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Measuring Healthcare Value

*Linking cost and quality of patient outcomes
to drive organization and industry improvements*

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Introduction

Few in the United States are satisfied with the quality of healthcare and the escalating costs to deliver that care. The United States spends more per capita on healthcare than any other industrial country — nearly 18% of gross domestic product — but ranks in the bottom quartile for life expectancy.¹ Despite criticism of U.S. healthcare performance — from patients, employers, insurers, government, and those working in and supporting the industry — the ability to link quality of care with the cost of care (healthcare value) has been elusive.

Gradually efforts have emerged around the country to enable healthcare professionals and consumers to better identify provider costs and quality performance. Recent work performed by the Wisconsin Collaborative for Healthcare Quality (WCHQ) establishes new ground in blending quality and cost into a single, actionable healthcare *value* measure specific to a healthcare condition. WCHQ proved that such a condition-specific value measure is possible, paving the way for broader development and dissemination of healthcare value measures.

The work of WCHQ and others is important because value measures can be the foundation from which to address the root cause of healthcare-industry problems:

- *Subjective improvements:* What you cannot measure, you cannot manage, and what you cannot manage, you cannot improve. If healthcare organizations understood the value of their specific services relative to competitors or what's possible, they would more likely address organizational weaknesses and remove wasteful activities that diminish value. Donald Berwick, former administrator of the Centers for Medicare and Medicaid Services, says that 20% to 30% of health spending is waste that yields no benefit to patients.² At today's rate of spending, that amounts to \$500 billion or more per year.
- *Underinformed consumers:* Patients want to make informed decisions about where and from whom they obtain healthcare, trying to understand both the likelihood of good outcomes as well as what they'll have to spend for their care. With the increase in urgent-care centers around the country, patients increasingly have more healthcare options, but they have no better understanding of which provider offers the highest quality of care at the lowest possible cost.
- *Misinformed payors:* Private health-insurance spending accounts for more than one-third of U.S. hospital care.³ If private payors could correlate their massive spending with the value received by the individuals in their plans, they would likely shift billions of dollars to better-performing healthcare organizations and drive weaker organizations to improve.

Julie Bartels, executive vice president, national healthcare information at ThedaCare Center for Healthcare Value, says that a major step in establishing value measurements is communicating

¹ *OECD Health Data 2011*, ranking by Organization for Economic Cooperation and Development of 34 countries, and Centers for Medicare and Medicaid Services and Medicare, 2010.

² Robert Pear, "Health Official Takes Parting Shot at 'Waste,'" *The New York Times*, Dec. 3, 2011.

³ Centers for Medicare and Medicaid Services and Medicare, 2010.

the power of value measures. “People need to understand the whole concept of healthcare value measurements better.” Those engaged in healthcare can be better informed as well as influencers of the industry — foundations, philanthropies, national institutes — that provide funds and grant money to improve healthcare. “Most simply do not understand the scope of what needs to be measured, and so they fall back on what was measured before, which is primarily healthcare quality. That is a great start, but it is an incomplete picture. You don’t necessarily drive efficiencies based on quality measurements, and without that we cannot get costs under control.”

What Bartels and others encourage and are working to develop are rating systems that encompass both quality *and* cost that can be applied to specific types of care and reported for a local area, state, and across the nation.

“We’re not able to look at this from a global, accurate, procurement perspective,” says Dr. John Toussaint, CEO of the ThedaCare Center for Healthcare Value.⁴ “What we need to be able to do is build a common set of value metrics or a value metric. I think it will be a set because there is not *one* way to measure value. We have to measure it across the patient experience, and the experiences will vary based on the type of disease people have and the care they’re going through. The bottom line is that we have not been able to measure this.”

It is not surprising that a transparent view of patient value for specific medical treatments has not existed. Even within the Healthcare Value Network — with more than 50 member healthcare organizations following a mission to fundamentally improve healthcare delivery through lean thinking — it’s been difficult to compare value, says Dr. Toussaint. If there is no current standard for value, how can healthcare organizations hope to establish improvement targets, identify gaps between where they are and where they should be, and then close the gaps? How will organizations improve conditions across the value stream of a patient’s treatment, remove waste (non-value) from their work, and support innovation and fundamental transformation in their organizations and across the industry?

The healthcare industry certainly is not without measurement. Many yardsticks, internal and external, regulate the industry and have helped organizations and the public gain more awareness of healthcare performance. But these existing measures still fail to address value from a patient outcome perspective, and are insufficient for helping the industry address root causes of problems that impair quality and exacerbate costs:

- *Department- or process-centric measures:* Metrics available from healthcare organizations as the result of internal patient surveys or provider reviews often look at a department or function — e.g., satisfaction with experience in an emergency room. While beneficial to teams working to improve that department or function, they don’t describe the full value stream of patient care. Similarly, a patient’s journey through a facility consists of many discrete processes that are tracked to satisfy audits. For example, a Joint

⁴ In 2008, Dr. John Toussaint, president emeritus and former CEO of healthcare provider ThedaCare, Appleton, WI, formed the ThedaCare Center for Healthcare Value. In March 2009, the Center partnered with the Lean Enterprise Institute to form the Healthcare Value Network.

Commission standard requires hospitals to implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections — clearly a worthy measure that contributes to overall quality, but only one process contributing to an outcome.

- *Too broad:* Healthcare rankings such as Thomson-Reuters' 100 Top Hospitals or U.S. News Best Hospitals examine organizationwide care or large areas of care. Thomson-Reuters scores hospitals on a balanced scorecard of 10 performance measures, such as risk-adjusted mortality index (in-hospital), severity-adjusted average length of stay, and profitability.⁵ U.S. News ranks hospitals in 16 different specialties, from cancer to urology, scoring hospitals on reputation, patient survival, patient safety, and care-related factors.⁶ These rankings laude hospitals on a national level, but they are far too broad to be of use to patients when evaluating value for the specific treatments they need where they need them.
- *Subjective:* Healthcare grading websites — HealthGrades, Angie's List, Healthcare Reviews — have proliferated. These online tools are indicative of the appetite of consumers for local healthcare information, but these services typically deliver extremely subjective information provided by patients, family, healthcare professionals, etc. Opinion rankings are fine when selecting a hotel or restaurant, but should patients rely solely on them for decisions that may involve life and death?
- *One-half of value:* Many public and private organizations have focused on improving healthcare quality, exploring ways to quantify and improve outcomes. But many such efforts exist in isolation of costs. Conversely, many initiatives document and report costs but with no measure of the effectiveness of care. Claims data provides a clear picture of costs, but has not been intricately linked to the quality of patient care for specific expenditures.

Without widespread, reliable measures of healthcare value for specific treatments, payment systems have evolved into dysfunctional reimbursement systems that are motivated by objectives other than quality of patient care and/or cost of the care. Michael E. Porter writes, “The inability to properly measure costs and compare costs with outcomes is at the root of the incentive problem in healthcare, and has severely retarded the shift to more effective reimbursement approaches.”⁷

The belief is that with reliable value measures for outcomes, reimbursement programs will evolve, eventually rewarding organizations that deliver highest quality of care while minimizing costs. “The quest of defining value in healthcare, measuring it, and publicly reporting it in a simple, easily accessible way is of course a critical activity — it is necessary but not sufficient,” says Karen Timberlake, director, Partnership for Healthcare Payment Reform (PHPR). Those

⁵ *Methodology: 100 Top Hospitals and Everest Award*, Thomson Reuters, March 28, 2011.

⁶ Avery Comarow, “Best Hospitals 2011-2012, the Methodology,” *U.S. News & World Report*, July 18, 2011.

⁷ Robert S. Kaplan and Michael E. Porter, “How to Solve the Cost Crisis in Healthcare,” *Harvard Business Review*, September 2011.

acquiring care must then base their decisions on the value information. To that end, the PHPR is a collaboration of 60 healthcare providers, payors, employers, and consumers working to improve quality of healthcare while reforming the healthcare payment structure.

PHPR is sponsored by the Wisconsin Health Information Organization (WHIO). “In April 2010, the WHIO board launched a statewide multistakeholder, multipayor series of payment-reform initiatives,” says Timberlake. “The genesis for this work was the board’s sense that it’s one thing to build an all-payor claims database, it’s one thing to identify variation in cost effectiveness and quality, but it’s another thing to do something about it. Part of doing something about it was to launch this series of payment-reform projects.”

Two PHPR pilot programs, involving 12 provider organizations and seven commercial payors, will be launched this year and address quality and payment reform for total knee replacements and for adult diabetes:

- *Total knee replacement pilot program:* This three-year pilot involves nine providers that along with payors will negotiate bundled payments for total knee replacement of one knee for the commercially insured adult population (ages 18-64). The bundled payment covers the episode of care, starting on the day of admission for surgery and including any services provided for 90 days post discharge. To achieve critical mass, many participating providers will work with more than one commercial payor. The intent is that bundled payments will motivate providers to focus on the entire value stream of patient care and manage the many departments and individuals that make up that care. If providers’ cost performances beat the established bundled payment, they keep the difference, provided they meet benchmarks for nine publicly reported quality measures.
- *Adult diabetes pilot program:* The four-year diabetes pilot is a more complex, modified total-cost-of-care approach. Three providers and three payors will evaluate historic costs for commercially insured adult diabetes care, including commonly occurring co-morbid conditions (hypertension, hyperlipidemia, and ischemic heart disease), and negotiate a reduced-trend cost (i.e., an improvement target). Claims are paid as usual, but if after 12 months the actual cost of care is less than the reduced-cost target, the savings are shared (75% to providers and 25% to payors); if providers’ costs are higher, they’re not required to contribute money back. Here, too, the providers are evaluated against publicly reported quality measures. The idea, according to Timberlake, is that after two or three years the shared-savings model will be shifted to an episode payment model.

The unique impact of the two programs will not necessarily be the total number of patients served, notes Timberlake, but will be — and already has been — the reimbursement conversations taking place, getting providers and payors to think differently about reimbursement methodologies, and setting a framework for conversations about payments for *total episodes* of care.

“On the provider side, the motivation to participate, in part, would be that as the market place gets increasingly informed by considerations of value, they, in theory, would be better positioned, both on knees and diabetes, to compare favorably to their competitors,” says Timberlake. “From a payor standpoint, the same thing. As customers are increasingly demanding [to know] your latest cost control strategy and how you are delivering better value, here is an answer to that as well.”

Defining and Driving Change with Value Measures

Contributing to the difficulty in providing measures of healthcare value has been a lack of industrywide agreement on the definition of value. Multiple good models for computing value exist; Dr. Toussaint aligns with views put forth by Porter⁸ and others in which value is a measure of outcomes divided costs. Such a measure, adds Dr. Toussaint, also must be based on patient-focused results and viewed from the patient’s perspective, and it must be relative to the patient need or condition for the full extent of the care. For example, a patient admitted for the implant of a pacemaker should understand the costs for the duration of the treatment (from hospital admission to the time of resuming normal day-to-day activities) and quality for that entire value stream of care.

Value measures also must be accessible and transparent. “Not only do we have to create the measures, we have to publicly report them in order to drive through change,” says Dr. Toussaint. “If you have to put all your value metrics in the newspaper, and half of them look terrible, you’re going to change. This is another key component to the metric. It’s not just creating a metric, but making it transparent to the industry.”

A Wisconsin study revealed how public reporting incites improvement. Four researchers — Dr. Geoffrey Lamb, Medical College of Wisconsin; Dr. Maureen Smith, University of Wisconsin Health Innovation Program; Dr. William Weeks, The Dartmouth Institute for Health Policy and Clinical Practice; and Chris Queram, Wisconsin Collaborative for Healthcare Quality — evaluated how publicly reporting healthcare performance information through WCHQ impacted the quality of ambulatory care in Wisconsin. The group studied 13 quality measures related to diabetes, hypertension, and preventive cancer screenings from 567 practice sites in 20 medical groups. It also surveyed WCHQ members on how public reporting of the quality findings affected their priorities and strategies for improvement. The WCHQ study showed significant overall improvement in seven of the eight measures that had at least three years of reporting and evidence that public reporting of ambulatory measures led to sustained improved performance among WCHQ member organizations.⁹

⁸ Michael E. Porter, “What is Value in Healthcare,” *New England Journal of Medicine*, Dec. 23, 2010.

⁹ “Commonwealth Study Demonstrates ‘Public Reporting Matters’ 2009 — 2010,” Wisconsin Collaborative for Healthcare Quality, 2011.

The WCHQ quality initiative shows how public reporting of healthcare metrics motivates providers to improve care, but is still just one-half of a value measure. That's because connecting quality and cost data for specific episodes of care presents challenges. "We are going to have to build this process by creating a common definition of value, and then creating the formulas to measure it," says Bartels. "That will be hard work. To start with, we must have data. The source for measuring value has to be created. We don't have a common data set across the nation that we can build this on — yet."

"There will be difficulty in moving from status quo to ideal state," says Dr. Toussaint. "There are a lot of people that will consider this threatening, certainly insurance companies who look at this information as proprietary and providers that may be scared that if their actual performance hits the street they will be negatively impacted." There are individuals and organizations, he adds, who prefer healthcare information remain in a "black box" and not change.

Within the industry, though, incentives to publicly report measures of value exist. Organizations committed to the improvement of value want public reporting so they can differentiate their organizations in the marketplace. On the payment side, government, employers, and patients increasingly want to make more informed decisions.

"Without true knowledge of who is delivering the highest quality product at the lowest price, [payor plan managers] make bad decisions, they make the wrong decisions, and it negatively impacts their ability to manage their healthcare costs," says Dr. Toussaint. "The way the industry is structured today, organizations like ThedaCare and others get lumped together into a single healthcare insurance premium. You have efficient providers, extremely inefficient providers, and everyone in between lumped together. The average increase is the average of all of those providers, with most of the cost increases being driven by the extremely inefficient providers. That's why the present structure of the insurance industry is such a disaster for cost because they can't isolate truly high performers and move patients to those higher-performing organizations. That's because there is no transparency, there is no agreed-upon set of metrics that define who is delivering better value."

Emergence of Value Measures

The good news for the healthcare industry and patients is that concern over quality of care and escalating costs has fueled widespread efforts by national, regional, and state organizations to more clearly identify and report quality or costs — and with some efforts report more complete value perspectives — and move the industry further toward establishing the necessary components for value measures:

- *The Centers for Medicare and Medicaid Services (CMS)* plan to implement value-based purchasing for Medicare hospitalizations. Authorized by the Affordable Care Act, the Hospital Value-Based Purchasing program is intended to link payment to quality

outcomes in order to incentivize best care and improve transparency for beneficiaries. In fiscal year 2013, an estimated \$850 million will be allocated to hospitals based on their overall performance on a set of quality measures that have been shown to improve clinical processes of care and patient satisfaction. Funding will come from the Medicare budget, and, over time, value-based funds will increase as more monies shift to quality-performance allocations.¹⁰

- *National Committee for Quality Assurance (NCQA) Relative Resource Use (RRU)* measures are intended to show how healthcare services relate to quality. NCQA reports that RRUs, combined with HEDIS (Healthcare Effectiveness Data and Information Set) measures, begin to reveal value that people get for the healthcare resources provided to them. RRUs measure use of services (e.g., doctor visits, hospital days, surgeries, drugs) for people with five chronic diseases: asthma, cardiac disease, chronic obstructive pulmonary disease, diabetes, and hypertension. RRUs represent actual service use, based on audited data from health plans, that has been risk-adjusted for factors like age, gender, and serious health conditions. RRUs do not reflect payment rate plans negotiated with providers, according to NCQA, but instead are calculated with standardized prices.¹¹
- *Aligning Forces for Quality (AF4Q)* is a Robert Wood Johnson Foundation (RWJF) effort to lift the overall quality of health care in targeted communities, reduce racial and ethnic disparities, and provide models for national reform. RWJF has committed to improve health care in more than a dozen geographically, demographically, and economically diverse communities that combined account for more than 12% of the U.S. population. AF4Q asks critical stakeholders — those who get care, give care, and pay for care — to work toward common, fundamental objectives that RWJF and others believe will lead to better care. Among the beliefs reported by AF4Q: proper measuring and reporting on health care can help providers improve their ability to deliver quality care; help providers measure and publicly report their performance; and help patients and consumers understand their role in recognizing and demanding high-quality care.¹²
- *Health Care Incentives Improvement Institute (HCII)* is a non-profit organization with programs to measure healthcare outcomes, reduce care defects, promote a team approach to caring for patients, realign payment incentives around quality, and reward excellence. One HCII program is PROMETHEUS Payment, a compensation approach for payment reform based on medical episodes of care. PROMETHEUS — Provider Payment Reform for Outcomes, Margins, Evidence, Transparency Hassle-Reduction, Excellence, Understandability, and Sustainability — is intended to compensate providers fairly by allowing top performers to earn more; offer incentives for providers to deliver greater value and better outcomes; encourage caregivers to work in teams, share information, and take collective responsibility for a patient's health; and provide a framework to transform

¹⁰ Administration Implements Affordable Care Act Provision to Improve Care, Lower Costs, U.S. Department of Health and Human Services, April 29, 2011.

¹¹ “The Surprising Health Care Cost-Quality Disconnect: Using NCQA’s Relative Resource Use Measures To Get Value: Efficient, High-Quality Health Care,” www.ncqa.org.

¹² Aligning Forces for Quality, Robert Wood Johnson Foundation, www.forces4quality.org.

healthcare's fragmented and inefficient system into one that is more integrated and accountable.¹³

- *Network for Regional Healthcare Improvement (NHRI)* is the national membership association for Regional Health Improvement Collaboratives. NRHI works to support the efforts of the more than 40 collaboratives in the U.S. NHRI reports that the collaboratives help communities covering more than 40% of the U.S. population to improve the quality of healthcare services while controlling costs. Collaboratives are intended to serve as neutral, trusted sources of actionable information about the cost and quality of healthcare services, the health of the population, and/or the extent to which state-of-the-art methods of delivery, payment, and health promotion are being used. Collaboratives publish reports for the public and/or healthcare providers on aspects of quality and cost of care. These measurements and reporting initiatives are developed and operated with the involvement and supervision of the physicians and hospitals whose performance is being measured, which, according to NHRI, increases the willingness of participating providers to change care processes in order to improve their performance.¹⁴

Groundbreaking Work on Value at WCHQ

WCHQ (Wisconsin Collaborative for Healthcare Quality) was one of seven founding collaboratives of NHRI in 2003, formed by seven large healthcare organizations in Wisconsin, major employers, and consumer groups. Its objective is to encourage public reporting of previously unreported healthcare quality data. Two years later, another group — Wisconsin Health Information Organization (WHIO), consisting of insurance companies, employer purchasing coalitions, Wisconsin Hospital Association, Wisconsin Medical Society, and representatives of state government — was formed to compile and publish critical claims (cost) data.

Members of WCHQ and WHIO have worked together to create transparency of healthcare cost and quality information in Wisconsin. At its website, www.wchq.org, WCHQ publishes the *Performance & Progress Report*, which includes dozens of ambulatory and hospital-based quality measures. The Wisconsin Collaborative first experimented with value measures in 2005 when it reported inpatient quality of care metrics in conjunction with hospital charges in the form of a quality-cost quadrant. These Effectiveness Reports have limitations, but were a bold attempt to measure and demonstrate the relationship between quality outcomes and charges for three common hospital-based conditions: heart attack, heart failure, and pneumonia.

WCHQ workgroups also conduct initiatives to help organizations act on their findings. In his book, *Potent Medicine: The Collaborative Cure for Healthcare*, Dr. Toussaint writes, “Every single hospital and clinic that has joined our project to provide healthcare transparency in

¹³ Health Care Improvement Initiative Institute, www.hci3.org.

¹⁴ Network for Regional Healthcare Improvement, www.NHRI.org.

Wisconsin has shown real improvement in patient care. This is the result of a simple chain reaction: providers see how their care stacks up against the competition and then throw resources into improving the lowest numbers. Healthcare is full of competitive people.”¹⁵

In late 2010, WCHQ embarked on the ambitious endeavor to link quality data and cost data for a specific condition and episode of care. WCHQ formed a Resource Use Work Group (RUWG) to develop a diabetes value metric using:

- Quality data provided by WCHQ provider organizations, and
- Diabetes standard cost data, provided by the WHIO, which consisted of claims-based data submitted by WHIO insurer or payor organizations.

RUWG participants included representatives from several WCHQ organizations and strategic partners who have experience working with resource use data.

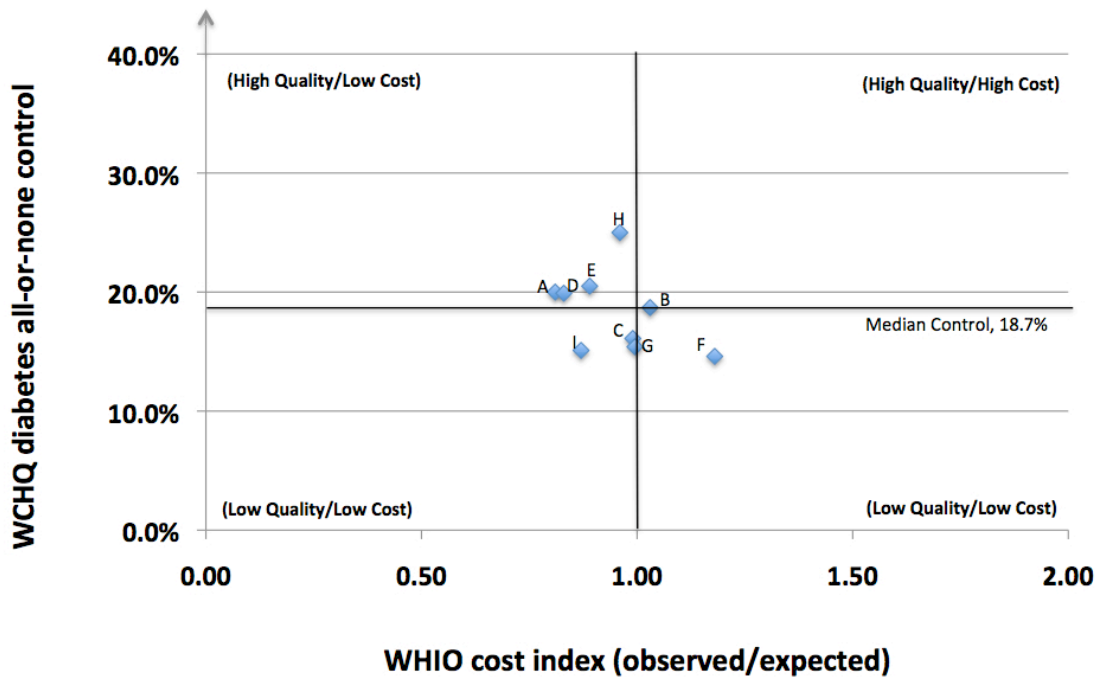
The RUWG developed a methodology by which the data from these two different sources could be merged to create a meaningful measure that would provide new insights about the value of the care provided to diabetic patients in Wisconsin. The first set of diabetes value-measure reports was presented to WCHQ members in December 2011. No timetable has yet been set to release the findings publicly. The December release lists diabetes value metrics for each WCHQ organization meeting the criteria for which “apples-to-apples” quality and cost comparisons could be applied, and displays the value metric in a quadrant-analysis format — high quality/high cost, low quality/high cost, low quality/low cost, and high quality/low cost (greatest value):

- X axis = cost index (ranked 0.0 to 2.0), and
- Y-axis = percentage of all-or-none diabetes control measure (0% to 40%)
(see *Figure 1 on next page*).

The WCHQ work proves that value measures for specific conditions can be compiled and can serve as a model for other parts of the country. “We have actually delivered something,” says Dr. Toussaint. “People have been talking about this forever. I’ve been in discussions about this type of metric since 2003, and nobody has done anything. The difference is we did something. We created databases, abetted the data, we attributed the data, and we can actually give some usable information on quality and cost for the care of diabetic patients across the state of Wisconsin for pretty much every single doctor. That’s pretty powerful.”

¹⁵ Dr. John Toussaint with Emily Adams, *Potent Medicine: The Collaborative Cure for Healthcare*, ThedaCare Center for Healthcare Value, 2012.

Figure 1 — Sample Diabetes Value Measure



This quadrant (absent organization identities) is representative of RUWG's diabetes value analysis as presented to WCHQ members in December 2011.

Jack Bowhan, network manager at HVN and RUWG team leader, says, “There are number of issues to be resolved (see the “Notes” on *Diabetes Value Metric*) before there will be comfort in public reporting, but it’s as apples-to-apples as we can get at this time. Building the value-metric criteria to link the two different sources of data and to provide a relatively fair comparison across providers was hard. It’s not straightforward or easy to do, but it can be done.”

Bartels says the WCHQ work should put to rest arguments that a value measure is impossible. “There have been numerous studies in the past that have talked about the complexities: Clinical data as a source of reporting is not perfect. Administrative claims data as a source of reporting is not perfect. However, both of them have value in and of themselves. The complexity of tying administrative data to clinical data to produce a value metric — something that reflects both the quality measures that would typically be pulled from clinical data along with efficiency measures that would be pulled from administrative claims data into a measurement that actually shows this relationship between cost and quality — is something that has been talked about, but generally not acted upon because of the complexity of it. Now we can show what has been done on the diabetic measure, and begin to test its application in the real world. Will these value metrics be accepted by providers and payors and actually motivate healthcare systems to change their processes to create value? We have a start — a cross between cost and quality is a valid measure of performance. That is the breakthrough.”

The WCHQ program may also impact and inform the pilot programs underway at Partnership for Healthcare Payment Reform. “We want to take our early adopters and our innovators and give them an opportunity to learn from [the WCHQ work] and see how their work fits into this evolving landscape,” says PHPR’s Timberlake. “In the case of the diabetes value metric, in particular, perhaps the sites that are doing the payment reform diabetes projects will find that they end up with a bit of an advantage.”

Diabetes Value Metric

Notes from the Wisconsin Collaborative for Healthcare Quality (WCHQ) Resource Use Work Group (RUWG)

The first set of diabetes value-metric reports includes quality and claims results for commercial (under age 65-years-old) and Medicaid payor groups (each payor group reported separately). In presenting the findings to the WCHQ, the RUWG noted:

- Standard pricing — The commercial payor standard price algorithm is based, in part, on billed amounts. The Medicaid standard price equals the current Medicaid allowed amount when available. If a Medicaid allowed amount is not available, the standard price reverts to the commercial payor algorithm.
- Quality — WCHQ diabetes all-or-none measures are two separate measures, one for process (optimal testing) and one for outcomes (optimal results). Each measure contains three goals, and *all three goals* within a measure must be achieved in order to be reported as satisfying the criteria.

Elements of optimal control include:

- Most recent A1C test result is less than 7.0% or less than 8.0% for high risk patients,
- Most recent LDL cholesterol test result is less than 100 mg/dL, and
- Most recent blood-pressure measurement is less than 130/80 mm Hg.

Elements of optimal testing include:

- Two A1C tests performed during the 12-month reporting period,
- One LDL-C cholesterol test performed during the 12-month reporting period, and
- One kidney function test during the 12-month reporting period, and/or diagnosis and treatment of kidney disease.

- Cost index — The cost index (actual resource use divided by expected resource use) is built from Medicare, Medicaid, and commercial payor data. The cost index data cannot be filtered by the commercial-only or Medicaid-only payor groupings at this time.
- Risk adjustment — The cost index data is risk-adjusted for age, sex, and severity level.
- Dates of service report periods — There is a significant but not complete alignment of WCHQ and WHIO dates of service. The WHIO report period covers April 2010 through March 2011; the WCHQ report period includes July 2010 through June 2011.
- Provider types — The report includes patients assigned to an internal medicine or family practice physician.
- Prescription drug data — The report excludes patients without a prescription drug benefit or without a prescription drug claim.
- Clinic and parent organization alignment — WCHQ and Wisconsin Medical Society are working with WCHQ member organizations on a standard process to assure the correct alignment of clinics to parent organization in the WHIO data mart.

Future for Value Measures

The diabetes value measure should lead to the development of more value measures for other types of conditions. “We have learned a lot,” says Bowhan. “There is more work to do, but I am pretty convinced that you can apply the basic model and the value-measure specification to any of the chronic diseases.”

Creating the diabetes value measure certainly ran into challenges, and Bowhan doesn’t deny that surprises emerged along the way. Despite the challenges, RUWG was able to present WCHQ members with a viable means to report diabetes value metrics and the lessons learned, which will inform future efforts. For example, the patient populations represented in the WHIO and WCHQ data needed to be as similar as possible, which meant excluding Medicare fee-for-service and uninsured populations because these groups are not available in the WHIO data.

Accommodations also were made for characteristics unique to the WHIO data, such as applying standardized reimbursement amounts to all claims data and done to alleviate concerns about proprietary provider agreements. Additional adjustments were made to accommodate the ratio of commercial-to-Medicaid episodes in the WHIO data and variations in access to pharmacy data. (see *Diabetes Value Metric*).

Remember that WCHQ involvement represents a completely voluntary decision by participating healthcare organizations to publicly report their quality results. Not surprisingly, participation has not been 100% across that state. For the RUWG diabetes value measure — or future value measures — to be supported by the healthcare industry, is 100% participation necessary? If not, what level of participation is sufficient for findings to be credible and, consequently, for non-participants to be penalized by market forces? Or if 100% participation is necessary, then must government or payor mandates drive that level of participation?

Dr. Toussaint says to get to full participation will likely require healthcare organizations to report to a qualified entity if they want to participate in a specific government or payor program. Once a “critical mass” of participation is achieved for the program, the providers on the sidelines would then be motivated to participate.

Bartels does not believe 100% participation is possible on a voluntary basis; full participation will require the leverage of the federal government (via the CMS and its associated programs) or large healthcare industry associations. “They can create a tremendous amount of influence by tweaking some of the industry regulation or guidelines that are already in place, such as the NCQA (National Committee for Quality Assurance) and the development of the national healthcare data exchange standards development. Even if certain organizations are not inclined for their own benefit to adhere to them, they are certainly inclined from a public-play standpoint to be a part of that. It’s difficult to fly in the face of CMS or NCQA, even if you don’t like what they’re measuring. To the degree that we can capture the interest of these industry thought leaders and are able to influence their thinking on alignment with value metrics as we will define

them, it will go a long way in getting participation, even from some of those who would sit on the fence otherwise.”

And the final issue to be proven out will be the role and responsibility of consumers (patients). Will they be empowered by value measures? Will consumers rely on value metrics to decide where to obtain specific treatments, and, thus, drive their business toward better performers and drive the healthcare industry toward the changes it so desperately needs?

*by George Taninecz
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Lean Leaders

To learn more about efforts to improve healthcare value, please contact the individuals and their organizations that contributed to this Healthcare Value Report:

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