

Quality Alliance Steering Committee

Quarterly Meeting
Tuesday, March 17, 2000
9:00 am to 12:00 pm

Brookings Institution
Washington, DC

Quality Alliance Steering Committee
Quarterly Meeting
The Brookings Institution
Tuesday, March 17, 2009
9:00 am – 12:00 pm

- 9:00 am – 9:15 am** **Welcome / Introduction to Agenda**
Objective: For approval (minutes)
Tab 1: QASC Meeting Minutes 12/17/2008
Membership list/contact info
- Presenters: Mark McClellan | Carolyn Clancy
- 9:15 am – 10:00 am** **Update: Data Aggregation Solution (claims-claims)**
Objective: For discussion
Tab 2: Cover Memo
Presentation: Background, Key Findings, Next Steps
- Presenters: Carmella Bocchino | Aparna Higgins | Lew Sandy
- 10:00 am – 10:20 am** **Update: Data Integration Solutions (claims-clinical data)**
Objective: For discussion
Tab 3: Cover Memo
Presentation: Background, Key Findings, Next Steps
- Presenters: Mark Legnini | Joachim Roski
- 10:20 am – 11:20 am** **Next Steps QASC Road Map:
Three-year work plan for realizing data collection/
measure implementation objectives**
Objective: For discussion
Tab 4: Cover Memo
Presentation: Background, Draft Work Plan, Next Steps
- Presenters: Mark McClellan | Joachim Roski | Kristine Martin Anderson
- 11:20 am – 11:30 am** **Key QASC Workgroup Updates:
National-Regional Implementation Workgroup
Cost-of-Care Measurement Workgroup**
Objective: For discussion
Tab 5: Cover Memo
- Presenters: Jim Chase | Shannon Robshaw
Chuck Cutler | Gregg Meyer
- 11:30 am – 11:45 am** **Update: Promoting Health Care Equity**
Objective: For discussion
Tab 6: Cover Memo
Presentation: Background, Key Issues, Next Steps
- Presenter: Kalahn Taylor Clark

11:45 am – 11:50 am Membership

Objective: For discussion

Tab 7: Cover Memo

Letter: American Health Quality Association

Bio: Marc Bennett

Presenters: Mark McClellan | Carolyn Clancy

11:50 am – 11:55 am Update: Stand-for-Quality Effort

Objective: For discussion

Tab 8: Cover Memo

Presenters: Mark McClellan | Peter Lee

11:55 am – 12:00 pm Communication

Objective: For discussion

Tab 9: Cover Memo

Presenters: Joachim Roski

TAB 1

Quality Alliance Steering Committee (QASC) Meeting Minutes
December 17, 2008
10:00 am ET – 12:00 PM EST

QASC Members Participating in Person: Mark McClellan, Carolyn Clancy, Bob Ihrie, Mary Naylor, John Lumpkin, Frank Opelka, John Rother, Joyce Dubow (for John Rother), Chris Kahn, John Tooker, Janet Corrigan, Rich Umbdenstock, Jim Guest, Andrew Webber, Karen Ignagni, Nancy Nielsen, Jim Chase, Andrew Wisniewski, Shannon Robshaw, Gerry Shea

QASC Members Participating by Phone: Peter Lee, Kathy O'Connor, Laura Cranston, Barry Straube, Chris Queram

Opening Remarks

Mark McClellan and Carolyn Clancy welcomed the following new members to the QASC: Bob Ihrie, Andrew Wisniewski, Fred Edwards, Shannon Robshaw, and John Chase. They informed participants that there is a full agenda for the meeting. Mark McClellan noted the progress made towards increasing regional participation with the formation of the new Regional National Coordination Workgroup which will be co-chaired by Shannon Robshaw and John Chase. He stated that staff has worked closely with AHRQ and RWJF to increase collaboration between regional and national efforts, a significant part of the Roadmap discussion. The September 17, 2008 QASC meeting minutes were approved.

Discussion of “Making Healthcare Performance Information Available: The Foundation for Improving Quality and Affordability”

Carolyn Clancy noted that since the last meeting, there have been serious efforts to move health care reform forward and that there is an opportunity for the quality enterprise to inform congress and the new administration on the importance of delivery reform. She stated that discussions have been underway to determine how to best present the lessons learned, current progress and existing leadership within the quality enterprise. Specifically, these deliberations have included a discussion on how to best coordinate the work of the QASC and NQF and have led to the development of a draft paper entitled *Making Healthcare Performance Information Available: The Foundation for Improving Quality and Affordability*.

One participant provided an overview of the document and stated that, in an attempt to be as clear as possible, the paper contains a number of redundancies. It was noted that the document explicitly states the infrastructure required to accomplish the tasks mentioned and highlights the intersection between health information technology and quality improvement. The document was written in the understanding that (1) any changes towards quality reform should be based on/coordinated with delivery reform and (2) delivery reform should inform payment reform.

Nancy Nielsen noted that the title and the focus of the document are too narrow and seem to misrepresent developing performance reports as the end, instead the means. She stated that the tone of the document could be interpreted as offensive, as it lacks explanations for the current gaps in achieving high-quality and high-value care. Furthermore, the document seems to present a more hierarchical quality infrastructure and a new quality entity as the best way to achieve quality improvement.

Karen Ignagni noted that the verbal explanation of the document was helpful, yet it is concerning that this overview/precursor is not included in the document. She suggested that the document should be centered on the information that is most useful for Congress at the present time and should state how the proposed changes will affect patients, practitioners, and employers/purchasers. Language should be rephrased to convey the importance of presenting quality information to physicians and consumers, as well as the importance of attaining information in “real-time.” Karen Ignagni expressed skepticism with implementing a structure in which all information is reported to one entity. She suggested that a conversation is needed to further discuss coordination between the alliances and to address concerns over ways that various stakeholders will be able to provide feedback in the future.

Jim Guest stated that information is of little importance unless it is used for quality improvement and moving towards patient-centered care. He noted that a culture change is necessary for making these reforms. He also noted the need for developing broad support by strategically presenting how this process will benefit various stakeholders as broad support will be needed.

Rich Umbdenstock suggested that the process should start with the “end” in mind and should specifically address (1) ways in which the system could function differently and (2) information that can be leveraged in ways that will lead to change. He stated that the document and the recommendations within it should be as concise as possible and that there should be a greater focus on achieving improvement through episodes-of-care.

Debra Ness noted that although the document states what all present parties believe, the document needs to be written in language that is understandable to people outside of the quality enterprise. Even though it is apparent to those around the table that the goal of implementing performance measurement is quality improvement, this is not explicit to those outside of this line of work. She suggested that the discussion should focus on substantive areas of disagreement instead of the details of how to repackage information. Debra Ness noted that the document needs to clarify what is being asked for and what can be expected if the request is granted. As delivery reform is an essential part of expanding coverage and increasing affordability, she suggested that the message of the document should be that, developing an infrastructure for further implementing performance measurement and public reporting should be pursued as the building blocks of quality improvement. Furthermore, Debra Ness noted that the proposed data infrastructure should be based upon a public-private partnership. Andy Webber suggested that this overview statement be placed at the front of the paper to provide the readers with the context of the document and recommendations.

Frank Opelka stated that quality improvement consists of more than performance measurement and noted that other innovations and aspects of care are crucial for increasing value in the health care system. He noted that physicians are not currently able to get a complete picture of the services and treatments that their patients are receiving which hinders their ability to adequately address current gaps and redundancy in care rendered. Frank Opelka suggested that health care systems should not only focus on quality measurement but also on ways to address the current problems and move towards episodes-of-care.

Chip Kahn stated that as Congress and the new administration will soon be addressing ways to decrease waste, the document presented should (1) explain the system that is currently in place, (2) identify key, future deliverables, and (3) offer a simple structure for the future quality enterprise. He noted that if the document is not clear and concise and does not present concrete recommendations, it will not receive adequate attention.

Mary Naylor stated that increasing population health and sector-spanning measures and moving towards more “team-centric” and community-based measurement should be included in the recommended next steps. Kevin Weiss noted that the value of partnerships and community quality efforts should be emphasized, as well as performance measurement. Margaret VanAmringe stated that the benefit/utility of various types of measures should be evaluated, as certain measures offer greater opportunities to affect change.

Gerry Shea suggested that the document presented should clearly state what has been learned thus far and what has yet to be understood within the quality enterprise (e.g., little is known relative to how to create/implement culture changes). Furthermore, he noted that the document should aim to inform function first and structure second. Andy Webber stated that the document be separated into an Executive Summary and a more in-depth addendum for clarity purposes.

Janet Corrigan suggested that the two main purposes of the document are:

1. Providing a message, direction and information for the new administration so that they may better understand the current system for increasing quality and value, and
2. Creating a common understanding that in moving forward there will be a greater degree of coordination among organizations and less work will be done “on parallel tracks.”

Nancy Nielsen stated that working in parallel is beneficial since certain entities are able to gain momentum and make more progress on aspects of quality improvement when working individually. John Tooker stated that the Vision Wheel should be central when determining the function of different alliances and organizations and that there should be a focus on performance measurement in moving towards quality improvement. The possibility of giving all responsibility to one organization was described as problematic.

Shannon Robshaw suggested that the roles that communities play in the collection and use of information should be stated in the document along with the need for balancing a local and national infrastructure. She noted that a group of national and regional thought-leaders should be established for making recommendations on how to move from quality measurement to quality improvement and stated that a third-party entity is needed to confirm that organizations are successfully serving the functions with whom they were entrusted. Mark McClellan noted that in the document it was stated that the QASC will work with regional organizations to develop a national and regional infrastructure for data collection and that adding another accreditation process would only create more labor for regional organizations.

Gerry Shea conveyed a sense of urgency with presenting something to communicate to Congress and the new administration as soon as possible, as well as the need for keeping the message simple and high-level. Another participant stated that the current situation requires balancing this sense of urgency with the need for an iterative process. It was suggested that the current graphic be reorganized and that the various alliances should submit a few paragraphs describing their key roles/functions.

Debra Ness stated that more discussion is needed on how NQF's role as a "coordinating" body will be defined; however, releasing the document should not be delayed while awaiting clarity and consensus on how to define organizations' roles. Although the current alliance structure is unsustainable, it is imperative that legislative language is drafted quickly.

Janet Corrigan suggested that before the document is sent out, clarity is needed on who will accept funding and for what purpose and the role of each organization. Gerry Shea stated that a best estimate of the funding needed for this type of work is all that is necessary for the document at this stage of the process. Upon receiving feedback from the initial document, the QASC can determine areas where more information is needed.

It was stated that, once revised, the document should be presented to Congress/the new administration, and in the near future, efforts should be made to further synchronize functions. Members were reminded that there should continue to be a strong focus on the groups that will be affected by potential changes.

Mark McClellan noted that Debra Ness and Peter Lee will make changes to the current document and circulate changes and that the QASC will continue to move forward with its role as stated in the Roadmap. Janet Corrigan pushed for the group to commit to a process for defining the relationships between the alliances. Mark McClellan stated that at this time the focus should be on laying out a path and deliverables for improving care. Gerry Shea stated the importance of further discussing coordination yet emphasized that the most pressing discussion will be on moving these efforts forward with public-private collaboration.

Updates

Carmella Bocchino provided an update on the data aggregation solution project. She stated that progress is being made on the validation contract and ensuring that the metrics are valid.

Joachim Roski informed participants that a draft document laying out a process for achieving person-centered measurement through alliance coordination will be sent to QASC members for their review.

Debra Ness provided an update on the *Recommendations for Reporting Cost and Price Information to Consumers*. She informed participants that the outstanding issue with the recommendations has been the lack of consensus on the disclosure of negotiated rates. She stated that language has been crafted which reflects the issues and concerns addressed. She noted that while the document does not call for the disclosure of negotiated rates, the spirit of the document reaffirms the need for transparency to ensure that consumers have the ability to make informed choices. Even though the document recognizes that transparency is necessary for moving forward, our current system is not in a position for the changes in the document to be implemented. Debra Ness stated that there were a diversity of opinions on whether this level of transparency is achievable and the changes in the current system that will be necessary to reach these goals. A motion was passed to approve the *Recommendations for Reporting Cost and Price Information to Consumers*.

Membership

Mark McClellan informed participants that as Bob Dickler is retiring, the American Association of Medical Colleges (AAMC) requests that Joanne Conroy replace him as the AAMC representative on the QASC. Additionally, Jill Berger from Marriott International, Inc. is proposed to replace Brian Marcotte. Both membership requests were approved.

Closing Remarks

Carolyn Clancy and Mark McClellan thanked participants for the lively discussion.

**Quality Alliance Steering Committee
Membership List (as of 3/17/09)**

Mark McClellan (Co-Chair)
Brookings Institution

Carolyn Clancy (Co-Chair)
Agency for Healthcare Research &
Quality

Allan Korn
Blue Cross/Blue Shield Association of
America

Andy Webber
National Business Coalition on Health

Anthony Wisniewski
U.S. Chamber of Commerce

Barry Straube
CMS

Bob Ihrle
Lowe's

Chip Kahn
Federation of American Hospitals (FAH)

Chris Queram
Wisconsin Collaborative for Healthcare
Quality

Clarion Johnson
Exxon Mobil

Debra Ness
National Partnership for Women and
Families

Frank Opelka
American College of Surgeons/LSU
Health Sciences Center

Fred Edwards
Society of Thoracic Surgeons

Gerry Shea
AFL-CIO

Janet Corrigan
NQF

Jill Berger
Marriott

Jim Chase
Minnesota Community Measurement

Jim Guest
Consumers' Union

Joanne Conroy
AAMC

John Lumpkin
Robert Wood Johnson Foundation

John Rother
AARP

John Tooker
American College of Physicians

Karen Ignagni
AHIP

Kevin Weiss
American Board of Medical Specialties

Laura Cranston
Pharmacy Quality Alliance

Mark Chassin
JCAHO

Mary Naylor
Nursing Profession/Science

Nancy Nielsen
American Medical Association

**Quality Alliance Steering Committee
Membership List (as of 3/17/09)**

Pam French

Boeing

Peggy O’Kane

NCQA

Peter Lee

Pacific Business Group on Health

Rich Umbdenstock

American Hospital Association

Shannon Robshaw

Louisiana Health Care Quality Forum

Anthony Wisniewski

US Chamber of Commerce

TAB 2

Date: March 17, 2008
To: QASC members
Re: AHIP Foundation data aggregation update

Action required from QASC:

- *For discussion.*

Background:

The America's Health Insurance Plans Foundation is currently developing a nationally consistent, technologically sound, and efficient approach to generating performance information on physician quality . The approach will be tested in two areas of the country in 2009 before it will be promulgated for widespread use around the country as of 2010.

This approach will benefit and support regional efforts around the country in making a "turn-key" solution available for generating needed performance information. Scarce local resources can then be used to focus on improving care in their communities or to augment the information where desired. The system being developed by QASC would allow private insurers to consistently calculate information on quality and cost without exchanging the names of patients. Records of claims will remain in the hands of insurers, just as they are now, however, doctors will be able to access those records through a single interface.

The attached materials provide a more detailed update on progress-to-date on the AHIPF data aggregation project.

Next steps:

QASC members will continue to receive updates on the AHIPF data aggregation project throughout 2009.

TAB 3

Date: March 17, 2009
To: QASC members
Re: HVHC – Data Integration Activities

Action required from QASC:

- *For your information.*

Background:

The goal of the High Value Health Care Project's data integration activities is to develop national strategies linking clinical data with claims databases for more valid and comprehensive performance measures that can be applied to quality improvement, performance-based payment and public transparency. Clinical foci for these projects ARE cardiovascular disease, cancer, and diabetes due to their collective disease and socioeconomic burden.

Specific project activities and deliverables include:

- Testing the application of claims data augmented by clinical information to calculate performance results for quality improvement, performance-based payment and public transparency
- Engaging stakeholders to assess technical feasibility, replicability and the value case needed to sustain such activities financially in local or regional markets over time
- Developing recommendations for the QASC and preparing reports/publications for wide-scale dissemination.

These activities are designed to be integrated in the future with the performance results of aggregation models within the context of a distributed data network. They will be coordinated through the MIS Workgroup and will result in a set of recommendations to the QASC.

Projects by Disease Area:

Cancer

While cancer care has a unique national data infrastructure with population-based tumor registries in all 50 states, data from these repositories are typically not available for performance measurement and reporting initiatives. The time lag between a patient's initial diagnosis/treatment and the corresponding appearance of this information in a tumor registry can be a year, limiting tumor registries to a role as repositories of historical information for retrospective epidemiological surveillance. Timely tumor staging information, the single most important determinant of subsequent cancer treatment, is essential to monitor adherence to treatment guidelines, an important performance metric for management and reimbursement of physician networks as well as for consumer information.

This project will focus on a national strategy to re-orient and re-engineer components of existing cancer data to provide accurate and timely information during a patient's treatment, applying these data to clinical decision support, performance-based reimbursement and quality monitoring.

Key activities:

- a. Convene an expert panel to develop a “roadmap” for re-orienting and re-engineering the cancer data infrastructure**
 - Two meetings to develop a “roadmap” of tactics for producing timely and comprehensive information on the diagnosis and treatment of cancer patients. Identify technical (information and communication technology), policy, and resource solutions, both short-term opportunities to speed up the exchange of current information and medium-term solutions to permanently change existing data flows and repositories. (May 2009)

- b. Execute an initial study to determine if physician-reported staging information is accurate and therefore a viable data source for decision support tools to apply recommended treatment protocols.**
 - Determine the accuracy of provider-reported tumor staging in comparison to state tumor registry staging records. (September 2009)

Diabetes

Adding laboratory results to claims will enhance the ability to measure and report on provider performance in the care of patients with diabetes and more broadly in chronic disease management. Using merged lab and claims data, there is an opportunity to move beyond process measures of quality to more meaningful intermediate outcome measures that can better translate to value for patients, payers and purchasers.

This project will focus on developing a national strategy for merging clinical lab results with claims data for physician-level performance measures and performance-based reimbursement. The project will address the technical as well as value cases in successful examples of market-wide collaboration or plan sponsored programs not only to link these sources of data but also to apply resulting performance measures to support chronic disease management, performance-based physician reimbursement and public reporting on the quality of care.

Key activities:

- a. Document existing models for linking lab results with claims for diabetes care.**
 - Document applied technical solutions, data exchange protocols, stakeholder engagement, and business models for collecting lab results and linking with claims for use in performance-based payment, chronic disease management, QI, and public transparency; determine the replicability of these models in markets other than those where they now occur.

- b. Convene a series of technical panels on linking lab data to claims.**
 - Develop detailed descriptions of current technical, policy, and financing solutions to overcome barriers to more widespread linking of lab results to claims and produce

policy recommendations to promote wide-scale linkages of lab results and claims data.
(August 2009)

Cardiovascular Disease

Clinical registries, most prominently among cardiovascular care specialty societies, are a rich source of clinical information about the care of patients undergoing several types of treatments and diagnostic procedures. These registries are usually peri-operative in focus, however, limited to inpatient care within a short time horizon. Combining these data with claims information can improve the utility of both sources of data: claims databases obtain clinical data elements to better define and risk-adjust performance measures, and registries get a longer time horizon and more events to follow patients after hospital discharge.

Projects will focus on linking data between registries and claims databases to improve performance measurement, inform physician practice, provide a performance basis for reimbursement and enhance public information.

Key activities:

- a. Collaboration with the American College of Cardiology (ACC), UnitedHealthcare (UHC) and Medicare to produce performance measures for the care of patients with STEMI.**
 - Using UHC and Medicare claims databases and the ACC's CathPCI registry, produce measures of quality, cost and variation in treatment to assess provider performance, and organize a multi-stakeholder assessment of the resulting performance measures for QI, payment reform and public transparency. (December 2009)

- b. Collaboration with the Society of Thoracic Surgeons (STS) and WellPoint to produce performance measures for coronary artery bypass graft (CABG) surgery.**
 - Using WellPoint claims databases and the STS adult cardiac surgery database, produce performance measures for CABG surgery and organize a multi-stakeholder assessment of the resulting performance measures for QI, payment reform and public transparency. (December 2009)

- c. Collaboration with the American Heart Association to produce a "blueprint" for the future of clinical registries.**
 - Most current registries were developed as voluntary physician feedback programs, not for applications to which they will increasingly be applied in the near future (P4P, public reporting, linkage across registries and with administrative data, etc.). This project will identify prevalent shortcomings in current disease registries and define recommendations for enhancing the framework and content of registries to enable their broader use in support of QI, performance-based payment and public transparency. (August 2009)

- d. Collaboration with Virginia Health Information (VHI) to test the utility of an augmented state-wide hospital discharge database.**
 - VHI is one of four pilot states in AHRQ's program to augment hospital discharge data with additional clinical data elements to enhance their use for performance

measurement. VHI currently publishes reports on the quality of hospital care for non-invasive cardiology admissions (STEMI, CHF, etc.), invasive cardiology procedures such as PCI, defibrillator and pacemaker implants, and open heart surgery. Virginia's hospital discharge database for hospitals participating in the AHRQ pilot program now includes up to 36 laboratory results and a present-on-admission indicator for each secondary diagnosis in the patient record. Brookings will work with VHI to convene hospitals, payers and VHI's existing constituency of audiences for public reporting to assess the utility of this augmented database for measuring and reporting on risk-adjusted hospital-level outcome measures. The augmented data base will be used to test applications of HVHC goals for QI, performance-based payment and public reporting. (December 2009)



An initiative of the Quality Alliance Steering Committee

Data Integration Update

Supported By:

Robert Wood Johnson Foundation

Engelberg Center for Health Care Reform at the Brookings Institution

Background

- Administrative data are comprehensive but lack clinical detail (e.g., risk adjustment variables) for valid performance measurement
- Clinical registry data are too narrowly focused (e.g., peri-operative) for comprehensive performance measurement
- Using both administrative and clinical data allows for more valid and comprehensive performance measurement

Goals

- The High-Value Health Care Project's data integration activities will develop broadly-applicable strategies to:
 1. Link clinical data with administrative databases to enable more valid and comprehensive performance measurement
 2. Test applications of augmented data for quality improvement, performance-based payment and public transparency.
- Data integration activities will target cardiovascular disease, cancer, and diabetes

“Blueprint” for Registries of the Future

■ Collaborators:

- American Heart Association (lead), American College of Cardiology, Society of Thoracic Surgeons

■ Objectives:

- Develop recommendations regarding registries as sources of clinical information for the next generation of performance measurement
- Participate in discussions with AHA on how new cardiovascular registries can better address future applications

■ Deliverables:

- QASC presentation describing health care reform issues related to registries as a tool for performance measurement (June 2009)
- Policy brief describing “principles for the next generation of clinical registries” (August 2009)



Hospital Discharge Data Augmentation

- **Collaborator:**

- Virginia Health Information (VHI)

- **Objectives:**

- Produce cardiovascular care performance measures from hospital discharge data augmented by laboratory results and present-on-admission codes for secondary diagnoses
- Use results to engage Virginia hospitals, consumers, physicians and payers in assessing practical applications for payment reform, public reporting and QI

- **Deliverables:**

- Final Study Report (December 2009)

Performance Measures for CABG

■ Collaborators:

- Society of Thoracic Surgeons (lead)
- WellPoint

■ Objectives:

- Integrate CABG registry with claims data to produce performance measures (including analysis by race/ethnicity) for CABG surgery
- Assess replicability, sustainability, utility for various audiences

■ Deliverables:

- Develop recommendations on continuing and broadening this approach (December 2009)

Performance Measures for STEMI

▪ **Collaborators:**

- American College of Cardiology (lead)
- UnitedHealthcare
- Medicare

▪ **Objectives:**

- Integrate CathPCI registry with claims data to produce performance measures (including analysis by race/ethnicity) for STEMI intervention
- Assess replicability, sustainability, utility for various audiences

▪ **Deliverables:**

- Develop recommendations on continuing and broadening this approach (December 2009)

Physician Tumor Staging Comparison

▪ **Collaborators:**

- Roswell Park Cancer Institute (lead)
- UnitedHealthcare
- Tumor registries in Florida, Georgia and Texas

▪ **Objectives:**

- Assess the accuracy of physician-reported tumor staging compared to stage recorded in state cancer registries

▪ **Deliverables:**

- Report on feasibility of direct reporting by physicians of tumor stage (September 2009)

Re-engineer the 20th-century Cancer Data Infrastructure to Support 21st-century Applications

▪ **Collaborators:**

- Expert panel Chaired by Mark McClellan (Brookings) and Stephen Edge (Roswell Park Cancer Institute)

▪ **Objective:**

- Recommend how to re-engineer and augment the current cancer data infrastructure to better support quality monitoring, decision support and payment reform

▪ **Deliverables:**

- Recommended short- and mid-term actions to provide physicians, payers and tumor registries with more timely disease status information for newly diagnosed cancer patients. This will facilitate the use of evidence-based treatment guidelines, tools that better incorporate patient preferences in treatment decisions, and bundled or episode-based payment models. (May 2009)

Diabetes

- **Informants:**

- Large health plans, HIT vendors, public agencies

- **Objectives:**

- Assess the value case for provider, purchaser, payer, and community investments in systems to acquire and integrate clinical data, e.g., lab results, for chronic disease management. Focus on type 2 diabetes management for QI, payment and public reporting applications
- Convene experts to address barriers and challenges to systematic and standardized acquisition and use of clinical data; propose technical and policy solutions

- **Deliverables:**

- Report of value case assessments
- Recommendation for wide-spread implementation for improved performance measurement (August 2009)

TAB 4

Date: March 17, 2008
To: QASC members
Re: Three year work plan for data aggregation/integration

Action required from QASC:

- *For discussion.*

Background:

Attached is a slide presentation outlining a 3 year draft work plan to make additional progress towards a bold, national infrastructure for measuring health care performance, building on the Quality Alliance Steering Committee (QASC) “road-map”. The work plan identifies options for key activities, policies, and projects that would enable the nation to make patient-level health care performance information more widely available to support quality improvement, payment reform and advance consumer engagement in making decisions about their health and health care.

These activities are meant to represent meaningful actions steps to be pursued through public private partnerships and to be aligned with the recommendations set forth by the “Stand for Quality” Coalition.

The attached work plan speaks to a number of key issues

- An evolving framework for data aggregation and integration to support person-centered measurement (sector-spanning, outcomes-oriented) across multiple performance dimensions (safety, effectiveness, cost, experience) using a distributed data network
- Identification of clinical data that is or can soon be generally electronically available, has high potential to be combined/integrated with administrative data in a distributed data network, and pertain to high priority (e.g. NPP priorities; variable quality/high cost) health care areas.
- A short list of potentially viable, private/public sector pilot projects that
 1. are consistent with the QASC goals of patient-centered measurement of outcome and care episodes;
 2. may be viable for long-term sustainability (due to a value case); and
 3. where technical solutions underlying the approach could be developed within 12-18 months.
- Identification of critical technical, methodological, and other challenges that should be addressed (e.g., through pilot projects), including addressing racial/ethnic disparities.
- Commentary on how such integration/aggregation efforts fit into the potential larger HIT development/implementation infrastructure around the country

- A starter set of options for governance, data stewardship, validation/audit processes and financing mechanisms for a distributed network

Next steps:

The attached draft work plan represents a “discussion starter” regarding critical tasks and issues, building on the objectives and goals laid out in the roadmap, that we have to make more progress on over the next few years.

Between March and June of this year, staff will engage QASC members to improve, clarify, and modify the draft work plan in order to be able to lay out a more fully fleshed out and vetted proposed work plan in time for the June 19, 2009 QASC meeting.

TAB 5

Date: March 17, 2009
To: QASC members
Re: Workgroup updates

Action required from QASC:

- *For your information.*

Background:

Vision Workgroup

The Vision workgroup continues to be on hiatus.

Price-Cost Transparency Workgroup

The Price-Cost Transparency workgroup continues to be on hiatus.

Measure Implementation Strategy Workgroup

The MIS workgroup has met once since the last QASC meeting, most recently on February 10. At these meetings the workgroup have received updates from Carmella Bocchino and Aparna Higgins at the AHIP Foundation regarding the data aggregation project. Some of the issues discussed by the MIS workgroup have included:

- Reports from AHIPF Data Oversight Workgroup
- Review of the overarching methodology document for the data aggregation initiative
- Review of the data integration activities being implemented by the Brookings Institution

Comprehensive presentations on the data aggregation and integration activities are included in Tabs 2 and 3 of your meeting materials.

The next meeting of the MIS workgroup is scheduled for April 14, 2009. At this meeting, in addition to continued updates and review of data aggregation and integration activities, the MIS workgroup will receive an update on the Brookings activities surrounding racial and ethnic equity.

Episodes Workgroup

The Episodes workgroup has met multiple times since the last QASC meeting, most recently on February 19. The workgroup continues to receive updates from Kevin Weiss at the American Board of Medical Specialties on the progress of the RWJ-funded project to develop episode-based cost of care measures. At the January 5 meeting of the workgroup, Dr. Weiss provided workgroup members with an overview of the draft measure specifications for congestive heart

failure and a high-level overview of the breast cancer measure concepts. At the February 19 meeting of the workgroup, Dr. Weiss provided workgroup members with an overview of the draft measure specifications for low back pain and a high-level overview of the pneumonia and coronary artery disease measure concepts. Dr. Weiss also provided the workgroup with answers to some questions they had raised with regard to the diabetes measures during a previous workgroup meeting.

In addition to the episode-based cost of care measurement activities, the workgroup has provided feedback on the activities surrounding the possible pilot-testing of NQF-endorsed readmission measures at the local level. QASC staff have engaged productively with the staff at CMS/Yale/Mathematica responsible for developing and implementing the measures for the Medicare population and are also working closely with staff at three regional quality collaboratives (Save Lives Save Dollars in Detroit, the Wisconsin Collaborative for Health Care Quality, and the Pittsburgh Regional Health Initiative) to assess the feasibility of incorporating these measures into their reporting activities.

The next meeting of the Episodes/Cost-of-Care workgroup is scheduled for April 17, 2009.

National-Regional Implementation Workgroup

The National-Regional Implementation workgroup has met multiple times since the last QASC meeting, most recently on February 19. At the January 14 meeting of the workgroup, a workplan for 2009 was approved. This workplan includes the following key activities:

- Establishing effective communication channels between national and regional organizations
- Developing a resource guide for nascent and developing regional collaboratives
- Making recommendations on effective ways of implementing national practices at the regional level

At the February 19 meeting of the workgroup, workgroup members discussed a draft table of contents for the planned resource guide, proposed additional questions the resource guide could potentially address, and suggested additional resources that could be consulted during its development. Workgroup members also discussed possible structures for communication channels to disseminate national organizations' updates to regional collaboratives and to communicate among regional collaboratives. It was proposed that, until a national organization is established to represent regional collaboratives at the national level, QASC staff would develop and disseminate a regular e-newsletter containing this information.

The next meeting of the National-Regional Implementation workgroup is scheduled for March 18, 2009.

Next steps:

QASC members will continue to receive periodic updates from workgroup chairs on the progress of workgroup activities throughout 2009.

TAB 6

Date: March 17, 2009
To: QASC members
Re: HVHC – Racial/Ethnic Equity Initiative

Action required from QASC:

- *For your information.*

Background:

The goal of the High Value Health Care Project's Racial/Ethnic Healthcare Equity Initiative (REHEI), as defined by the Quality Alliance Steering Committee (QASC), is to develop regional and national strategies to promote a) coordinated processes and mechanisms for collecting race/ethnicity identifiers, and b) appropriate stratification of performance information by race/ethnicity groups. The REHEI efforts have focused on the development of pilot projects and demonstrations to advance these objectives. This work will culminate in a National Conference in October 2009 to highlight lessons learned and next steps for national coordination.

Specific project activities include:

- Develop and test state-of-the-art methods for direct data collection on race/ethnicity identifiers;
- Identify and test state-of-the-art approaches to estimating disparities for application with administrative data sets; and
- Identify practical steps to assist communities and others to understand and effectively address equity problems in health care performance.

These efforts will be coordinated through the MIS Workgroup and will result in a set of recommendations to the QASC.

Pilots and Demonstrations:

ACTIVITY 1

Indirect Estimation of Race/Ethnicity - Brookings/ RAND Collaboration

While there is wide consensus on the goal of increasing racial/ethnic health care equity, significant barriers remain to achieving it in a timely manner. One such challenge is health plans' lack of race and ethnicity data on enrollees. Though many plans have begun collecting self-reported race/ethnicity data from their members, the process is proving to take many years to complete. A related challenge is that even after plans obtain race/ethnicity data, they are finding that conventional analytic approaches and related quality improvement infrastructure are often insufficient for effectively targeting disparities at local levels.

Brookings has asked RAND to help overcome these challenges by leveraging two types of tools RAND has developed to assist plans participating in the National Health Plan Collaborative (NHPC) to Improve Quality and Reduce Disparities: indirect estimation of member

race/ethnicity; and GIS mapping tools to target disparities. Initial versions of RAND's indirect estimation algorithms have proven to be sufficiently accurate to allow plans lacking race/ethnicity data to quickly assess and begin acting on disparities, even at the level of local communities and provider groups. More recent versions of RAND's estimation algorithm appear to substantially increase accuracy though these approaches have yet to be fully validated and most plans beyond the NHPC remain unaware or unconvinced of the potential utility and cost-effectiveness of these approaches.

Key activities:

- a) Conduct a series of validation activities to see how well the indirect estimation algorithm works (Completion Date: 11/26/08)
- b) Finalize best indirect estimation algorithm (Completion Date: 12/31/08)
- c) Assess the implications of the error rate and feasibility of simple corrections for the utility of indirect estimates in outreach programs (Completion Date: 2/28/09)
- d) Leverage established working relationships with and data from NHPC plans and health care organizations in the Value Exchanges for pilot tests in 3 regions. (Target Completion Date: 5/31/09)
- e) Develop a practical toolkit type product (Target Completion Date: 6/15/09)
- f) Develop the specifications and work with a suitable vendor to develop software or a web based tool that automates the indirect estimation process (Target Completion Date: 6/30/09).

ACTIVITY 2

Standardizing Race/Ethnicity and Language Data Collection and Reporting - Lessons from a State: Brookings/Massachusetts Health Care Quality and Cost Council (QCC) Collaboration
REHEI is providing technical assistance to the QCC and health plans in the Commonwealth of Massachusetts (MA) to develop and comply with regulations to report race/ethnicity and language data.

In July 2009, under regulations promulgated by the QCC, all health plans in the Commonwealth will be provided with a statistical plan to report (required) standard race/ethnicity and language data. Although, some of the health plans in MA are already collecting race/ethnicity data, many others are not and may benefit from assistance as they undertake these efforts. Further, while there is wide consensus on this goal, significant barriers remain. One such challenge is health plans' lack of expertise regarding best practices for areas such as: formats for asking questions, data collection points and methodology, meeting thresholds for response rates, and IT processes to link data and report quality of care for various racial/ethnic groups.

REHEI will work with QCC and MA health plans to facilitate the data collection and reporting process, including assisting plans to collect standardized data, as well as assisting QCC to develop thresholds for reporting r/e/l data.

Key Activities:

- a) Assess health plans' current status and plans for collecting (and reporting) data (Completion Date: 9/1/08)
- b) Assess patient/enrollee population preferences for data collection and reporting (Completion Date: 10/31/08)

- c) Convene an expert advisory panel on racial/ethnic data collection in health plans (Completion Date: 3/5/09)
- d) Convene a working group of health plan representatives (Completion Date: 2/3/09)
- e) Develop training module for health plans to collect standardized racial/ethnic data (Target Completion Date: 3/31/09)
- f) Train senior health plan staff to collect standardized data (Target completion date: 4/3/09)

ACTIVITY 3

Integrating Survey and Claims Data to Address Disparities: Brookings/King County Collaboration

Making an investment in interventions (either at the workplace, at the site of health care delivery, or through a health plan) to reduce health care disparities may produce financial benefit to employers through lower medical care costs or indirectly through reduced absenteeism and/or increased productivity at the workplace. The proposed analyses will illustrate an approach for identifying these financial benefits through integration of medical claims and HRA data. They will also provide a preliminary estimate of the magnitude of both types of benefits. The existence of a large data set that includes demographic information, health risk appraisal data, claims/utilization data, and self-reported information on workplace attendance and productivity creates a unique opportunity to examine a prerequisite for developing a business case for eliminating racial/ethnic disparities in health care.

This pilot offers a unique opportunity because in cases where disparities in quality exist, it is possible to compare self-reported absenteeism and productivity in a Health Risk Assessment (HRA) data set across racial/ethnic groups or between those who received recommended care and those who did not. If racial/ethnic disparities in quality are associated with increases in absenteeism or decreases in productivity, then the basis exists for calculating a business case for eliminating disparities by assigning dollar values from the employer perspective to those differences in absenteeism or productivity.

The results of this pilot will be shared with the broader Puget Sound Alliance, a multi-stakeholder collaborative, who has an interest in addressing health disparities. This pilot will demonstrate the processes through which employers and health plans can link race/ethnicity and performance data.

Key activities:

- a) Merge HRA and claims data supplied by King County (Completion Date: 3/1/09)
- b) Apply cost of care and performance measures to merged data set (Target Completion Date: 3/31/09)
- c) Stratify performance data by race/ethnicity (Target Completion Date: 5/8/09)
- d) Produce report on process of merging HRA and claims data and implications of results for disparities reduction (Target Completion Date: 8/1/09)

ACTIVITY 4

Developing Regional Approaches to Promote Appropriate Stratification and Use of Race/Ethnicity Data: Montgomery County Hospitals/Brookings Collaboration

Given that much of race/ethnicity data collection activities are local, REHEI is advancing an effort to collect and report standardized race/ethnicity data that can be linked with performance measures, and integrated into a larger (county-wide) system. Coordinating efforts to measure and address disparities at the county level will prove important in reducing the ‘small numbers’ problems that many hospitals face when trying to develop effective interventions.

The goal of this collaborative is to assist local hospital systems to use local demographic data to develop equity-increasing interventions. With a better understanding of county-level disparities across hospitals, systems will be better poised to develop (cost-) effective interventions. This pilot will serve to encourage other hospital systems state-wide (and nationally) to collect, integrate, and disseminate quality information by race/ethnicity in order to advance (regionally) health care equity.

With more detailed and accurate information on patients’ race, ethnicity, language preference, and other data, across hospital systems in Montgomery County, organizations and providers can identify where health care disparities exist and can target interventions to deliver patient-centered, quality care.

Key Activities:

- a) Train front-line staff and trainers on collecting standard race, ethnicity, and primary language data (Completion Date: 1/31/09)
- b) Develop data storage warehouse, which integrates stratified performance measures across hospitals and analyze health care disparities (Target Completion Date: 1/31/10)
- c) Develop report on process of data integration and community utilization of data (Target Completion Date: 9/30/09)
- d) Build awareness among community stakeholders and regional collaboratives (including Primary Care Coalition) about disparities in health care performance, and develop innovative methods to utilize data (Target Completion Date: 10/29/09)
- e) Develop health care equity report for Montgomery County Hospitals (Target Completion Date: 3/31/10)



An initiative of the Quality Alliance Steering Committee

Racial/Ethnic Health Care Equity Initiative

Supported By:

Robert Wood Johnson Foundation

Engelberg Center for Health Care Reform at the Brookings Institution

Racial/ethnic Health Care Equity Initiative

Motivation and Goals



Goals of Racial/ethnic Health Care Equity Initiative
Promulgate best practices for collecting, monitoring, and disclosure of race/ethnicity data to promote equity in care across all groups.

Motivation

Findings

- Consistent body of research demonstrates significant variation in the rates of medical procedures by race, even when insurance status, income, age, and severity of conditions are comparable.

Recommendations

- Health care organizations should collect, report, and monitor patient-care data to build a foundation for solutions to racial/ethnic disparities in care
- Increase equity in care by increasing accountability and monitoring and improving clinical care quality

Challenges

- Despite continued attention to data concerns, inadequate information continues to limit the analyses of health care-related disparities and their outcomes.



An Initiative of the Quality Alliance Steering Committee

Quality Alliance Steering Committee

Objectives for Equity Initiative

OBJECTIVE 1

Promote coordinated processes and mechanisms to collect race/ethnicity identifiers at multiple entry points

OBJECTIVE 2

Promote appropriate stratification of performance information by racial/ethnic groups

Racial/Ethnic Health Care Equity Initiative

Overview of Efforts

Collaboration

- Key stakeholders and experts focused on next steps to measure disparities and increase equity, including through pilot demonstrations
- RAND
- AHIP; National Health Plan Collaborative (NHPC)
- Massachusetts Health Care Quality and Cost Council (QCC)
- King County, Washington, Aetna, GHC, and Puget Sound Regional Alliance
- Montgomery County Hospitals
- Out of Many, One (OMO); Summit Health Institute for Research and Education (SHIRE); California Pan-Ethnic Health Network (CPEHN)
- Agency for Health Care Research and Quality (AHRQ) and/or Institute of Medicine (IOM)/National Quality Forum (NQF)

Scope of Work

- Develop and test state-of-the-art methods for direct data collection on racial/ethnic identifiers
- Identify and test state-of-the-art approaches to estimating disparities for application with administrative data sets
- Identify practical steps to assist communities and others to understand and effectively address equity problems in health care performance

Major Deliverables

- Easy-to-use software modules for estimating community-specific disparities
- Manuscripts and reports outlining the process of activities (related to both direct data collection and indirect estimation)
- Working paper outlining consensus-based recommendations for voluntary standards to collect racial/ethnic identifiers at the local, state, and federal levels
- National conference on health care equity: advancing methodological approaches to measuring and advancing racial/ethnic health care equity (October 2009)

Indirect Estimation Project

RAND/Brookings

Goal

- Validate and pilot RAND's estimation algorithm and assist owners/users of administrative databases to estimate racial/ethnic healthcare disparities at the population level

Scope of Work

- Conduct a series of validation exercises with National Health Plan Collaborative (NHPC) plans to determine the validity of algorithm in various regions
- Conduct 3 regional pilots with health plans and produce a series of maps for each pilot showing how patterns of performance are distributed by local geography and member race/ethnicity
- Develop a practical guide designed to provide operational guidance to health plans in using indirect estimation, including use of the software product or web-based tool, basic GIS mapping, and other value-added tools for their business plans

Deliverables

- White papers on:
 - Validity of indirect estimation algorithm
 - Translation of key results from validation on accuracy and bias into practical guidelines
- Series of maps for regional pilots
- Free of charge toolkit that includes web-based tool

Status
3/17/09

- Target pilot sites: MA, CA, and CO.

HIGH-VALUE
HEALTH CARE
PROJECT

An initiative of the Quality Alliance Steering Committee

Demonstration: MA Health Care Quality and Cost Council/Brookings

Goal

- Provide MA QCC technical assistance to develop a statistical plan for health plans in MA who will be subject to a state mandate requiring the collection/acquisition of racial/ethnic/language enrollee data

Scope of Work

- Health plan and consumer assessments (Collaboration: Romana Hasnain-Wynia)
- Convening of expert advisory panel
- Convening of working group
- Training of senior health plan staff

Deliverables

- Policy brief outlining recommendations for:
 - Reporting thresholds
 - Category standardization
 - Methods for populating race/ethnicity categories
 - Use of indirect methods for estimating racial/ethnic health care disparities
- Conference presentation on MA process

Status 3/17/09

- Convened Expert Panel and Stakeholder Meetings
- March 18, 2009 will present recommendations of Expert Panel to QCC
- 10/28/08 first in-person expert panel meeting scheduled



Pilot:

Integrating HRA and Claims Data to Assess Health Care Equity King Cty., WA/Puget Sound Alliance/Brookings

Goals

- Merge employer (King Cty.) HRA data with claims data (Aetna and GHC) to assess the relationship between health care quality (using NQF-endorsed performance measures) and indirect/direct costs to employers
- Evaluate direct and indirect costs associated with health care equity 'gap' using productivity/absentee measures and costs of care episodes
- Provide feedback on proposed interventions (if any) to utilize stratified performance data

Scope of Work

- Work with consultant (David Nerenz) to produce equity reports and measure costs to employers associated with 'equity gap'
- Share results of effort with Puget Sound Health Alliance representatives

Deliverables

- Manuscript: Establishing a Prerequisite for Advancing a Business Case to Collect Race/ethnicity Data
- Policy brief outlining process for:
 - Methods for populating race/ethnicity categories
 - Use of existing data sources for assessing racial/ethnic health care health care equity
- Conference presentation on merging data to produce health care equity reports

Status 3/17/09

- Milliman is applying cost of care and quality measures to merged data set. Will be sent to HFHS for analysis by March20, 2009.

HIGH-VALUE
HEALTH CARE
PROJECT

An Initiative of the Quality Alliance Steering Committee

Pilot: Regional Collaboration to Advance Health Care Equity

Montgomery County Health Care Equity Initiative

Goal

- Advance equitable health care across hospital systems in Montgomery County

Scope of Work

- Conduct staff training to enhance *accurate* collection of race/ethnicity/language data
- Link quality measures to race/ethnicity/language data and establish reporting processes to track progress toward strategic goals and on improving quality of care
- Build community engagement and education about race/ethnicity/language data collection
- Build greater awareness among community stakeholders of disparities in health care performance and develop innovative methods for improving demographic data collection among health care organizations

Deliverables

- Training sessions
- Newsletter entries, brochures, radio/TV ads, news articles, and press releases (in multiple languages where possible)
- Equity report on health care quality in Montgomery, Cty., MD

Status 3/17/09

- Training was completed on 1/28/09. Data submission will take place in September and December 2009.



Next Steps

- Develop conference planning committee
- Integrate effort into MIS Workgroup

Agenda

TAB 7

Date: March 17, 2009
To: QASC members
Re: Changes to QASC membership

Action required:

- *For approval: Marc Bennett, American Health Quality Association*

Background:

In accordance with the QASC operating rules, the QASC co-chairpersons and the QASC Agenda Group may recommend new QASC members for approval by the full QASC when members have resigned from the QASC.

Mr. Marc Bennett, representing the American Health Quality Association (AHQA), is proposed as a new member. A letter requesting membership co-signed by David Schulke, AHQA's Executive Vice President, and Mr. Bennett, in addition to a short bio for Mr. Bennett is attached.

Next steps:

Approved changes to the membership will be noted as soon as possible to the current QASC website at (<http://www.brookings.edu/projects/qasc/materials.aspx>)

February 19, 2009

Mark McClellan, M.D., Ph.D.
Carolyn Clancy, M.D.
Co-Chairs
Quality Alliance Steering Committee
c/o Engelberg Center for Health Care Reform
The Brookings Institution
1775 Massachusetts Avenue NW; Suite 600
Washington, DC 20036-2103

Re: Membership on the Quality Alliance Steering Committee

Dear Drs. Clancy and McClellan:

We are writing to request appointment of Mr. Marc Bennett, representing The American Health Quality Association (AHQA), to serve as a member of the Quality Alliance Steering Committee (QASC).

QASC members are probably most familiar with the Medicare role of our members, who comprise a national network of health care quality improvement organizations (QIOs) created by Congress to implement the Medicare program's important quality initiatives. The Medicare QIO program, and AHQA members, developed and tested most of the measures now in use in the Hospital Quality Alliance. After thirty-five years of continuous evolution in their role as Medicare contractors, our members are now engaged in multiple care settings, helping providers and professionals to implement Medicare initiatives to--

- Reduce patient safety risks and re-hospitalizations through better execution of "hand-offs" by health professionals both within the hospital setting and between hospitals and post discharge care providers;
- Improve patient safety in hospitals and long term care facilities by reducing pressure ulcers and controlling hospital acquired infections, such as MRSA;
- Engage health care executives in patient safety and quality improvement initiatives;
- Respond to individual case reports of quality failures with analysis and improvement assistance;
- Prevent surgical complications such as post-operative infection and venous thromboembolism;
- Support efforts by physicians, pharmacists, and Medicare Advantage and Prescription Drug Plans in reducing adverse drug events;
- Promote diabetes self-management and reduce quality disparities;
- Promote early recognition and appropriate treatment of chronic kidney disease to forestall costly end-stage dialysis treatment and improve patients' quality of life;
- Support physicians in using health information technology (HIT) to improve patient care.

Beyond their role as implementation agents of the Medicare program, we ask the QASC to recognize that AHQA members are also change agents contributing to greater transparency, efficiency, and effectiveness in the health care system through a wide array of other public and private initiatives across the country. AHQA member organizations:

- Support value-driven health care through active involvement in 20 of the 24 multi-stakeholder Value Exchanges chartered by the HHS Secretary.
- Participated in founding local health information exchanges in 40 states, and participated in establishing a formal HIE organization and governing body in 20 states.
- Publish quality and cost performance data on health plans and providers under a continually growing number of state projects.
- Serve as state- and federally-recognized Patient Safety Organizations, facilitating provider reporting of quality failures and near misses, as well as providing analysis of root causes to eliminate recurrences.
- Serve as local “node” leaders for 44 of the IHI Quality Campaign state nodes (QIOs are primary node organization in 32 states).
- Participate actively in other national health care quality partnerships and organizations including: The National Quality Forum, The AQA, the Network for Regional Healthcare Improvement, Advancing Excellence in America’s Nursing Homes, and numerous other initiatives.
- Serve as independent review entities under a score of state laws.
- Serve as NCQA-approved HEDIS auditors.
- Provide oversight and analysis of the quality of Medicaid- and SCHIP-financed health care services in most states.

These initiatives, among others, reflect the great potential of AHQA’s QIO membership as a national infrastructure with extensive local relationships among a wide variety of stakeholders, long experience in implementing national initiatives, and the effective working relationships with individual institutional health care providers and physician practices necessary to resolve differences and advance those initiatives. This same QIO infrastructure, if properly directed, could also become a field force for gathering systematic information about how QASC and NQF supported measures are actually being used in the field, and how they might be updated or otherwise improved.

In addition, as a result of a joint national effort by AHQA and CMS, all of our member organizations are now governed by a diverse group of stakeholders in each State where they do work. These local stakeholders governing the modern QIO program include health care professionals, providers, payers, employers and other purchasers, policymakers and health care consumers.

Mr. Bennett presently serves as President of AHQA, and is President and Chief Executive Officer for HealthInsight, a private, non-profit organization dedicated to improving the health care systems of Utah and Nevada. HealthInsight is an AHQA institutional member. Mr. Bennett currently serves on the QASC NRI Workgroup and previously served on the QASC Infrastructure Workgroup. In addition to its work as a Medicare QIO contractor in two western states, HealthInsight publicly promotes analyses of national performance data on hospitals, nursing homes, and home health agencies, and has been tasked by state initiatives with direct technical assistance to physician offices, to ensure that electronic health record (EHR) technology is adequately implemented and utilized to improve health care quality.

In closing, we emphasize AHQA's activities in support of public policy consistent with the QASC value-based health care agenda. In addition to cosigning the recent QASC "Stand for Quality" letter, AHQA has proposed legislation to make public outreach and education on health care quality a core function of the Medicare QIO program, supported legislation funding the National Quality Forum's role in setting priorities for health care quality measurement, secured enactment by Congress of a national initiative to support Medicare drug plans in improving the safety and quality of drug therapy, and initiated a joint call to Congress and the new administration—with our partners, the National Business Coalition on Health, the Network for Regional Healthcare Improvement, and the National Partnership for Women and Families—to strengthen Medicare engagement in regional measurement, reporting, payment reform, and improvement assistance (attached).

AHQA also submitted to Congress and the Obama Administration a white paper proposing ways in which the national QIO infrastructure can be relied upon to improve the likelihood of successful implementation of health information technology, transparency, comparative effectiveness, payment incentive programs, and improved coordination of hospital and community-based care (also attached).

We applaud the growing attention of the QASC on implementation of quality and value measurement and creating accountability for outcomes. We look forward to joining you at the table in actively planning and promoting this agenda.

Sincerely,



Marc H. Bennett
President



David G. Schulke
Executive Vice President

Attachments

cc: Joachim Roski, Ph.D., M.P.H.

Marc H. Bennett

Marc H. Bennett is President and Chief Executive Officer at HealthInsight, a private, non-profit healthcare improvement company. HealthInsight holds the Medicare quality improvement organization (QIO) contracts for Utah and Nevada and sponsors the AHRQ-designated Chartered Value Exchanges (CVEs) in both states as well. HealthInsight is a recognized leader in the QIO industry in Transparency & Public Reporting, in HIT initiatives, Payment Reform efforts, Human Factors Science research and application, and for innovation in the Beneficiary Protection program. The company employs a staff of approximately 60 FTEs and more than 100 physician consultants.

Nationally, Mr. Bennett has just concluded his service as President and Board Chair of the American Health Quality Association (AHQA), the trade association for QIOs. He began his term in February 2007. He continues to serve as a member of the Board and Executive Committee of AHQA. Additionally, Mr. Bennett serves on the National/Regional Implementation Workgroup of the Quality Alliance Steering Committee (QASC) and is a member of the National Advisory Board for the Center for Healthcare Quality & Payment Reform and serves as a Board member for the Network for Regional Health Improvement (NRHI). He has also served previously as a founding Board member of Q-mark, Inc., a company which provides HEDIS reporting software and support to health plans and other purchasing groups across the country.

In Utah, Marc is currently Chair of the Utah Patient Safety Steering Committee, the coordinating committee for statewide quality and safety initiatives in the state. In addition, he is a member of the State-sponsored Governance Consortium for Health Information Technology in Utah. And he also serves on the Board of the Utah Health Information Network, the community-based health information network and clinical health information exchange (cHIE).

TAB 8

Date: March 17, 2009
To: QASC members
Re: Stand for Quality effort

Action required:

- *For your information*

Background:

A verbal update on current activities of the Stand for Quality effort will be provided at the meeting.

TAB 9

Date: March 17, 2008
To: QASC members
Re: QASC/High-Value Health Care Communications activities

Action required:

- *For your information.*

Background:

The Web presence of the Quality Alliance Steering Committee (QASC) and the High Value Health Care (HVHC) Project needed to be updated and work has been underway in developing a new independent site. The new QASC Web site will be live online beginning March 17.

Found at www.healthqualityalliance.org, the site will help support the QASC and its efforts – most centrally, HVHC. The site will provide details about the ongoing work of HVHC, the QASC, and related issues, making such information readily available for audiences. The redesigned Web site aims to achieve the following:

- Convey the QASC/HVHC in an effective and professional manner that is easy to navigate and clearly communicates its role and work,
- Educate key stakeholders, policymakers and the public, providing core information about QASC/HVHC and the issues being addressed,
- Acknowledge and showcase the HVHC project, in particular, as a central initiative of the QASC,
- Provide a handsome visual online presence that is distinct from Brookings, and
- Support logistics for the QASC and its Work Groups, providing core information for QASC members and interested parties to keep tabs on QASC and HVHC activities and events.

Web site content will include:

Content Type	Characteristics
Web Site Pages	<ul style="list-style-type: none">• About QASC• Contact us• Member Center• Work Group information• High-Value Health Care Project• What's New/commentary: listing of news items and more• Events: listing of QASC events and related events• Resource Library: materials, papers, etc. for downloading
"What's New"	A column on the home page and a separate page listing latest

	news, announcements, commentary, tips, news from partners etc, along with an RSS feed. Will function similarly to a blog.
E-alert sign up	For possible email lists or a newsletter, users will be able to sign up after providing basic information such as name, organization, and email address.
RSS	Allows users to track new content additions to the site using a RSS reader.
Search Engine	Standard Drupal search engine
Interactive map	Shows the location of quality measurement and reporting initiatives underway around the country. Initiatives can be clicked upon to open an information page about each.

We will briefly demonstrate the new Web site at the QASC meeting.

In addition, please find attached the first in a series of HVHC Issue Briefs that will be released on key activities. This issue brief provides a high-level overview of the project, "Charting the Course to High-Value Health Care."

Charting the Course to high-Value health Care

There are serious gaps between the health care Americans *should* receive and the care they *actually* receive. Patients get significantly different care—some better, some worse—depending on where they live and which doctors and hospitals they use. Meanwhile, the cost of care, even for patients with similar outcomes, varies significantly among providers and regions across the country.

The problem is that it is hard to tell the good from the bad or determine the best value. Unlike most well-functioning markets, there is a lack of consistent information about our fragmented health care system that can be used to improve outcomes for patients while keeping costs down.

Against this backdrop, the Quality Alliance Steering Committee's (QASC) High-Value Health Care Project is working with key stakeholders to make consistent and useful information about the quality and cost of health care widely available to patients, physicians, hospitals, health insurers and others who need information about health care delivery. The project's diverse collaborative of physicians, nurses, hospitals, health insurers, consumers, employers, government, regional and local initiatives, accrediting agencies and foundations supports the implementation and use of performance information to:

- Help health care providers improve the quality of patient care.
- Help consumers make informed choices about health care providers.
- Help provide payments that support provider efforts to improve quality and efficiency, rather than simply paying for more intensive treatments.
- Help reduce large racial and ethnic disparities in care.

Together, these represent critical steps to a high-quality, affordable and patient-centered health care system.

We're paying too much – and health care quality is not what it should be

With each passing day, the pressing need for valid, timely and consistent information about the performance of the U.S. health care system becomes increasingly obvious. The United States spends more per capita on health care than any other country in the world. Despite this, our nation ranks 10th in life expectancy among industrialized nations and 27th in infant mortality.ⁱ Adult patients receive only about 55 percent of recommended care, and children fare worse.^{ii,iii} As many as 91,000 Americans die each year because they do not receive the care experts recommend for chronic conditions such as high blood pressure, diabetes and heart disease.^{iv}

Making more accurately informed decisions on how to improve care, how to select the best providers and how to pay for care can help drive costs down while improving patient outcomes. The problem is we do not always know which providers are doing a good job and which are not. Still, we can build on important progress already underway: Medicare, for instance, now publicly reports key measures of the quality of care hospitals provide and the experience of their patients. Moreover, there are more than 70 regional measurement and reporting efforts underway. These include the organizations working with the Robert Wood Johnson Foundation's *Aligning Forces for Quality* program and the U.S. Department of Health and Human Services' Chartered Value Exchange program. They rely on a variety of measurement approaches and often face substantial barriers in obtaining consistent data. These pioneering efforts are a great start; the next step is to strive for consistency. Without it we will be left with multiple conflicting initiatives that hold the potential for significant and unintended consequences, ranging from unnecessarily burdening physicians, nurses, clinics and hospitals to creating confusion among consumers and detracting from employers' efforts to design programs that meet their employees' needs.

