derived from MEDPAR administrative billing data. We can and should do better*. Our predictive concern in 1999 plays out today – we don't have desired validated outcome measures, so there is a strong temptation to use whatever we have – regardless of evidence of bias and gaming.
- Commercial vendors striving to meet Consumer demand for "Report Cards" is driving more and more (inappropriate) use of the PSI measures that are biased.
- CMS can take a leadership role by only posting NQF validated measures on their Hospital Compare website, avoiding any composite measures incorporating indicators that are not ready for prime time, such as the PSIs for VTE and Accidental Lacerations.

[7] FOCUS-PDSA is a common process improvement strategy, with ongoing steps :

- **F**ind a process to improve,
- **O**rganize the team and its resources,
- **C**larify current knowledge about the process (analyze baseline data),
- **U**nderstand sources of variation and clarify steps in the process,
- **S**elect an improvement or intervention.

After selecting the process to improve, implement the iterative improvement process

- **P**lan how you will implement the intervention,
- **D**o it (carry out the change, preferably on a small scale),
- **S**tudy the process to see whether your intervention has made an improvement,
- **A**ct on what you have learned, which may mean either implementing the change on a larger scale, starting over or tackling a new area of improvement.

[8] Gregg W., Moscovice, I., & Remus D. (2006, September). The Implementation of Pay-for-Performance in Rural Hospitals: lessons from the Hospital Quality Incentive Demonstration Project. Upper Midwest Rural Health Research Center Working Paper 2. http://www.uppermidwestrhrc.org/pdf/pay_for_performance.pdf

[9] The Medicare Inpatient Hospital PPS includes adjusts for Critical Access Hospitals, Medicare-Dependent Small Rural Hospitals, Sole Community Hospitals, Rural Referral Centers, geographic wage reassignment, rural community hospital demonstrations, higher non-wage rate fraction for facilities with lower overall wages (mostly rural), etc. – see Federal Register, Vol. 71 (60), August 18, 2006.

[10] One model for "accredited" knowledge transfer is the Diabetes Self Management Program (in this case to patients.) It encompasses curriculum approval by the American Diabetes Association and requires trainers to be certified. Hospitals could be certified to teach their Best Practices by virtue of being a top performer, with other certification steps like Magnet Nursing status to teach nursing Best Practices, etc. A process to approve the curriculum could be implemented – possibly local/regional peer review with regional educational sessions (partially funded by VBP dollars to encourage participation) to teach some aspects of the Best Practices. In addition, hands-on reinforcement would be useful – nurses from the Certified facility going on-site to the facilities they are mentoring, etc.

[11] Institute of Medicine Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press, 2001, p 364.

[12] McGlynn, E., Asch, S., Adams, J, et al. The quality of healthcare delivered to adults in the United States. *New England Journal of Medicine, 348,(26):* 2635-2645.

[13] AcademyHealth – First State Health Policy and Research Interest Group (SHPRIG) Meeting, Boston, MA. June 25, 2005. John D. Shaw, Next Wave's President, is a member of the Advisory Committee of the Academy's SHPRIG.

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Oral Comments*

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Implementing Value Based Purchasing: *Policy Questions, Practical Solutions*

Oral Comments – John D. Shaw, President, Next Wave, January 17, 2007

1. Measures of Value (Quality, Patient Experience, Efficiency)

I wanted to address a few issues today and will address more in the written comments.

A. The first is recognizing the map or framework of where we are going.

a) We are looking primarily at process measures today, and in the near future.
b) We have already heard a desire to go to outcome measures - and the need thereby to have appropriate risk adjustment.
c) The third area to go to is an even more important area - one we need to start getting people directed towards - and that is looking at the coordination of care for the patients:
    a. Across an entire episode, regardless of setting, and
    b. Across time, particularly for the chronic care patients.
d) So in terms of flagging overall direction, I think it is important to really focus on the need for **more cooperation across settings and time**.

B. We also wanted to comment on the composite measures.

There are good composite measures, and there are not-ready-for-prime-time composite measures right now. Let me give you a couple of examples.

a) The best of the composite measures that we've seen is the communication portion of HCAHPs - and maybe not even just taking the composites as presented, but further collapsing some of them down.
    a. Back a number of years ago, after CAHPS were implemented in the HMO side, we found statistically significant correlations between:
        i. High communication scores and
        ii. High adherence to chronic disease management measures.
    b. So, particularly when targeting chronic disease populations, having a high weight for the communication function would seem appropriate because there the patient themselves are a major part of their own care team.
b) Some of the not-ready-for-prime-time composites we've seen over the years are composite measures for complications.
    a. We not only deal with the national and state policy side in designing, evaluating and implementing improvements, we also work with individual providers down in the trenches (with their physicians, with their coders) in trying to look at the data that is supporting all of this.
    b. We found 10 years ago that some of the composite measures for complications were actually being driven by one particular item, and that particular item was driven by whether the hospital actually did research or not. This is NOT what we are looking to try to measure in performance here.
    c. The item is VTE (venous thromboembolism.) This indicator is one of the current composite measures in the Patient Safety Indicators - VTE rates (pulmonary embolism and blood clots in patients.)

d. When you look at the details you will find that things other then providing good care have an impact on that measure that is **10 times greater than the actual clinical impacts.**
e. So, it was appropriate if you look at the SCIP (Surgical Care Improvement Project) scores, that the only VTE measures are now process measures.
    i. That came out the evaluation that was done through the NQF and the Joint Commission – eliminating VTE rates in the latest update to the SCIP measures.

C. The third measure area we should really want to look at is Measures of Coordination of Care. This is the second of the IOM cross-cutting Priority Areas for National Action - and that goes across settings.

2. Data Infrastructure & Validation (How data for the measures are collected and audited)

I want to address a just a couple of the items in this area.

A. First - in the previous discussions we talked about the need to move to outcome based measures which requires risk adjustment. Risk adjustments in turn are going to require full and accurate descriptions of the condition of the patient and that includes ALL of their diagnoses and procedures and everything that is going on in the hospital that you can capture from that. There is a major gap in the ability to do that in the MEDPAR database currently. The MEDPAR database is only keeping nine diagnoses and six positions. HIPAA standards allow for 25 of each. The Medicare contractors need to (in current guidelines) collect all 25 codes and be able to report them back out.[1] But the MEDPAR database is the only national database that everybody uses for all of this. And so, fix that - **making the CMS internal MEDPAR system fully HIPAA compliant is the #1 data infrastructure priority to be able to move forward.**

B. The second comments are relating to the whole data validation. In that area I think we can learn from other audit and data validation projects over the years in various settings. My belief is that the goal we are looking for is:

- The most accurate data,
- With the least burden, and
- Finding a way to assure that to everybody that is a player –
- Or "find and fix problems fast."

The mechanisms to do so in the projects I have been involved with or evaluated over the years use a combination of random and targeted audits. It is not one or the other, it is both. By doing so,

1 Note: We clarified Contractor guidelines subsequent to oral comments. Contractors must accept all 25 and be able to retransmit all to other Payors (e.g. Medicare Secondary Payors) that require them. They only must be able to transmit the number of Diagnoses and Procedures in the current paper Uniform Bill (currently 9/6, increasing to 15/6 when UB04 is implemented) to CMS. We have studied and demonstrated a systematic bias dependent on the number of positions reported in Quality Indicators such as AHRQ's PSI's. We have also found that it is now literally impossible to describe many complex procedures in only 6 positions. Our recommendations stand – restricting the number of data positions that "Count" will have the unintended consequence of rewarding "Code Sequencing" rather than valuable care. Computer vendors and consultants will benefit rather than patients.

you can actually save money and improve your findings. You don't have to audit everybody on the same schedule, all the time, on a random basis. If you do so, what you lose on the random audits is any low frequency findings patterns. You are not going to have enough cases to be able to see them until you put it all together in the CDAC. That is where you are going to find the pattern. You do random audits to make sure you are catching anything you don't know about ahead of time. You use targeted audits from analyzing patterns in the whole data base, then you can focus on subsets of those. At the individual facility if you find someone fails the first level, you can do a bigger sample - and things like that.

I think less frequent and larger samples make a whole lot more sense also. You want to be able to have enough to eliminate some of the variability issues in the reliability of your audit sample anyway. And also learn from some of the other audits where if the facility is able to demonstrate that their data is reliable maybe you want to sample them less frequently. Essentially what you are doing is "deeming" status to them to assure their own reliability - because they have given you reason to trust them. All of that can be factored into the process. What I suggest is look at the audit process, the PCA (the Progressive Corrective Action is a process within CMS for designing audits and really targeting the most important piece.)

C. The last area that you can consider is to make data reliability a reported measure itself.

3. Incentive Structure (Timing, Amounts, and Mechanisms for VBP payments)

I have a couple reactions on the structured incentives area - particularly in response to some of comments today. It struck a little bell - two years ago the NQF did a Pay-4-Performance brainstorming session a little bit south of here, and I was the scribe on the "unintended consequences" subgroup - and kept good notes. Essentially, some of the problems can be addressed by the structure of the incentives.

One problem is the unwillingness to share best practices. If it is a "tournament competition" (if I win, you have to lose), then the people at the top want to hold on to their edge, and that's a problem. Likewise, there is a doom loop for the small facilities, if you don't have the resources, how do you get to where you want to be - at least to the minimum expected level? So, some of our suggestions are to try to deal with those kinds of things. How do we continue to engage both ends of the spectrum?

A. One thing you can do is, when you are making the payments, it doesn't have to be a straight percentage so that large facilities always win and the small facilities always lose. Some costs are fixed and some costs are variable. **So you could pay $50,000 for this tier plus x dollars plus x % - a fixed amount to try and address some of the infrastructure issues plus a variable amount to reflect performance and volume.**

B. Another thing you can do is something I mentioned earlier. We are moving towards a cost effective system and the biggest area of waste that exists is coordinating care across an episode and over time. If you don't have dollars earmarked for that area you are not going to get it. So, we strongly recommend that **a portion of the dollars, however you get them, gets earmarked to**

fund sharing, and best practice dissemination, and working together between different settings to come up with a good system wide process.

C. Another thing related to that - looking at is 2% the right number, should it be budget neutral and so on, one of things you can do is accept the fact that change takes more than 10 minutes. We just got a $1.5 billion waiver in NYS to implement change with an expectation that we are going to spend more up front to invest and build the infrastructure, and basically regain the savings when the system improvements are in place. So, it's coming out of the savings everybody is generating, not out of necessary pay roll and staff. So, **look at the budget neutrality on a broader framework (e.g. 5 years vs. 1)** and **front load the investment.** This is not a cost saving - budgeting cutting - every quarter - every year we have to this do this - no matter what. You are not going to get change until you invest.

D. The other way of engaging all the participants: the top performers (whether it's the "top", or the better, or the most improved) have some knowledge that would probably be useful for those at the bottom (or the small facilities.) So, one of the ways of investing in the broader spectrum is to **pay the good performers to help the others with technology transfer**. And I am not just talking about people at policy levels. I am talking about paying nurses, paying therapists to go from the top performers to the others that need some additional technical assistance to help them build the infrastructure, and help them to be able to improve at that level.

4. Public Reporting (Transparency for all Stakeholders - in a useful format)

On the public reporting side - look at how consumers view health information.

A. In our experience both on a personal perspective (from being a caregiver for parents and so on) as well as some of the work groups we've had in building policy – consumers only care about health information when it is "here today for me, for whatever I've just been diagnosed with" and so on. The composite measures should reflect the kinds of information that people are looking for. So, **there should be a composite for each of the chronic disease categories**. If you are newly diagnosed and identified with this disease here are the measures that affect you.

B. If you are looking at "I'm going in for surgery"or "my husband was just admitted with heart failure" what do you do? Look for those **procedure composites**.

C. I think some of the other ones that are broader framework everyone wants to say "well, what's the bottom line? - How many stars does this whole hospital have?" **I am not sure you can do that very well without significant risk adjustment.** And I am not sure consumers need that. I think hospital boards would like that, but what their consumers really need to know is what is important to them.

D. The broad-based measures from **HCAPS** are going to help provide a lot of the bottom line.

E. If we can come up with and find a broad based **cooperation and coordination between settings set of measures** that would also be good.