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Stroke System of Care: Health Policy Perspective

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The reality....

- ♥ A lot of great work has been done to facilitate stroke systems adoption BUT
 - Fragmented delivery of care continues (silos)
 - Adoption of regionalized care is limited BUT needed to ensure patient is directed to most appropriate setting
 - Reimbursement system is not set up to facilitate certain elements of the stroke system of care model (e.g. transfers, diversions)



Current Policy Activities in Play

- ♥ Legislative Activities: Stop Stroke Legislation
- ♥ Regulatory Activities: Proposed Changes Prospective Payment System
- ♥ Multiple Relevant IOM reports:
 - Pending: Institute of Medicine Report on Pay-for-Performance (Anticipated release by September 21 2006)
 - Institute of Medicine: *Hospital Based Emergency Care at the Breaking Point & Emergency Medical Services at a Crossroads*



Stop Stroke Legislation

The Stroke Treatment and Ongoing Prevention (STOP Stroke) Act

- H.R. 898: Representatives Lois Capps (D-CA) and Chip Pickering (R-MS)
- S. 1064: Senators Thad Cochran (R-MS) and Edward Kennedy (D-MA).

Purpose: Help ensure that stroke is more widely recognized by the public and treated more effectively by healthcare providers. Would authorize federal grants for stroke systems planning. Would foster the development of a support network and coordination with EMS. Clearing house of best practices.

Update: Pushing for a vote on the bill in the Senate Health, Education, Labor, and Pensions Committee and in the House Energy and Commerce Committee before adjourn.



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Medicare Payment System: Change is Forthcoming!



Medicare Spending

Measures of Medicare Spending, 2005–2014

	2005	2006	2010	2012	2014
Spending as % of Gross Domestic Product*	2.7%	3.3%	3.5%	3.7%	4.0%
Spending as % of National Health Expenditures**	17.2%	20.4%	20.2%	20.3%	20.8%
Years to HI Trust Fund Depletion* (2005 projections)	15 years	14 years	10 years	8 years	6 years
General Revenue as a Share of Total Medicare Spending*	36.8%	42.8%	44.5%	45.6%	47.9%

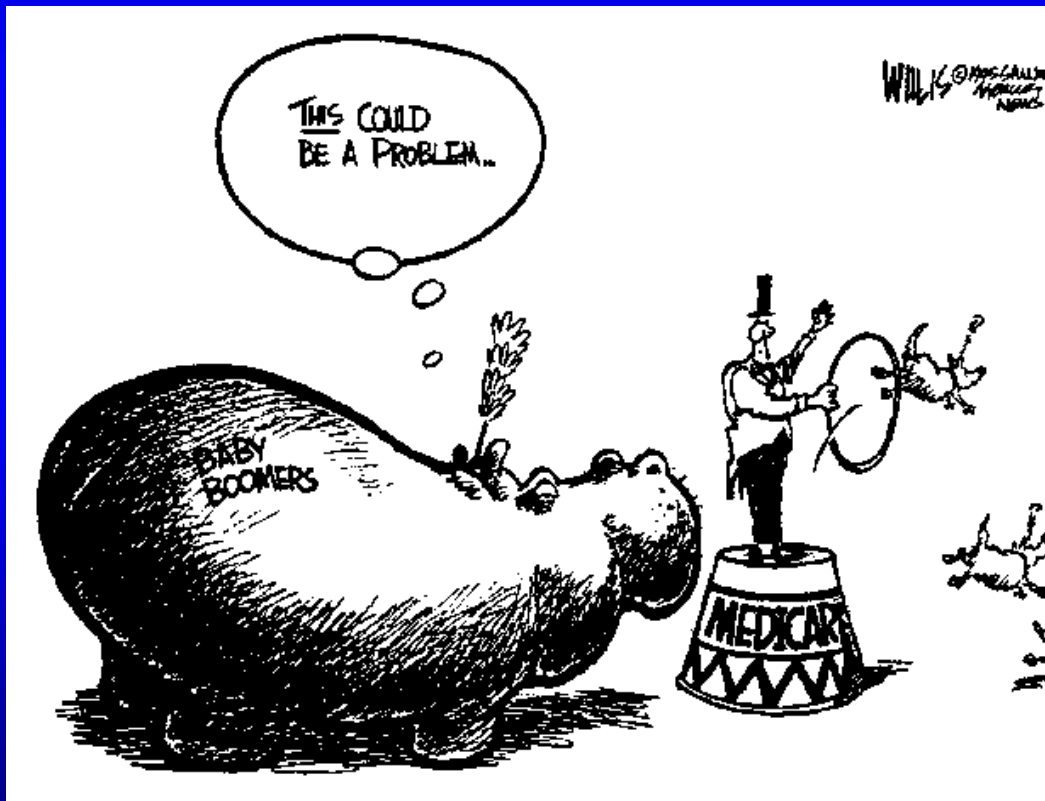
SOURCE: *2005 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. **Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, February 2005.



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Future Challenges to Medicare Spending



- ♥ Large number of baby boomers becoming Medicare eligible
- ♥ Estimated that btw 2000 to 2030 the number of people on Medicare is projected to rise from 40 million to 78 million
- ♥ Workers necessary to support beneficiaries is projected to decline from 4.0 workers p/ beneficiary to 2.4



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Regulatory Changes to Reimbursement





DRG 559: Stroke Patient Access to tPA

Problem: DRG 559 not included in APR-DRG system proposed by CMS. Proposed system could have been adopted as early as FY 07, or in FY 08.

What was done:

- ♥ Wrote joint letter with AAN and other partners to CMS expressing concern “system should include a DRG equivalent to DRG 559”
- ♥ Reiterate same data provided to CMS when creating code
- ♥ Multiple conversations with CMS staff once rule passed



DRG 559: Stroke Patient Access to tPA (cont)

Status: CMS issued Final Inpatient Prospective Payment System rule for FY 07

♥ DRG 559 is maintained. Base payment rate increased 3.16% and would go into effect October 1st

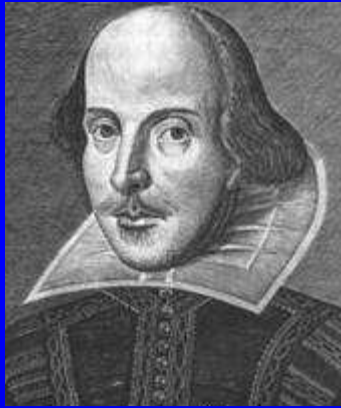
Next steps:

- ♥ Continue to monitor proposed IPPS changes
 - Impact Analysis report by CMS
 - Technical Advisory Panel



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Quality improvement efforts or pay for performance.... That is the question!



Influencing the Development of Voluntary and Mandatory Reporting Programs

Physician Voluntary Reporting Program

- ♥ Launched on January 1, 2006
- ♥ Intent to improve the health and function of beneficiaries by preventing chronic disease complications, avoiding preventable hospitalizations, and improving the quality of care delivered
- ♥ consists of 36 evidence-based, clinically valid measures.
- ♥ Starter set of PVRP 16 measures
- ♥ Receive data feedback on the 16 core measures in the spring of 2006.
- ♥ Confidential reports available to physicians will be limited to the 16 core starter set measures.

IMPORTANT:

- Included among priorities was stroke
- PVRP will be expanded to include these consensus measures after they are endorsed and implemented.
- But successful measures may become pay for reporting → pay for performance/pay for quality



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Influencing the Emergency Care and EMS Delivery System

IOM Hospital Based Emergency Care at the Breaking Point & Emergency Medical Services at the Crossroads

♥ Both emergency reports:

- Benefits of regionalization based on resource/experience.
- Benefits of coordination of care to ensure patient directed to appropriate setting
- Benefits of accountability to ensure emergency care system is responsible for improving quality of care, including realization of failures
- Note the value and need to assess use of health information technology
- Need to identify quality of care provided by EMS, national EMS efforts



Potential Health Policy Vehicles to Further Stroke Systems

IOM recommendation that DHHS convene a panel of individuals with emergency care and trauma care expertise to develop evidence based indicators for emergency care.

♥ Influencing the EMS measures that are developed irrespective or whether voluntary or mandatory reporting efforts.

- Work to ensure that measures are formulated on evidenced based guidelines and are national consensus based measures (federal and state)
- Possibility in future to include care coordination measures that could create data on stroke systems implementation
 - Include hospital, physician, EMS, and patient satisfaction measures
- Ensure measures are tested and then updated on a timely basis



Potential Vehicles to Further Stroke Systems

AHA Policy Recommendations

Payment for Quality: Guiding Principles and Recommendations

Principles and Recommendations From the American Heart Association's Reimbursement, Coverage, and Access Policy Development Workgroup

Vincent Bufalino, MD, FAHA, Chair; Eric D. Peterson, MD, MPH;
Gregory L. Burke, MD, MS, FAHA; Kenneth A. LaBresh, MD; Daniel W. Jones, MD, FAHA;
David P. Faxon, MD, FAHA; Adolfo M. Valadez, MD, MPH; Lawrence M. Brass, MD, FAHA;
Valere B. Fulwider, JD; Renee Smith, MPA; Harlan M. Krumboltz, MD, FAHA

Abstract— Payment-for-quality programs are emerging in the wake of rising healthcare costs and a demonstrated need for quality improvement in healthcare delivery in the United States. These programs, also known as “pay-for-performance” or “pay-for-value” programs, attempt to realign financial incentives with the quality of care delivered. The American Heart Association’s Reimbursement, Coverage, and Access Policy Development Workgroup provides in this statement a set of principles and recommendations for the development, implementation, and evaluation of these programs. The statement also suggests future areas for research around the realignment of financial incentives to improve both the quality of care delivered and patient outcomes. (*Circulation*. 2006;113:1151-1154.)

Key Words: AHA Scientific Statements ■ patients ■ quality of health care ■ delivery of health care
■ payment for health care

♥ Quality Measure efforts (demos, pilots or programs) should comply with recommendations included in statements such as AHA’s Pay for Quality Statement



Maximize on Recommendations Included in Emergency Care and EMS Reports:

♥ Recommends that an ad hoc workgroup be convened by CMS with expertise in EC, trauma and EMS systems to evaluate reimbursement of EMS (readiness, P4P, IT, and communications)

- Voluntary reporting, pay for reporting, pay for performance
- Gainsharing models?
- CDSTs and other IT systems (integrated and interoperable)

♥ Recommends HHS to conduct a study to examine the gaps and opportunities in emergency and trauma care and recommend strategies for optimal organization and funding of research effort

- Develop interest by researchers in pre-hospital emergency care
- Evaluate regulatory barriers (informed consent, HIPAA etc)
- Multicenter/Multisystem research consortiums
- Establish a research agenda (CVD and stroke)



Maximize on Recommendations Included in Emergency Care and EMS Reports:

- ♥ Congress to establish demonstration program to promote regionalized, coordinated and accountable EMS systems throughout the country (est \$88M for 5 yrs)
 - Need to ensure that information is publicly accessible (lessons learned)
 - Need to ensure that multiple stakeholder perspective are included in formulating these demos
- ♥ Professional organization w/ national highway safety administration would develop model for pre-hospital protocols for treatment, triage and transfer
- ♥ National certification as pre-requisite for state licensure and credentialing of EMS providers.



Let's Re-Cap

- ♥ Ideally– Single prospective payment might be ideal, **HOWEVER** difficult to accomplish short term.
- ♥ So then what?
Number of vehicles on which we can add stroke systems of care:
 - Affect regulatory process ensuring payment system change doesn't impede stroke systems maintainability and adoption
 - Influence the development of measures regarding stroke in both the inpatient and outpatient care (EMS, hospital, physician level)– EMS performance measurement project
 - Voluntary and non-voluntary reporting requirements including pay for reporting, pay for performance/pay for quality.
 - Identify means by which to share success stories..
 - ◆ What worked, what didn't
 - ◆ How HIT was used
 - ◆ Who were the stakeholders included in these conversations
 - Utilize existing reports as a vehicle to further stroke systems models.



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QUESTIONS???