

What surgeons should know about...

Chartered value exchanges

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Massachusetts Health Quality Partners (MHQP) has developed an online tool for consumers to review comparative data on providers. Using patient experience surveys for physicians' offices and clinical data for medical groups, MHQP allows consumers to compare results across the state of Massachusetts. As a whole, MHQP—a collaboration of physicians, hospitals, health plans, purchasers, consumers, and government agencies—has been recognized by the U.S. Department of Health and Human Services (HHS) as a community leader, a major step toward becoming classified as a chartered value exchange under the department's Value-Driven Health Care Initiative.

Soon, if not already, community leadership groups similar to MHQP likely will be organizing in your region. This article explains why this phenomenon is occurring and why you should consider participating in these collaborative organizations.

What spurred the development of the HHS' Value-Driven Health Care Initiative?

In August 2006, President Bush signed an Executive Order for Health Care Transparency, which became effective in January 2007. This order mandates that federal health care agencies carry out the following activities: disclosing information regarding prices and quality of health care services, promoting the use of health information technology (IT) to increase data sharing, and developing programs to increase the quality and efficiency of care. The objective of the transparency order is to allow consumers to compare the cost and quality of services and evaluate overall value of care that individual institutions and physicians provide so they can make informed decisions.

What are the key elements of the initiative?

The Value-Driven Health Care Initiative was launched by HHS Secretary Michael Leavitt in response to the President's mandate. This program centers on the following four cornerstones of value-driven care: interoperable health IT, measurement and dissemination of quality information, measurement and publication of price information, and promotion of quality and efficient care.

The first of these four pillars, the development of interoperable health IT, is critical to the success of the transparency initiative. Key stakeholders and health policymakers believe that interoperable health IT will affect health care in positive ways similar to advances that have occurred in the banking industry since the switch from paper to online billing occurred. They believe that enhanced health IT will reduce the time for reviewing test results and patient history and decrease the chance of human error by reducing opportunities for information to get lost. However, an electronic health care industry needs a strong financial foundation and principals and standards to ensure security, privacy, and accuracy. The American Health Information Community was created to help develop and implement these standards, including a certification process for health IT products. HHS' objective is to link providers and payors throughout the U.S., supplying a pool of data that will ultimately measure cost and quality for the Value-Driven Health Care Initiative.

The second cornerstone—measurement and dissemination of quality information—will allow consumers to have access to information about quality of care before making important health care decisions. Increasingly, consumers are being encouraged by their employers and their health plans to explore provider options and quality rankings and to take on a greater role in their own health care decision-making. Until recently, however, information that would be useful in making these decisions had been unavailable to the public. HHS' quality measurement initia-

tives are premised on measures developed by consensus-based organizations, including the AQA and the National Quality Forum. To date, most of the work on development of quality measures has focused on chronic care and preventive services. As a result, efforts to develop surgical quality measures and reports that provide meaningful information to consumers are still in their infancy.

Measurement and publication of price information—the third component of the initiative—is intended to ensure that patients are aware of costs before receiving treatment. However, this activity is more easily said than done. In order to effectively measure, control, and publish such information, it is necessary first to define the services that are paid for and the cost of those services. But in health care, costs are split across payors, providers, and patients, making this task extremely complicated. As the first step in this process, the Centers for Medicare & Medicaid Services (CMS) has published payment and cost information for specific and widespread procedures. The pricing information is classified by hospital, state, country, and procedure. These two pieces—measuring and reporting both quality and cost—are the building blocks for defining value and efficiency.

The fourth and final element is the promotion of quality and efficient care. This component provides incentives for medical centers and professionals that provide high-quality, economically priced health care for the patients who purchase it. These incentives include financial rewards for providers who offer this care and for consumers who select those providers. Consumer-directed health plan products, popular with large employers today, are an example of how this approach may be applied. HHS' stated goal is to stimulate competition throughout the health care industry based on quality and efficiency.

How is the Value-Driven Health Care Initiative being implemented at the community level?

To put the initiative into action in the marketplace, HHS has launched the development of chartered value exchanges. Through three new programs, HHS expects to increase the quality

and lower the cost of health care. These programs include the Better Quality Information (BQI) for Medicare Beneficiaries Projects, Community Leaders for Value Driven Health Care, and value exchanges. These three programs can be seen as stepping-stones, each building on the previous one until the U.S. has a network of value exchanges in every major community and region.

The BQI for Medicare Beneficiaries Project was funded by CMS in 2007 and involves six regional collaboratives chosen as pilot sites. These sites are operating as learning laboratories, helping to establish methods of combining private sector and Medicare claims data into a single community-wide quality report. The results of these efforts will be beneficial to physicians, allowing them to view performance information for Medicare beneficiaries and, thus, improve their quality of care. BQI pilot sites include the following: the MHQP, the California Cooperative Healthcare Reporting Initiative, the Indiana Health Information Exchange, Minnesota Community Measurement, Arizona State University–Center for Health Information & Research, and the Wisconsin Collaborative for Healthcare Quality.

Value exchanges are viewed as the ultimate vehicle for the implementation of value-based health care. A value exchange is defined on the HHS Web site (www.hhs.gov) as “a multi-stakeholder collaborative that has taken clear action in its community to convene community purchasers, health plans, providers, and consum-

Resources

- For more information on value-driven health care, visit <http://www.hhs.gov/valuedriven/index.html>
- For more information on the BQI pilots, visit <http://www.hhs.gov/valuedriven/pilot/index.html>
- To see who the designated community leaders in your area are, or to apply to become a community leader, visit <http://www.hhs.gov/valuedriven/communities/communityleaders/communities.html>
- To apply to become a chartered value exchange, download the application and instructions at <http://www.ahrq.gov/qual/value/chartered.htm>

ers to advance the four cornerstones of Value-Driven Health Care.” The first step to becoming a chartered value exchange is to be recognized as a community leader by the Secretary of HHS. A community leader must demonstrate the following:

- Active engagement with all stakeholders in the community
- Collaboration with stakeholders for information exchange
- Ability to serve as an independent nonprofit organization with experience
- Financial stability
- Collection of provider-level measurement across the Institute of Medicine domains
- Effective public reporting efforts using performance measures
- Rewards for performance improvements
- Use of interoperable health IT
- Continuing evaluation and improvement efforts

To date, the HHS Secretary has recognized 110 community leaders. Community leaders reflect the extensive diversity of health care markets throughout the U.S. Each area has unique marketplace and cultural health care characteristics, exemplifying the need for strong collaborative leaders in each community.

Once HHS recognizes an organization as a community leader with shared collaboration among purchasers, health plans, providers, and consumers, it may apply to become a chartered value exchange. HHS certifies new value exchanges every six months. At press time, the first round of applications (more than 30) was under review.

What exactly is a chartered value exchange, and why would I want to be part of one?

The value exchange continues its functions and roles as a community leader with continual modification and improvement, but participation has added benefits. A value exchange adapts the national efforts to a local effort. It allows a community to develop its own board to direct quality, reduce waste, and create safe and affordable care. A true value exchange has a balance of community leaders in purchasers, payors, providers, and patient advocates. Acting as the oversight board, the value exchange can provide population-based

studies to determine the best health and health care needs for the community.

Members of a value exchange can access the Learning Network. Sponsored by the Agency for Healthcare Research and Quality, this network plays a valuable role in promoting health care reform by evaluating methods within the value exchanges and encouraging change through sharing of evidence-based best practices from other value exchanges across the country. Quality initiatives developed in one part of the country will be available for other chartered programs to use in their own environment. Another benefit of chartered value exchange membership is that it includes access to summaries of Medicare provider performance data, which may be helpful in determining provider performance across all payors in a market.

Many organizations throughout the U.S. are in the process of becoming community leaders and chartered value exchanges. The American College of Surgeons encourages its members to look for such groups and to become involved in these efforts at the earliest possible opportunity. There are tremendous political forces at work to propel the development of value exchanges. Surgeons must be part of the development to ensure that their role in the medical community and in the overall care of the surgical patient is appropriately recognized and rewarded. ^Q