

August 2011

Commentary

The Imperative to Transform

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Contents

Director's Letter	2
Increasing the Value of VA Health Care	3
Transparency and Public Reporting of Quality and Safety in VA Health Care	4
VA Databases: Window into Clinical Operations?	5
Value-Based Purchasing in VA	6
Resource Use Measurement	7

“VA Health Care Defining Excellence in the 21st Century” was a theme adopted in 2010 to underscore the VA’s promise to honor our commitment to provide the best care anywhere to America’s Veterans. The VA’s “Excellence” campaign is guided by the principles of our system becoming patient-centered, team-based, data-driven, and continuously improving. This ongoing transformation serves our Veterans today and ensures we will stand ready to serve them tomorrow.

The journey of improvement is not easy. It requires the balancing of three big pieces: the best individual patient experience (including quality, access, and reliability), meeting (all) the needs of our Veteran population, while improving the value of care.¹

Efforts to maximize the performance of our mission will be unsustainable if the cost is excessive. Efforts to improve technical quality alone may be invisible to the patient in their actual experience of care. Patients see the organization’s ability to be respectful, answer the phone, and get what they need as their measure of quality.

Improving the VA Patient Experience

So, how does VA improve our patient experience while also becoming more efficient? Remember, improved quality is generally less (not more) expensive.² For example, just in the area of access, we know from VA studies that patients who wait are less satisfied, and have worse outcomes.³ Improved access (to

appointments, phone, and e-mail, etc.) reduces cost, and is an improvement in quality that patients do notice.

The transformation in “defining excellence” is underway in primary care through the implementation of the Patient Aligned Care Teams (PACT). We are redesigning care practices and team roles to be patient-centered by developing core teams that continuously improve the care they deliver. Significant investment in kiosks, telehealth technologies, and a portfolio of inpatient informatics tools is also underway. Communication paths with Veterans are being enhanced through secure messaging and planned improvements in telephone access. The Veterans Health Administration organizational structure is also being realigned to better support our mission.

While the work of finding better and more efficient ways to serve our Veterans can be challenging, sustaining improvements can prove to be even more difficult. Our systems and processes must be *reliable and sustainable*. VA is now adopting approaches other industries have found useful in this area: the ISO 9000 Quality System standard for one. This standard will complement existing statutory and regulatory requirements; it will help us better identify the added value in our processes, obtain the results of process performance and effectiveness, and give us a more reliable base for continual improvement of processes based on objective measurement.

In November 2010 the VA led the health care industry by releasing detailed quality and per-



Director's Letter: Writing A Winning HSR&D Research Proposal

Preparing a winning research proposal is always challenging. Following are six suggestions for improving the likelihood of funding of research proposals submitted to HSR&D (and other organizations).

- 1. Propose Innovative Hypotheses and Aims** – Thoroughly understand the state of knowledge of the area of research, as well as the most important ‘next steps’ that will be required to move the field forward. Develop research hypotheses, aims, and a research design that explicitly address the next steps.
- 2. Clearly Document What is Known and Not Known** – The fundamental goal of research is to measurably advance knowledge. Therefore, the research proposal must concisely and clearly present what is known and unknown related to the proposed research endeavor. The proposal also should convincingly describe why gaining greater understanding of the “unknowns” will significantly advance knowledge.
- 3. Present the Proposed Project in a Theoretical Context** – Present the proposed project’s research aims in a theoretical context or model. The model should include the most important variables and specify those that the project will address, and why.
- 4. Demonstrate the Potential Generalizability of the Project’s Results** – While the project may focus on a specific issue, the proposal will be stronger if the investigators convincingly argue that the results are likely to be generalizable to other situations. For example, a project that focuses on improving appointment-keeping in a substance abuse clinic is much more likely to be funded if results also are likely to be applicable to primary care and specialty clinics. A sound theoretical model supports the generalizability of results.
- 5. Avoid an Intervention that Proposes Increased Resources to Improve Outcomes** – Projects often propose to evaluate the impact of increased resources (e.g., a dedicated nurse, pharmacist, telephone manager) on outcomes. Such proposals are reviewed with limited enthusiasm, since the positive impact of increased resource allocations on health outcomes is usually predictable. Therefore, a project that proposes an intervention that involves increased resources must either hypothesize a dramatic impact, or provide an additional commanding benefit.
- 6. Identify and Engage a Program or Operations Advocate for the Project** – The long-term goal of many proposals is to evaluate a concept for subsequent adoption by a VHA program or operations office. Too often, however, the intended beneficiary is not particularly interested in the product; and the long-term impact of the project, even if completely successful, is minimal. Engaging the intended project beneficiary during the project’s development stage may greatly increase the project’s value, while requiring minimal modification of the project’s aims.

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formance information for all VA hospitals; it was another step in demonstrating our quality improvement and public accountability. Some goals are set above other health systems, but VA believes that the goals are worth seeking in order to improve our Veterans’ health. We are targeting opportunities for improvement, not finding fault. The VA Hospital Compare website permits Veterans, family members, and their caregivers to compare the performance of their VA hospital to other VA and non-VA hospitals nationwide. On this website, quality information: (a) summarizes outcomes in areas such as acute care, safety, intensive care, and other measures; (b) documents quality and safety goals for all VA hospitals and how well they are being met; (c) compares outcomes for congestive heart failure, heart attack, and pneumonia; and (d) tracks progress in reducing complications from surgery including infection, blood clots, cardiac and respiratory problems.

“Remember, improved quality is generally less (not more) expensive.”

Going for the Gold

The real “gold” for 2014 when health care reform changes take effect, however, will only be achieved when the talent of the entire organization is “released” to improve the efficiency and reliability of processes in every single part of the organization so that taxpayers know VA is a good investment and Veterans affirm that “VA is the care I want” by choosing us!

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Response to Commentary

Increasing the Value of VA Health Care

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Technological advances have improved health care outcomes, but at great cost. Health care now represents more than one-sixth of the U.S. economy and it is widely agreed that the current rate of growth in U.S. health care expenditures is not sustainable.

The challenge to health care systems, including the Veterans Health Administration (VA), is to achieve higher value with the resources already available. Developing a value-based health care system will require many changes: comprehensive and transparent assessment of outcomes; improved health care delivery; activated health plan members; and an emphasis on prevention, screening, and health maintenance. Dr. Petzel et al. describe some of the VA transformational efforts that are already under way.

Strategies to Improve Value

A value-based health care system will create better outcomes for each dollar of cost. The strategies that VA has used to successfully improve health care quality can also be employed to improve its value. These strategies include practice guidelines, performance measures with incentives, and implementation efforts. Each of these strategies can help VA “bend the cost curve.”

Practice guidelines and coverage decisions can consider whether new treatments deliver sufficient value to justify their cost. Cost-effectiveness analysis is a formal evaluation of the efficiency of an intervention in terms of cost per quality-adjusted life year gained. Cost-effectiveness analysis is widely used in other countries, but less widely in the United States, where it has sometimes been misunderstood to be a form of health care rationing. Cost-effectiveness methods have been applied in thousands of studies. Findings from these studies are ordinarily applied to decisions about new interventions. Since much of the growth in health care cost stems from more intensive use of interventions already adopted, this limits the potential

impact of cost-effectiveness research for improving health care value.

Performance measures have been developed to rate provider efficiency.¹ Statistical measures, like Stochastic Frontier Analysis, have been used in many academic studies, but rarely applied by health care systems. Private vendors have developed benchmarks for the cost per covered life and cost per treatment episode. Products such as the Diagnostic Cost Group Classification Model, the Episode Treatment Group System, and the Medical Episode Grouper are being used by managed care organizations to reward providers who spend less than the benchmark.

There are limitations to these efficiency measures. Most current measures do not include outcomes. This may give providers an incentive to reduce high-value care. Although these measures identify high cost providers and high cost episodes of care, they do not identify which practices must be changed to increase value. Researchers are also concerned that these methods may misclassify some efficient providers.

Implementation efforts of the VA HSR&D Quality Enhancement Research Initiative (QUERI) program have helped VA improve quality. Quality improvement is only one way to increase value. These strategies could also help VA increase value by reducing inappropriate use of high cost services. There are many examples of this type of value-enhancing implementation study in the literature, including efforts to reduce inappropriate use of pharmacy, laboratory, blood bank, and imaging services. The overall impact of these efforts has been small. VA could use education, audit and feedback, clinical reminders, organizational interventions, and other implementation strategies proven effective in QUERI, to increase health care value in this way.

There is no shortage of clinical areas where this effort is needed. The New England Healthcare Institute documented 460 stud-

ies that identified health care waste or inefficiency.² Low-value services were identified in the Tufts Cost-Effectiveness Registry. Lists of inappropriate services have also been identified by a coalition convened by the National Quality Forum, and by the National Institute on Clinical Effectiveness (NICE), which makes recommendations to the British National Health Service.³ An implementation effort directed at changing provider behavior could help VA switch from these low-value services, freeing resources that can generate greater value.

Seeking Veteran Input

More Veteran input will be needed to provide the patient perspective on what constitutes value. In countries that use cost-effectiveness to make coverage decisions, both academic and government decision makers seek public input to define health care value.

Achieving a value-based, efficient health care system will be a difficult undertaking. To stimulate the flow of information between VA leaders and researchers, the Health Economics Resource Center (HERC) is hosting cyber-seminars on health care efficiency. These seminars feature VA leaders, researchers, and experts from other organizations. For upcoming seminars, or to view past seminars, visit the HSR&D website at http://www.hsr.d.research.va.gov/for_researchers/cyber_seminars/.

Greater efficiency is about achieving better health for patients. If we stop spending resources on expensive things that yield little value, it will free resources that can be used in a more productive way. Doing so is an ethical imperative as it will improve the health of the nation's Veterans and, additionally, can address the challenges of the “campaign for excellence” that Dr. Petzel et al. discussed.

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Research Highlight

Transparency and Public Reporting of Quality and Safety in VA Health Care

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VA is committed to transparency as part of our health care delivery. We do this out of respect for Veterans' service and our accountability to the American people. Transparency takes many forms—such as disclosure of errors and adverse events to patients and family members—but is increasingly viewed as a proactive strategy of sharing ongoing performance data in order to improve trust in government. VA's considerable experience in health delivery transformation and quality measurement, if shared widely, can catalyze our internal transformation as well as benefit the wider debate on national health care reform.

History of Data Transparency in VA

VA began sharing comparative performance data in 2005 by transmitting Hospital ORYX measures directly to The Joint Commission for public posting on www.QualityCheck.org. In 2008, we began posting outpatient indicators based on the Healthcare Effectiveness Data and Information Set (HEDIS), and the following year VA released a comprehensive Hospital Quality Report Card that included data on quality of care, waiting times, staffing, nosocomial infections, availability of services, health disparities, and accreditation. We have updated and expanded the Hospital Quality Report Card each year thereafter.¹

The next phase of quality and safety transparency involved transmission of VA administrative and clinical data to the Centers for Medicare & Medicaid Services (CMS) to allow direct comparisons of VA and Medicare hospitals on www.hospitalcompare.hhs.gov. Core quality metrics first appeared in March 2010 and have been updated quarterly. Outcome indicators, including risk-adjusted mortality and readmission rates for acute myocardial infarction, chronic heart

failure, and community-acquired pneumonia, will appear in early August 2011. In calibrating its risk models, CMS uses VA data that includes subsequent admissions to Medicare hospitals when calculating readmission rates. The combination of VA and Medicare data thus allows a more complete picture of quality for Veterans with dual eligibility. VA also adopted the CMS methodology for measuring patient hospital experiences via the Hospital Consumer Assessment of Health Providers and Systems (HCAHPS) survey tool, and currently, those results are available on our own website, www.hospitalcompare.va.gov. Because these HCAHPS results are now adjusted for patient mix using the risk model provided by CMS, fair comparisons of VA to non-VA patient experiences are now possible.

Although direct comparisons of performance between VA and Medicare hospitals can be compelling, they fall short in several ways. The data on www.hospitalcompare.hhs.gov are delayed by 18 months or more, and the reported quality indicators are limited to those obtained from chart abstraction, billing claims, or patient surveys. Our electronic health record systems actually allow more detailed and timely reporting, which is why we continue to post quality and safety data on VA websites. Our most recent public tools are the web application ASPIRE and the Linking Information Knowledge and Systems (LINKS) dashboards.² ASPIRE documents our journey toward high reliability by showing facility and network-level progress toward “aspirational” goals that represent the highest possible attainment (e.g., the aspirational goal for health care associated infection is zero infections). LINKS provides a quarterly “snapshot” of our outcomes for acute care, ICU, surgery, outpatient, and safety measures.

VA Data Now Broadly Available

Now that VA data is available on our websites and those of CMS, as well as through government-wide sites such as www.Data.gov, a variety of secondary users can further analyze our performance and display in ways that may be more accessible for certain readers. These include established and well-known organizations such as Consumer Reports and the Commonwealth Fund (sponsor of reporting site WhyNotTheBest.org), as well as new entities such as FindTheBest.com, which has just released a beta-version for comparing VA hospitals based on proximity to a given Zip code.³

If successful, transparency has the potential to be “game-changing” in the national health care debate. Transparency provides a powerful signal of VA's commitment to transformation and its willingness to compete for clients based on measureable value. Embracing transparency of clinical quality and safety data on the national level offers one hope of countering the “tyranny of the anecdote” that so often besets public institutions. Finally, public transparency reinforces other accountability mechanisms by creating strong incentives to maintain the highest possible reliability.

Important questions remain, however. Health literacy and numeracy remain low in the general U.S. population, and making public reports more “user-friendly” is a challenge. We know very little about how clinicians and administrators respond to these reports. Comparisons among VA and non-VA providers may not always be fair ones—our patients differ, our diagnostic coding practices have evolved in a different payer environment, and current methods of risk adjustment may not fully level the playing field especially for providers with complex populations or safety-net missions. Citizens may not find the data particularly relevant to their own health decisions. We welcome the engagement of the VA health services research community to assist us in exploring these critical questions.

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3. <http://va-hospital.findthebest.com>

Research Highlight

VA Databases: Window into Clinical Operations?

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The Veterans Administration (VA) garners praise as a quality leader, despite tremendous complexity associated with being the largest health care system in the United States, with a reach from Manila to Maine. Rich national databases have contributed to VA's remarkable transformation. These centralized data sources provide ample opportunities for clinical leaders, policymakers, and researchers to peer into the workings of the VA, to understand where it excels and where it can improve. Compared to primary data collection methodologies, these data sources offer an opportunity to study the universe of VA patients at relatively low cost and without selection bias issues inherent in other approaches. Thus, VA data sources contribute greatly to system transparency.

However, if data is the glass through which we examine VA, it is important to understand imperfections that can distort the view. This article describes a few queries one might make of these databases, to illustrate problems that can arise.

Who are the Veterans using VA Outpatient Services?

This sounds simple. However, it turns out that there are many non-Veterans (e.g., employees, CHAMPVA, Tricare, etc.) included in National Patient Care Database (NPCD) outpatient files. If the focus is upon Veterans, then failure to exclude these people would lead to over-estimation of numbers of patients, and under-estimation of health care needs. This data issue impacts women much more than men: half of women in VA outpatient files are non-Veterans.¹

Are We Providing High Quality Care?

VA data includes a spectrum of processes of care. However, any work on processes of care should account for uncaptured care occurring outside VA. For example, some diabetic VA patients who appear to have failed to receive glycemic monitoring (based on VA data alone) may actually have been tested outside VA. One strategy is to link VA utilization data to other data sources, e.g., fee basis data, Medicaid data, Medicare data.² Another strategy is to link NPCD to survey data (e.g., Office of Quality and Performance Survey of Health Experiences of Patients), using the latter to select patients who identify VA as their exclusive source of care.

How Do Veterans Fare in Terms of Outcomes of Care?

As one example, data quality control checks for the HSR&D funded project, IIR 04-248 revealed that, at many facilities, Decision Support System (DSS) lab data indicated that zero warfarin-treated patients with atrial fibrillation had received International Normalized Ratio (INR) testing in 2003. This represented a problem with data transmission to the centralized database in the first year of roll-out of this new data element, and improved in subsequent years. In cases like this where irreconcilable data issues arise at some facilities, those analyzing the data may have to settle for conducting a "multi-site" query (i.e., at sites with reliable data), rather than a study of patients using every facility in the country.

How are Veterans Using VA?

Since every encounter generates a record, NPCD reliably describes many types of utilization. However, some data elements are popu-

lated inconsistently, precluding secondary data manipulations to resolve data limitations. For example, the Women's Health Evaluation Initiative (WHEI) conducts database analyses for the Women Veterans Health Strategic Health Care Group (WVH-SHG) to inform national women's health policy development. WHEI data quality checks on the clinic "stop code" (clinic type) 322, labeled "Women's Clinic," revealed erratic application of the code across facilities: sometimes the code reflected care in a comprehensive Women's Health Center, sometimes care in a preventive health "pap" clinic, and sometimes care in a general medical clinic.³ Therefore, it was not possible to draw meaningful conclusions about how women were using gender-specific primary care services. However, in response to these findings, the instructions for coding of 322 have been modified to permit systematic capture of women's health model of care. This points to VA's commitment to continuously improving robustness of its databases.

Clinical leaders, policymakers, and researchers need to attend to caveats like these when using national VA databases to reduce the hazard of drawing erroneous conclusions. However, they should not shy away from taking advantage of these rich sources of information. With a little polishing, these databases provide a valuable window into the care that we provide to Veterans.

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Research Highlight

Value-Based Purchasing in VA

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Value-based purchasing (VBP) is a relatively new term in health care that encompasses, at its heart, the idea that the value equation includes both utilization or cost of services, and the quality of care delivered with those services. This article explores the concept of value-based purchasing in the context of issues that arise in the Department of Veterans Affairs (VA) given its relatively unique role in the U.S. health care system as both a payer and provider of services.

The best early definition of the term ‘value-based purchasing’ comes from Meyer et al. (1997): “*The concept of value-based health care purchasing is that buyers should hold providers of health care accountable for both cost and quality of care. Value-based purchasing brings together information on the quality of health care, including patient outcomes and health status, with data on the dollar outlays going towards health. It focuses on managing the use of the health care system to reduce inappropriate care and to identify and reward the best-performing providers. This strategy can be contrasted with more limited efforts to negotiate price discounts, which reduce costs but do little to ensure that quality of care is improved.*”¹ The Centers for Medicare & Medicaid Services (CMS) has been a leader in making VBP a central organizing concept as it has approached health care reform in the Medicare program. In that context, in ways that both meld well with challenges for VA and in ways that do not, CMS works from the following eight goals: financial viability; payment incentives; joint accountability; effectiveness; ensuring access; safety and transparency; smooth transitions; and electronic health records.

VA competes with the private sector by offering its own diverse blend of quality, access, and cost within a specific eligible patient population that thereby is offered universal access to health care.² But since the VA operates as both the regulator of health care

service provision and the provider of those services, many of the goals that CMS is promulgating apply to VA only in the ‘make or buy’ decision to provide services directly or contract for those services with the private sector. This article will explore CMS’ eight goals as an organizing principle for briefly discussing some of the issues that arise for VA in pursuing these goals.

VA differs from the Medicare program in that it does not operate off of a specific trust fund, so the financial viability of the federal government is not directly at issue, but it does mean that in evaluating ‘make or buy’ decisions the current Treasury interest rate is the best approximation of borrowing costs for VA. Whenever the federal government runs a budget deficit, the VA implicitly borrows money through the Treasury. The use of payment incentives by VA in using VBP for ensuring quality and efficiency when buying from the private sector face the same challenges as when health plans use such incentives, including the key challenge in directing the “incentive payment to an organized entity capable of bringing resources and organizational expertise to support process improvement.”³ This latter point for a VA that might be trying to contract with general health care providers for services that are specialized for Veterans dovetails into the CMS goal of joint accountability.⁴

VA HSR&D already is a key contributor to the effectiveness goal in VA through comparative effectiveness research. It can be difficult in some cases to convince outside contractors to follow VA directives and other evidence-based and outcomes-driven guidelines developed in VA if the contract represents only part of the contractors’ business and requires costly redesign. VA and Medicare face a

comparable challenge in ensuring access to an equal level of high quality, affordable care to beneficiaries all across the country, wherever they choose to live. The ability of the health care system to meet the clinical needs of patients is increasingly challenged by the cost of technological solutions to bring care to the patient in the community. VA and CMS already are partnering on joint standards for safety and transparency to bring beneficiaries direct information on the quality, cost, and safety of the health care they receive. Smooth transitions to coordinate patient care across multiple providers and settings requires seamless information flows. The focus of CMS in trying to incentivize electronic health records illustrates the transitions and effectiveness challenges perfectly, for a contractor providing care to Veterans: fully adopting seamless information exchange with the VA electronic health records system would be especially costly and challenging.

These challenges for effective VBP are true across all health care systems and payors. VA faces special challenges as a payor with its own provider health care system as well as options to purchase care from outside vendors. The complexity of the problem increases the closer one gets to capitation of care across a wide range of services. The considerable challenge of defining quality in purchasing is simpler the smaller the slice of health care services one is purchasing, though by no means easy. The challenge in VBP is the same as the wider challenge in the health care system, defining quality and efficiency in what services we provide to patients.

Note: James F. Burgess, Jr., Ph.D., through his Boston University academic appointment, has been a contractor to the Centers for Medicare & Medicaid Services for its Value Based Purchasing programs.

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Definition

Resource Use Measurement

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Health care “efficiency” or “resource use” measurement is in the early stages of development. Although public and private payers express considerable interest in calculating the value of health care services, it remains a challenge to develop and implement nationally accepted measures. The term “resource use measures” is intended to broadly capture indicators of the cost and efficiency of health care provision. Health care resource use measures reflect the amount or cost of resources used to create a specific product of the health care system. The specific product could be a visit or procedure, all services related to a health condition, all services during a period of time, or a health outcome. “Efficiency” measures are a subset of resource use measures that compare the production of products of a specified level of quality. Most resource use measures today are not efficiency measures by this definition because they do not explicitly incorporate a measurement of the quality of the product.

A systematic review of available resource use measures was published by AHRQ at www.ahrq.gov/qual/efficiency/index.html. There are three main groups of resource use measures that have been developed:

1. Relatively simple measures of the resources used to produce health care, such as mean length of stay; readmission rates for hospitals; and consultation or test ordering rates for outpatients with common complaints such as low back pain. These measures focus on utilization and are widely

used. However, they generally do not provide information about whether the utilization was efficient or inefficient.

2. More complex measures of health care resource use, including both inpatient and outpatient services, and using econometric or mathematical programming techniques to account for multiple outputs. The complexity of these methods may have inhibited the broad use of these measures beyond academic research, because measurement results can be sensitive to a multitude of specification choices and difficult to interpret.

3. Measures of the resources used in an episode of care for a patient, or to treat a patient with a specified burden of comorbidity for a specified period of time. Of the two approaches, episode-based measures have been used most widely by commercial payers, and have been recommended for use in Medicare by the Congressional Budget Office and the Medicare Payment Advisory Commission, among others. Episodes are defined using “groupers” tools, such as the Episode Treatment Groups (ETGs) developed by Symmetry Health Data Systems or Medstat Episode Groups (MEGs) developed by Thompson Medstat. These tools group related services into episodes primarily using diagnosis codes; episodes include services furnished by different providers in different care settings. The cost or resources used to produce each episode are then tallied across providers. A population-based approach to efficiency measurement, such as Diagnostic Cost Groups

(DCGs), classifies a patient population according to morbidity burden in a given period (e.g., one year). The cost or resources used for all health care for that patient over the time period are then measured.

The state-of-the-art in health care resource use measurement contrasts sharply with that of the measurement of health care quality. Little is known about the validity of resource use measures, or the advantages and disadvantages of different measures. Only a few resource use measures (length of stay and readmission measures) have been endorsed by the National Quality Forum (NQF). Unlike the evolution of most quality measures, current resource use measures are not typically derived from practice standards in the research literature, professional medical associations, or expert panels. Unlike most quality measures, resource use measures have been subjected to few rigorous evaluations of their reliability and validity. However, many groups including CMS and private organizations are investing in further development of these measures.

Why should managers and researchers care about resource use measures? Because of the desire, indeed the demand, for better value in health care. As our methods of assessing quality have matured to the point where there are now well-accepted, standardized measures that can be used to benchmark providers on the outcomes of care, the next logical question to ask is how we can measure (and ultimately improve on) the resources used to produce those outcomes. Not all the care being currently delivered necessarily contributes to producing good health outcomes, and identifying and rooting out care that does not meaningfully contribute to good care is needed in order to achieve the goal of providing the highest possible value for taxpayer-supported health care. Measures that accurately assess resource use and efficiency are going to be needed for doing this in a scientific manner.

FYI: Evidence Synthesis

The VA Evidence-based Synthesis Program (ESP) was established to provide timely and accurate syntheses of targeted health care topics of particular importance to clinicians, managers, and policymakers, as they work to improve the health and healthcare of Veterans. Three new ESP Reports are now available on the HSR&D website:

- Health Effects of Military Service on Women Veterans
- Rural vs. Urban Ambulatory Health Care Review
- A Critical Review of the Literature Regarding Homelessness among Veterans

Access these reports and other ESP Reports at <http://www.hsrd.research.va.gov/publications/esp/reports.cfm>

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Special Journal Supplement on Women's Health

In 2004, VA's Office of Research and Development put forward a VA women's health research agenda, spanning biomedical/laboratory, clinical sciences, rehabilitation, and health services re-

search that has led to a growing research portfolio. In fact, more research on the health of women Veterans was published from 2004 through 2008 than in the previous 25 years combined. Furthering these efforts, VA's Health Services Research and Development Service (HSR&D) with supplemental support from the VA Women Veterans Health Strategic Health Care Group, funded a special issue in the journal *Women's Health Issues*. The issue includes 18 peer-reviewed manuscripts summarizing health services research findings about women Veterans and women in the military, framed in the context of informing evidence-based practice and policy. The articles are complemented by commentaries from HSR&D and the Women Veterans Health Strategic Health Care Group leadership as well as an editorial from the Editor-in-Chief of the journal. All articles are accessible, regardless of subscription status, and may be accessed at <http://www.whijournal.com/content/supplements>.

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