

YOUR **TOMORROW** IS IN YOUR HANDS **TODAY!**



The AAA is fighting for you!



SESSION 26: POINT-COUNTER POINT – EMS COMPASS, MEASURING AND VALUE BASED PURCHASING

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EMSWORLD[®]

“Get Ready for Value-Based
Purchasing”
June 2014



Is EMS Next to Transition to Medicare's
Value-Based Payment Model?

February 2014



Value-Based
Purchasing:
Linking Reimbursement
to Quality



The New Role of 'Patient Experience'

December 2013



Overview

The Health Care Environment

What are the drivers of quality?

What does quality in Medicare look like: Dialysis a case study

Are ambulance services/EMS next for value-based purchasing?

What is the anatomy of a quality program?

Where do ambulance services fit in?



The Shifting Sands HHS's Better, Smarter, Healthier Plan

Alternative Payment Models (ACOs, bundling)

- Currently, 20 percent
- 50 percent by 2018
- Reducing Medicare spending

Value-based Purchasing

- 90 percent FFS by 2018
- Improving patient outcomes
- Cutting payments to low performers



Example Questions about Alternative Payment Models Abound

Health Economist

- Are the savings real long-term or only one-time success stories?
 - Benchmarks to determine savings shift over time

Kaiser Family Foundation

- Will ACOs lead to greater health care consolidation?
 - Requires 5,000 lives; can smaller providers engage in these models?



Concerns about CMS Measuring

“The Commission has become increasingly concerned that Medicare’s current quality measurement approach has gone off track in the following ways:

- It relies on too many clinical process measures that, at best, are weakly correlated with health outcomes and that reinforce undesirable payment incentives in FFS Medicare to increase volume of services.
- It is administratively burdensome due to its use of a large and growing number of clinical process measures.
- It creates an incentive for providers to focus resources on the exact care processes being measured, whether or not those processes address the most pressing quality concerns for that provider. As a result, providers have fewer resources available for crafting their own ways to improve the outcomes of care, such as reducing avoidable hospital admissions, emergency department visits, and readmissions and improving patients’ experience of care. “



MedPAC's Concerns (con't)

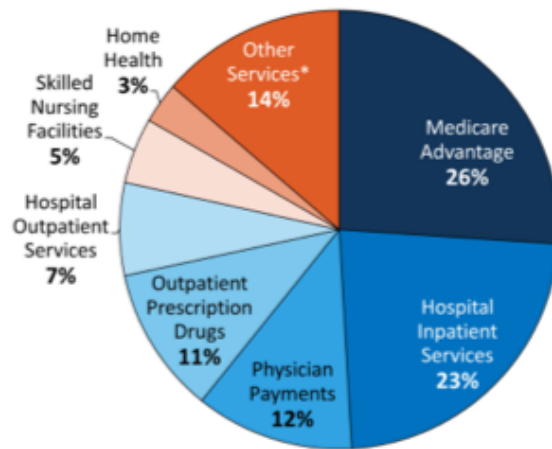
- “In short, Medicare’s quality measurement systems seem to be increasingly incompatible with the Commission’s goal of promoting clinically appropriate, coordinated, and patient-centered care at a cost that is affordable to the program and beneficiaries.”



Would CMS Include Ambulance Services?

Figure 2

Medicare Benefit Payments, 2014



Total Medicare Benefit Payments, 2014 = \$597 billion

NOTE: *Consists of Medicare benefit spending on hospice, durable medical equipment, Part B drugs, outpatient dialysis, ambulance, lab services, and other Part B services; also includes the effect of sequestration on spending for Medicare benefits and amounts paid to providers and recovered.

SOURCE: Congressional Budget Office, 2015 Medicare Baseline (March 2015).



Ambulance services are only about 1 percent of Medicare payments, according to MedPAC

- Not at all clear CMS would try to incorporate emergency or non-emergency in expanded bundles or integrated care models; also not clear would require VBP



Drivers of Quality: No Single Program

Internal Quality Initiatives

- Activities such as deploying standardized protocols, identifying and disseminating best practices, and benchmarking
- May involve performance measures for longitudinal tracking within an organization/physician practice or to analyze the outcomes of different interventions

Research

- New knowledge and its dissemination are essential to improving the quality of care
- Foundation of quality initiatives
- Focus should be on knowledge gaps for which research could advance understanding



Drivers of Quality: No Single Program

System Innovation

- Potential system delivery changes, potential technological advances, or potential policy changes explored through small-scale projects or testing because they might be promising based on the existing knowledge base, but for which widespread adoption might be premature

Federal and State Policy

- Payment policy drives care provided and quality of that care
- Establish initiatives not linked to payment
- State licensure and protocols



Drivers of Quality: No Single Program

Public Reporting/Value-Based Purchasing/Pay-for-Performance

- Create accountability through publicly available information about quality performance
- Withholds payment from providers unless certain quality performance levels are attained

Community Initiatives

- Providers identify their own quality goals, metrics, and public reporting systems



Types of CMS Quality Initiatives: A Case Study

Claims-Based Reporting

QIO/Network Programs

Compare sites

Five Star

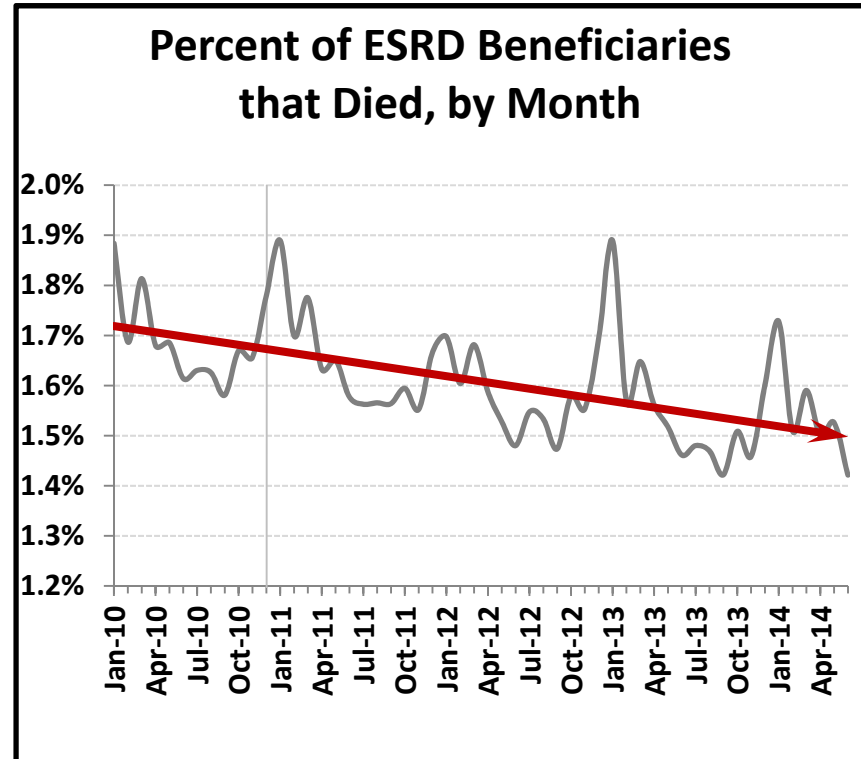
Quality Improvement Programs

Community-Based Initiatives



CMS: Claims-Based Reporting

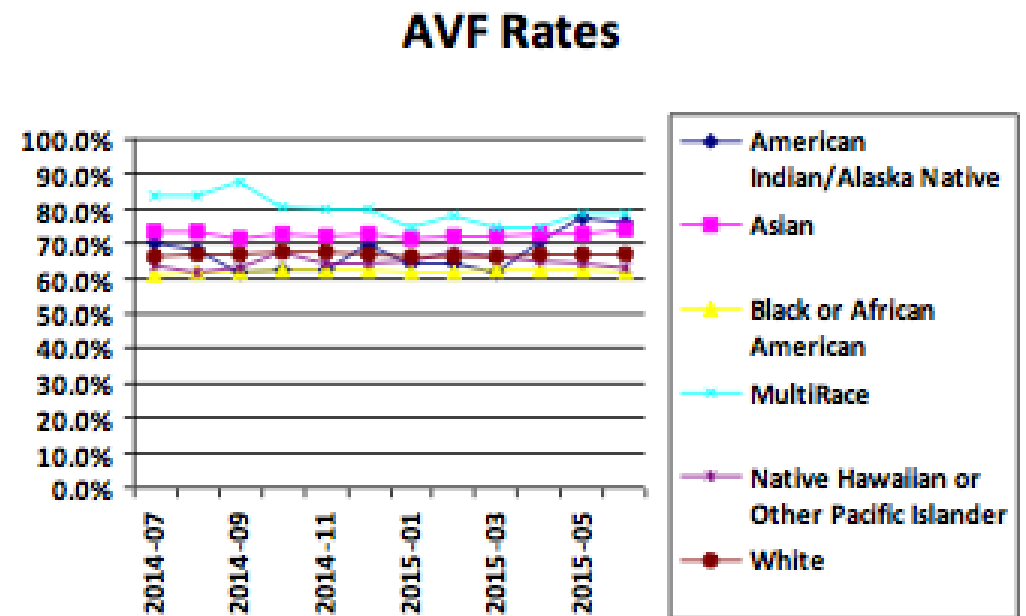
- Dialysis facilities must report dialysis adequacy, hemoglobin levels, and other metrics, which CMS then publishes
- Measures not always consistent with other programs





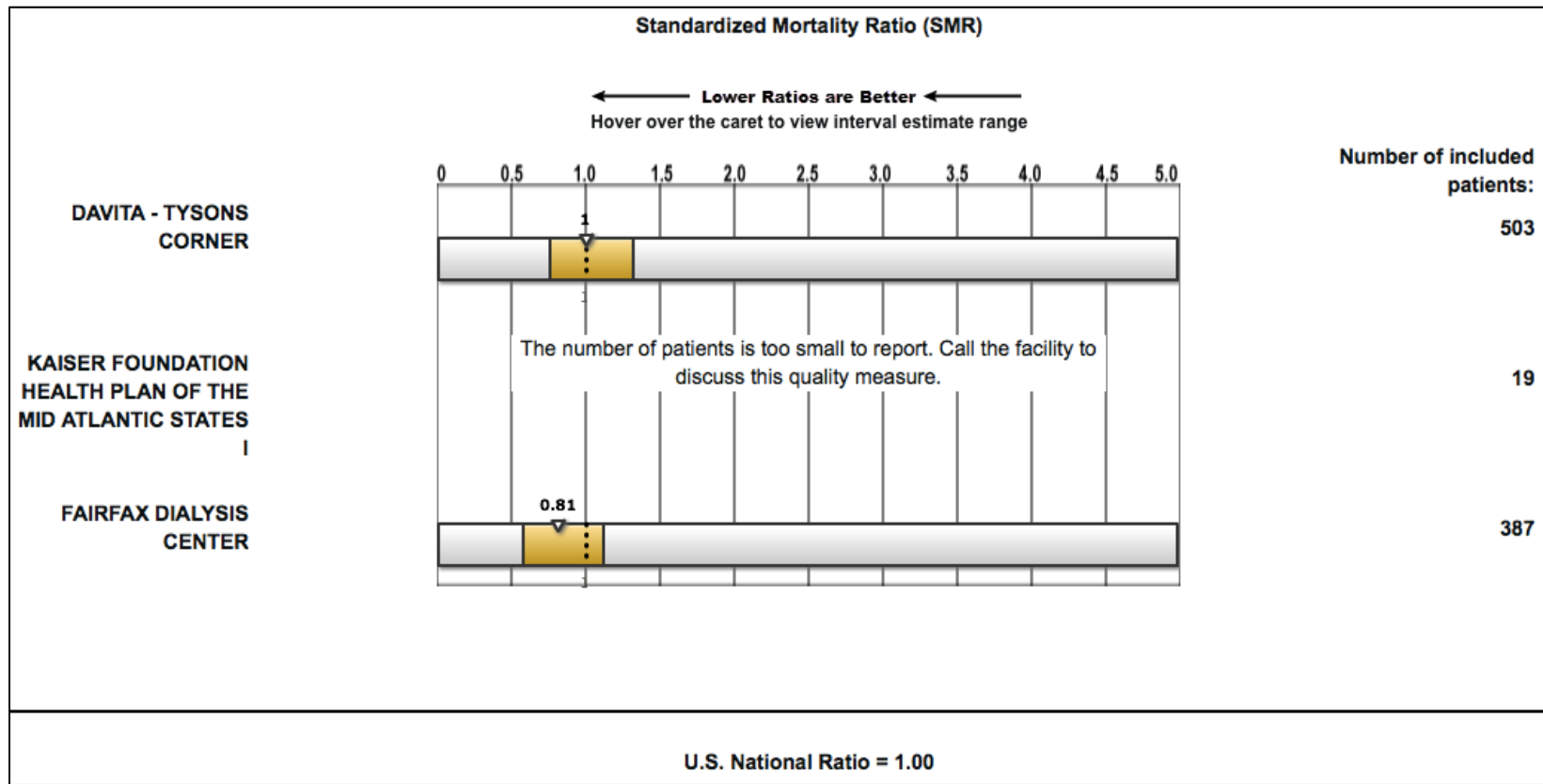
CMS: QIOs/Network Programs

- Fistula First, Catheter Last
 - Networks set goal of 68 percent of patients having an AVF
 - Provides forums for discussion and resources to assist facilities in achieving the goal
 - Not consistent with ESRD QIP





CMS Compare Websites



- Patients can compare providers based upon measures CMS determines appropriate
- Often inconsistent with other quality programs



CMS Five Star

Viewing 1 - 20 of 92 results

Filter by:

Overall Star Rating

- ★★★★★ (8)
- ★★★★☆ (20)
- ★★★☆☆ (39)
- ★★☆☆☆ (7)
- ★☆☆☆☆ (6)

Dialysis Facility Characteristics

- Shifts starting after 5PM
- In-center hemodialysis
- Peritoneal dialysis
- Home hemodialysis training

Want to start a new search?

Start New Search

Dialysis facility information	Overall Rating	Distance	Shifts starting after 5PM	In-center hemodialysis/No. of stations	Peritoneal dialysis	Home hemodialysis training
FAIRFAX DIALYSIS CENTER 8316 ARLINGTON BLVD STE 108 FAIRFAX, VA 22031 (703) 698-8070	★★★★☆	3.5 Miles	Yes	Yes/ 28	Yes	Yes
Add to Compare						
Add to my Favorites						
TOTAL RENAL CARE - FAIRFAX 8501 ARLINGTON BOULEVARD STE 100 FAIRFAX, VA 22031 (703) 876-8445	★★★★★	3.9 Miles	Yes	Yes/ 10	Yes	Yes
Add to Compare						
Add to my Favorites						
DAVITA - ARLINGTON 4805 FIRST ST NORTH ARLINGTON, VA 22203 (703) 527-0652	★★★★☆	6.2 Miles	No	Yes/ 23	No	No
Add to Compare						

- Dialysis facility performance compared on a bell curve: 10 percent will always be 1 star
- Uses measures that are relative along with rate measures
- Inconsistent with other quality programs



Quality Improvement Programs

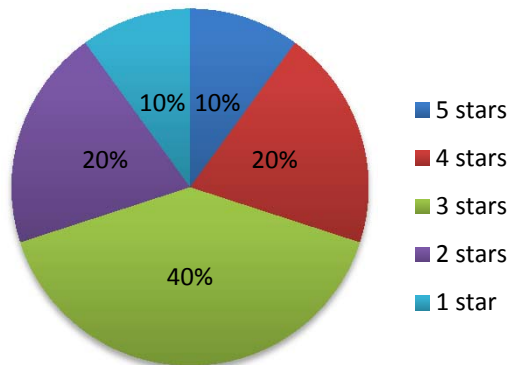
- Penalty-based program, despite industry call for rewards structure
- Does not adequately address small numbers
- Number of measures proliferating
- Includes measures for which facilities have little or no ability to influence

Total Performance Score	Payment Reduction
60 to 100	No Reduction
50-59	0.5% Reduction
40-49	1.0% Reduction
30-39	1.5% Reduction
0-29	2.0% Reduction

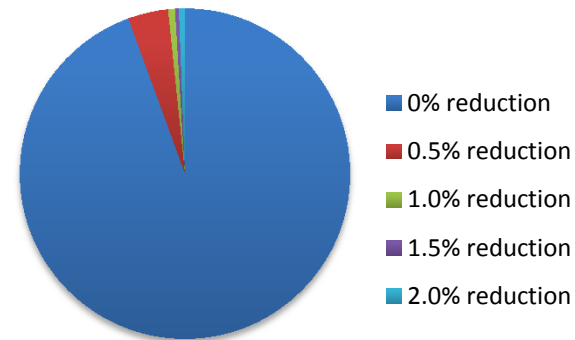


CMS Lacks Consistency

Percentage of Facilities
DFC Star Ratings



Percentage of Facilities
ESRD QIP



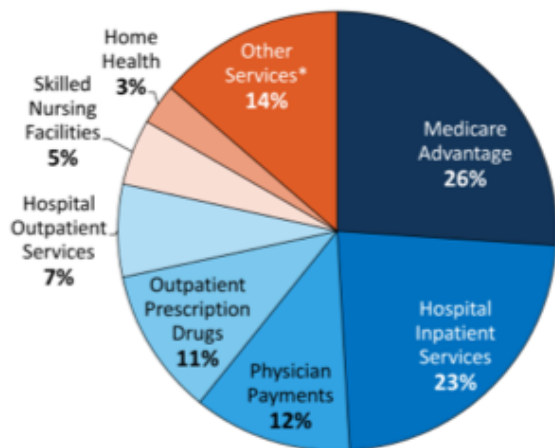
**More than 1,400 dialysis facilities receive no QIP penalty,
but given only 1 or 2 Stars**



Is CMS Considering Ambulance for Value-Based Purchasing?

Figure 2

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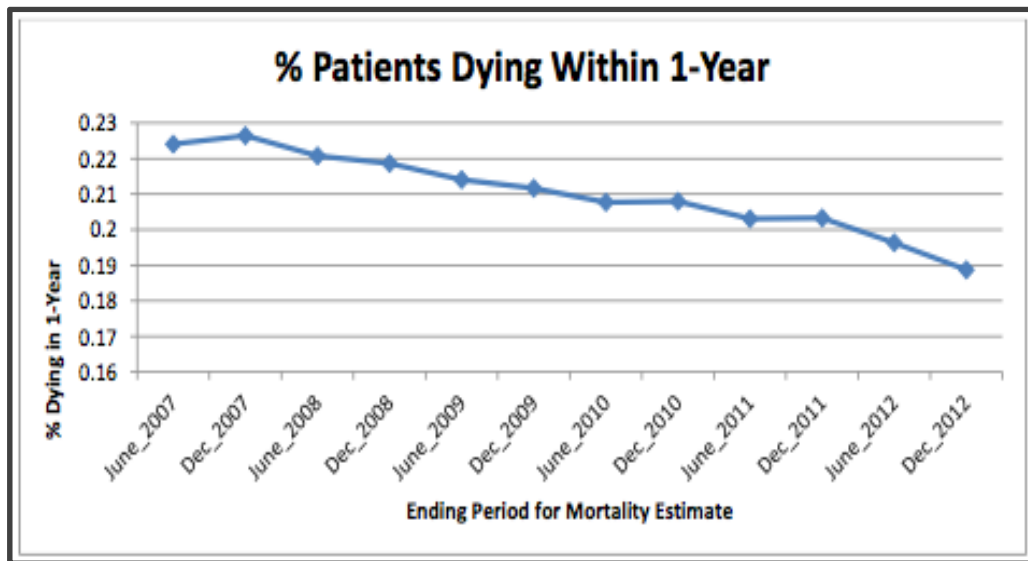


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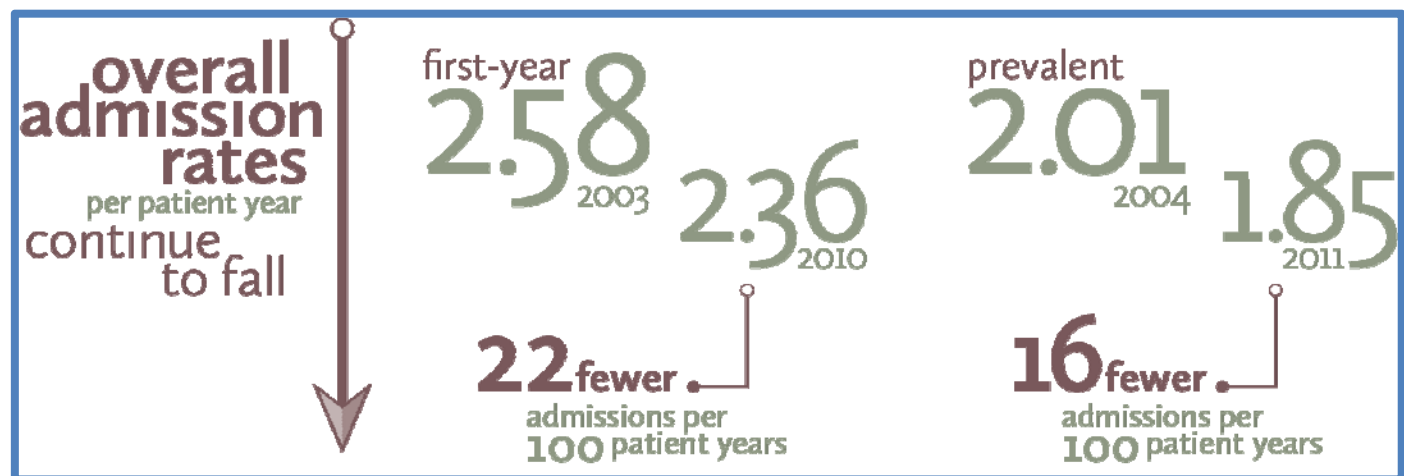
- Not at all clear CMS would try to incorporate emergency or non-emergency in expanded bundles or integrated care models; also not clear would require VBP



Community Initiatives Improve Outcomes



- PEAK Initiative reduced first-year mortality
- PEER seeks to improve quality through collaboration and data analysis



Source: Kidney Care Partners, *Peak: Performance, Excellence and Accountability in Kidney Care: Final Report 13* (Sept. 2013) available at <http://www.kidneycarequality.com/JoinPeak.htm>; The Peer Kidney Care Initiative, *Peer Report: Dialysis Care & Outcomes in the U.S., 2014*, "Infographics: Incidence" 15 (2014) available at <http://www.peerkidney.org>.



Measures Are Only One Part of Quality Programs

Standards of Practice

Measures

Benchmarks

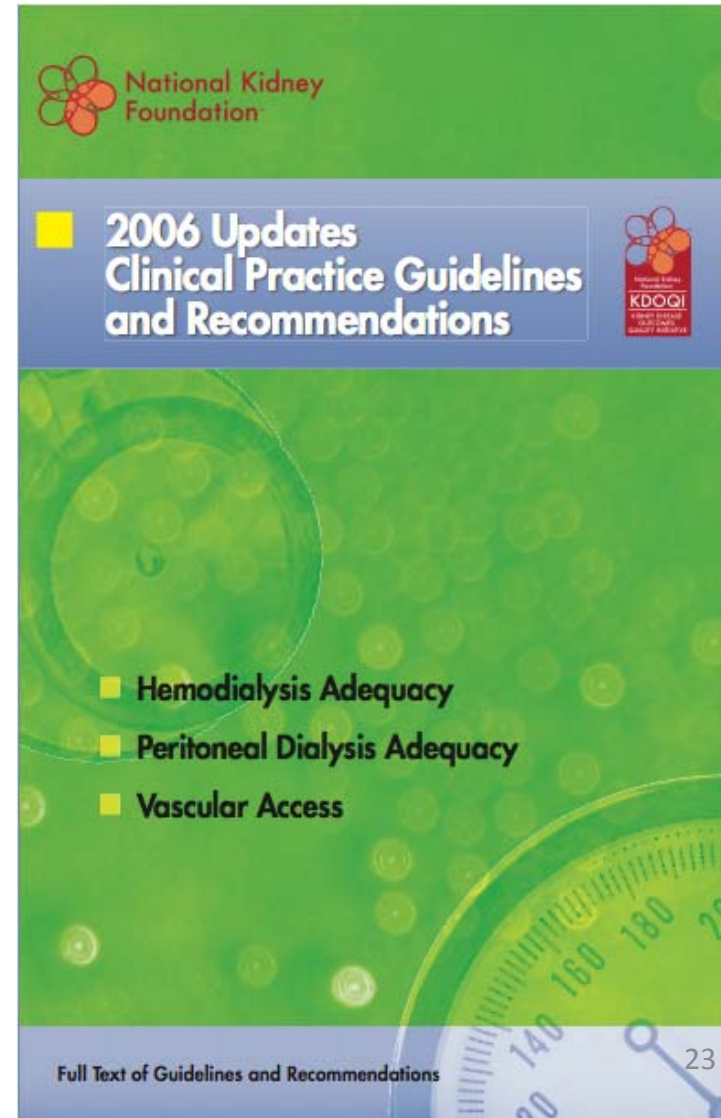
Reporting and to whom

Purpose



Standards of Practice

- Consensus-based standards serve as the basis for defining quality performance
- Measures should be driven by standards rather than have measures drive standards





Measures: What Are They?

Definition

- A standard: a basis for comparison; a reference point against which other things can be evaluated
- To bring into comparison against a standard

Foundation

- There should be community consensus before a measure is defined

Domains and Subdomains

- Clinical or structural areas in about which specific measures are developed
- Should be determined with a specific set of goals in mind



Types of Measures

Process

- Show whether steps proven to benefit patients are followed correctly
- Measure whether an action was completed — such as writing a prescription, administering a drug, or having a conversation

Outcomes

- Take stock of the actual results of care

Patient Experience

- Record patients' perspectives on their care



Types of Measures

Structural

- Reflect the conditions in which providers care for patients
- Can provide valuable information about staffing and the volume of procedures performed by a provider

Composite

- Combine the result of multiple performance measures to provide a more comprehensive picture of quality care

There is no such thing as a “balance” or “financial” measure



Components of a Measure

Numerator

- Condition, event, or outcome being measured

Denominator

- Target population

Exclusions

- Individuals who are in the target population, but should not be counted for purposes of the measure



Testing Measures

Reliability

- What amount of error is there in the measure?
- Will it accurately distinguish performance over time?

Validity

- Does the measure provide the information it claims to?

Will the measure provide consistent and credible information about quality over time?



Who Develops Measures

Non-governmental organizations

- American Medical Association (physicians)
- Physician Specialty Societies (physicians and other providers)
- Kidney Care Quality Alliance (physicians and dialysis facilities)
- Ambulatory Quality Alliance (AQA) (general)

Centers for Medicare and Medicaid Services

- Contractors
- Technical Expert Panels

Ownership is a key issue because it creates a seat at the table for further iterations of measures



What is the NQF?

- Oversight
 - Endorses performance measures as voluntary consensus standards
 - Serves as the gold standard in most legislation
 - Establishes expert panels to evaluate measure submissions as part of call for measures process
 - Applies specific criteria to evaluate measures



NQF Measure Evaluation Criteria

Evidence, Performance Gap, and Priority (Impact)— Importance to Measure and Report

- Measure focus is evidence-based (outcomes, intermediate outcomes, process, structure, efficiency) AND
- There is a performance gap

Reliability and Validity—Scientific Acceptability of Measure Properties

- Reliability: Measure can be implemented consistently within/across organizations; produce the same results a high proportion of the time
- Validity: Measure is consistent with evidence presented and specified to capture the population; measure score correctly reflects the care provided; exclusions support by evidence
- Disparity: Measure allows for the identification of disparities in care



NQF Measure Evaluation Criteria

Feasibility

- Extent to which the specifications, including measure logic, required data that are readily available or could be captured without undue burden and can be implemented for performance measurement

Usability and Use

- Extent to which potential audiences (e.g., consumers, purchasers, providers, policymakers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations



NQF Measure Evaluation Criteria

Comparison to Related or Competing Measures

- If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure



Measures Require Benchmarks

- Process of comparing performance with external best practices or with peers
 - Attainment: define a specific goal (*e.g.*, national average) and determine if meet it or not
 - Improvement: demonstrate improvement in performance over time relative to self



ESRD QIP Example

TABLE 14 – ESTIMATED NUMERICAL VALUES FOR THE PERFORMANCE STANDARDS FOR THE PY 2018 ESRD QIP CLINICAL MEASURES USING THE MOST RECENTLY AVAILABLE DATA

Measure	Achievement Threshold	Benchmark	Performance Standard
Vascular Access Type			
%Fistula	53.52% ^a	79.67% ^b	66.02% ^c
%Catheter	17.44% ^a	2.73% ^b	9.24% ^c
Kt V			
Adult Hemodialysis	89.83% ^a	98.22% ^b	95.07% ^c
Adult Peritoneal Dialysis	74.68% ^a	96.50% ^b	88.67% ^c
Pediatric Hemodialysis	50.00% ^a	96.90% ^b	89.45% ^c
Pediatric Peritoneal Dialysis	43.22% ^a	88.39% ^b	72.60% ^c
Hypercalcemia	3.86% ^a	0.00% ^b	1.13% ^c
NHSN Bloodstream Infection SIR	1.811	0	0.861
Standardized Readmission Ratio	1.261	0.649	0.998
Standardized Transfusion Ratio	1.488	0.451	0.915
KHC/HPS	50th percentile of eligible facilities' performance during CY 2015	15th percentile of eligible facilities' performance during CY 2015	90th percentile of eligible facilities' performance during CY 2015 ⁵



Why Measure Performance?

Many options

- Internal improvement
- Inform patient decision-making
- Compare providers to one another

Critical to understand purpose of measure
before developing it



Where do ambulance services fit in?

Performance Data

- Some metrics exist in connection with Emergency Departments (hospitals)
- NEMSIS collects data, but system not validated
- Some states track certain metrics
- Individual services have performance tracking

No consistency in data reporting or collection



Measure Development and EMS Compass

- NHTSA and NASEMSO project to develop measures for EMS
 - Not comprehensive approach to all ambulance services
 - Focused on NEMSIS data elements, but may also recommend new data collection



Concerns with EMS Compass

Remains unclear how many measures it is looking to create

- Released multiple stroke measures for comment
- Steering Committee met to consider additional measures for comment

New to the field of measure development and not always consistent with NQF and other measure developer processes

- Inconsistent domains: *e.g.* financial measures
- Inconsistent criteria: *e.g.* validation and reliability

End goal of project unclear

- Indicating not about value-based purchasing
- Yet, meetings with CMS and AHRQ



Mid-Stream Correction: AAA & NAEMT

NHTSA and NASEMSO seem willing to adjust project

- Important to prioritize measures (gaps in care)
- Focus on fewer measures
- Must be fully specified and tested
- Need to prepare industry for standardized data reporting and collection
- Critical to avoid pushing industry into value-based purchasing before it is ready

Quality measures are unique

- Cannot try to be all things for all services



What's Next?

Control own destiny

- Need to validate data reporting and collection resources
- Identify gaps in quality of care and prioritize measure domains, then develop and test a few critical measures
- Keep financial metrics out of quality programs
- Understand and follow NQF measure evaluation criteria

Work together to bring industry to a place where can report consistently and accurately