

Quality Alliance

Steering Committee

Quarterly Meeting
Wednesday, June 15, 2011
9:00 a.m. - 12:00 p.m.

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Falk Auditorium
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- 9:00 a.m. Welcome and Call to Order**
Mark McClellan, Engelberg Center for Health Care Reform at Brookings
Carolyn Clancy, Agency for Healthcare Research and Quality
- Objective: for approval*
Tab 1: meeting minutes 03/15/2011
- 9:10 a.m. Performance Measurement Implementation: How Do the Beacon Communities Do It?**
Craig Brammer, Office of the National Coordinator for Health IT
- Objective: for discussion*
Tab 2: cover memo, presentation slides
- 9:45 a.m. Implementing Performance Measures Consistently Across the Country: Opportunities for Public/Private Sector Collaboration**
Kerri Petrin, Engelberg Center for Health Care Reform at Brookings
Joachim Roski, Engelberg Center for Health Care Reform at Brookings
- Objective: for discussion*
Tab 3: cover memo, presentation slides
- 10:30 a.m. Performance Measurement Implementation Efforts: Cost of Care-Lessons Learned from Implementing Episode-based Measures in Two AF4Q Communities**
Sophie Shen, Engelberg Center for Health Care Reform at Brookings
Iris Chan, Engelberg Center for Health Care Reform at Brookings
- Objective: for discussion*
Tab 4: cover memo, presentation slides

11:00 a.m. **Performance Measurement Implementation Efforts: MONAHRQ 2.0**
Anne Elixhauser, Agency for Healthcare Research and Quality
Carol Sniegowski, Agency for Healthcare Research and Quality

Objective: for discussion
Tab 5: cover memo, presentation slides

11:25 a.m. **QASC Work Group Updates**
QASC Work Group Chairs and Co-chairs

Objective: for discussion
Tab 6: cover memo, presentation slides, Patient-Reported Measurement Charter and Tasks

11:55 a.m. **Closing Remarks**
Mark McClellan

TAB 1

Quality Alliance Steering Committee (QASC) Quarterly Meeting
March 15, 2011
9:00 a.m. - 12:00 p.m.

Participants: Mark Bennett, Carmella Bocchino, Jim Chase, Carolyn Clancy (co-chair), Joanne Conroy, Joyce Dubow (representing John Rother), Fred Edwards, Pam French, Tom Granatir, Ardis Hoven, Clarion Johnson, Randel Johnson, Chip Kahn, Mark McClellan (co-chair), Debra Ness, Peggy O’Kane, Frank Opelka, Chris Queram, Joachim Roski, Lew Sandy, Mary Jean Schumann, Gerry Shea, Diane Stollenwerk (representing Janet Corrigan), Margaret VanAmringe (representing Mark Chassin), Steven Weinberger, Janet Wright

Carolyn Clancy welcomed participants and provided an overview of the agenda. The December meeting minutes were approved.

Role of QASC and Its Mission

Carolyn Clancy discussed how the QASC can inform broader implementation efforts. Health care reform touches all parts of the health care system, but a significant number of people and organizations are unaware of reform efforts such as ACOs or do not know how to participate in these efforts. Because the Affordable Care Act will most likely continue in law, aligning public-private and national-regional efforts with regard to implementation and data collection will be important. The National Quality Strategy, which should be released shortly and will follow the framework shared at the December 15 QASC meeting, can play an important role in guiding alignment.

Mark McClellan emphasized the need to implement consistent approaches to performance measurement. As reform efforts increase in scale, it will be important to understand how these efforts can reinforce each other. For example, if multiple states create multi-payer databases, using similar methods and equivalent data sources will enable cross-state comparison. Further, the importance of evaluating how performance measurement is affecting quality of care should not be overlooked.

Diane Stollenwerk stated that the QASC should focus on improving health as well as health care and questioned whether the proposed emphasis on data collection/aggregation adequately focuses on health. Mark McClellan responded that over the next two years, the focus of the QASC will move from creating a standardized measure set to building out more sophisticated measures (e.g., clinically-enriched) that might be more relevant to outcomes and population health. Carolyn Clancy pointed to Craig Jones in Vermont as an example of someone who has begun to link community data with clinical data.

Gerry Shea stated that it seems as though the QASC is at a turning point. QASC efforts to build consensus have been successful and topics that the QASC has discussed are now beginning to play out in Medicare and Medicaid. However, in order to remain relevant, the QASC now needs to think about changes that will happen soon in Medicare and Medicaid and lend its expertise. For example, the QASC might work to help the Innovation Center develop a strategy for collecting clinically-enriched data given the ongoing problem of calculating clinically-enriched measures without an adequate health IT infrastructure.

Building on this point, Debra Ness stated that with enormous pressure on states to cut budgets, there is more and more interest in how delivery system reforms and measurement can more quickly create cost savings. For the first time, delivery reform is being seen as a way to avoid cuts in Medicaid. The QASC should apply its expertise where it is needed.

Frank Opelka stated that around the United States, there is an enormous disconnect between how the QASC thinks about health care reform and how everyone else thinks about reform. Currently, for example, most organizations still conduct pure chart review, which rarely results in meaningful clinical transformation. The QASC needs to think about new ways to translate performance results into actual change. Ardis Hoven stated that nobody knows what to do with quality dashboards and suggested that the QASC focus on incremental improvements on the ground at the regional/local level. Carolyn Clancy agreed that many people leading hospitals and other health care organizations were not brought up using databases and still struggle to translate and use performance results.

Pam French stated that despite these disconnects, there have been some success stories. The QASC should share these examples (e.g., Puget Sound Health Alliance) to help other groups see the path forward. The QASC should also look at steps that organizations (e.g., large employers) can take right now before some major elements of health reform begin. Janet Wright stated that the American College of Cardiology has been working to issue guidance to 1,500 sites on how to interpret the results of forthcoming revascularization reports.

Chip Kahn asked if there is sufficient money to fund the types of activities that QASC members have raised. Mark McClellan stated that much work to date has been funded by seed money from organizations and in-kind funding, and he agreed that the QASC should think about how its work matches up with funding streams. The Affordable Care Act provides only limited funding.

Fred Edwards stated that one element of disconnect is the lack of a feedback loop; physicians do not know their own performance rates, and improvement is not possible without feedback to physicians. Steven Weinberg and Joanne Conroy agreed and stated that emphasis on quality improvement is not imbedded in the culture of physicians. Mark McClellan suggested that the framework for quality measurement should be made more practical and concrete.

Aligning Toward Consistent Data Collection/Aggregation

Mark McClellan stated that a large number of private-sector payers (e.g., Aetna, Cigna, WellPoint) have committed to alignment on data collection/aggregation. Alignment with Medicare and Medicaid has also been discussed with CMS staff. Pilots will be started in some communities using Medicare data and will inform the development of a national strategy. The goal is to create a set of performance measures derived using consistent methods. Initial measures will focus on preventive and chronic care, safety, and overuse and will use routinely available administrative data. Eventually, measures will also incorporate patient-reported and clinical data.

Debra Ness stated that the QASC should consider expanding into looking at data that can pinpoint cost hot spots; desire for these data are coming directly from communities. Mark McClellan stated that the goal is to use NQF-endorsed measures for this effort and that there are no NQF-endorsed measures for pinpointing cost in this manner. Pam French stated that claims data can easily be used to identify high-cost individuals with serious/multiple chronic conditions. Physicians can then reach out to these patients to develop action plans. The next step is to build this process into a referral model.

Gerry Shea asked where the proposed pilot sites will be located and the amount of time it would take for sites to have learned valuable lessons. Mark McClellan stated that pilots will occur in communities in which HHS is already involved, such as the ONC Beacon communities. CMS is aiming to have better mechanisms for using data for performance measurement by 2012. The hope is that enough would be learned from the pilots to develop a national strategy by 2012.

Diane Stollenwerk stated that NQF recently conducted a survey of state and community leaders that showed that leaders desire coordination on a national level and asked if the measures used in

this effort will be aligned with CHIPRA, meaningful use, NQF dashboards, and AHRQ Quality Indicators.

Mary Jean Schumann asked how far upstream this effort can intervene. Debra Ness stated that better health will be a strong focus in the National Quality Strategy, which will help integrate broader population-level health components with individual health care components. Mary Jean Schumann expressed concern that a purely national focus could sweep away some early state- and region-based intervention efforts. Mark McClellan stated that the QASC will create both regional- and provider-level measures of readmissions rates. Pam French agreed that the QASC should focus not just on people who are sick, but also on people who are not yet sick (e.g., through interventions for pre-diabetics).

Use of Community-Level Performance Measurement and Reporting

Harold Miller provided overarching comments on the use of community-level performance measurement and reporting to support quality improvement, payment reform, and consumer engagement. There is broad consensus that the Triple Aim goals (improving health, improving quality of care, and reducing costs) are critical. Four areas will be important in meeting those goals: data; clinical transformation; payment and benefits; and patient education and engagement. Within each of these areas, many different functions must be coordinated. Regional collaboratives, such as the Aligning Forces for Quality (AF4Q) and Beacon communities, are uniquely positioned to coordinate at the community level (e.g., for public reporting). In turn, the Network for Regional Healthcare Improvement plays an important role in helping collaboratives share information, allowing these collaboratives to build on the experiences of others.

Chris Queram discussed the impact of public reporting on quality of care in Wisconsin. The Wisconsin Collaborative for Healthcare Quality (WCHQ) found that there has been a steady improvement in quality over time and a decrease in variation between physician groups since public reporting began in Wisconsin. For some measures, improvement has been statistically significant. Further, the WCHQ identified an inverse relationship between an organization's performance rank and its rate of improvement, suggesting that measures that are publicly reported get improved and get improved faster than other measures. Lastly, Wisconsin performed better than Iowa and South Dakota on all diabetes measures, except for a measure on eye exams, which was the only measure not public reported. In sum, the evidence suggests that public reporting drives higher levels of performance.

Mark Bennett discussed four important areas of coordination across programs. First, a vision and desire for change must be built at the community level; at this stage, board and leadership training is essential. Second, stakeholders must be convened to get alignment and break down existing silos of care. Third, organizations that lack capacity must be given assistance for skill development. Fourth, one-on-one consultation with providers (e.g., in physician offices) are important, particularly for teaching providers how to handle clinical data.

Jim Chase discussed the statewide measurement partnership between Minnesota Community Measurement and the Institute for Systems Improvement. Various condition-specific initiatives were implemented across the state with a generally high level of success. For example, provider groups that implemented depression care measures (both a medication measure and the PHQ-9, a NQF-endorsed patient survey measure) saw much greater improvement than groups that did not. However, efforts to reduce the use of costly lower back care were less successful. Now, one of the most significant challenges is creating a sustainable payment model. Plans in Minnesota agreed to pay differently for the depression initiative, but plans cannot be expected to change their payment for each new initiative.

Joyce Dubow asked if the drivers of improvement in certain practices have been determined. Gerry Shea stated that because voluntary initiatives tend to attract high-quality organizations, it

can be difficult to draw conclusions about all organizations based on voluntary initiatives. Going forward, it will be important to explore the organizational characteristics (e.g., culture, strategy) that impact improvement in more detail.

Randel Johnson asked who tends to embrace reform efforts first when collaboration is required. Harold Miller stated that in Maine, an organization that had lost its quality rating was the first to adopt a global payment structure. Jim Chase stated that although readmission measures for specialty procedural areas (e.g., back surgery) have been less readily adopted, organizations have been quick to implement hospital readmission measures.

Peggy O'Kane stated that tensions between local and national measurement efforts are not so much around the measures, but around the business model. QASC members agreed that the business model needs to change and that any new business model must be sustainable, although envisioning how a new model will work is a challenge. Lack of Medicare data, for example, is a huge barrier to good analysis.

Ardis Hoven asked how to select measures to report in the context of trying to balance local and national measurement needs. Gerry Shea stated that there was little guidance from a national standpoint at the outset of quality improvement initiatives in Wisconsin, and measures were therefore based on local needs. However, meaningful use has now crowded out other measurement efforts; significant resources are required within provider organizations to ensure alignment with meaningful use. Mark McClellan stated that managing the meaningful use burden while also working toward payment reform will be important going forward.

QASC Work Group Updates

Cost of Care

Gregg Meyer updated the QASC on the February meeting of the Cost of Care Work Group. The Work Group is monitoring the performance of American Board of Medical Specialties (ABMS) cost of care measures in the field, as well as the endorsement process for these measures. The Cost of Care Work Group is also providing technical assistance to three Aligning Forces for Quality communities to implement cost of care measures.

Measure Implementation Strategies

Lew Sandy gave an overview of the charter and work plan for the Measure Implementation Strategies (MIS) Work Group. The MIS Work Group is focusing on the Beacon Community project and the Brookings-Dartmouth ACO initiative and has discussed various technical issues, including attribution, clinically-enriched measurement, and alignment of measurement efforts.

National-Regional Implementation

Jim Chase stated that on its February call, the National-Regional Implementation (NRI) Work Group discussed the NQF dashboard project, regional feasibility assessments on sustainability, and how to create better communication channels between national and regional organizations.

Patient-Reported Measurement

Debra Ness reminded QASC members of the broad scope of the Patient-Reported Measurement (PRM) Work Group, including patient experience, outcomes, engagement, and shared decision-making. The short-term focus of the PRM Work Group will be identifying measures that are immediately available for use in new models of care delivery. An advisory group will also be created to vet recommendations before sharing them with the full QASC.

Frank Opelka stated that the PRM Work Group should look into BREAST-Q, a psychometrically validated instrument for patient-reported outcomes in breast surgery. Debra Ness agreed that the PRM Work Group will need to focus on condition-specific measures. Tom Granatir stated that many innovative tools for obtaining patient-reported data are being used in the United Kingdom.

Membership Action

Mark McClellan informed the QASC that John Tooker is retiring and has proposed that Steven Weinberger, also of the American College of Physicians, replace him on the QASC. The QASC voted to approve Steven Weinberger as a member of the QASC.

**Quality Alliance Steering Committee
Membership List (as of 6/15/11)**

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

Mark McClellan (Co-Chair)
Brookings Institution

Polly Bednash
American Association of Colleges of
Nursing

Marc Bennett
HealthInsight

Jill Berger
Marriott

Jim Chase
Minnesota Community Measurement

Mark Chassin
The Joint Commission

Joanne Conroy
AAMC

Janet Corrigan
NQF

Laura Cranston
Pharmacy Quality Alliance

Fred Edwards
Society of Thoracic Surgeons

Pam French
Boeing

Jim Guest
Consumers' Union

Ardis Dee Hoven
American Medical Association

Karen Ignagni
AHIP

Bob Ihrle
Lowe's

Clarion Johnson
Exxon Mobil

Randel Johnson
U.S. Chamber of Commerce

Chip Kahn
Federation of American Hospitals (FAH)

Allan Korn
Blue Cross/Blue Shield Association of
America

John Lumpkin
Robert Wood Johnson Foundation

Debra Ness
National Partnership for Women &
Families

Peggy O'Kane
NCQA

Frank Opelka
American College of Surgeons/LSU
Health Sciences Center

Chris Queram
Wisconsin Collaborative for Healthcare
Quality

John Rother
AARP

Gerry Shea
AFL-CIO

TBN
Centers for Medicare & Medicaid Services

Rich Umbdenstock
American Hospital Association

Andy Webber
National Business Coalition on Health

Steve Weinberger
American College of Physicians

Kevin Weiss
American Board of Medical Specialties

Janet Wright
American College of Cardiology

TAB 2

Date: June 15, 2011
To: QASC members
Re: The Beacon Community Program: Performance Measurement

Action required from QASC:

- *For your information.*

Background:

To learn more about ongoing performance measurement efforts and opportunities for alignment, harmonization, and the identification of best practices, we will continue to present on key initiatives around the country. Previously, we presented on performance measurement efforts of ACOs in the private sector as well measurement and improvement efforts in communities. Today we will report on efforts to measure and improve on important health care goals within the Beacon Communities Program

The Beacon Communities are 17 communities across the United States who have collectively been awarded a total of \$250 million from the Office of the National Coordinator for Health Information Technology (ONC). These communities were selected because of their relatively high rates of health information technology (HIT) adoption, including EHRs and health information exchange. The Beacon Program will support these Communities to build and strengthen by leveraging their HIT infrastructure and exchange capabilities to: improve care coordination; increase the quality of care; and slow the growth of health care spending.

Each of the Beacon Communities is focused on specific and measurable improvement goals in the three vital areas for health systems improvement: quality, cost-efficiency, and population health. Each community has defined a set of clinical interventions (enabled by advanced HIT) and specific health improvement aims. As part of their work, each Beacon Community must complete a quarterly data submission to ONC, reporting performance results from available data sources that map to their selected clinical interventions. The Beacon Communities' work in the area of data and performance measurement can be represented in the following framework:

1. Building and strengthening data and measurement infrastructure and approach
 - Beacon Communities must build and strengthen their measurement infrastructure and processes to enable reliable and valid reporting
 - Measures and methods should be documented, including data sources, elements, and specifications
2. Performance measurement to support quality improvement
 - In addition to reporting measure results to ONC, communities are encouraged to establish a feedback loop whereby measure results are shared with providers to support and encourage quality improvement
3. Innovation
 - Beacon Communities may develop innovative, replicable data collection, aggregation, and reporting strategies to inform future policies (e.g. patient-reported outcomes, meaningful use).

The communities completed their most recent data submission in April. ONC and technical assistance team members analyzed the data submission and provided feedback to each of the Beacon Communities.

Today's presentation will describe the performance measurement landscape across the Beacon Communities and how their approaches are anticipated to evolve over time.

TAB 3

Date: June 15, 2011
To: QASC members
Re: Advancing Nationally-Consistent Measure Implementation Across Public/Private Sectors

Action required from QASC:

- *For discussion.*

Background:

A critical element of improving health care quality, engaging consumers as more informed decision-makers, and effective payment reform is the availability of compelling performance results. The recently enacted health care reform legislation (PPACA) identifies processes by which the HHS Secretary will identify national priorities for improvement and ensure that missing performance measures are developed and become endorsed. However, needed performance results will not be produced effectively and efficiently without robust data collection and aggregation processes that are aligned and coordinated between the public and private sectors. PPACA authorizes the Secretary to develop, coordinate, and enact such processes. While PPACA does not provide specific direction and guidance on how these processes could be most effectively and efficiently met for the country, the role of public-private partnerships in carrying out such strategies is emphasized.

To date, the public sector (e.g., Medicare), health plans, providers, communities, and others have engaged in numerous efforts to calculate performance results to serve a variety of purposes. Many of these ongoing efforts could provide significant insights to HHS on how to formulate effective and efficient processes for generating needed performance results. At the same time, current data collection and aggregation structures are not well aligned and harmonized, resulting in costly and inefficient means to acquire the data needed to calculate health care performance. Timely, coordinated and well-informed input to HHS and the private sector is needed to create and execute a national data collection and aggregation strategy to support quality improvement, increased consumer engagement, and effective payment reform.

The QASC, representing a broadly-constituted public-private partnership and supported by staff from the Engelberg Center for Health Care Reform at Brookings, has focused its efforts on identifying, coordinating, and testing best practices in data collection, reporting, and aggregation that could be widely adopted across the public and private sectors. Building on past pilot efforts and with funding from the Wellpoint Foundation, the QASC has an opportunity to develop detailed recommendations on developing and executing a national data collection and aggregation strategy by leveraging experiences of current public-private partnerships and promoting best/good practices in aggregation data and results to foster improvement and performance.

This presentation will lay out key areas in which recommendations are needed in order to produce an "implementation guide" for interested communities and potential data contributors. Such a guide will review suggested methodological approaches to be implemented in order to generate consistent, comparable data to support clinical transformation across sites and systems. Key areas for recommendations include:

- Data Collection and Measure Calculation
- Data and Results Validation
- Data Aggregation
- Communication

These topic areas will be adjudicated by the QASC Work Groups, namely Measure Implementation Strategy (MIS) and National-Regional Implementation (NRI). Work Group recommendations will be shared with the QASC for additional feedback and direction.

Next Steps:

- Seek input from QASC on proposed approach and process for adjudicating recommendations;
- Present methodological issues and other key areas for recommendations during upcoming meeting of the QASC's Work Groups, MIS and NRI; and
- Continue ongoing discussions with potential collaborators.

TAB 4

Date: June 15, 2011
To: QASC members
Re: Cost of Care: Lessons Learned from Implementing Episode-based Measures

Action required from QASC:

- *For discussion.*

Background:

Over the last three years, the American Board of Medical Specialties Research and Education Foundation (ABMS REF), in collaboration with staff from Brookings, has developed 22 episode-based cost-of-care measures for 12 of the highest-cost conditions paid for through the Medicare program. Staff has recently submitted all developed measures to the National Quality Forum (NQF) for endorsement.

These newly available, episode-based cost of care measures have the potential to help communities analyze resource use and efficiency and leverage efforts to improve performance. All Aligning Forces for Quality (AF4Q) communities are expected over time to integrate such measures into their public reporting efforts to evaluate and improve health care value in their regions. To assist communities in their efforts to meet this goal, the AF4Q National Program Office has requested that Brookings provide technical assistance (TA) to select AF4Q communities to implement some or all of these 22 episode-based cost-of-care measures in FY 2011 (September 2010 to August 2011). It is expected that the lessons learned from implementing these measures in those communities should be widely disseminated to further improve the measure specifications, if necessary, and to aid additional communities in implementing these measures.

Brookings selected three AF4Q communities to implement the cost of care measures: The Puget Sound Health Alliance (Puget Sound), Oregon Health Care Quality Corporation (Q-Corp) and Greater Boston Aligning Forces For Quality. Brookings subcontracted with ABMS-REF and University of Illinois for this effort. Tailored assistance includes the following:

- With Puget Sound and Q-Corp, Brookings collaborates with their designated data aggregator, Milliman, to implement eight cost-of-care measure specifications and calculate and present results at a level of greatest interest.
- With Great Boston AF4Q, Brookings provides training to a programmer at the Commonwealth of Massachusetts Division of Health Care Finance to calculate diabetes measure on Health Care Quality and Cost Council database and report the measure results at physician and medical group level.

The PowerPoint presentation will provide high-level project information, challenges and concerns, and possible solutions to the challenges and concerns. The presentation will also detail how the QASC can assist with this effort.

Next Steps:

Brookings is writing an issue brief to summarize lessons learned from implementing these measures in those communities and is planning to disseminate the lessons to aid additional communities in implementing these and other cost measures.

TAB 5

Date: June 15, 2011
To: QASC members
Re: Performance Measurement Implementation Efforts: MONAHRQ 2.0

Action required from QASC:

- *For your information.*
- *For discussion.*

Background:

Performance measurement activities are occurring through out the United States. QASC's vision is to actively support the implementation and use of health care performance information to support:

- Performance improvements by providers;
- Public reporting, increased consumer engagement, and more informed consumer decision making; and
- Effective public policies, payment policies, and consumer incentives that foster better provider performance.

As such, QASC meetings will now include presentations that highlight key developments in performance measurement around the country. The presentation at this meeting will focus on MONAHRQ 2.0, a software product that allows organizations to input their own hospital data and generate a data-driven website. This presentation will provide information on MONAHRQ 2.0, and will discuss how MONAHRQ 2.0 has the potential to support important aims laid out in the Affordable Care Act, such as payment reform, quality improvement and consumer engagement. Members of the QASC will have the opportunity to provide input into the future development of MONAHRQ.

The screenshot shows the MyState website interface. At the top left is a logo with a stethoscope and the text "MyState". Below the logo is a navigation bar with tabs: Home, Hospital Quality, Hospital Utilization, Maps of Avoidable Stays, County Rates, and Resources. The main content area is divided into four panels:

- Hospital Quality Ratings:** Contains two sub-sections: "Ratings for the Public" (with an image of a diverse group of people) and "Detailed Quality Statistics" (with an image of a hand holding a pen over a document). Below these is the text: "Find and compare hospitals in your area. Some hospitals provide better quality care than others. Learn more."
- Hospital Utilization:** Contains an image of a hospital building and the text: "Find and compare hospitals by the number of patients they treat for different medical conditions and procedures."
- Maps of Avoidable Hospital Stays:** Contains an image of two healthcare professionals and the text: "Map and compare counties by rates of potentially avoidable hospital stays. Compare cost savings from reducing avoidable stays."
- County Rates of Hospital Use:** Contains an image of two people looking at a map and the text: "Map and compare counties by rates of inpatient medical conditions and procedures."

TAB 6

Date: June 15, 2011
To: QASC members
Re: Work Group Updates

Action required from QASC:

- *For discussion.*
- *For your information.*

Background:

The Work Groups have been active in implementing the tasks outlined in their respective charters for 2011. The following represents the breadth of activity that has occurred since March 2011 and outlines next steps for each Work Group.

Cost of Care Work Group:

The Cost of Care Work Group met on February 18 and May 20, 2011. During the February meeting, the Work Group introduced new members, reviewed the ABMS/Brookings Episode-Based Cost of Care National Quality Forum submission process, discussed Aligning Forces for Quality (AF4Q) measure implementation, and reviewed Beacon Community technical assistance and Medicare quality measurement. The Work Group provided input on strategies for attribution and measure uses for the AF4Q communities. The Work Group also discussed implications of publicly reporting on cost, implications and next steps for applying cost measures to all payers, and differences between cost and efficiency measurement.

The next Cost of Care Work Group call is scheduled for August 19, 2011 from 12 p.m. - 1 p.m. (ET).

Measurement Implementation Strategy Work Group:

The Measure Implementation Strategy (MIS) Work Group met on March 31 and June 2, 2011. During its March meeting, the Work Group heard an update on QASC activities since the Work Group last met. The Work Group also heard an overview of the National Performance Measurement Strategy from Joachim Roski, and Ayodola Anise reviewed the results of a survey of the Brookings-Dartmouth ACO pilot sites regarding their approaches to clinically-enriched measurement. The Work Group provided input on potential audit strategies as well as considerations for ensuring the representativeness of sample-based measures. In June, the Work Group heard an update on Accountable Care Organization activities and discussed methodological issues related to the National Performance Measurement Strategy.

The next MIS Work Group call is scheduled for August 4, 2011 from 3:00 p.m. - 4:00 p.m. (ET). Likely topics include methodological issues related to the National Performance Measurement Strategy.

National Regional Implementation Work Group:

The National Regional Implementation (NRI) Work Group met on May 18. During the call, the Work Group discussed a draft report on the unmet needs of regional collaboratives related to health care and payment reform efforts. Unmet needs were identified through discussions with collaboratives participating in projects with Brookings (Brookings-Dartmouth ACO pilot sites, Beacon Communities, AF4Q Communities) and staff who work on these projects. Unmet needs and recommendations on how the QASC can support these needs were grouped into the following broad areas: payment reform alignment, ACOs and opportunities/roles for regional collaboratives, measure alignment, development and endorsement, and technical/policy issues (e.g., selecting cost measures and using results, risk adjustment, alignment of data submission processes across

various groups). While many unmet needs and recommendations were identified, the Work Group indicated that several other groups (e.g., NQF) were already in the process of addressing the unmet needs. The Work Group identified four key potential areas where the QASC could assist:

- Guidance on payment reform options and selecting the option that best suits the needs of the collaborative and the community;
- Guidance on how collaboratives can work with and support ACOs in their region;
- Coordinate with NQF on opportunities to streamline process of multiple data submission for various groups; and
- Coordinate with NQF on incorporating testing of measures with collaboratives into the measure development process.

The next NRI Work Group call is scheduled for August 17, 2011 from 3:30 p.m. - 4:00 p.m. (ET). This call will address the specific steps the QASC can take to assist with the aforementioned unmet needs and recommendations. The call will also address pathways to make nationally consistent performance information widely available across the United States in alignment with the public and private sectors.

Patient-Reported Measurement Work Group:

The Patient-Reported Measurement Work Group convened twice since the last QASC meeting in December. These meetings generated productive discussion about the Work Group's operating principles and scope of work. The group has finalized its Charter (see attached) and agreed to a short-term and long-term work plan. The Work Group agreed that patient-reported measurement, whether collected via paper or electronically is foundational to the success of new payment and delivery models. In the short-term the Work Group will identify existing tools and initiatives that can be adopted immediately to acquire patient-reported data for use by patients, health professionals, and systems of accountability. In the long-term the Work Group will focus on defining ways to acquire patient-reported data *electronically* and efficiently integrate those data in electronic health records in order to facilitate "real-time" patient engagement and shared decision-making.

The Work Group will convene a meeting in July 2011 to a) ground the group in the initiatives/projects that currently exist in this arena, and b) get moving on the immediate scope of work that could advance the work of the Brookings-Dartmouth ACO pilots. In advance of this meeting, Brookings' staff will create a matrix of initiatives/tools that organizations are using or testing to better align Work Group activities with existing efforts.

PATIENT-REPORTED MEASUREMENT WORKGROUP MISSION AND CHARTER

This memo specifies the general purpose of the Patient-Reported Measurement Work Group and the deliverables to be accomplished, a description of members' requisite expertise/background, how the Work Group operates, and the membership composition.

BACKGROUND

The Quality Alliance Steering Committee (QASC)¹ is a collaborative effort aimed at implementing measures to improve the quality and efficiency of health care across the United States. The QASC appoints Work Groups to carry out assignments or projects with specific deliverables and milestones that support the goals of the QASC. The Work Groups include: National-Regional Implementation (NRI), Measure Implementation Strategy (MIS), Cost of Care, and Patient-Reported Measurement (PRM).

WORK GROUP GOALS AND OBJECTIVES

The PRM Work Group is grounded in the belief that the collection and use of patient-reported data is critically important to patients, health professionals, and new delivery and payment models for a number of reasons:

- First, patient-reported data is vitally important for serving patients' needs.
 - Providing a timely response to patient-reported data, which includes information from patients about “what matters to them” and “what is the matter with them” (e.g. the experience of care, functional status, health risk behavior, engagement level, shared decision-making), is an important vehicle for building trust among patients and facilitating improvement in the patient-health professional relationship.
- Second, patient reports can tell health professionals whether they are delivering high-quality care to patients and achieving desirable health outcomes.
 - Patient reported data can provide real-time feedback that is immediately useful to health professionals, patients, and family caregivers for improving clinical quality, decision-making, patient engagement, health outcomes, and health professionals' satisfaction. This is especially important for high-risk and high-cost patients who suffer from multiple chronic conditions as well as those who experience disparities in care and outcomes.
- Third, standardized, patient-reported data can be used to assess the effectiveness of various delivery models, make comparisons and calculate trends over time, and provide meaningful information to consumers and payers for decision-making and accountability, including public reporting and payment.
 - Data can be used to determine whether or not new models of care, such as ACOs, medical homes, and other delivery models, are actually providing better care and improving health outcomes (especially from the patients' perspective) in addition to lowering costs.
 - Data can be used in health systems and community-wide planning to direct resources toward “high-leverage” areas (e.g., through early intervention to reduce health risk behaviors).

¹ To obtain more information regarding the Quality Alliance Steering Committee, see <http://www.healthqualityalliance.org/>.

The PRM Work Group will have a short-term and long-term focus:

- **Short-term focus:**
 - *Identify the best available measures and tools* for immediate incorporation of patient-reported data into ACOs and other models of care:
 - Identify the essential domains to be captured and used by patients, health professionals, and the health care system.
 - Identify the ways that patient-reported data can be used by ACOs and purchasers for purposes of accountability.
 - Identify ways that patient-reported data practices and technical assistance can be disseminated to other ACO pilots.
 - *Determine the most efficient electronic data collection methods* for use by patients and health professionals:
 - Identify ways the QASC can immediately implement and provide technical assistance for collecting patient-reported data in its ACO pilot project.
 - *Determine how to efficiently integrate such data into practice* to facilitate decision-making among patients and health professionals and their teams.
 - *Identify a strategy for longer-term work in this area.*
- **Long-term focus:**
 - Identify ways to move to all-electronic data collection and to integrate data collection with electronic health records.
 - Determine the kinds of measures and tools that are needed to encourage patients and families to become partners with their health care teams and act as change agents.
 - Identify ways to facilitate longitudinal collection and use of patient-reported data by health professionals and patients for quality and health outcomes improvements.
 - Ensure effective use of patient-reported data for accountability, which includes:
 - Accountability measures
 - Assessment of ACO effectiveness
 - HIT financial incentives tied to meaningful use
 - Public reporting
 - Payment strategies and benefits design

HOW THE WORK GROUP OPERATES

Work Group members will convene on a regular basis, typically via teleconference, with the frequency to be dictated by the scope and timeline of its required deliverables. Group meetings are planned and chaired by the Work Group co-chairperson(s) with the assistance of QASC project staff.

QASC staff will support Work Group chairpersons and members in carrying out its tasks and deliverables.

MEMBER SELECTION AND COMPOSITION

Work Group members will be comprised of co-chairpersons and a number of stakeholders representing consumers, practitioners, professional organizations, research and health information technology experts, community representatives, government, and public and private sector payers with significant experience in quality measurement and reporting along the continuum of care.

Work Group members may invite other experts to participate in Work Group deliberations to inform specific deliberations and issues discussed by the Work Group.

Work Group members are expected to:

- work with QASC staff to achieve the goals of the project;
- shape Work Group recommendations to the QASC;
- participate actively and constructively in all Work Group meetings;
- respond to email notifications and solicitations in a timely manner;
- be prepared to contribute to Work Group deliberations by being familiar with all documents and materials distributed in advance; and
- ensure the timely completion of Work Group products and deliverables.

MEMBERS²

1. **Michael Barr (co-chair)**
American College of Physicians
2. **Debra Ness (co-chair)**
National Partnership for Women and Families
3. **Lawrence Becker**
Xerox Corporation
4. **Polly Bednash**
Association of Colleges of Nursing
5. **Melanie Bella**
Federal Coordinated Health Care Office
6. **Carolyn Clancy**
Agency for Healthcare Research and Quality
7. **Janet Corrigan**
National Quality Forum
8. **Joyce Dubow**
AARP
9. **Susan Edgman-Levitan**
Massachusetts General Hospital
10. **Steve Findlay**
Consumers Union
11. **Eric Holmboe**
American Board of Internal Medicine
12. **Karen Kmetik**
American Medical Association

² As of May 25, 2011

13. **Lisa Latts**
WellPoint
14. **Sarah Scholle**
National Committee for Quality Assurance
15. **Darcy Shargo**
Maine Aligning Forces for Quality
16. **Sharon Sprenger**
Joint Commission
17. **John Wasson**
Dartmouth Medical School

PATIENT-REPORTED MEASUREMENT WORK GROUP MEETINGS FOR 2011

Date	Time
March 28, 2011	3:00 p.m. - 4:00 p.m. (ET)
May 25, 2011	3:00 p.m. - 4:00 p.m. (ET)
September 7, 2011	3:00 p.m. - 4:00 p.m. (ET)
November 30, 2011	3:00 p.m. - 4:00 p.m. (ET)

Additional calls will be scheduled as needed.