



Measures: The Heart and Battleground

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Medicare Hospital Value-Based Purchasing

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Topics for Today

1. VBP Scoring Approach – a cook’s tour
2. Value: benefits of services in relation to their cost
3. Inherent goals should determine what and how to measure

“If CMS is going to place a significant burden on the industry, please let’s do it right, and make it worthwhile for everyone.”



Calculation of the VBP Total Performance Score

Performance Score for Domain:

Total earned points ÷ Total possible points x 100

- **Attainment**
- **Improvement**

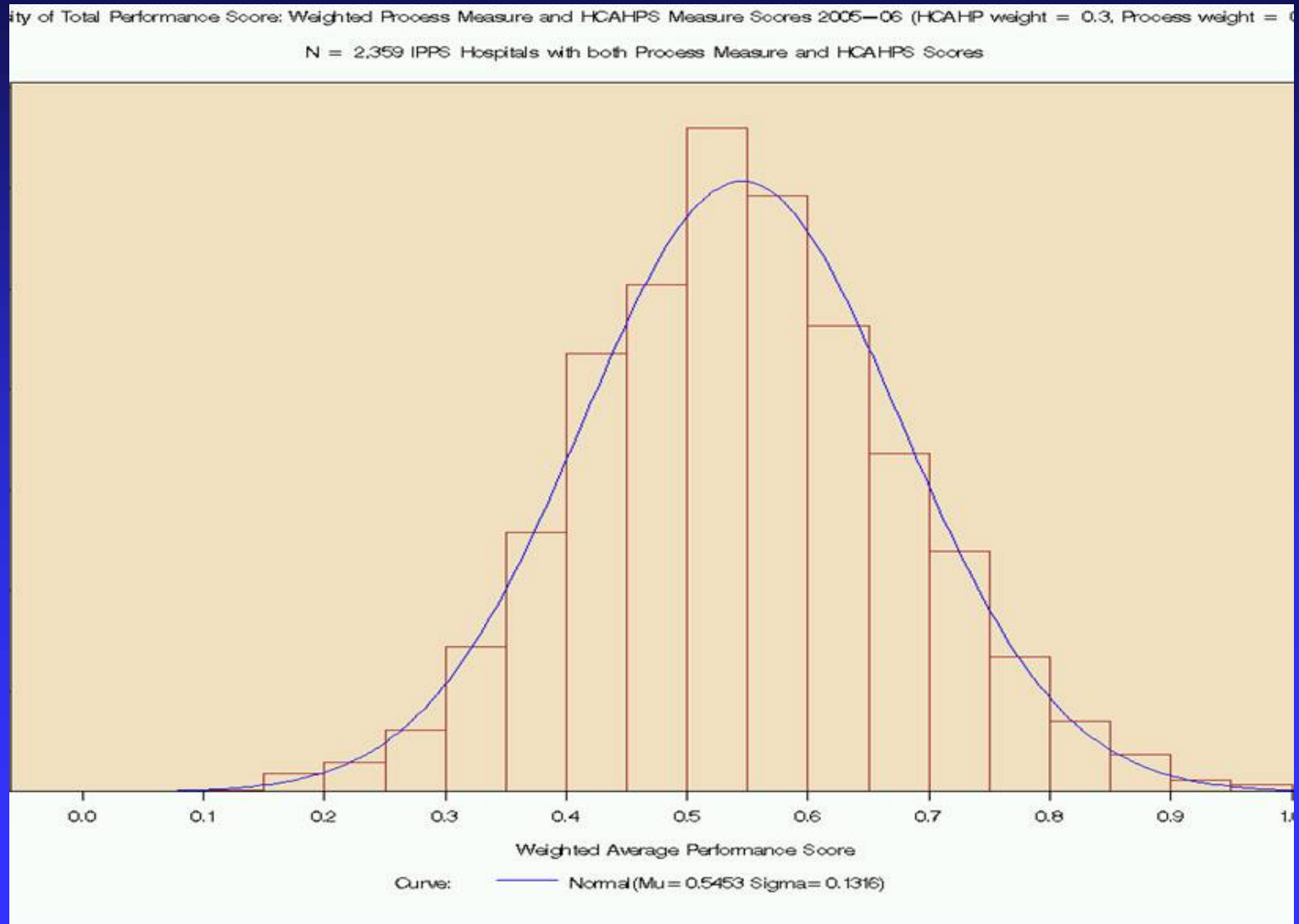
Total Performance Score:

**Weighted average of the Performance Score for the
respective domains**

- **Clinical process**
- **Patient-centered care**
- **Clinical outcomes**

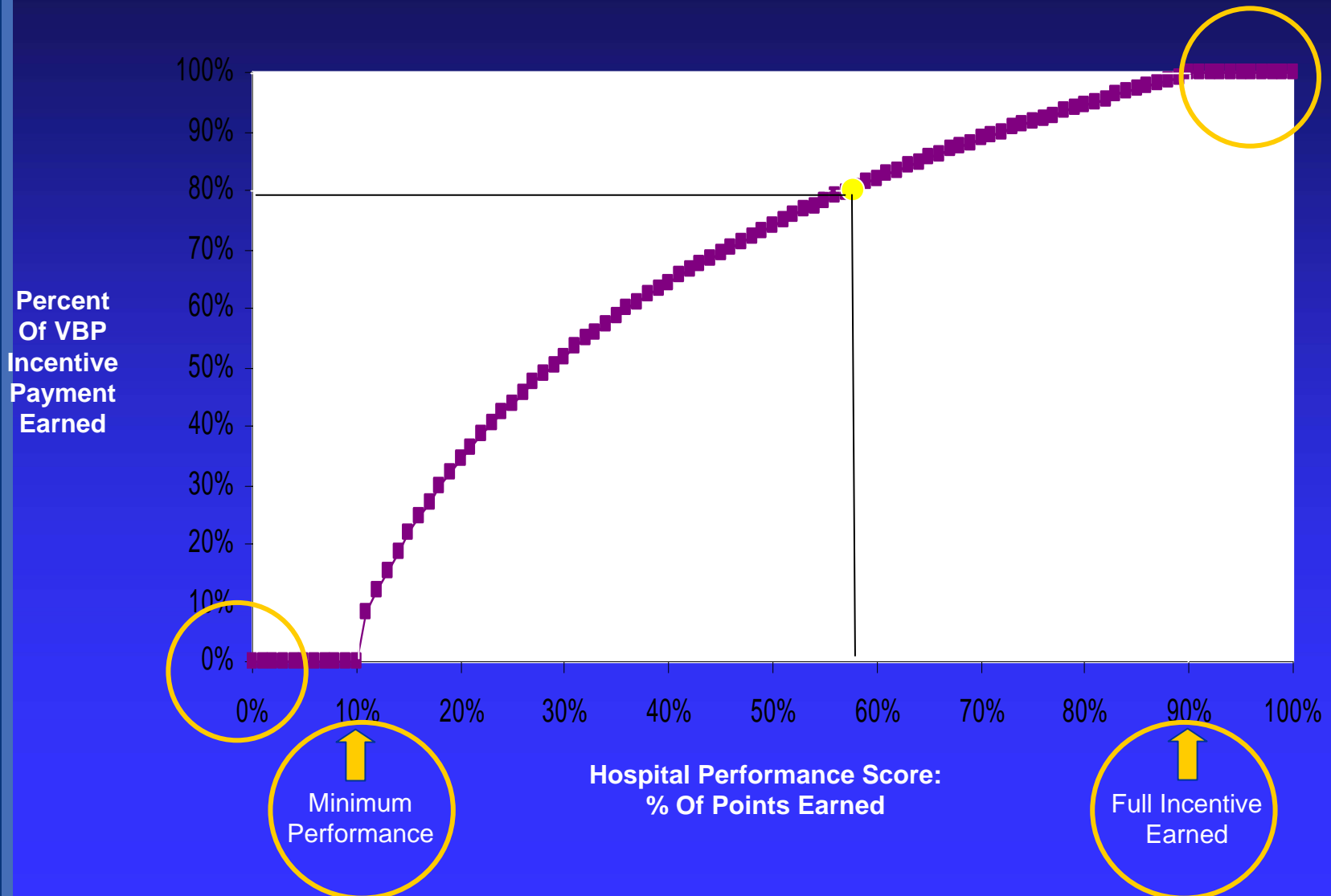


Total Performance Score: Clinical process (70%), HCAHPS (30%)



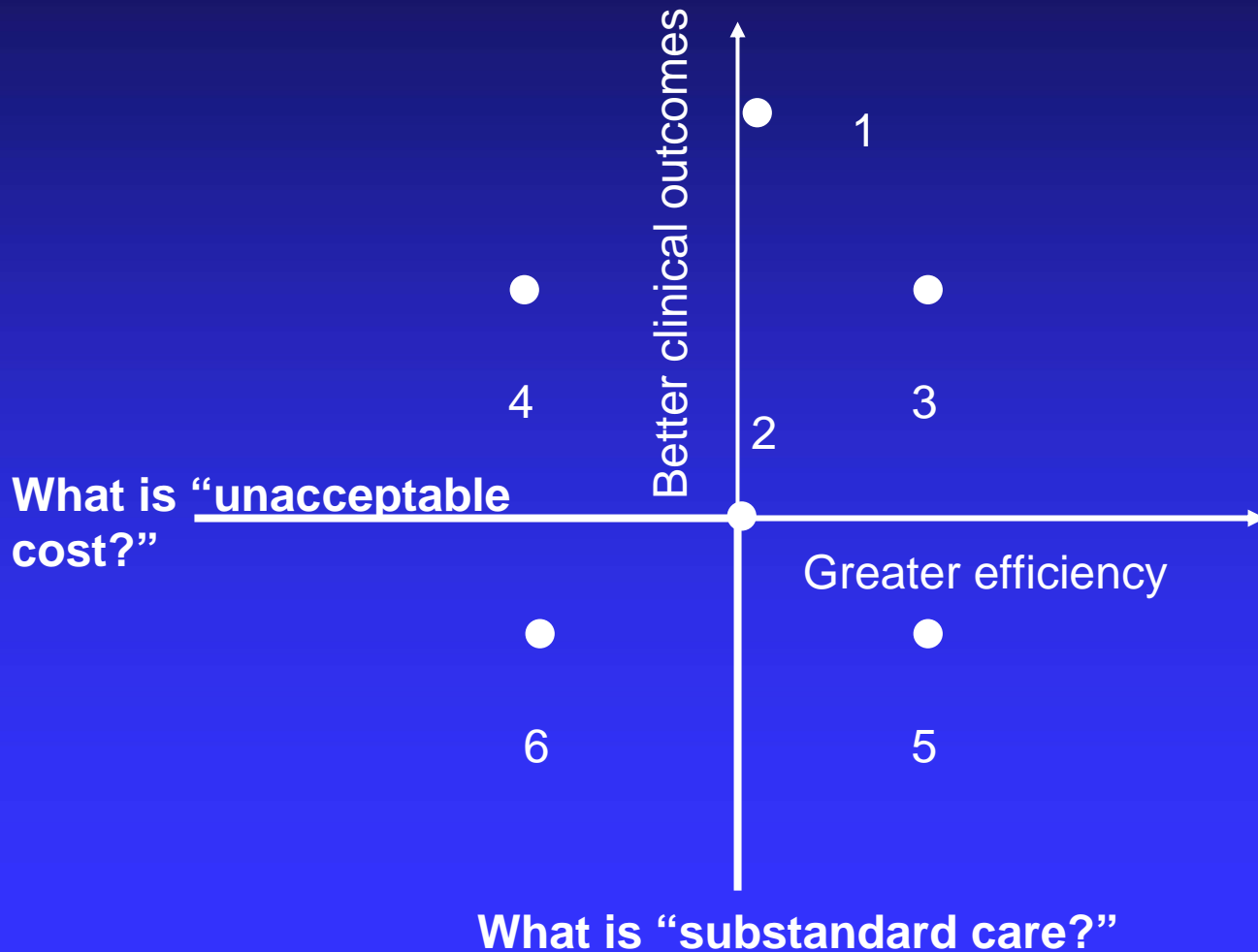


Translating Performance Score into Incentive Payment: Example



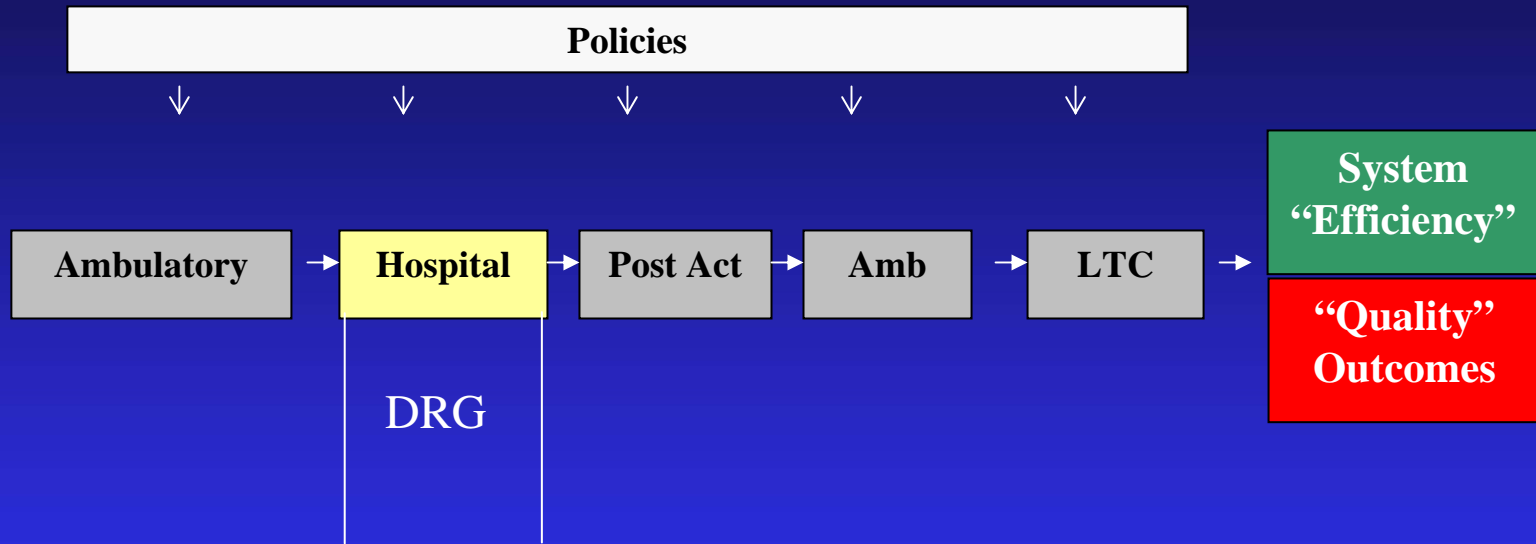


Opportunities for VBP to Increase Value





Policy Goals: Quality and Efficiency





Hierarchy of changes

1. **Easier:** Frequency of service units
e.g., fewer images or more well-baby visits
2. **Harder:** Complexity within units
e.g., screening during routine visits,
medications or ancillaries within a DRG
3. **Hardest:** System level improvements
e.g., upstream prevention, downstream outcomes,
care coordination, information sharing,
shared accountability



Roll Call: Agents of Change (graph instead from article?)

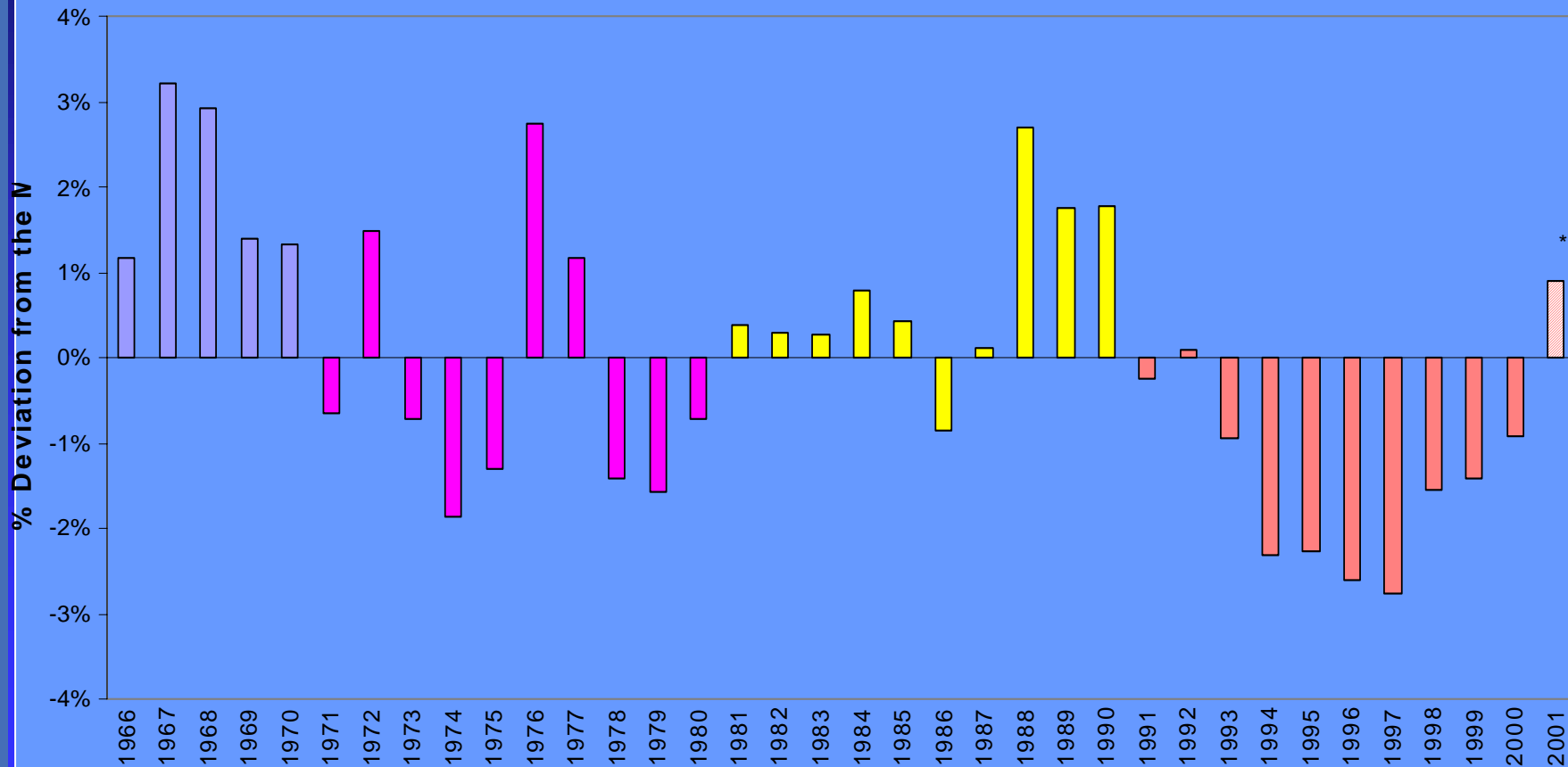
- 1970s: Regulation
 - 1980s: Market mechanisms
 - 1990s: Managed Care
 - Transcended providers
 - Information systems
 - Utilization management
 - Population-based medicine
 - 1990s: Disease management
 - 2000s: Consumers
 - 2000s: Providers via P4P
- Practice management
- Patient management
- Either, both, or neither?

Altman, S., C. Tompkins, et al. "Escalating Spending for Health Care: Is it Desirable or Inevitable?" *Health Affairs*, 8 January 2003, W3-1 – W3- 14.



Expenditure Growth Rates

Chart 2: Per Capita National Health Expenditure Growth Rate - Deviation From the Mean 1966 - 2001 (Adjusted for Inflation, 1996 reference year)





Criteria for VBP Measures Lifecycle

- Importance
- Scientific Acceptability
- Feasibility
- Usability
- Improvability
- **Controllability**
- Potential for Unintended Consequences
- Contribution to Comprehensiveness



SCOPE of Measurement for VBP

- **Structure**
- Cost
- Outcomes
- **Process**
- Experience



Process measures

- Reliance on Condition-specific Process Measures (Controllable)
 - Evidence of causal linkages to outcomes for provider acceptance
 - Evidence does not always show effectiveness of process measures (Fonarow et al.)
 - Issue of Teaching to the test and *saturation in performance*
 - May hinder innovation and practice of “technologies” outside of the processes being measured
 - Less of a *laissez-faire* approach
 - Need for measurement to be *agile* (Vaccine shortage/antibiotic supply)
 - Small n issues
- Parallel data infrastructure set up alongside DRGs, mimicking the purpose and burden of FFS



Outcome Measures

- Existing outcomes measures are not discriminatory
 - HF 30-day mortality

	<u>Better Than U.S. National Rate</u>	<u>No Different Than U.S. National Rate</u>	<u>Worse Than U.S. National Rate</u>
Out of 4477 hospitals in US	17	4453	7 (now 0)

CMS 30-Day Mortality Measures Acute Myocardial Infarction (AMI) Heart Failure (HF),
Barry M. Straube. Sep. 18, 2007. Hospital Quality Alliance Principals Meeting



Outcome Measures

- Clinical Outcomes and Cost as the *frontline* of measurement
 - Controllability?
 - Inferring lack of “appropriate” interventions
- Clinical Outcomes measurement
 - Broad construct of clinical outcomes including mortality and morbidity
 - Define relevant patient cohorts (based on clinical conditions)
 - Create composite clinical outcomes measures that:
 - Reflect outcome ‘severity’
 - Are patient-centric
 - Allow inference of “appropriate care”



Prototype Outcomes Domain

	1	2	3	4	5	6	7
	Ambulatory Follow-up	null	Minor Complication	Major Complication	2+ ER	Readmission	Mortality
Cohort 1							✓
Cohort 2						✓	
Cohort 3	✓						

- Hierarchical scoring: (examples depicted in the chart)
 1. patient died=7;
 2. patient survived but readmitted=6;
 3. no negative outcomes but appropriate ambulatory follow-up=1
- Combines negative (complications) and positive (coordination of care)
- Risk-adjusted: observed compared to expected



Cost of Care

- Measure cost of care in conjunction with clinical outcomes and using the same “unit of measurement”
- Allow for examining the cost-clinical outcomes relationship, including trade-offs
- Measure the efficiency frontier



Role of Structure and Process

- *Fallback* measures (?)
- Important for quality improvement but not VBP
- Allow market or the *producers* of healthcare to determine
- Foster learning networks
 - Medical technology as a “public good”
 - Funding for sharing of technologies



Unit of Accountability

- Practitioner-centric measurement
 - Practice management
 - Unit of accountability is single organization: hospital, individual physician or medical group etc.
- Patient-centric measurement
 - Patient management
 - **Shared Accountability** of all organizations and entities involved in care provision (Fisher et al. 2005)
- Ability to operationalize patient-centric measurement and shared accountability
 - Integrated Delivery Networks (IDNs)
 - *Virtual* practitioner teams: hospital and extended medical staff (Fisher et al. 2006)
 - *Virtual* delivery networks



Conclusions

- Altman's Law (paraphrased)
 - The status quo is everyone's first or second choice
 - A political majority is against any particular reform
- Tompkins' Corollaries
 - Industries tend to defend the status quo
 - Inertia resists significant change
- Measures represent the heart of VBP
- Selection and implementation is the key battleground