

Quality Alliance

Steering Committee

Quarterly Meeting
December 15, 2010
9:00 am to 11:00 am

Quality Alliance Steering Committee

Quarterly Meeting Agenda Wednesday, December 15, 2010 9:00 – 11:00 a.m.

QASC Vision:

The QASC will actively support the implementation and use of standard health care performance information for:

- *Performance improvement directly by providers*
- *Public reporting and more informed consumer decision-making*
- *Effective public policies, payment policies, and consumer incentives that reward or foster better provider performance*

9:00 – 9:10 a.m.

Welcome, Call to Order

Objective: For approval (minutes)

Tab 1:

- *QASC meeting minutes 09/15/2010*
- *Membership list*
- *2011 QASC dates*

Mark McClellan | Carolyn Clancy

9:10 – 9:35 a.m.

Aligning Toward Nationally Consistent Data Collection/Aggregation to Support Performance Measurement

Objective: For discussion

Tab 2:

- *Cover Memo*

Mark McClellan | Carolyn Clancy

9:35 – 10:30 a.m.

Proposed QASC activities in 2011

- *QASC accomplishments, current activities, and potential projects*
- *QASC Work Group updates, timelines, and deliverables*
 - *Measurement Implementation Strategy*
 - *National-Regional Implementation*
 - *Cost of Care*
 - *Patient Reported Measurement*
- *QASC discussion of potential areas of focus for 2011*

Objective: For discussion

Tab3:

- *Cover memo*
- *Presentation slides*
- *Work Group draft charters*

QASC Work Group Chairs and Co-chairs | Del Conyers

10:30 – 10:55 a.m.

Other Opportunities to Align with Performance Measure Implementation Efforts

- Brookings-Dartmouth accountable care organization measurement initiative
Ayodola Anise | Joachim Roski
- Beacon Community measurement initiatives
Kerri Petrin | Joachim Roski
- Alignment of public sector initiatives
Carolyn Clancy

Objective: For discussion

Tab 4:

- *Cover memo*
- *Presentation slides*

10:55 – 11:00 a.m.

Closing Remarks

Objective: For information

Mark McClellan

Quality Alliance Steering Committee (QASC) Meeting
September 15, 2010
9:00 a.m. – 12:00 p.m.

Participating in person: Tom Granatir (representing Kevin Weiss), Jennifer Shevchek (representing Ardis Hoven), Randel Johnson, Greg Pawlson (representing Margaret O’Kane), Gerry Shea, Jim Guest, Allan Korn, Andrew Webber, Michael Painter (representing John Lumpkin), Jean Johnson (representing Polly Bednash), Joanne Conroy, Chip Kahn, Cynthia Wark, Carolyn Clancy, Mark McClellan, Joachim Roski, Laura Cranston, Janet Corrigan, Debra Ness, Marc Bennett, Frank Opelka, Chris Queram, Joyce Dubow (representing John Rother), Margaret VanAmringe (representing Mark Chassin), Janet Wright, and Nancy Wilson

Participating by phone: Jim Chase, Clarion Johnson, Juliette Jenkins, and Sheera Rosenfeld

Mark McClellan welcomed participants and provided a brief overview of the agenda. Carolyn Clancy introduced participants representing absent QASC members and participants attending by phone. The June meeting minutes were approved.

National Health Care Quality Strategy and Plan: Overview and Request for Feedback

Carolyn Clancy discussed the ongoing development of the National Health Care Quality Strategy and Plan, required by the Affordable Care Act. The Department of Health and Human Services (HHS) has drafted a framework for the Quality Strategy that calls for better care, affordable care, and healthy people and communities. HHS would like feedback on the proposed Quality Strategy from a variety of stakeholders. Key concerns include determining the appropriateness of the proposed principles, identifying national priorities and aspirational goals, addressing the needs of states and vulnerable populations, and engaging key entities and stakeholders.

Jim Guest suggested that HHS should develop a communication strategy to ensure that the Quality Strategy will resonate with members of the public and other stakeholders. HHS should also be prepared to respond to attacks from naysayers. Debra Ness noted that given the short time frame for public comments, HHS should frame the development of the Quality Strategy as a process with ongoing opportunity for community involvement and input. Carolyn Clancy agreed that communication is an important concern and stated that HHS would welcome the opportunity to present briefings to existing stakeholder groups.

Debra Ness stated that the Quality Strategy should make the distinction between priorities and goals more explicit. Priorities should be framed as underlying principles that guide the formation of concrete goals. Carolyn Clancy agreed that goals are specific statements of what should be achieved. Making hospitals safer is a priority, for example, while reducing hospital infections by 50 percent is a goal.

Mike Painter stated that greater attention should be given to individual markets, communities, and regions in the Quality Strategy. In addition, he noted that the Quality Strategy should not be cordoned off from discussion of payment and delivery reform. Carolyn Clancy stated that while

HHS recognizes that payment reform is important, payment reform will not be accomplished with a quality strategy alone. In addition, HHS recognizes that communities and state governments are important. However, engaging communities that are not already engaged in quality improvement has been difficult. HHS would like to hear from communities and states regarding their engagement in the quality improvement process.

Frank Opelka suggested that HHS should more explicitly state that the goal is to create a culture of metric-driven improvement in health care. The health care system needs to be taught to look at and improve metrics. HHS should also consider how to tie in aligned incentives for improvement and how to best use improvement cycles and learning networks to improve quality.

Greg Pawlson stated that a patient-centered health care strategy will present a challenge to health professions such as nursing and medicine. Therefore, the Quality Strategy should lay out how that part of the health system should rethink the way that it operates. HHS should also work to convince consumers that certain types of harm and cost present in the current health care system, such as hospital infections, are not inevitable and should be eliminated. Consumers need to be convinced that health care reform will help them rather than harm them.

Andrew Webber stated that the proposed Quality Strategy should explicitly prioritize health care cost reduction rather than simply affordable care. Since this is the first significant statement by HHS on genuine quality reform, it must be framed appropriately. Quality improvement must go hand in hand with cost reduction. Carolyn Clancy agreed that HHS must focus on cost, but stated that HHS is trying to avoid explicitly instructing government on how it should address cost. Although the National Prevention and Health Promotion Strategy will not be delivered until March, HHS is working to ensure that the two Strategies are complementary.

Randel Johnson requested that HHS give examples of practical goals for those who want to start talking about quality improvement to members of the business community. Concrete goals will help explain to business stakeholders what the Quality Strategy really means.

Nancy Wilson clarified that public comments on the Quality Strategy background are due October 15. Carolyn Clancy recognized the efforts of Nancy Wilson and Juliette Jenkins in helping to develop the Quality Strategy.

NQF-QASC Work Group Report on Enhancing Availability of Performance Information

Mark McClellan introduced a report from the joint NQF-QASC Work Group on enhancing the availability of performance information. Two recommendations of particular relevance to QASC were highlighted. First, QASC should develop best practices guidelines for data collection and aggregation. Second, QASC should encourage collaboration between measure stewards and communities in implementing pilot testing of measures.

Janet Corrigan further explained that the NQF-QASC report reflects the fact that only a subset of NQF-endorsed measures is used for public reporting. NQF intends for endorsed measures to be used for accountability as well as quality measurement. However, some measures, such as component measures used to form a composite, may be appropriate for accountability purposes

but not for public reporting. NQF is continuing to work to identify which measures are appropriate for which use. A robust feedback mechanism is needed to assess the appropriate use of measures and their salience to a broader audience. Leadership and support from AHRQ may be needed to fund research on which measures are most appropriate for public reporting.

Jennifer Shevchek expressed concern that the NQF-QASC Work Group was not sufficiently transparent with regard to membership and frequency of meetings. In addition, she emphasized the importance of evaluation and feedback mechanisms to facilitate ongoing learning about performance measurement and reporting programs. QASC must focus not just on measure providers but also on consumers. Accurately measuring progress on quality reporting will require finding a better way to determine how patients react to public quality reports.

Mark McClellan stated that membership of the NQF-QASC Work Group would be disseminated and clarified that the report was intended to focus on implementation of measures after endorsement. Janet Corrigan listed the NQF-QASC Work Group members: Carmella Bocchino, Bernie Rosoff, Bob Ihrie, Chip Kahn, Andrew Webber, Art Levin, Frank Opelka, Gerry Shea, Chris Queram, David Shahian, Janet Wright, and Steve Findlay.

Carolyn Clancy stated that while the report focuses on technical challenges and opportunities, governance should also be discussed. It will be important to identify best practices surrounding the actual dissemination of quality data to the public.

Janet Corrigan recommended that the QASC build on the work of the Consumer-Purchaser Disclosure Project and the Patient Charter for Physician Performance Measurement. QASC should work to facilitate more consistent adoption of reporting principles across communities so that measure stewards will be more comfortable reaching out to communities and having their measures publicly reported.

Mike Painter expressed concern that QASC might be opening the door to exempting measures from public reporting requirements. He also stated that the NQF-QASC Work Group was missing an opportunity to discuss the role of e-measures in future public reporting. Janet Corrigan stated that the burden of proof would rest with the measure steward to show that a specific measure is not appropriate for public reporting. She also stated that the recommendations in the report are applicable for public reporting regardless of whether measures have electronic specifications.

Debra Ness suggested that the Work Group charter should be expanded to include e-measures and agreed that the role of EHRs in public reporting should be considered more closely. She praised the parallel efforts of NQF and QASC regarding measure implementation and agreed that not every accountability measure is appropriate for public reporting. NQF and QASC should work to further study the audiences for which accountability measures make sense. Jean Johnson stated that the NQF-QASC report should more explicitly discuss how publicly reported measures are understood and used by the public.

Greg Pawlson stated that disclosure standards are very important and are typically the result of heavily negotiated consensus with communities. QASC must anticipate privacy issues stemming

from combining data sets for public reporting to prevent pushback from consumers. He also emphasized that the NQF-QASC report marked a major turning point for NQF in terms of beginning to look at how measures are implemented in a more robust way. However, more attention should be given to the role of the public sector in defining measure implementation standards, particularly for physician organization reporting. Standards for implementing measures and auditing data will require public-private collaboration with NQF.

Joyce Dubow stated that if public reporting is intended to inform choice and consumer use, having fewer measures may be beneficial. However, consumer choice should not be confused with full disclosure. Some measures may not be appropriate for informing choice but should nonetheless be disclosed for use by advocates and other stakeholders. Debra Ness concurred and stated that public reporting is for quality improvement as well as consumer choice and that disclosure has the potential to inform quality improvement through a variety of channels.

Gerry Shea expressed concern that the public might be overwhelmed if too many measures are reported. The effect of public reporting on the patient-physician relationship should also be considered. More generally, HHS should provide strong leadership and challenge not just health care providers but also consumers and purchasers to take an active role in quality improvement.

Overview and Discussion of QASC Priorities for 2011

Joachim Roski gave an overview of the QASC Work Plan for 2011. General priorities include ironing out the technical issues of taking the baton from NQF and developing a data platform through which endorsed measures can be used on a wide-scale basis. With regard to clinically enriched measurement, priorities include determining how to more widely promote best practices and how to support communities interested in implementing these best practices. A new Work Group focusing on patient-generated information, chaired by Debra Ness, was also introduced.

Greg Pawlson stated that a consistent way to get reliable, valid, and comparable data from physician entities is needed. The first step should be a public sector solution such that all government projects collect performance measures in the same manner. QASC should develop a strategy to pull together lessons learned from AF4Q, Beacon, IHA, ACO, and other state projects. Mark McClellan agreed that further discussion is needed regarding how to get ACOs to adopt a consistent measure set and suggested that this issue be addressed in the next work plan.

Allen Korn suggested that QASC should move outside of the public sector and actually steer something. Standardized and easily understandable PowerPoint presentations are needed to communicate quality measurement priorities and goals to constituents in the private sector. Anecdotes can be effective means of communicating the value of performance measurement. Cross-group collaboration can also be an effective way to facilitate communication.

Debra Ness expressed excitement at the prospect of looking at patient experience and patient decision making. She also suggested that there should be cross-fertilization between the National-Regional Implementation (NRI) and Measurement Implementation Strategy (MIS) Work Groups. Joachim Roski stated that Work Group membership and goals would be realigned and clarified for 2011.

Laura Cranston raised a question about the roles that NQF and QASC should take in sharing best practices for measure collection. Mark McClellan stated that much more can be done to track actual use and adoption of NQF-endorsed measures. Janet Wright clarified that her role would be to share regional projects using NQF measures with the QASC.

Margaret VanAmringe asked how QASC intends to evaluate the effectiveness of quality measures and stated that developing electronic specifications for quality measures could have unintended consequences. Mark McClellan stated that more clarity regarding QASC work on methods of evaluating measures was a recurring concern.

Jennifer Shevchek stated that QASC should consider how to change workflow patterns to help physicians start reporting quality measures and how to disseminate best practices in this area.

Carolyn Clancy stated that quality improvement requires leadership and execution. QASC needs to disseminate its knowledge of best practices to a much broader audience. Private sector collaboration will be crucial in disseminating best practices. Mark McClellan concurred and stated that recent pilot efforts have shown that the private sector does indeed push government along. For the forthcoming QASC meeting, the goal is to have a more concrete plan for QASC work in 2011 that reflects new health care regulation.

Recommendations from the Advanced Measurement Best Practices (AMP) Project

Ayodola Anise presented the results of the AMP project and discussed recommended practices for selecting and maintaining clinically enriched measures, collecting and aggregating data, and implementing measure specifications. Next steps for QASC and technical recommendations for measure endorsers and developers were also discussed. Cheryl Damberg, a consultant on the AMP project, emphasized that national leadership and dissemination of best practices will be necessary to achieve standardization of performance results across organizations.

Greg Pawlson cautioned that a single set of standards may not work in the immediate future except for specific programs, such as meaningful use, ACOs, and possibly PQRI. Some decisions, such as determining a single reliability coefficient, may be political. Cheryl Damberg concurred and stated that the unit of measurement drives how data are collected. Organizations will most likely have to compromise between best practices and what stakeholders bring to the table. The AMP project presents an opportunity to demonstrate “better practices,” since many organizations are just starting to think about collecting clinically enriched measures.

Frank Opelka stated that EHRs can often create more problems than solutions. EHRs are not beneficial unless providers are both inputting data and pulling data back out to inform clinical care. Given the potentially overwhelming amount of data in the EHR, integrating this data into the physician workflow is a major concern.

Joanne Conroy asked how the information from the AMP project can inform national coordination efforts. Mark McClellan stated that the lessons from the AMP project are meant to help organizations get past stage one of clinically enriched measurement and to facilitate cross-

organization consistency. Allan Korn stated that he would like the information in the AMP report distilled down to four simple PowerPoint slides so that he could share best practices for clinically enriched measurement with an audience of non-insiders. Clarion Johnson agreed that this would make communication with stakeholders much easier.

Accuracy of Physician Reported Cancer Stage for Analysis of the Quality of Cancer Care

Stephen Edge, Chair of the Commission on Cancer and surgeon at Roswell Park Cancer Institute, discussed the accuracy of physician-reported cancer stage for analysis of the quality of cancer care. Administrative data are not sufficient to judge the quality of cancer treatment and existing cancer registry systems are incomplete and slow to make data available. This pilot assessed whether physician reporting of cancer stage could be used as a work-around solution. Agreement between stage reported by physicians and stage reported in state cancer registries was 80 percent. This level of accuracy is not high enough to use physician-reported cancer stage for defining either reimbursement or physician accountability.

Carolyn Clancy asked if this pilot had any overlap with CDC cancer projects. Stephen Edge stated that the CDC is a member of the Commission on Cancer.

Jim Guest asked for clarification on how information is added to cancer registries and how data collection and linkage can be improved. Stephen Edge stated that either the accuracy of stage data collected from physicians must be improved or new ways to rapidly collect stage data must be developed. The Commission on Cancer is currently attempting to enhance the speed at which cancer registries report staging data. Jim Guest raised a question about cancer registries in other countries. Stephen Edge stated that although many Scandinavian countries have better registries than those in the United States, data problems still exist there as well.

Mark McClellan stated that the forthcoming QASC meeting will take place on December 15 from 9:00 a.m. to noon at the Brookings Institution.

**Quality Alliance Steering Committee
Membership List (as of 8/31/10)**

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

Ardis Dee Hoven
American Medical Association

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 &
Families

Frank Opelka
American College of Surgeons/LSU
Health Sciences Center

Fred Edwards
Society of Thoracic Surgeons

Gerry Shea
AFL-CIO

Janet Corrigan
NQF

Janet Wright
American College of Cardiology

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

Marc Bennett
HealthInsight

Mark Chassin
The Joint Commission

**Quality Alliance Steering Committee
Membership List (as of 8/31/10)**

Pam French

Boeing

Peggy O’Kane

NCQA

Polly Bednash

American Association of Colleges of
Nursing

Randel Johnson

U.S. Chamber of Commerce

Rich Umbdenstock

American Hospital Association

Date: December 15, 2010
To: QASC members
Re: 2011 QASC Quarterly Meeting Schedule

Action required from QASC:

- *For your information.*

Schedule:

1. March 15 Tuesday
2. June 15 Wednesday
3. September 14 Wednesday
4. December 14 Wednesday

Meetings will run from 9:00 a.m. to 11 a.m. or 12:00 p.m. either at The Brookings Institution, 1775 Massachusetts Ave. NW, Washington, DC 20036 or virtually. Details will come prior to meeting date.

TAB 2

Date: December 15, 2010

To: QASC members

Re: Moving from pilot activities to wide scale implementation; advancing nationally consistent data collection/aggregation to support performance measure implementation

Action required from QASC:

- *For discussion.*

Background:

A key goal of the Affordable Care Act (ACA) is to support better quality care at lower costs through public-private collaboration. Aligning data collection and aggregation efforts across the public and private health care sectors will facilitate valid, reliable comprehensive performance information that can be used to improve care. Specifically, such effort efforts can:

- Provide consumers with more useful comparative information about where to receive appropriate care;
- Supply providers with consistent feedback on a core set of performance measures that can be used to improve patient care; and
- Give providers an opportunity to review and correct data used for performance measures.

That ACA goal is supported by QASC efforts focusing on best practices in data collection and aggregation relying initially on already widely available data. These best practices can be implemented by both the public sector (e.g., CMS) as well as the private sector. The QASC's broad-based public-private partnership, involving key national and regional leaders including physicians, consumers, employers, payers, quality improvement organizations, and others, is well poised to facilitate this effort.

QASC is now ready to promote the wider adoption of these data collection and aggregation practices by both the private sector and health plans in making physician and medical provider performance information available. Major health plans stand ready to support an approach in which the public and private sectors work together to produce an initial set of performance measures in collaboration and alignment with CMS. As a starting point, initial measures can be calculated using routinely available administrative data. This reflects the fact that health IT systems are not yet widely available, and that administrative data are needed for many performance measures that span the spectrum of care. Additional performance measures that rely on electronic clinical data and consumer-reported data, in addition to more measures in development now that cover other aspects of the quality and cost of care, should be added as next steps.

The QASC and the National-Regional Implementation Work Group can support and guide such efforts in the following ways:

- Facilitate the use of consistent methodology across the public and private sectors to make performance information for an initial set of important measures available for clinicians and provider organizations;
- Build on previous work under the High-Value Health Care project and current activities to expand the original set of administrative-only measures to include measures that can be generated with administrative data in conjunction with clinical data and patient experience (e.g., data from laboratories, electronic medical records, local registries, patient surveys). The work will include identifying data collection sources and strategies for obtaining this information;
- Identify, coordinate, and test best practices in data collection, reporting, and aggregation that could be widely adopted across the public and private sectors through pilots and demonstration projects; and
- Support an approach to promote consistency in reporting across health plans, provide comprehensive performance results, enable comparison across public and private payers, streamline reporting for physicians, and offer improved reliability in the feedback of data that are used for quality improvement.

The discussion will provide an update on next steps to advance this opportunity across the public and private sectors.

TAB 3

Date: December 15, 2010

To: QASC members

Re: QASC and QASC Work Group Updates

Action required from QASC:

- *For your information.*

This memo includes a summary of QASC accomplishments in 2010. Additionally, this memo highlights each QASC Work Group's focus and proposed activities for the upcoming year.

The intent of this memo is to inform QASC members and promote discussion on December 15 about the future direction and activities of QASC and its Work Groups.

Background:

The success of the Engelberg Center and QASC rely upon important collaborations among key stakeholders. QASC has played a major role as a convener — both in building consensus on policy solutions and in implementing key aspects of health care reform.

1. QASC Accomplishments and Current Activities

QASC has supported a number of pilot initiatives intended to generate nationally consistent performance information through collaborative and technically sound processes for data integration and aggregation. The QASC has provided guidance on alternative methods for data collection and analysis using different data sources (e.g., electronic health records and administrative claims) which will aid in the availability of standardized, reliable health care performance results. The QASC has also provided feedback on detailed measure specifications for cost-of-care measures focused on 12 high-cost/prevalence conditions. Lastly, the QASC has supported the advancement of equity in health care quality through the identification of best practices for collecting and reporting race, ethnicity, and primary language identifiers as well as steps to measures and use these data.

In 2011, QASC's identified best practices in measure implementation stand ready to be adopted by measurement efforts around the country, including Beacon Communities, Brookings-Dartmouth Accountable Care Organization (ACO) Pilots, and to form the basis for a national-consistent approach for data aggregation and collection. At the same time, lessons learned about performance measurement implementation practices from the Beacon Community and the ACO pilot initiatives will be brought forward to QASC Work Groups and QASC (see Tab 4) for adding to the knowledge about best measure implementation practices. Additionally, QASC work will focus on the identification and promotion of best practices to effectively and efficiently collect care experience data from patients and how to effectively coordinate the adoption of best practices in data collection and aggregation throughout the country.

2. QASC Work Group Charters

In an effort to support and execute the goals of QASC in 2011 and beyond, the work of the three existing Work Groups will continue and a fourth will be formed. The existing groups include the National-Regional Implementation (NRI), Cost of Care, Measure Implementation Strategy (MIS) Work Groups; the newly formed Work Group is the Patient-Reported Measurement (PRM) Work Group. The following describes the focus and key objectives of each QASC Work Group.

National-Regional Implementation Work Group

The objective of the NRI Work Group is to establish effective communication channels between national and regional organizations. To meet this objective, the Work Group will develop a resource guide for new and developing regional collaboratives, as well as make recommendations on effective methods of implementing consistent, locally adaptable best practices in data collection and aggregation at the regional level. To that end, this group will continue to focus on disseminating best practices in measure implementation to communities.

Cost of Care Work Group

The objective of the Cost of Care Work Group is develop a comprehensive approach to efficiency that includes examination of costs/resource use for episodes of care as well as total cost of care across provider and care settings. This Work Group will continue refining episodes of care methodology and identifying pilot sites for continuous cost of care measure improvement.

Specifically, this Work Group will provide technical assistance for developing and testing episode-based cost-of-care measures as well as promote the implementation and application of a core set of efficiency measures.

Measure Implementation Strategies Work Group

The purpose of the Measure Implementation Strategy (MIS) Work Group is to provide strategic guidance on identifying advanced methods of data aggregation and integration, best practices from the public and private sector, and selecting measurement strategies that could align across different reform priorities (e.g., Pay for Performance and Meaningful Use). These efforts will ensure that methods can be applied consistently and that pilots incorporate clinically-enhanced performance measures. The MIS Work Group will provide feedback and guidance on the following: scalable methods to coordinate the flow and collection of information from existing sources (claims, health information technology systems, clinical databases); aligning measurement capacity with payment and delivery reform needs; and proposed approaches to integrate cost measurement and quality measurement. The MIS Work Group will identify best practices for measure implementation.

NEW - Patient-Centered Measurement Work Group

The objective of the PRM Work Group is to provide strategic guidance on methods to acquire patient reported measures through surveys and personal health records. Such measurement includes identifying best practices and modes for implementing patient experience surveys in multiple settings to determine measurable effects on patient health care and outcomes. For the upcoming year, the PRM Work Group will work to identify best practices and current demonstrations to acquire, analyze, and use patient-reported information across all care sectors; pilot a core set of relevant patient experience/satisfaction measures; and promote a feasible data

aggregation/integration mechanism to accommodate patient-reported measures in broader measurement.

3. Next Steps:

Each Work Group will finalize its charter and proposed set of activities for 2011 in upcoming weeks. Revised draft charters for each Work Group have been included in your meeting materials.

QASC Work Plan Overview for 2010-2011

QASC's Strategic Focus	Accomplishment to Date	Remaining Gaps	Work Plan for 2010- 2011	Work Plan for 2011 beyond	Workgroup Assigned
<p>Identify effective, efficient, and widely-applicable measurement practices that can be replicated and implemented across the nation.</p>	<ul style="list-style-type: none"> ▪ Incorporate advanced measures through six Brookings-Dartmouth Accountable Care Organization (ACO) pilots: <ol style="list-style-type: none"> 1. Clinically-enriched measures 2. Patient-reported measures ▪ Provide technical assistance for <i>one</i> Aligning Forces for Quality (AF4Q) community to pilot test <ol style="list-style-type: none"> 1. Cost of Care measures 2. acquisition and use of indirectly estimated race/ethnicity data ▪ Develop toolkits/primers to disseminate best practices in data collection and implementation of clinically enriched measures ▪ Potential pilot testing of quality reporting and payment reform with regional collaboratives (i.e. Beacon community, CVEs, etc.) 	<ul style="list-style-type: none"> ▪ Develop advanced patient-focused measures ▪ Construct an infrastructure upon which aggregation and measurement can occur on an ongoing basis ▪ Use technologies to support efficient data collection and processing of information, while protecting patient confidentiality ▪ Build collaboration between measure stewards and communities in implementing pilot testing of measures prior to endorsement ▪ Refine measurement methodology, such as consistent and valid physician/group attribution of patients methodology 	<ul style="list-style-type: none"> ▪ Identify best practices to measure integration of patient experience in decision making ▪ Identifying scalable methods to coordinate the flow and collection of information from existing sources (claims, HIT systems, clinical databases) ▪ Seek more pilot sites to improve quality reporting and use of measurement results 	<ul style="list-style-type: none"> ▪ Identify best practices to leverage technologies to support efficient data collection and processing of information ▪ Identify best practices for use of measure information to improve patient outcome and lower cost 	<p>-Patient – Reported Measurement Group (PRM)</p> <p>- Measure Implementation Strategies WG (MIS)</p>
<p>Disseminate the best practices for collecting and aggregate data to produce and report measures</p>	<ul style="list-style-type: none"> ▪ Under discussion 	<ul style="list-style-type: none"> ▪ Align improved care with quality reporting and expand availability of performance results ▪ Apply a national – consistent approach for data aggregation and collection ▪ Integration of cost measures with quality measures 	<ul style="list-style-type: none"> ▪ Align measurement with payment reform and delivery initiatives ▪ Promote use of health care disparities measures in strategic planning for payers and providers ▪ Promote use of best practices in data collection and implementation of clinically enriched measures 	<ul style="list-style-type: none"> ▪ Integrate cost measures with quality measures ▪ Refine measurement methodology such as physician/patient attribution 	<p>- MIS</p> <p>- PRM</p> <p>- National/Regional WG (NRI)</p> <p>- Cost of Care Workgroup (CC)</p>

MEASURE IMPLEMENTATION STRATEGY WORK GROUP MISSION AND CHARTER

This memo specifies the general purpose of the Measure Implementation Work Group and the deliverables to be accomplished, how the Work Group operates, and the workplan for 2011.

BACKGROUND

The Quality Alliance Steering Committee (QASC¹) 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, Cost of Care, Measure Implementation Strategy, and Patient-Reported Measurement.

WORK GROUP GOALS AND OBJECTIVES

The purpose of the Measure Implementation Strategy (MIS) Work Group is to provide strategic guidance on identifying advanced methods of data aggregation and integration, best practices from the public and private sector, and selecting measurement strategies that could align across different reform priorities (including: P4P and Meaningful Use). These efforts will ensure that methods can be applied consistently and that pilots incorporate clinically-enhanced performance measures and will support the overall QASC vision of advancing a high-quality, affordable, patient-centered health care system.

The Work Group will achieve this goal through the following objectives:

- Providing feedback and guidance on scalable methods to coordinate the flow and collection of information from existing sources (claims, health IT systems, clinical databases).
- Identifying best practices to leverage technologies to support efficient data collection and processing of information.
- Identifying best practices for using performance measure results to improve patient outcomes and lower costs.
- Providing feedback and guidance on aligning measurement capacity with payment and delivery reform needs.
- Providing feedback and guidance on proposed approaches to integrate cost measurement and quality measurement.
- Support staff in recruiting additional pilot sites to improve quality reporting and use of measurement results.

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

HOW THE WORK GROUP OPERATES

MIS 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 project staff. The chairpersons for the MIS Work Group are Dr. Lew Sandy and Dr. Paul Tang.

MIS Work Group members are expected to:

- Work with QASC staff to achieve the goals of the project;
- Make recommendations to the QASC Steering Committee;
- 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 products² and deliverables.

QASC staff will support Work Group chairpersons and members in conducting the Work Groups' business.

MEMBERS

A full list of members will be provided in the next version of the charter.

MIS MEETINGS FOR 2011 (PROPOSED)

February ??, 2011: 3-4pm ET

April ??, 2011: 3-4pm ET

June ??, 2011: 3-4pm ET

August ??, 2011: 3-4pm ET

October ??, 2011: 3-4pm ET

December ??, 2011: 3-4pm ET

² The *product* may be a set of recommendations, designated best practices, guidance documents, white papers, or other specified deliverables.

WORKPLAN FOR 2011

Issue	Deliverables	Timeline
<p>Performance measurement within the accountable care organization (ACO) pilots</p> <p>Five ACO pilot sites and their payer partners are participating in a five-year pilot jointly led by Brookings and Dartmouth. Pilots include two integrated delivery systems, two independent physician organizations, and one physician-owned hospital system.</p>	<p>Provide feedback and input to help ensure comparability of performance measurement results across a variety of sites and systems.</p>	<p>2011</p>
<p>Project overview</p>	<p>Overview of ACO project and performance measurement strategy/timeline</p>	<p>February 2011</p>
<p>Clinically-enriched performance measurement</p>	<p>Review summary of calls on data sources and methodologies, advise on best ways to ensure comparability of results across sites.</p> <p>Review results from pilot testing of data collection, aggregation, and validation methods; advise on best ways to ensure comparability of results across sites.</p>	<p>February 2011</p> <p>June/August , 2011</p>
<p>Administrative measurement</p>	<p>Review results from administrative testing measures (including utilization, NCQA all-cause readmissions); advise on measure selection moving forward.</p>	<p>April 2011</p>
<p>Patient experience measurement</p>	<p>Review results from piloting of patient experience surveys; advise on implementation.</p>	<p>June/August , 2011</p>
<p>National performance measurement initiative</p> <p>Initiative to apply a nationally-consistent approach to data collection, data aggregation, and performance measurement</p>	<p>Advise on methodological and technical issues</p>	<p>2011</p>

NATIONAL- REGIONAL IMPLEMENTATION WORK GROUP

MISSION AND CHARTER

This memo specifies the general purpose of the National-Regional Implementation Work Group and the deliverables to be accomplished, a description of members' requisite expertise/background, how the Work Group operates, and the workplan for 2011.

BACKGROUND

The Quality Alliance Steering Committee (QASC¹) 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, Cost of Care, Measure Implementation Strategy, and Patient-Reported Measurement.

WORK GROUP GOALS AND OBJECTIVES

The objective of the National-Regional Implementation (NRI) Work Group is to establish effective communication channels between national and regional organizations. To meet this objective, the Work Group will develop a resource guide for new and developing regional collaboratives, as well as make recommendations on effective methods of implementing national practices at the regional level. This group will also make recommendations on effective ways of expanding regional practices to national adoption.

This Work Group will achieve its goal through the following objectives:

- Promulgation of best practices that support wide-scale adoption, reporting and use of consistent provider performance information. The current focus is the promulgation of recommended practices around data collection and measure implementation for clinically-enriched measures, which can be used in the development of standards for data collection and aggregation practices.
- Identification of effective ways to make easy-to-use and nationally consistent performance information available to communities across the United States, including optional methods for regional information supplementation.
- Increase the ability of regional improvement initiatives to act on such information in improving health care quality and outcomes.
- Identification of means to expand and sustain locally-focused quality improvement initiatives around the country.
- Inform national initiatives in priority setting, standard development, and technological support of the lessons learned from local improvement efforts.
- Develop recommendations for the detailed roles, responsibilities, operational requirements, sustainable operational models, and timelines that public-private partnerships and other stakeholders could adopt to make performance results more widely available.
- Identify potential implementation barriers of reporting health performance information (e.g., accountability, variation of attribution (payment vs. quality

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

- improvement), measure calculation, risk adjustment, reporting, governance, confidentially).
- Identification of pilot sites to apply to a consistent data collection, aggregation, and reporting strategy to ensure the effectiveness of the piloted measures and methods.
 - Align improved care with quality reporting and expand availability of performance results.
 - Develop recommendations on how to establish a system to monitor progress within regional collaboratives thus allowing comparisons and generation of performance report cards.

HOW THE WORK GROUP OPERATES

Work Group members are comprised of a chairperson or co-chairpersons and a number of representatives of regional collaboratives and national organizations with significant experience in quality measurement and reporting along the continuum of care. Representatives of regional collaboratives are drawn from those collaboratives who actively participate in national programs or efforts such as “Aligning Forces for Quality,” “Chartered Value Exchanges,” “CMS Better Quality Information,” etc.

Work Groups members are expected to:

- work with QASC staff to achieve the goals of the project;
- make recommendations to the QASC Steering Committee;
- 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 products² and deliverables.

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.

MEMBERS

Name	Organization
Jim Chase (Chair)	Minnesota Community Measurement
Andrew Baskin	Aetna

² The *product* may be a set of recommendations, designated best practices, guidance documents, white papers, or other specified deliverables.

Name	Organization
Marc Bennett	HealthInsight
Karen Wolk Feinstein	Jewish Healthcare Foundation
Alan Glaseroff	Humboldt Del Norte IPA
Aparna Higgins	America's Health Insurance Plans
Denise Love	National Association of Health Data Organization
Peggy McNamara	Agency for Healthcare Research and Quality
Harold Miller	Network for Regional Healthcare Improvement
Jill Nault	Healthy Memphis Roundtable
Michael Painter	Robert Wood Johnson Foundation
Barb Rabson	Massachusetts Health Quality Partners
Ted Rooney	Maine Health Management Coalition/Quality Counts
Chris Schultz	Indiana Health Information Exchange
Jennifer Sweeney	National Partnership for Women & Families
Diane Stollenwerk	National Quality Forum
Andrew Webber	National Business Coalition on Health
Ann Woo	Hill Physicians Medical Group
Scott Young	Kaiser Permanente

NRI MEETINGS FOR 2011

February xx, 2011: 3:00 p.m. – 4:00 p.m. (ET)

May xx, 2011: 3:00 p.m. – 4:00 p.m. (ET)

August xx, 2011: 3:00 p.m. – 4:00 p.m. (ET)

November xx, 2011: 3:00 p.m. – 4:00 p.m. (ET)

Additional calls will be scheduled as needed.

WORKPLAN & TASKS FOR 2011

	Tasks	Deliverables	Timeline
1	Identify options for effective and efficient communication and feedback mechanisms and channels between regional implementation and national coordination efforts	Establishment of effective, ongoing communication channels to regularly update regional and national organizations regarding key issues in national/regional coordination of performance measure implementation activities	02/2011
2	Identify options for promulgating consistent good practices in quality measurement and reporting (with a focus on practices to enable the use of clinically-enriched measures)	Resource guide for current, nascent, and future regional collaboratives (in collaboration with AHRQ, RWJF, etc.)	02/2011 (Updated regularly)
3	Identify currently unmet support needs for regional collaboratives and develop recommendations on meeting those needs	Report to QASC on unmet needs of regional collaboratives and recommendations on how they could best be met	06/2011
4	Identify approaches used by accountable care organizations (ACOs) and other regional collaboratives to be implemented nationally and consistently, as well as approaches that could be made available to communities across US.	Recommendations on pathways to make nationally consistent performance information widely available across US (in alignment with the public and private sectors).	07/2011
5	Ensure effective implementation mechanisms are being established to make performance information widely available around the country.	Recommendations on effective implementation mechanisms and coordination needs for QASC	08/2011
6	Address components of a national distributed data model - network design, software development, and development and implementation of the common data model	TBD	9/2011
7	Discuss role of data intermediary – selection criteria, measure calculation	TBD	9/2011 – 10/2011
8	Establish a national strategy to promote consistency in reporting across health plans, provide comprehensive performance results, enable comparison across public and private payers, streamline reporting for physicians, and offer improved reliability in the feedback of data that are used for quality improvement.	Recommendations on how to mitigate data collection/aggregation and reporting implementation for QASC	12/2011
9	Identify pilot sites to apply to test data collection, aggregation, and reporting strategies.	Pilot sites begin test collection, aggregation, and reporting methods	02/2012

COST OF CARE WORKGROUP MISSION AND CHARTER

This memo specifies the general purpose of the Cost of Care Workgroup and the deliverables to be accomplished, how the Workgroup operates, and the workplan for 2011.

BACKGROUND

The Quality Alliance Steering Committee (QASC¹) 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 Workgroups include: National-Regional Implementation, Cost of Care, Measure Implementation Strategy, and Patient-Reported Measurement.

WORKGROUP GOALS AND OBJECTIVES

The purpose of the Cost of Care Workgroup is to advise Brookings staff's activities on developing and implementing strategies for measuring costs, resource use, and efficiency. Building upon previous efforts, this Workgroup will identify pilot sites and guides beta testing/measure implementation for continuous efficiency/cost measure improvement during 2010-2011.

Specifically, the workgroup will achieve this goal through the following activities:

- Monitor progress on the ABMS episode-based cost-of-care measure endorsement process
- Provide technical and implementation expertise for testing episode-based cost-of-care measures in Aligning Forces for Quality (AF4Q) cost-of-care measurement technical assistance projects (potentially 2 to 4 sites to be finished by September 2011)
- Provide technical expertise to implement cost measures for Accountable Care Organizations.
- Identify opportunities for cost-of-care measure development in the context of HIT-related initiatives, including Beacon Community, state Health Information Exchanges, etc
- Collaborate with Measure Implementation Strategy QASC Workgroup to link cost measures with quality measures
- Promote a core set of efficiency measures (e.g., per capita, episode based, procedure based and etc) for different applications.
- Promote adoption and testing of National Quality Forum-endorsed measures regarding cost, resource use and efficiency

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

HOW THE WORKGROUP OPERATES

Cost of Care Workgroup members will convene quarterly, typically by conference call. Group meetings are planned and chaired by the Workgroup (co-) chairperson(s) with the assistance of project staff. The chairpersons for the Cost of Care Workgroup are Gregg Meyer and Charles “Chuck” Cutler.

Workgroups members are expected to:

- work with QASC staff to achieve the goals of the project;
- make recommendations to the QASC Steering Committee;
- participate actively and constructively in all Workgroup meetings;
- respond to email notifications and solicitations in a timely manner;
- be prepared to contribute to Workgroup deliberations by being familiar with all documents and materials distributed in advance; and
- ensure the timely completion of Workgroup products² and deliverables.

QASC staff will support workgroup chairpersons and members in conducting the workgroups’ business.

MEMBERS

Name	Organization
Gregg Meyer	Massachusetts General Hospital & Physicians Organization
Kevin Weiss	American Board of Medical Specialties
James Andrianos	Puget Sound Health Alliance
Steve Bandeian	AHRQ
John Bertko	Brookings Institution
Bruce Bagley	American Academy of Family Physicians
Judith Bouldter (Lou Diamond)	Thomson Reuters
Patricia Brennan	Industrial and Systems Engineering College of Engineering, University of Wisconsin-Madison
Christine Chen	Puget Sound Health Alliance
Bud Chumbley	Medical Associates, Milwaukee
Kathy Coltin	Harvard Pilgrim Health Care
Laura Cronston	PQA
Christopher Dezii	Bristol-Myers Squibb
Louis Diamond	Thomson Medstat
Tina Edlund	Oregon Healthcare Quality Corporation
Catherine Eikel	The Leapfrog Group
Jennifer Faerberg	Association of American Medical Colleges
Karen Wolk Feinstein	Pittsburgh Regional Health Initiative
Nancy Foster	American Hospital Association

² The *product* may be a set of recommendations, designated best practices, guidance documents, white papers, or other specified deliverables.

Pamela French	Boeing Word Headquarters
Norbert Goldfield	3M
Mary Gordon	Wisconsin Collaborative for Healthcare Quality
Bruce Hamory	Geisinger Health System
Cynthia Helstad	Wisconsin Medical Society
Amy Helwig	eHealth Initiative
Mark Kirschbaum	Univ. Wisconsin Health
Larry Kocot	Brookings Institution
Robert Krughoff	Center for the Study of Services/Consumers' CHECKBOOK
Lisa Latts	WellPoint
John Lewis	
Sharon McGill	American Osteopathic Association
Dennis O'Leary	The Joint Commission
Frank Opelka	American College of Surgeons; LSU Health Sciences Center
Mike Painter	RWJF
Greg Pawlson	NCQA
Jeff Rich	Society of Thoracic Surgeons
Deborah Rich	Greater Detroit Area Health Council
Jim Rohack	Scott and White Health Plan/American Medical Association
Gerry Shea	AFL-CIO
Jennifer Shevchek (Nancy Nielsen)	American Medical Association
Karthik Shyam	AHIP
Matt Stiefel	Kaiser Permanente
Howard Underwood	Deloitte Consulting LLP
Robin Wagner	ABMS
Andrew Weier	St. Joseph's Hospital and Marshfield Clinic
Richard Weiss	MAXIMUS Federal Services
Jan Whitehouse	Greater Detroit Area Health Council
Mark Xistris	Employer Health Care Alliance Cooperative

EPISODES/EFFICIENCY WORKGROUP MEETINGS FOR 2011

We will schedule quarterly calls, but frequency of the calls may change, depending on project progress. We will work with you to schedule the call times.

February ??, 2011: 3-4pm ET

May ??, 2011: 3-4pm ET

August ??, 2011: 3-4pm ET

November ??, 2011: 3-4pm ET

PATIENT-REPORTED MEASUREMENT WORK GROUP MISSION AND CHARTER

This memo specifies the general purpose of the Patient-Reported Measurement (PRM) 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 (QASC¹) 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, Cost of Care, Measure Implementation Strategy, and Patient-Reported Measurement (PRM).

WORK GROUP GOALS AND OBJECTIVES

The purpose of the PRM Work Group is to provide strategic guidance on methods to acquire patient reported measures through surveys, personal health records, and other means. This work is intended to promote continuous solicitation and use of patient-reported experience and outcomes to improve patient care and outcomes, to foster re-design of care delivery to be more patient-centered, and ensure accountability to patient-centric metrics. Patient-reported information ranges from basic demographics to care experience and satisfaction with care, functional status, and need/preferences and values related to care. This Work Group will identify best practices and modes for acquiring these data from patients and using this data to measure effects on patients' care experience, outcomes, and the physician-patient relationship. Acquiring patient-reported information and integrating these data in broader electronic health records and personal health records will enable health care teams to: a) monitor patients' care experience, b) enhance quality improvement efforts, c) develop individualized care plans, d) support more meaningful physician-patient interactions and partnerships, and e) align payment and reporting incentives.

Specifically, the Work Group will achieve its goals through the following objectives:

1. Identify best practices and current demonstrations to acquire, analyze, and use patient-reported information across all care sectors.
2. Identify early opportunities to construct a demonstration to pilot a core set of patient-reported data for use in pilots and new models of care and payment.
3. Identify focused, early opportunities to enrich current data collection approaches to make them more useful in clinical- and patient-decision making.
4. Develop vetted recommendations and pathways to move towards increasingly person-focused measurement approaches (e.g., "road-map" to patient-reported measurement).

Recommendations would address:

- a. Identifying best practices for acquiring patient-reported information.

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

- b. Identifying how current data aggregation/integration mechanisms have to be modified (if at all) to accommodate patient-reported measures in broader measurement activities (What technological and methodological solutions will need to be developed? What resources will be required?).
 - c. Identifying key levers for promoting more widespread collection and use of patient-reported information.
5. Test these recommendations through potential demonstration activities, which utilize personal health records and other new forms of data collection.
 6. Coordinate with the National Priorities Partnership Patient Engagement Work Group and ensure measure endorsement and harmonization through NQF as effectively and quickly as possible.
 7. Identify data stewardship functions that should be in place for public reporting and other activities.

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 Groups members are expected to:

- work with QASC staff to achieve the goals of the project;
- shape Work Group recommendations to the QASC Steering Committee;
- 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.

PROPOSED MEMBERS

Name	Organization
Debra Ness* (co-chair)	National Partnership for Women & Families
Michael Barr* (co-chair)	American College of Physicians
TBD	TBD

PATIENT-REPORTED MEASUREMENT WORK GROUP MEETINGS FOR 2011

February xx, 2011: 3:00 p.m. – 4:00 p.m. (ET)

May xx, 2011: 3:00 p.m. – 4:00 p.m. (ET)

August xx, 2011: 3:00 p.m. – 4:00 p.m. (ET)

November xx, 2011: 3:00 p.m. – 4:00 p.m. (ET)

Additional calls will be scheduled as needed.

TAB 4

Date: December 15, 2010
To: QASC members
Re: Quality Project – Other Opportunities to Align with Performance Measure Implementation Efforts

Action required from QASC:

- *For your information.*

Background:

The Engelberg Center for Health Care Reform at Brookings is undertaking new projects geared toward aligning performance measure implementation efforts. The projects, in collaboration with other entities, include the Brookings-Dartmouth accountable care organization measurement initiative and the Beacon Community measurement initiatives. Below is background information regarding each of these projects.

Brookings-Dartmouth Accountable Care Organization Measurement Initiative

Accountable care is based on the principles of clear aims (better health, better care, and lower costs), provider accountability through transparent performance measures that reflect those aims, and payment reforms that use the measures to align provider support with the aims. Accountable care organizations (ACO), established on a strong primary care foundation, are expected to enhance informed patient choice and to support effective redesign of clinical practice.

To test the potential of ACOs to improve the health care system, the Brookings-Dartmouth Team established a project in early 2009 to implement the ACO model in five pilot sites and their payer partners: Carilion Clinic, Roanoke, VA; Norton Healthcare, Louisville, KY; Tucson Medical Center, Tucson, AZ; Monarch HealthCare, Orange County, CA; and HealthCare Partners, LA County, CA. This project will allow ACOs to assess performance through ongoing performance measurement and reporting; over time, measures will become progressively more comprehensive to address critical areas and priorities including clinical effectiveness, health outcomes, care coordination, and patients' experiences. Additionally, in order for ACO providers to be successful in increasing quality and appropriately controlling utilization, providers must participate in ongoing performance measurement aimed at reducing costly errors, improving the quality of care delivered to patients, and ensuring that appropriate and efficient care is delivered. Therefore, among these pilot sites, performance results pertaining to health care quality will be linked to accessing a shared savings or shared risk pool by the ACO. Finally, sites will participate in ongoing monitoring and evaluation to advance public understanding of the ACO model and how it can be improved.

The goals of performance measurement in the Brookings-Dartmouth ACO pilot include the following:

- Create consistent, actionable information on quality and utilization for providers to make improvements within the ACO;
- Provide an assurance to patients and payers that any shared savings accumulated by the ACO was not gained at the expense of patient care;
- Create a template for performance measurement that is nationally replicable and available for use by private payers and the Medicare program; and
- Establish a foundation for public reporting of quality and utilization data by the ACO.

Beacon Community Program

In 2010, the Office of the National Coordinator for Health Information Technology awarded 17 grants totaling \$250 million to communities across the country that are leading the way in health IT. Communities will use funding to:

- Build and strengthen their health IT infrastructure and exchange capabilities;
- Demonstrate how meaningful use of electronic health records and health IT can lead to improvements in health care quality, reductions in unnecessary costs, and gains in public health; and
- Provide support and guidance to other communities for achieving meaningful use and measurable health care improvements and cost savings.

The goals of our engagement with the Beacon Community Program include the following:

- Provide technical assistance, in partnership with Booz Allen Hamilton and the Institute for Healthcare Improvement, to the communities. There are five domains: Clinical Transformation, Data & Performance Measurement, Health IT and Meaningful Use, Leadership and Stewardship, and Sustainability. Brookings has a lead role in two domains: Data & Performance Measurement and Sustainability.
- In each area, administer a Community of Practice and related Affinity Groups to support communities' work.