Getting Under the Hood

Eye Care Perspectives on Value-Driven Health Care

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Overview

The following is a series of five articles written as an update to our June 2007 paper entitled, "A White Paper for Optometry, Medicare Pay-for-Performance & Value-Driven Health Care".[1]

Much reform in U.S. health care is already evident as we move through PQRI towards Pay-for-Performance and Value-Driven Health Care. The current article series seeks to reinforce the need for optometrists as individuals and groups, indeed the profession at large, to engage with health care reform. Participation in PQRI 2008 remains voluntary. Certification of eye care EHRs is potentially years off. However, the time is now for eye care leaders to see what's "under the hood", what is driving value-driven health care today.

Contents

1. A free copy of "A White Paper for Optometry, Medicare Pay-for-Performance & Value-Driven Health Care" is available for download. Please click on the following link: http://www.odprofessional.com/must_read.htm

Part 1

VDHC here now, here to stay, must-know principles

Without question, value-driven health care is here now and here to stay. We begin to understand the drivers and principles behind value-driven health care by considering the costs in our current system that do not directly improve patient health. Understanding reform starts with asking what it takes to eliminate these costs. After all, payers want to identify providers who can and will deliver the best possible health care and to reward them for the quality of care they offer. In light of previous unsuccessful attempts to fix the health care cost crisis, it is not surprising that there exists much skepticism about health care reform. By understanding the principles of value-driven health care, we can understand how and why reform must occur, how change is in the long-term best interests of all providers, and how we may participate successfully in the new era of health care delivery.

The driving force behind health care reform is payers. Payers recognize the critical need to decrease the cost of health care.

Which current costs in health care do not improve patient health?

Let's consider three costly health care factors with little or no value:

1. Providers and facilities that deliver the poorest care are often paid the most
2. Patients lack information to select providers based on quality of care
3. Inefficient records systems do not allow the health history to follow the patient between providers

Two examples illustrate the significance of these three factors:

Example #1. Current reimbursements financially reward poorer care and offer little incentive to provide best care.

Most of us are aware of the problem of secondary infections in American hospitals. We'll use gall bladder surgery as an example. The numbers are arbitrary but demonstrate the principle. There are two rules of thumb:

- First, the solution to increased secondary infections is simply to clean the hospital better and for staff to follow proper cleanliness procedures. In reality, this is a major commitment for any health care facility and involves up to 20% of income to be dedicated to the cleanliness effort.
- Second, the reimbursement for treating secondary infection is approximately 2½ times the cost of the patient's original condition.

Using these rules, let's compare the income of two hospitals. The first uses best cleaning practices and has a very low secondary-infection rate. The second chooses not to invest in the necessary cleaning. Let's assume gall bladder surgery pays $6,000.

Hospital #1 does 10 cases and gets paid $60,000. It has already invested $12,000 in cleaning. None of the 10 gall bladder patients develops a secondary infection. The net for this hospital is $48,000.

Hospital #2 does the same 10 surgeries and is paid the same $60,000. It does not invest in extra cleaning and two patients develop secondary infections. This hospital is reimbursed an additional $30,000 to treat the secondary infections. The second hospital, therefore, nets $90,000 in income for its poorer quality care, in contrast to the first hospital with its $48,000 for delivering best quality care.

Throughout health care, there are innumerable cases where improper diagnoses, inefficient treatments and inferior practices result in significantly higher income for providers and facilities. On the other hand, it is difficult to find instances in the reimbursement system where providers and facilities that deliver the best care are financially rewarded for doing so.

Did you know? Analysis contractors are already working to combine quality scores from PQRI with cost histories from National Claims History (NCH) files. This will yield a numerical cost-quality "value score" for each provider.

This same example demonstrates the second problem listed above, that patients do not have the information available to select providers and facilities based on quality. We might ask why patients would go to the second hospital. The answer is simple - patients simply do not have access to the statistical information that would allow them to know the difference. This is one of the hallmarks of value-driven health care. It's called Transparency. If patients had access to that information, they would almost always select the facility or provider delivering the best care.

Example #2 Inefficiency – lack of portability of patient records – results in cost doubling.

Let's consider a patient who goes to hospital A for a medical problem that results in a $20,000 work-up. The physician gives her recommendations to the patient but he decides to get a second opinion. The patient goes to hospital B, and another $20,000 work-up is completed. Patient records were not sent to hospital B and, in addition, the second facility wanted its own test results. The second physician's recommendations are identical to those of the first, as there was nothing wrong with the first work-up. Had there been mandatory portability of patient health records and information, a second opinion could have been obtained for approximately $130 instead of another $20,000. A system that simply pays for the tests again resulted in double the cost with no greater benefit to the patient's health.

Value-driven health care means eliminating ineffective costs

1. **Reform efforts will reduce or eliminate financial incentives for poor care in favor of a system that rewards best practices**

In order to pay best-care providers more than those who provide poor care, the system must evaluate outcomes. The Physician Quality Reporting Initiative (PQRI) is in the early stages of achieving that goal. It is designed to foster a reporting mechanism that tracks detailed outcomes. PQRI will provide sufficient information to develop true quality comparisons of the care delivered between providers. Analysis contractors are already working to combine quality scores from PQRI with cost histories from National Claims History (NCH) files. This will yield a numerical cost/quality (value) score for each provider. It is likely this score will be per condition, rather than as an overall score, although the exact reporting mechanism is still being developed.

2. **Transparency**

Transparency is the process of taking the above-mentioned value score and making it known to the public. Value scores will certainly be distributed with insurance packets to covered recipients, most likely with incentives to the patient to select higher value providers. Scores will also be available to consumers on numerous web sites. Without doubt, the news media will also make them available at every level. One of the hallmarks of reform is that quality comparisons will not only be local, they will compare each provider to regional, state and national scores.

Transparency means making the "value score" known to the public.
Payers will provide financial incentives to choose providers with high value scores.

3. **Electronic health records and mandatory portability of patient health information**

The first step in these reforms is to make all patient health information electronic. The second step is to send patient health information electronically between providers. For these things to occur, there must be communication standards so exchange of information is efficient. Many standards are already in place, and more are being developed. The applicable standards are being consolidated into a certification process called CCHIT (Certification Commission for Health Information Technology), which every electronic health record eventually must meet. Regulations are already in place allowing Medicare and other insurance payers to deny payments to providers who do not utilize available CCHIT certified EHRs for their profession. CCHIT certification is now available for ambulatory care EHRs. It is not yet known when the certification standards for specialty EHRs, such as eye care, will be available.

Health care reform rewards providers who deliver best care. Value-driven health care is cropping up all around us, driven by payers, supported by legislation, in efforts to decrease the cost of health care. The savings come from paying less to providers who do not deliver best care. Clinical outcomes, measured per provider, are used to assess the quality of care, combined with the cost of delivering that care, resulting in a value score for each provider. The value score is reported to the public who may use that information, with payer-based incentives, to select providers who deliver best value care. These steps, combined with electronic health records, mandatory portability and reduced duplicate services, represent the core elements of value-driven health care reform.

Part 2

So you wanted proof?

A day doesn't go by that optometrists don't express some form of skepticism about whether value-driven health care will ever reach eye care. There is an implied misunderstanding that health care reform is an anticipated legislative effort yet to be passed or debated. This couldn't be further from reality. Value-driven health care is a powerful movement, already well underway, being driven by payers and payer groups demanding a more accountable health care delivery system.

Health care systems are already operating under value-driven health care principles. Consider what has already been put in place given this February 2008 press announcement:

News Release

FOR IMMEDIATE RELEASE
Friday, February 1, 2008

Contact: HHS Press Office
(202) 690-6343

HHS Secretary Awards Health Leaders with Special Distinction for Improving Quality and Value of Health Care

Today, HHS Secretary Mike Leavitt recognized 14 communities with a special federal distinction for their strong commitment to improving quality and value in health care.

The Secretary designated these partnerships of providers, employers, insurers, and consumers as the country's first Chartered Value Exchanges (CVE) for their work to implement cutting-edge, collaborative methods to transform health care at the local level.

"These pioneers are at the forefront of a nationwide movement to transform our current health care sector into a patient-focused marketplace," Secretary Leavitt said. "Together we are building the foundation of a transparent system that empowers consumers to seek high-quality health care at competitive prices."

As Chartered Value Exchanges, communities will have access to information from Medicare that gauges the quality of care physicians provide to patients. These performance measurement results can be combined with similar private-sector data to produce a comprehensive consumer guide on the quality of care available. The Centers for Medicare & Medicaid Services (CMS) will begin providing physician-group level performance information by the summer of 2008.

Consider also the following programs and initiatives, already established:

… health care reform necessitates restructuring how we think about delivering care to our patients …the time to begin is now.

- **Bridges to Excellence** makes primary care physicians who participate in value-driven health care eligible for up to $100,000 in bonus payments per year. This program is being organized in all 50 states but has already begun issuing payments to physicians in 18. Among other things, physicians are re-organizing their diabetic eye exam referral patterns. One bonus pay requirement is for the physician to obtain 100% of eye exam reports on diabetic patients.
- A host of new national diabetic reading centers are meeting the growing demand by physicians to ensure they get all their reports returned on diabetic retinopathy patients. (Note the new opportunity for optometrists who are willing to build referral relationships and can ensure they deliver reports.)
- RHIO's (Regional Health Information Organizations) have been developed in many parts of the country to facilitate the exchange of patient health information
- Google recently announced a trial of 10,000 patients to have online access to their complete medical records
- Wal-Mart recently announced plans to open outpatient medical clinics in all Wal-Mart stores
- PQRI, now in its second year, has been adopted as a formal method to develop quality data on health care providers
- A national registry of insurance payments, called the National Claims History file, has been established and Medicare has provided the payment history of every provider
- Independent contractors have been engaged to combine payment history and quality data
- As announced above, CMS has certified the first *Chartered Value Exchanges*
- Regulations are already in place authorizing government agencies to deny insurance payments to providers who do not utilize CCHIT approved electronic health records, as they become available in their area of health care
- The formal policy of the HHS (U.S. Department of Health & Human Services) is that value-driven health care has advanced sufficiently across the country for future Medicare requests for payment decreases, if not overturned by Congress, to be tied to provider use of EHRs.
- Portability standards have been completed and adopted for use in enforcing the mandatory portability of patient health information

- Standards and regulations for tracking specialty exams per patient instead of per provider have already been written.

Each of the above-listed steps represents an aspect of value-driven health care. As eye care providers, it is important that we recognize value-driven health care is already well established and will, without question, make its way into the eye care domain. The examples above provide a way to start looking at one's local community and become aware of the need for reform and what is already occurring to meet that need. It is important to understand that health care reform necessitates restructuring how we think about delivering care to our patients. The preparation process is long and will affect virtually every decision in the practice. The time to begin is now.

Part 3
PQRI the alternative to decreasing Medicare reimbursements

The Physician Quality Reporting Initiative (PQRI) represents an alternative to the methodology already in place to protect Medicare and other government programs against huge deficits. The existing method simply cuts Medicare reimbursements by 10% per year until 45% of the current reimbursement rate is achieved and payments are maintained at that level. This formal approach has already been in place for two years and represents the level of decreased spending necessary within today's health care system to sustain Medicare and other government programs. In both of the past two years, a 10% reduction in Medicare fee schedules was requested by CMS. Fortunately for health care providers, Congress blocked the decreased reimbursements, but largely to give more time to establish the PQRI alternative. PQRI provided the political motivation to delay the decreases.

HHS Secretary Michael Leavitt has already announced his intention to ask that further decreases in payments not be across-the-board, that decreased reimbursements continue to be delayed for eligible providers who are using electronic health records and participating in the PQRI process. Therefore, it is expected that decreased reimbursements will take effect for providers not participating in PQRI.

Since 45% of current Medicare reimbursements rates appeals to none of us, it is important that we recognize the new Medicare program as our only viable alternative. PQRI is a way of maintaining approximately current reimbursement levels. Should Congress follow Secretary Leavitt's recommendations, as soon as next year, we could see the Medicare system begin to develop into a two-tiered reimbursement system. Providers designated through PQRI as high-value practices will be reimbursed as much as 10% more than offices that elect not to participate or that cannot demonstrate best-practice outcomes. Over a period of years, this could progress to more than a 40% difference in reimbursement rates.

Knowingly or unknowingly, we are all choosing the system we want for our future reimbursements. Those who practice today, and plan for the future, as if health care isn't changing, effectively elect to participate in the decreasing reimbursement system. For those who have already begun the move

toward PQRI, the effort to participate in an outcomes-based system is apparent. We owe it to ourselves to understand thoroughly the principles of value-driven health care.

Part 4
Implications for provider groups and their leaders

Value-driven health care has implications at all levels for both providers and patients. Eye care leaders, be they leaders of group practices or professional associations at the state or national levels have a special responsibility to help our profession prepare now.

1. Leaders must understand the basic principles of value-driven health care in order to:

a. Develop the best long term plan for the organization

Without knowledge of the basic principles of health care reform, organization leaders will find it difficult to develop effective new strategies and procedures and adapt their organization to the changes involved in the reform process. We readily understand that our organizations are evolving; as leaders, we have some degree of control over these changes. However, the move toward value-driven health care is a type of 'climate change' over which we have relatively little control. If we cannot control the changes in our environment, we must at least understand them.

b. Deliver a consistent message to members at all levels of the organization

The principles of value-driven health care are fairly straight forward but the implications vary tremendously depending on the practice setting, the type of provider and the current status of health care reform. Members will increasingly read and hear about reform in a variety of contexts. The information may be confusing or contradictory. Much of it will necessitate a different way of thinking about almost every aspect of providing patient care, so members will increasingly rely on the organization to provide guidance through the process. They will expect their leaders to articulate how reform relates to their particular circumstances.

All sizable organizations have multiple levels of administrative staff that interact with members. It is important that staff at all levels understand the basic principles of health care reform, know the formal position of the organization regarding these changes, and have a consistent message to deliver to members.

c. Design a simple position statement regarding health care reform

Most of us are by now familiar with organizational mission and vision statements. A concise statement that can be shared with all members can bring clarity and consistency of purpose for the entire organization.

2. Leaders must drive the message that "time counts!"

a. Opportunities in early phase of reform

Health care reform is not a government led program waiting for regulations or a bill to be passed. It is a payer-led movement well underway. Eye care, and especially optometry, is far behind in understanding and taking part in the process. As with all system changes, there are both new opportunities and the loss of existing ones. Income streams change over time. Value-driven health care offers many new opportunities but some are already disappearing. As new referral relationships are established to meet the new demands of value-driven health care, it will become increasingly difficult for providers to take advantage of the new opportunities.

b. Lost income later in reform

The components of value-driven health care that will result in loss of current income will not come into full play until later in the reform process. Consequently, providers who delay their involvement will miss the early opportunities then be subject to the loss of traditional revenue streams without viable replacement alternatives. The key is to take advantage of the early opportunities as quickly as possible. (Part 2 of the "Getting Under the Hood" series delineates numerous early opportunities.)

3. Leaders must help member providers understand value-driven health care and foster good decision-making for their practices

Value-driven health care will eventually affect every aspect of clinical practice. Until providers understand the principles at play in the reform process, they will be hard pressed to make good long or short-term decisions consistent with the way in which they will be practicing in the near future. Potentially worse is understanding the principles only in part. For example, providers who recognize the need for an EHR, but don't understand the eventual requirements for EHRs, beyond existing capabilities, may spend their money on a product that ultimately will not or cannot meet their needs. Similarly for equipment purchases, unless instruments meet interoperability requirements for future reimbursement, the current way of thinking about equipment utilization may end up being misguided.

4. Leaders must use the power of their organization to help members compete better. Volume also counts!

The manner in which individual optometrists may best compete in the value-driven health care world is yet to be determined. Organizations can actively lead their members by being a group that coordinates trials, shares best practices and member experiences, insights and opinions. Groups can work together with foresight and innovation to develop, try and initiate new procedures and techniques so members may thrive within the new health care structure. By developing efficient internal communications, members can collaborate and learn from each other. Sharing successful efforts, developing improved relationships with other health care providers or initiating national programs locally mean that the whole organization gains.

The scale of an organization, when utilized properly, can make each member more qualified and provide the level of experience that, in the future, may be required for reimbursement. One of the fundamental tenets of value-driven health care, which is well documented by numerous evidence-based medicine studies, is that volume counts. For most medical conditions, there exists a minimum level of both patient volume and practitioner experience to attain best practices. One way to attain the minimum requirement is for providers with lower levels to associate themselves with those who have a higher level of experience in providing the specific care in question. This can be accomplished by physically relocating, but also through team management of patients or even sharing cases electronically via telemedicine .

Once best practices are established and accepted as such, the organization can facilitate their adoption by individual members. Sharing the implementation steps utilized by offices that most successfully implemented the best practice amounts to more than just disseminating information.

5. Leaders need to contribute to optometry's professional knowledge base

AOA's Optometric Clinical Practice Guidelines (OCPGs) represent perhaps optometry's best available starting point towards a professional knowledge base. "OCPGs are recommendations for patient care developed through a formal process … and combine the best available current scientific evidence and research with expert clinical opinion to recommend appropriate steps in the diagnosis, management, and treatment of patients with various eye and vision conditions"[1].

Yet optometry, as a profession, is not well prepared for value-driven health care. Some OCPGs originate as far back as 1993 though many have been reviewed as recently as 2007. In many cases, the "best available current scientific evidence and research" was not based on measuring outcomes and best practices as defined by value-driven health care. Many of the common things we do in optometry have no formal evidence base or supporting literature. There is no comprehensive and current reference guide for selecting best practices. We have not documented the outcomes against which we want to be measured. There is no established consensus on how to measure outcomes or what to do with the results once measures are taken.

Hospitals and research institutions provide such materials for medicine but the closest equivalent in optometry is a handful of organizations with the ability to collaborate internally and develop needed knowledge bases such as those required by value-driven medicine. All optometric organizations have an obligation to consider this role for the profession and, in so doing, have an opportunity to emphasize the importance of the organization to our profession and to individual optometrists.

As optometry traverses the storm of health care reform, we will encounter a flood of decisions to be made on behalf of the profession, areas where we can offer self-directed results. Each organization can play a role in this process. The opportunity is now for members and for the profession.

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1. Ref. http://www.aoa.org/x4813.xml

Part 5
EHR essentials

Electronic Health Records (EHRs) are the new hot topic in optometry today. Not quite so popular is PQRI and value-driven health care. Yet these movements form an essential-to-understand foundation for the must-haves in any EHR solution. What will health care reform require of your EHR? Providing an electronic form of patient data is only the beginning. Many drivers are in place to require the use of EHRs in all health care practices. The effort involved at the national level to develop standards and mandate EHRs is not simply so each of us can have electronic data in our office. The question is what can be done with the data once it is electronic, portable and interoperable? What must our EHR do, not simply for us but for national health care cost reduction? Many EHR systems exist but few vendors are familiar with the technical and functional requirements being driven by health care reform. Of greater concern, some systems are technically incapable of meeting the standards.

Some EHR systems are technically incapable of meeting CCHIT and value-driven health care standards.

1. **CCHIT readiness**. Although CCHIT certification criteria for most specialty EHRs (eye care included) have not yet been developed, the requirements to utilize a certified EHR are already in place for Medicare reimbursement. Specialty EHRs can be "CCHIT ready" even if the certification process is not yet available. Does the vendor have a plan for meeting the certification requirements? The importance of this step must not be underestimated as certification is a major commitment on the part of an EHR vendor. CCHIT certification testing involves an eight-hour screening by a team of testers. If one function fails, the software fails certification.

2. **Mandatory portability**. Not only must patient health information be electronic, HIPAA-compliant electronic communications with other health care facilities will be mandated. Some EHRs can already meet the required standards. Considering EHRs without this capability means purchasing additional software at some point. The EHR will also need to meet national portability standards.

3. **Patient compliance.** Value-driven health care centers on outcomes, possibly the biggest change health care providers must grasp. Patient compliance now has a direct impact on the provider's outcomes or "value score". In order to drive the best outcomes, providers must ensure patients are engaged in co-developing their Plan of Care, and that they follow the agreed treatment plan. Both steps require a way of maintaining contact with the patient to drive compliance when the patient is not in the office. Some EHRs have already teamed with software solutions that provide this capability. Again, an EHR without this capability will mean either purchasing or contracting for this type service in the future at additional cost.

4. **Measurable outcomes**. Value-driven health care will progressively require the reporting of more complex clinical outcomes. Outcomes will need to be tracked and reported by the EHR. Only in the initial PQRI program will reporting be accomplished through the billing component. True outcomes will be measured and reported through the EHR. Such tracking will involve multiple information components and drawing conclusions about the plan and resulting outcome. One of the proposed outcome measures for 2008 was to report on what percentage of glaucoma patients achieved a 15% reduction in IOP from pre-treatment levels. (This measure was withdrawn for 2008 but will certainly return.) We can do the calculations manually for this type of outcome, but as we are required to track more and more outcomes, we will want an EHR that allows us to designate what we want tracked. Using tracked outcomes, a comprehensive EHR will be able to extract the necessary data, complete the required calculations, and provide a HIPAA-compliant report that can be included in any reporting requirement.

In addition to mandatory reporting, it is likely that many optometrists, as they become aware of the value of tracking outcomes, will want to do so voluntarily for virtually any condition. The ability of the EHR to efficiently and effectively track whatever is of interest to the provider will be one of the biggest benefits of going to an EHR in the first place.

5. **Electronically-auditable reports**. To meet interoperability requirements the EHR will need not only to include diagnostic tests and reports, but also reports containing extracted data to be incorporated into the EHR of the receiving office. Simply creating and sending, or faxing, a Word document will not meet these requirements. Already-established standards dictate that reports will be HL7-XML reports. Although the report may appear to be a Word document, individual elements of the report can be identified and extracted automatically and used wherever required by the receiving office. For example, the receiving office may be tracking the outcomes of a diabetic patient, their software creating a timeline graph of VA and IOP for every time the patient is seen in any office. The report format sent by the eye care provider will need to be such their system can extract the reported VA's and IOP's and place those values in the graph generated by their EHR. Likewise, eye care EHR will need to be capable of utilizing data supplied by their reports for tracking and documentation purposes. All EHRs, therefore, must meet HL7-XML standards.

6. **Data mining and business intelligence**. Once data is electronic, the ability to analyze both clinical and business data becomes potentially limitless. Some EHRs have data analysis and data mining capabilities built in. Providers should seek real data mining tools and not be fooled by canned reports with the appearance of a dashboard. No list of reports pre-defined by the software company can equate a true Business Intelligence solution. This means the ability to create any type of analysis and display the results in the most meaningful format, be that a table, graph or chart.

7. **Audit capability**. Once electronic data meets portability requirements, it is likely we will see payers adopt automatic audits as a pre-requisite for reimbursement. This gives the payer a means of ensuring best practices are incorporated into the workflow and treatment plan, and also provides a way

of making sure everything billed was also completed. For example, most dental payers currently require every x-ray to be submitted along with the claim for reimbursement. Optometry EHRs will need the ability to generate an HL7 compliant XML report plus the ability to include diagnostic test results in required audits.

8. **Best practices**. The way to obtain best outcomes is to utilize best practices. EHRs must assist the provider in the consistent use and documentation of best practices. If the EHR uses a traditional format with lots of fields and drop down menus, or data entry by various menus into fixed fields, providers will have to rely on more extensive training of both assistants and professional staff to ensure that best practices are consistently employed in all patient care. The alternative is an EHR that largely accomplishes the task itself and automatically documents the best practices employed. EHRs should clearly incorporate best practices and document that they were used in the care of every patient.

About the authors

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Jim has been an avid observer of all that happens in Washington with regard to health care and, in particular, eye care. A special interest for him has been the portability of patient health information and telemedicine technology. Jim developed Image Consultant, now integrated into OD Professional™ as ImageManager. Jim serves as a consultant to EMRlogic Systems Inc., leading the growth and clinical development of OD Professional, a PMS-EHRs solution for eye care that exceeds PQRI, pay-for-performance and value-driven health care standards.

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Alistair is VP Sales for EMRlogic /OD Professional™. Following a 20-year career as teacher and school administrator, he brought his organizational and relational skill set to the world of eye care technology. Alistair is keenly interested in the educational component of his work: helping optometrists understand why the most important part of a software solution is *everything we cannot see*, what's "under the hood".