

Quality Alliance

Steering Committee

Quarterly Meeting
September 15, 2010
9:00 am to 12:00 pm

Quality Alliance Steering Committee

Quarterly Meeting Agenda

The Brookings Institution

Falk Auditorium

Wednesday, September 15, 2010

9:00 a.m. – 12:00 p.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 06/22/2010*
- *Membership List*
- *2011 QASC Dates*

Mark McClellan | Carolyn Clancy

9:10 – 11:00 a.m.

Planning for QASC activities and deliverables in light of the Affordable Care Act: Performance measure implementation, public-private partnerships

- HHS/Administration and quality strategy
 - What are key dimensions of strategy
 - How can QASC support HHS and private sector?
- QASC activities
 - Activities and accomplishments over last two years
 - Future opportunities for identifying additional data collection/aggregation best practices
 - Promoting and using QASC-identified best practices across the country
 - Aligning public and private sector efforts
 - Coordinating activities across the “quality enterprise”
- Adjusting current QASC practices and procedures
 - Revisiting vision/mission
 - Frequency of meetings
 - Needed workgroups, activities/deliverables
 - Other

Objective: For discussion

Tab 2:

- *Cover Memo*
- *Draft QASC Work plan (09/10-08/11)*
- *Analysis of potential gaps for QASC activities*
- *QASC workgroup charters (new/revised as need be)*
- *Joint Task Force Report NQF/QASC on needed activities to make performance information more widely availability*

Carolyn Clancy | Mark McClellan

11:00 – 11:25 a.m.

Consistent performance measure implementation: Best practices in computing results from clinically enriched data (administrative data and limited clinical data); next steps

Objective: For discussion

Tab 3:

- *Cover Memo*
- *Project report & recommendations for producing 15 clinically-enriched measures*

Ayodola Anise | Cheryl Damberg

11:25 – 11:50 a.m.

Improving cancer care quality: Findings from pilot effort to link “cancer stage information” to already available data

Objective: For information

Tab 4:

- *Cover Memo*
- *Presentation Slides*

Stephen Edge

11:50 a.m. – 12:00 p.m.

Various

Objective: For information

Tab 5:

- *Cover Memo*
- *Workgroup updates*

Mark McClellan | Carolyn Clancy

Quality Alliance Steering Committee (QASC) Meeting
June 22nd, 2010
9:00 a.m. – 12:00 p.m.

Participating in person: Gerry Shea, Joyce Dubow (representing John Rother), Kirsten Sloan, John Lumpkin, Carmella Bocchino (representing Karen Ignagni), Steve Findlay (representing Jim Guest), Fred Edwards, Laura Cranston, Janet Corrigan, Carolyn Clancy (co-chair), Mark McClellan (co-chair), Joachim Roski, Polly Bednash, Jim Chase, Randy Johnson, Jayne Chambers (representing Chip Kahn), Steve Thomas, Janet Wright, Jennifer Shevchek (representing Nancy Nielsen), and Mark Chassin.

Participating by phone: Pam French, Frank Opelka, Chris Queram, and John Tooker

Carolyn Clancy welcomed participants and provided an overview of the agenda. Polly Bednash requested an editorial change to the meeting minutes to note that she is representing the Nursing Alliance for Quality Care (NAQC) instead of the Nursing Quality Alliance. The March meeting minutes were approved.

The Affordable Care Act: Performance Measure Implementation, Public-Private Partnerships

Carolyn Clancy stated that there is a great deal of quality legislation in the Patient Protection and Affordable Care Act (PPACA), yet explicit coordination and guidance for these activities is still needed. Examining the need for emerging measures in pilots and intersections with Meaningful Use is a logical transition from the current work. While exciting, this transition is also challenging, and operationalizing a more coordinated approach will require a great deal of work. The QASC, among other entities, will be pivotal in accomplishing this. Jayne Chambers noted that funds were authorized but may not be necessarily appropriated for this work. Carolyn Clancy noted that several of these funds are associated with AHRQ and are being monitored.

Consistent Performance Measures Implementation: Best Practices in Computing Results from Administrative Data; Next Steps

Carmella Bocchino stated that the grant for this project is coming to the end; built upon the work of innovative communities, the overall goal is to develop and apply a robust, transparent, and naturally-consistent approach to aggregating health care information. Reducing variation will enable an examination of care across communities. With the goal of evaluating, reliable methods were considered and chosen. More detailed information on these methods will be disseminated in the near future.

Aparna Higgins provided an overview of the project to date; lessons learned include the need for selecting measures that are in broad use, using consistent measure specifications, and providing consistent reports, as well as engaging physicians and educating specialty societies about the project early on. She noted that thus far there has been a good response among these physician communities concerning the project.

Carmella Bocchino noted that Medicare offices in the pilot states showed a strong interest, yet did not have the necessary resources to participate. Jim Chase emphasized the importance of demonstrating the feasibility and replicability of the distributed data model.

Mark McClellan stated that there are technical and implementation issues that need to be further addressed, such as how to incorporate pharmacy data from Medicare part D. He noted that there is a great deal of work underway in the administration to make this data available for broader use. The use of Medicaid data will be more complex as it will need to be resolved on an individual state basis and will require overcoming resource issues.

Polly Bednash raised that more attention should be given to ways to collect and merge data from various types of providers. It was noted that at the practice level, nursing practitioners are included in the data submission process, yet they are often not included when data is aggregated at a different level. It was also noted that data collection would be easier if practitioners were reimbursed differently.

Gerry Shea congratulated AHIP on coordinating support among their members. Aparna Higgins stated that since several other factors were being examined, a more rudimentary and familiar set of measures were used for reliability. Carmella Bocchino stated that during initial discussions with physicians, it became clear that the early and continual engagement of physicians would be important and that there is more flexibility and therefore a greater opportunity to influence change in the private sector.

Gerry Shea stated that several recent discussions have been more focused on barriers than solutions, yet this project does not. He noted that the issue of flexibility will be key moving forward and inquired about how this is perceived and how it will develop in the future. Carmella Bocchino stated that the solutions to data issues are evolving, and must be considered as payment mechanisms change. Carolyn Clancy emphasized the need for focusing on what can and should be operationalized in the immediate future and noted that this type of immediate direction is not provided in the bill.

Mark McClellan stated that the initial goal is to collect data using consistent, validated methods, initially drawing from administrative data starting with a core set of performance measures. The vision laid out in previous documents assigns the QASC to overseeing the implementation and expansion of measures with the goal of uniform, valid, and comparative measures for quality improvement across the health care system. In addition to implementation of measures, there are technical issues to be addressed including determining the most feasible and useful attribution methodology.

Carolyn Clancy raised that the QASC could be instrumental in consensus-building among stakeholders. It was suggested that the QASC may need to meet more frequently.

Mark Riley inquired if there are any plans to collaborate with state-based, all-payer databases or regional collaboratives aggregating data at the community level. Mark McClellan stated this is the goal and that current efforts are focused on overcoming technical issues and balancing the

tension between not disrupting current efforts while laying the foundation for a measurement infrastructures with greater consistency and efficiency. There is an emerging recognition that certain measures are more useful and impactful, and the aim is to move towards the consistent use of these measures among communities.

Carolyn Clancy raised that Avalere is coordinating the development of a multi-player claims database; consensus will be needed on the best way to use the database. Although a meticulous search for data solutions would be ideal, the need for rapid implementation precedes the ability to accommodate large variation.

Mark Riley reiterated that state databases have been underutilized; furthermore, there is considerable variation in existing state databases. The relevant stakeholders (NAHDO or others representing state government) should be included in these discussions.

Jayne Chambers inquired how the need for consistent formats among EHR vendors is being addressed and emphasized a need for a discussion pertaining to EHR vendors. She highlighted that although the measures used in this project are claims-based, physicians must coordinate and carry out data submission and therefore greater consistency would be beneficial. Carolyn Clancy noted that the administration is aware of this topic, particularly the need for addressing this issue in a timely manner.

Janet Corrigan informed participants that NQF has examined all the necessary data elements for computing each endorsed measure, as well as when the data elements need to be accrued, from whom they should be received, and how they need to be calculated for producing consistent results. She emphasized the need for a rapidly evolving system in which EHR systems are set up to capture the appropriate codes.

Jim Chase echoed the need for including state databases in future work and suggested the initiation of a pilot project examining how to increase use of data among health plans and other stakeholders. Mark McClellan stated that thus far, overcoming technical issues has been a priority; however, as measures are more widely used, more attention will be given to promoting the effective and coordinated use of measures.

It was inquired whether patient experience data will be included in the next phase of work. Joachim Roski stated that this is the intent with a dueling focus on the consistent production of measures in broad use and expanded use of measures which can be computed using clinically-enhanced data which includes care experience measures.

Carolyn Clancy raised that it is still not clear how to define consumer-engagement measures and inquired about opportunities to further this work moving forward. Laura Cranston noted the opportunity for the QASC to serve as a laboratory in testing how to expand and finance the incorporation of care experience measures into current measurement efforts. It was stated that quarterly meetings may not be frequent enough for the QASC to provide sufficient guidance on this topic, among others. Joachim Roski noted that Work Groups meet more frequently and ways for the QASC members to meet more frequently will be explored. Gerry Shea suggested that the role and processes of the QASC going forward should be discussed by the group.

Joyce Dubow stated that certain plans and other entities have been able to overcome the cost of aggregating measures and have determined how to do it. She noted that efforts to further the use of care experience data may need to be carried out on a “parallel track” in order to address unique data issues. Joachim Roski noted that there are multiple models for scaling up these efforts.

Best Practices in Computing Results from Clinically-Enriched Data

Min Gayles Kim provided an update on the best practices project.

Ayodola Anise provided an overview of two projects linking registry and claims data. Carolyn Clancy inquired why there was a HIPAA issue in one project and not the other. Ayodola Anise noted that one project required asking hospitals for data and therefore encountered HIPAA issues.

Fred Edwards stated that with the combined data, predictions pertaining to long-term mortality as well as longevity could be made and that the dataset represents a rich dataset for comparative effectiveness research (CER). He noted that it would be ideal if this linkage could be routinely done. Janet Wright stated that ACC learned a great deal from this – especially related to the feasibility and need for this work. She noted that the refinement of these measures is needed and that the physicians willing to participate were those with the highest scores. She stated the need for transitioning to more broad participation and increased engagement. Fred Edwards stated that one of the biggest lessons learned is the limits of this work imposed by current HIPAA regulations. Pam French stated her excitement with the projects described and inquired how this work will connect to the larger vision. Mark McClellan stated that the general strategy thus far has been to pilot test, document lessons learned, address barriers, and plan for expansion, and that a similar path will be used with this work. Carolyn Clancy stated that there is a proactive role to be taken here. Across numerous sections of the bill, it is inherent that high-quality, affordable care is critical, yet given the minimal guidance, strategic plans will be imperative.

Pam French emphasized the need for greater coordination in this area, especially given the number of stakeholders involved. It was inquired, once information is shared with physicians, what the timeline will be for sharing information with the consumers. Mark McClellan stated that this is one of the main goals and that this is a natural transition to a discussion of public reporting.

QASC/NQF Joint Effort

Mark McClellan stated that NQF Work Group has convened and a white paper will be released in the next few months. To further advance the availability of measures, the Work Group is identifying pathways to expand public reporting of endorsed measures and develop recommendations for QASC on how to best integrate and coordinate the implementation of endorsed measures. Efforts are focusing on a few areas, such as demonstrating progress towards public reporting during the measure review process – including use of measures internally and piloting measures for public use. It was noted that NQF is requiring measure stewards to assess

the usability of their results by specifically examining how findings can be reported. Another recommendation made was further examining whether emerging measures will make use of EHR data and coordinate with electronic systems. These efforts are focused on increasing the ease with which measures can be used by increasing collaboration between measure stewards and users. The QASC will provide guidance on ways that measures can be plugged into current efforts to address potential implementation issues. Finally, there was a recommendation related to monitoring the consequences of measure results (e.g. changes in access).

Janet Corrigan stated that there are a number of endorsed measures that are very rarely used and that the goal is not to endorse all measures, but to develop a portfolio for those engaged in performance measurement, public reporting, and quality improvement. As the majority of measure developers are not directly involved in the use of measures, there is a need for further developing these relationships. Furthermore, given the complicated process of public reporting, there is a delicate balance in ensuring that there is integrity to this process and moving forward with an appropriate number of measures.

Fred Edwards stated that a further assessment of the benefits of public reporting is needed. Carolyn Clancy stated that the most important question for public reporting at this time is under which circumstances is most useful and beneficial. She also noted that one goal of the NQF work is to promote collaboration between measure developers and users.

Mark McClellan stated that ways to further incorporate this work into the broader strategy will be examined. Frank Opelka stated that where quality improvement and performance measurement work do not naturally intersect, they should remain separate to ensure that progress is not inhibited with combination efforts. Janet Corrigan concurred and stated that it is not well understood how quality improvement links to the use of performance measurement among consumers.

Joyce Dubow noted the importance of transparency for patients and encouraged better development of a path for increasing consumers' understanding of performance measurement.

Data-Driven Strategies for Eliminating Disparities

Kalahn Taylor Clark provided an overview of the findings of the disparities conference and articulated key concerns going forward. A paper articulating recommendations will soon be released.

Carolyn Clancy emphasized the need by the group to focus more on the recommendation to further engage more diverse populations in the quality enterprise.

Michael Painter encouraged further examination of these issues at the individual facilities and community level, as it was found that certain hospitals do not have resources to implement quality activities. He noted that frequently areas with a high percentage of minorities do not have the resources to sufficiently address these issues. Going forward, community health centers will need to play a key role in eliminating disparities. Kalahn Taylor Clark stated that patient

centric measures can be examined at the regional level and thanked participants for their suggestions.

Finding Solutions to Current Implementation Challenges

Carolyn Clancy stated that a discussion on the use of information and how data are collected and aggregated is needed. She noted that there are number of issues to be addressed in addition to the technical ones. She noted that in response to previous discussion, more attention will be given to this at the next meeting and that a framework will be provided for addressing this.

John Lumpkin stated a great deal of time was spent developing the vision, yet it is not well remembered and or frequently revisited in these discussions. Pilot projects are examining how data are collected and aggregated. He stated that future changes should be considered based on how they impact patients, communities and physicians' ability to consistently deliver high-quality care. Looking at how this work fits into the vision could allow us to better see gaps and overlaps.

It was stated that the vision previously articulated more of a mission/focus for quality-related work than a vision for the system. He noted that performance measurement is not fruitful unless directly connected to quality improvement and care experience.

Jennifer Shevchek stated that one of the biggest opportunities for acquiring data in "real time" is assisting physicians in consistently and accurately capturing data in EMRs. Focusing solely on the release of quality information will have limited effects.

Jayne Chambers stated the Stand for Quality was developed out of the need for a broader national strategy for ensuring that efforts are coordinated in a synergistic manner instead of an antagonistic fashion. Carolyn Clancy thanked participants for their comments and noted the need for greater collaboration with communities to understand their needs.

Jim Chase noted that as communities can get lost in the details as well, considering the current barriers to progress would be helpful. Carolyn Clancy noted that the comment frequently articulated by communities is the need for not inhibiting or burdening current community efforts.

Membership Action

Carolyn Clancy stated that the American Medical Association (AMA) has proposed that Dr. Ardis Hoven replace Dr. Nielsen in representing the AMA on the QASC. A motion was passed for Dr. Ardis Hoven to join the QASC.

**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: September 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

All meetings will run from 9:00 a.m. to 12:00 p.m. at The Brookings Institution, 1775 Massachusetts Ave. NW, Washington, DC 20036.

TAB 2

Date: September 15, 2010
To: QASC members
Re: Draft QASC work plan (09/10-08/11)

Action required from QASC:

- *For discussion.*

This memo includes a summary of potential gaps that proposed QASC's future activities can begin to close. We have also included proposed updated areas of focus for QASC Work Groups in line with needed future activities.

The information in this memo is meant inform a broad discussion at QASC on 9/15 about future directions and activities in light of the Patient Protection and Affordable Care Act (PPACA). These draft documents will be reviewed and discussed in detail at upcoming QASC Work Group meetings.

Background:

A health care system that effectively measures and reports on quality and costs consistently across the country will require a robust national infrastructure for summarizing health care data. To meet this need, QASC has taken an active leadership role over the past three years in advancing a high-quality, affordable, patient-centered health care system through the coordination of various stakeholders working to provide public information on providers' performance. Specifically, QASC began implementing a three-year (2009-2012) plan based on a previously identified roadmap that aims to significantly advance the ability to consistently collect and aggregate needed electronic health care data to make performance information more widely available. Needs laid out in the three-year plan have been addressed through a variety of pilot and demonstration efforts supported through the High-Value Health Care project. Many of the best practices identified through those efforts now stand ready to be implemented on a much wider scale.

PPACA calls for the development of a national strategy for improving health care quality. As part of that strategy, the U.S. Department of Health and Human Services (HHS) is required to measure care quality and resource, as well as to make performance information increasingly available to the public. Looking forward, QASC should align its activities to be able to support PPACA programs, existing and ongoing health care payment and delivery reform efforts including health IT and its "meaningful use," as well as value-based purchasing and pay-for-reporting.

PPACA requires the HHS Secretary to identify a national data collection and aggregation strategy and to collaborate through public-private partnerships to execute the strategy.

QASC stands ready to provide leadership and to collaboratively align its priorities, goals, and objectives with health care reform implementation. Specifically, QASC can exert its leadership by:

- Accelerating efforts to identify a set of best practices for data collection and aggregation and working with public and private sectors to ensure adoption of these guidelines;
- Documenting how current performance information is used by different targeted groups;
- Encouraging collaboration between measure stewards and communities in pilot testing measures prior to endorsement; and
- Facilitating widespread use and consistent public reporting once measures are endorsed.¹

Staff reviewed the previously identified three-year plan of needed activities, requirements laid out in the PPACA, and progress made to date through previous QASC pilot and demonstration projects. Based on this review, staff identified potential current gaps and opportunities to close them in the coming year to accomplish our mission of moving towards a national measurement infrastructure that supports health care reform.

1. Potential Gap Analysis and proposed QASC Work Plan for 2011:

Based on an analysis of current gaps in needed best practices, recommendations from the NQF-QASC Work Group and activities already underway, staff drafted a work plan for the upcoming year to make further progress towards a national data collection and aggregation infrastructure that can support multiple programs and needs as outlined in PPACA. *Table 1* provides details at a high-level about accomplishments to date, remaining gaps, potential activities for 2010/11, and assigns activities to specific work groups. Major new areas of focus include the identification and promotion of best practice to effectively and efficient collect care experience data from patients and how to effectively coordinate the adoption of best practices in data collection and aggregation throughout the country.

These details can inform the QASC deliberations on 9/15 on how to structure activities to best support health care reform implementation.

2. QASC Work Group Charters

Given the ambitious timelines and pressing need for nationally consistent standards of quality measurement and improvement, we identified one work group for each key activity to facilitate rapid implementation and evaluation of pilot tests and their greater diffusion and impact. The following describes the focus of various QA Work Groups.

¹ NQF-QASC Work Group Report. Enhancing Availability of Performance Information. Revised 08/31/10.

National/Regional Work Group

Focus: Promote and coordinate the adoption of nationally consistent, locally adaptable best practices in data collection and aggregation. Establish effective communication channels between national and regional organizations.

Cost of Care Work Group

Focus: 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.

Patient-Centered Measurement Work Group

Focus: Providing strategic guidance on methods to acquire patient experience measures through surveys. Such measurement includes identifying best practices and modes for implementing patient experience surveys in multiple settings to determine measurable effects on patient outcomes.

Quality Measurement/Measure Implementation Strategies Work Group

Focus: Providing 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.

3. Next Steps:

Work Groups will discuss in further detail the proposed set of activities for 2010/11. An update on more detailed work plans for all Work Groups will be provided at the December 2010 QASC meeting.

Figure 1. QASC Work Plan for 2010

QASC's Strategic Focus	Accomplishment to Date	Remaining Gaps	Work Plan for 2010-2011	Work Group Assigned	Work Plan for 2011 beyond	Work Group 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. Care Experience measures ▪ Provide technical assistance for one 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-centered 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 	<p>Patient – Centered Measurement Group (PCM)</p> <p>Quality Measurement/Measure Implementation Strategies Work Group (MIS)</p> <p>MIS</p>	<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>MIS</p> <p>MIS</p>
<p>Disseminate and coordinate the adoption of 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 capacity with payment and delivery reform needs ▪ Promote use of health care disparities measures in strategic planning for payers and providers ▪ Coordinate the wide-scale adoption and implementation of best practices in data collection and implementation of performance measures 	<p>MIS</p> <p>PCM</p> <p>National/Regional Work Group</p>	<ul style="list-style-type: none"> ▪ Integrate cost measures with quality measures ▪ Refine measurement methodology such as physician/patient attribution 	<p>MIS</p> <p>Cost of Care Work Group</p>

Enhancing Availability of Performance Information

NQF- QASC Workgroup Report

REVISED 08.31.10

Executive Summary:

Wider availability of performance information is a critical driver of quality improvement across the health care delivery system. Accordingly, promoting greater access to and effective use of data on provider performance and patient outcomes is a key component of the recently enacted Patient Protection and Affordable Care Act (PPACA). Currently, publicly available performance information is far from widespread. To address this concern, the National Quality Forum (NQF) and the Quality Alliance Steering Committee (QASC) established a Joint Workgroup to identify opportunities for enhancing availability and effective use of performance information. Opportunities discussed include:

- Implementing reporting requirements into NQF's Maintenance of Measure Endorsement processes;
- Expanding QASC's focus on the identification and implementation of best practices and technical assistance to build feasible, sustainable, and evolving data aggregation and reporting efforts; and
- Establishing an ongoing evaluation and feedback loop to rapidly learn from measurement and reporting initiatives across the country.

Five recommendations were formulated to be acted on by NQF, QASC, and other relevant parties:

Recommendation 1: As a general rule, NQF should require measure stewards at the time of the 3-year maintenance review to provide evidence of the use of their measures in either a national or community reporting program. Recognizing that there will be exceptions to this general rule, NQF should exercise judgment in applying the public reporting expectation to

endorsed measures. Measure stewards unable to meet the public reporting requirement should be given an opportunity to present evidence and a rationale for their continued endorsement based on the use and usefulness of the measures to a narrower audience engaged in some accountability function. As more is learned about the types of measures most useful for public reporting versus other accountability applications, NQF should focus the public reporting requirement on measures most relevant to consumers.

NQF endorses measures intended for use in accountability programs (e.g., public reporting, payment, regulation and accreditation) *and* quality improvement. There are costs associated with measure endorsement and maintenance, so NQF focuses on those areas where there is a compelling need for national standardized measures. In Fall 2009, the NQF Board affirmed that there should be a general expectation that NQF-endorsed measures will be used in public reporting programs, since reporting to the public at large affords the greatest opportunity for all stakeholders to make the best use of performance information. The Board also recognized that there may be exceptions to this general rule and that measure stewards should be given the opportunity to provide a rationale for continued endorsement of their measures based on their usefulness to more focused audiences (e.g., health plans, state regulatory agencies).

While the joint workgroup believes that there should be an expectation of public reporting, there should also be flexibility in the scope of public reporting (e.g., targeted populations or communities) and in identifying possible exceptions to the general rule. The burden of proof should rest with the measure steward to provide evidence and a compelling rationale for why a measure should remain a national standard in the absence of use in public reporting. Possible exceptions to public reporting could include the following: individual measures within publicly reported composites; and measures for which national standards are clearly required (e.g., payment or accreditation programs) but not necessarily useful to a broad set of end-users (e.g., narrow measures of technical quality, measures that assess unintended consequences of payment models).

Recognizing that measure development and use in various applications is in early stages of development, measure stewards should be encouraged to work in partnership with others to conduct assessments of the salience of performance information to various audiences (consumers, purchasers, regulators, referring clinicians), followed by ongoing evaluation of the actual use of the information in decision-making and its impact on performance. As a part of the measure maintenance process, NQF should ask stewards to provide information on the use and usefulness of measures and revisit its public reporting requirements on an annual basis to further refine the guidance to stewards based on lessons learned. .

Recommendation 2: QASC should accelerate its efforts to identify a set of best practice guidelines for data collection and aggregation. QASC should also work with public and private sectors to ensure these guidelines are adopted in data collection and reporting efforts around the country for a core set of NQF-endorsed measures. QASC should also document whenever possible how the collected performance information is used by different targeted users.

Several steps can help communities and others make performance information available, including disseminating best practices for data collection and aggregation, and developing partnerships between measure stewards and communities to integrate measures into established or emerging data collection and reporting infrastructures. Coordination of these efforts between public and private sectors is critical. Moreover, once performance information becomes available its use and impact by and with different stakeholder groups can provide important insights into the most effective deployment strategies for performance information.

Recommendation 3: NQF should work with the Consumer Purchaser Disclosure Group and others to expand the “Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs” to cover other

types of performance information. Entities engaged in measurement and reporting also should be encouraged to adhere to sound reporting principles.

The rapid proliferation of websites providing performance information has the potential to promote rapid innovation, but may also cause unintended consequences. Innovations in public reporting should be accompanied by the ongoing assessment of their utility and impact. The current public reporting principles articulated by the Consumer Purchaser Disclosure Project could evolve in line with new learning and encourage improvement in national, state, and community programs.

Recommendation 4: QASC should encourage collaboration between measure stewards and communities in implementing pilot testing of measures prior to endorsement, as well as facilitate widespread use and consistent public reporting once measures are endorsed. Such collaboration will help identify data collection/aggregation protocols for promising performance measures that are feasible, scalable, compatible with already ongoing efforts, and produce valid and reliable performance results. In addition, as a component of the pilot-testing information should be gathered on the most effective ways of displaying and using performance information for the targeted audiences.

In order to better understand the utility of recently endorsed performance measures, measure stewards, communities, and others should develop partnerships to 1) facilitate more rapid integration of measures into established or emerging data collection and reporting infrastructures; and 2) elicit feedback from different stakeholder groups about how to optimally display the information for the desired impact.

Recommendation 5: Evaluation and feedback mechanisms should be established that facilitate ongoing learning and improvement on performance measurement and reporting programs.

Establishing evaluation and feedback mechanisms has the potential to facilitate rapid learning and spread of best practices, as well as serve as an early warning system for unintended consequences. The Quality Community would benefit greatly from more formal methods for assessing specific performance measure benefits and costs, alternative data collection, and aggregation approaches; the utility of different types of performance information to various audiences; and more effective methods for making such information available.

DRAFT

I. Introduction

Wider availability of performance information is a critical driver of quality improvement across the health care delivery system. Performance information is essential to providers and clinicians seeking to improve the safety, effectiveness, and efficiency of care.

Widespread availability of comparable performance results for effective use in public reporting and payment programs is also essential to creating an environment of care that encourages and rewards performance improvement. Accordingly, promoting greater access to data on provider performance and patient outcomes is a critical component of the recently enacted Patient Protection and Affordable Care Act (PPACA). The law states performance results must be more readily available to consumers through expanding existing public reporting programs, such as Hospital Compare, and launching new public reporting programs, such as Physician Compare. In addition, linking measured performance to new ways of paying for care is another hallmark of the legislation, as public-private sector partnerships are stressed as critical components to implementing these reform provisions.

Although there has been steady growth in public and private sector performance measurement and public reporting programs over the last decade, publicly available performance information for use in payment and public reporting programs and an understanding about how to effectively convey it to targeted audiences is far from widespread. Numerous factors have limited more rapid progress, including:

- Lack of clarity on which measures should be used and what performance information should be publicly disclosed to support payment and public reporting programs;
- Lack of low-burden access to electronically available data and ways to aggregate it; and
- Lack of trusted or widely-used public reporting vehicles, as well as evidence-based, effective practices in providing performance information that impacts decision-making.

To address these challenges, the National Quality Forum (NQF) and the Quality Alliance Steering Committee (QASC) established a Joint Workgroup to identify opportunities to make performance information more widely available for effective use through individual and collective actions.

This paper provides an overview of the Joint Workgroup findings and recommendations. We describe current efforts in generating needed performance results, as well as steps NQF and QASC have undertaken to support such efforts. We also list a set of recommendations to accelerate the pace at which performance results can be made available.

II. Measuring and Making Performance Information Available

Performance measurement is fundamental to a variety of applications including quality improvement, professional certification, quality oversight (regulatory and accreditation programs), payment alignment, and public reporting.

Exhibit 1



Exhibit 1 illustrates the spectrum of applications that use information on performance results. Generally, moving left to right on the spectrum of activities involves a greater degree of disclosure of performance results. For example, sharing of performance information used to support continuous quality improvement activities may be limited to clinicians within a particular setting, or providers from multiple settings participating in a confidential benchmarking program (e.g., quality improvement registry program sponsored by a specialty society). On the other hand, performance results intended to inform the decisions of consumers – or those who purchase services on their behalf – are generally made widely available.

Several applications exist that fall between these two endpoints and may involve some degree of disclosure beyond the boundaries of the care delivery system. Two relevant applications include professional certification¹ and regulatory and accreditation programs.² Appendix 1 provides additional background information about the use of performance measures for different applications.

NQF endorsement is primarily intended for those measures for which there is a compelling need for national standards. Accountability applications on the far right—public reporting, payment, regulation and accreditation—make extensive use of NQF-endorsed measures. The need for national standardized measures is less compelling when measures are being used within an individual provider setting for quality improvement purposes only.

Regardless of the application area, measure parsimony is important to minimize risk of information overload and manage the cost and burden of measurement and improvement activities. Understanding the usefulness and relevant application of measures to different audiences to ensure quality improvement warrants further work. Effectively engaging consumers and patients about what data is available, why and how it can be useful, and how it can and should be interpreted is essential.

Limitations in accessing and aggregating electronic data have been a major impediment to more widespread availability of performance information. However, ARRA and PPACA legislation has the potential to dramatically expand the country's information technology platform and increase accessibility of electronic data for care improvement and performance measurement purposes. To that end, NQF is working collaboratively

¹ The majority of practicing physicians are certified by one or more specialty boards and most boards now have Maintenance of Certification programs that require physicians to submit certain types of performance information on a periodic basis. Although there is variability across boards, most publicly disclose only whether a physician is or is not board certified

² Many quality oversight programs such as federal and state regulatory authorities (e.g., safety reporting programs) and accreditation programs require submission of performance results on a specified set of standardized measures, and there is much variability in the degree to which this information is more broadly disclosed to the public at large.

with the U.S. Department of Health and Human Services (HHS) to develop eMeasures – performance measures that are collectable through electronic health records (EHRs) and personal health records (PHRs), and use standardized data elements and code sets. However, this process will take several years and adoption will likely be uneven across communities and providers. In the near term, we must continue efforts to make the best use of already existing electronic data, including laboratory orders and results, pharmacy claims, and clinical registries.

For many NQF-endorsed measures, measure steward specifications do not include detailed data collection and aggregation instructions; as a result, communities have developed a variety of different approaches. To reduce such variability and ease the resource burden on communities and others, QASC has focused on identifying best practices for collecting necessary electronic data – such as medical and pharmacy claims, lab results, and clinical data from registries – across multiple, alternative data sources and collection approaches to report on endorsed performance measures. Many of these practices are readily scalable across the country. By relying on distributed data methods, considerable progress has also been made in identifying feasible solutions that protect privacy and data security.

QASC is now focusing on efforts to identify consistent data collection and aggregation methods that could be adopted widely. A set of “best practices” in collecting and aggregating clinical and administrative data required to produce a core set of 15 NQF-endorsed measures is currently being tested in a diverse group of organizations – including medical groups, integrated delivery systems, health plans, and small physician practices. In addition, QASC has engaged in two pilot efforts with owners of registry data – the American College of Cardiology and the Society of Thoracic Surgeons – to identify avenues by which clinically-rich data could be combined with administrative data. Such data integration allows for better assessment of care quality and related costs than would be possible by relying on either database alone. In addition, QASC workgroups have also supported efforts to identify detailed regulatory, technical, and financial barriers and solutions to allow for more routine linkages of electronic laboratory

results with other administrative and clinical data for care improvement and performance measurement purposes. In response to these recommendations, the Clinical Laboratory Improvement Advisory Committee (CLIAC) has issued clarifications regarding such linkages and removed legal uncertainties preventing more routine linkages in an evolving health IT environment.

III. Public Reporting of Performance Information

Today, public reporting of performance is occurring both at the national and community levels. The Informed Patient Institute has identified more than 200 websites providing health care performance results. National efforts include: HHS' Healthcare Compare Series, NCQA COMPASS, and Consumers Union. In addition, communities have launched local/regional reporting efforts, many sponsored by multi-stakeholder programs participating in the Robert Wood Johnson Foundation's Aligning Forces for Quality Initiative or the HHS Chartered Value Exchanges (e.g., Massachusetts Health Quality Partners, Puget Sound Health Alliance, Oregon Health Care Quality Corporation, Minnesota Community Measurement, or Wisconsin Collaborative for Healthcare Quality).

The Consumer Purchaser Disclosure Project has developed a national set of principles to guide public dissemination of physician performance measurement and reporting. The "Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs" focuses on the selection of measures, reporting of information on both quality and cost – including data limitations – and also identifies a set of procedural safeguards to ensure that measurement is a transparent process with input from both consumers and physicians. The charter also states that physicians have adequate notice and opportunity to correct errors.

At present, limited attention has been focused on how useful performance information is to various audiences, or how this information impacts decision-making, quality, and cost. For example, little is known about how to best convey complex performance information

to consumers, clinicians, employers, and others. Public funding should be secured to establish a systematic mechanism for identifying and responding to information that emerges from testing with end-users, including ways of effectively conveying performance information to targeted audiences (cut-off points, display of summary/composite scores, etc.). In addition, such a system should monitor unintended consequences of public reporting or ineffective use of performance information.

IV. Workgroup Findings and Recommendations

Numerous opportunities exist for NQF, QASC and others – through individual and collective efforts – to enhance the availability and effective use of performance information. These opportunities include:

- Implementing reporting requirements into NQF’s Maintenance of Measure Endorsement processes;
- Expanding QASC’s focus on the identification and implementation of best practices and technical assistance to build feasible, sustainable, and evolving data aggregation and reporting efforts; and
- Establishing an ongoing evaluation and feedback loop to rapidly learn from measurement and reporting initiatives across the country.

The following sections elaborate on these opportunities and provide recommendations on making needed progress.

Maintenance of Measure Endorsement Criteria

NQF-endorsed measures are intended to be useful for accountability *and* quality improvement purposes. In September 2009, the NQF Board of Directors affirmed that the ultimate goal of NQF-endorsed measures is to make performance results available for effective use by multiple stakeholders. Measure stewards must demonstrate progress toward public reporting at the time of the three-year maintenance review and able to offer systematic feedback collected from intended users of the performance measures about their utility. The NQF Board recognized that there may be some exceptions to this

general rule and allowed for stewards to provide a rationale for why the measure was not being used for public reporting.

In implementing this requirement, NQF should recognize that there are public reporting programs and needs at both the national and community levels. Some measures will be selected for use in national programs – such as the Healthcare Compare series of HHS or Consumers Union – while others may be selected for use at the community level. Furthermore, there will likely be a good deal of variability in the use of measures for public reporting at the community level for two reasons. First, communities are at different stages of developing data platforms and reporting capabilities. For example, the communities participating in the Beacon Community demonstration project will possess far more advanced data platforms. Second, communities will vary in the priorities and expectations they set for performance improvement due to differences in population health and current capacity to address gaps.

Public reporting assessments that focus on the *usefulness* of the performance information to the intended audiences are equally important. Measure stewards working in partnership with others ideally would conduct systematic assessments of the salience of performance information to various audiences prior to involvement in a public reporting program. This should be coupled later by ongoing evaluation of the use of the information in decision-making and on performance once the performance measures have been deployed regionally or nationally.

Recommendation 1: As a general rule, NQF should require measure stewards at the time of the 3-year maintenance review to provide evidence of the use of their measures in either a national or community reporting program. Recognizing that there will be exceptions to this general rule, NQF should exercise judgment in applying the public reporting expectation to endorsed measures. Measure stewards unable to meet the public reporting requirement should be given an opportunity to present evidence and a rationale for their continued endorsement based on the use and usefulness of

the measures to a narrower audience engaged in some accountability function. As more is learned about the types of measures most useful for public reporting versus other accountability applications, NQF should focus the public reporting requirement on measures most relevant to consumers.

In implementing these new requirements, NQF should provide an appropriate degree of flexibility, recognizing that measure development and use in various applications is in an early stage of development and there is much to be learned. More is not always better when it comes to either the number of NQF-endorsed measures or the use of these measures in public reporting. Too much information, especially information of marginal value, can make it difficult for users to discern what is relevant to their decisions.

The goal should be to make information available on an essential set of measures that provide the most useful information to the intended audience. There will likely be NQF-endorsed measures that are useful for payment or regulatory purposes but ultimately prove to be of less interest to the general public. Measures may also be part of a “measure set” (i.e., process and outcome measures applicable to surgical site infections), with some being most useful for public reporting – such as infection rates, and all or nothing composite measure – and others for quality improvement benchmarking or board certification – such as compliance with steps in the recommended process for prevention.

Identification of Best Practices and Technical Assistance

Several steps can assist communities and others make performance information available, including:

- Disseminating best practice guidelines for data collection and aggregation to make performance information more widely available; and

- Facilitating partnerships between measure stewards and communities to integrate measures into established or emerging data collection and reporting infrastructures.

The PPACA requires the HHS Secretary to establish a strategic plan and set of national priorities for improvement by January 2011. In addition, the Secretary is required to develop a best practice-informed data collection and aggregation strategy in order to produce comparable performance information across the country. The national priorities, a catalog of NQF-endorsed measures, and the identification of effective data collection strategies are critical components of making nationally consistent performance information available. When linked with current efforts to assess and incent “meaningful use” of health IT and HHS public reporting and payment programs, these efforts might help identify a core set of measures that could be generated across communities. The core set of measures could be augmented locally with other measures to best meet individual community needs, priorities, and populations. Adherence to national guidelines for disclosing performance results, such as those developed by the Consumer Purchaser Disclosure Group, would engender greater trust by all stakeholders in the validity of the performance information.

Recommendation 2: QASC should accelerate its efforts to identify a set of best practice guidelines for data collection and aggregation. QASC should also work with public and private sectors to ensure these guidelines are adopted in data collection and reporting efforts around the country for a core set of NQF-endorsed measures. QASC should also document whenever possible how collected performance information is used by different targeted users.

The rapid proliferation of websites providing performance information has the potential to promote rapid innovation, but may also cause unintended consequences. Innovations in public reporting should be accompanied by the ongoing assessment of their utility and impact. The current public reporting principles articulated by the Consumer Purchaser

Disclosure Project could evolve in line with new learning and encourage improvement in national, state, and community programs.

Recommendation 3: NQF should work with the Consumer Purchaser Disclosure Group and others to expand the “Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs” to cover other types of performance information. Communities also should be encouraged to adhere to sound reporting principles.

In order to better understand the utility of recently endorsed performance measures, measure stewards, communities, and others should develop partnerships. Such partnerships may aid with the integration of measures into established or emerging data collection and reporting infrastructures. As noted above, measure stewards will be required to demonstrate progress toward public reporting at the time of their three-year NQF measure maintenance review.

Recommendation 4: QASC should encourage collaboration between measure stewards and communities in implementing pilot testing and use of measures prior to endorsement, as well as facilitate widespread and consistent public reporting once measures are endorsed. Such collaboration will help identify data collection/aggregation protocols that are feasible, scalable, compatible with already ongoing efforts, and produce valid and reliable performance results. In addition, as a component of the pilot-testing information should be gathered on the most effective ways of displaying and using performance information for the targeted audiences.

Establish a Learning System

In order to address quality, safety and cost concerns, the coming years will see extraordinary innovation at all levels. Many new types of performance measures will be developed, tested, and implemented, including measures of resource use and value,

measures of shared decision-making and patient health functioning, and composite measures. Significant investments have been made to promote increased adoption of EHRs/PHRS and other electronic data platforms that could support performance measurement and public reporting programs.

Establishing evaluation and feedback mechanisms has the potential to facilitate rapid learning and spread of best practices, as well as serve as an early warning system for unintended consequences. The Quality Community would benefit greatly from more formal methods for assessing specific performance measure benefits and costs, alternative data collection, and aggregation approaches; the utility of different types of performance information to various audiences; and more effective methods for making such information available.

Recommendation 5: Evaluation and feedback mechanisms should be established that facilitate ongoing learning and improvement on performance measurement and reporting programs.

Demonstrating how performance information can be used to create an environment that enables providers and clinicians to continuously improve and encourages and rewards excellence represents the “gold standard” of our collective efforts to reform health care.

Appendix

Uses of Performance Information

As shown in Exhibit 1, performance information is used in many different application areas including: public reporting, payment, quality oversight, professional certification, and quality improvement. In addition to degree of information disclosure, the application areas differ in other important ways:

- **Use of Standardized Measures.** With the exception of quality improvement applications within a particular setting, the use of standardized measures is beneficial to virtually all other application areas. Standardized measures facilitate “apples to apples” comparisons, an essential element of both quality improvement benchmarking and accountability applications. Accountability applications on the far right – public reporting and payment – make extensive use of NQF-endorsed measures when available. Use of NQF-endorsed measures enables national comparisons and minimizes burden on providers.
- **Volume of Performance Measures.** At present time, measures used for accountability applications on the far right constitute a relatively small proportion of the total universe of available measures, but it is unclear whether this will always be the case. For example, in the area of colorectal cancer, there are some performance measures likely to be useful for both accountability and quality improvement purposes, including: colorectal cancer screening rates; patient and family understanding and adherence to the treatment plan; and outcomes including complications, mortality, and quality of life. In addition to these, many other measures are needed for quality management; for example, dosage and delivery of radiation, and frequency of mesorectal excisions.
- **Types of Measures.** As colorectal cancer example shows, some measures are likely to be useful across many application areas. For example, health care-

acquired infection rates are of interest to many stakeholders – including ones not listed on the attached spectrum such as the public health community. However, some professional certification boards employ very extensive measure sets to evaluate clinical knowledge and skill in very narrow specialty areas – this information would likely be too detailed and clinically, technically complex for a broader audience. Although more granular process measures may be used primarily for quality improvement purposes, it is important to note that even these measures may be part of an “all or nothing” composite measure that indicates whether patients received the full set of appropriate services necessary to achieve the best outcomes. This type of composite measure may be very salient information for consumers and purchasers.

Not all measures that are used for accountability purposes will necessarily be appropriate for reporting to the public at large. For example, there may be measures used in conjunction with particular payment programs – for example, measures that monitor for unintended and potentially adverse consequences such as avoidance of very sick patients. This information may only be released to the general public in the event that a problem is detected.

- **Scientific Properties of the Measure.** Some have asserted that measures used for accountability purposes should be held to a higher standard than quality improvement measures because the “stakes are higher” in terms of potential impact on profession reputation and livelihood. Others maintain that valid and reliable measures are as important for internal quality improvement applications as well as accountability.

Of particular concern for accountability measures is misclassification of providers (e.g., incorrectly identifying a provider as a poor performer). All measures have some misclassification error. When measures are used for accountability, the risk of misclassifying some providers must be balanced against the benefits of having

transparent performance results that can be used by patients, purchasers, and others to encourage and reward improvement.

- **Coordinated Use of Measures Across Applications.** Although performance measurement and use is a relatively young science and innovation will be important to all applications, in some instances, some degree of coordination in the selection and application of measures may be helpful. For example, more rapid improvement might be possible through careful use of paired process and outcomes measures, with patients receiving the outcomes results that are salient to them, and clinicians receiving the granular process results to help them improve.
- **Deployment Strategy.** The spectrum of applications shown in Figure 1 is not intended to imply a trajectory of applications with measures moving from quality improvement to accountability applications. There is a large volume of measures used for internal quality improvement and certification that are not useful for public reporting and payment. However, some have asserted that all or most measures would benefit from an initial deployment period for internal quality improvement purposes to assess face validity to clinicians and providers, as well as to allow time to identify actionable strategies for improvement.

TAB 3

Date: September 15, 2010

To: QASC members

Re: High-Value Health Care Project – Update from QASC efforts to advance performance measure implementation: recommended practices/nationally consistent methods to collect clinically “enriched” performance results

Action required from QASC:

- *For your information.*

Background:

As discussed in a previous update to the QASC, the Robert Wood Johnson Foundation is funding a collaborative effort to analyze diverse care delivery systems’ processes for collecting and aggregating data to calculate clinically-enriched measures. Project objectives are to identify best practices in measure implementation processes and to promulgate nationally-consistent methods for these processes.

Since the June QASC meeting, staff has been in the process of completing phase 3 of the project, which includes the following:

- Assimilating and analyzing data collection/aggregation methods of participating sites gathered from using a comprehensive Site Assessment Protocol tool, to identify practices that could be used to guide more consistent measure implementation practices nationally;
- Conducting comparative analysis of technical specifications from the measures used by sites and the specifications provided by national endorsing bodies;
- Conducting follow-up calls with one or more staff at each participating site to determine that all outstanding questions regarding their performance measurement implementation efforts have been answered;
- Engaging project consultants and the NRI Work Group to develop a framework for determining best practices in measure implementation processes, to identify what are the ongoing challenges or barriers to consistent implementation of clinically-enriched measures to produce comparable results, and to identify best practices used by sites participating in this project; and
- Writing a draft report summarizing project findings and recommendations.

It is expected that project staff will be able to produce a final report for release in September 2010.

Next Steps:

The next meeting of the NRI Work Group is scheduled for October 27th from 3:30 – 4:40 p.m.

TAB 4

Date: September 15, 2010
To: QASC members
Re: Quality Project – Accuracy of Physician Reported Cancer Stage
for Analysis of the Quality of Cancer Care

Action required from QASC:

- *For your information.*

Background:

Systems for broad population evaluation of the quality of cancer care are critically needed. Existing systems, including cancer registries, do not provide sufficient information for timely quality assessment. Administrative claims data lack cancer staging data needed for analysis of the appropriateness of care. Linking claims and registry data is effective, but the data are still not timely. Staging data could be collected directly from oncology providers for linkage to claims. This strategy was used in the 2006 CMS Oncology Demonstration Project and is now used by UnitedHealthcare (UHC) in a program using claims to benchmark care against NCCN practice guidelines.

The accuracy of physician generated stage data has never been tested. To assess this tool for quality assessment, cases in the UHC program were matched with the cancer stage data on those cases from State Cancer Registries in the states with the most patients in the UHC program (Florida, Georgia, Ohio and Texas).

Physician-generated stage agreed with state cancer registry stage in approximately 80 percent of cases. There was more likely to be agreement for cases staged by physicians as stage 0, I, II, or III, possibly because some participating physicians reported the patient's current clinical status (recurrent/metastatic) rather than official stage defined as stage at diagnosis.

This strategy of using physician-generated stage for linkage to claims is attractive for quality improvement, but in its current form may not be sufficiently accurate for physician reimbursement or accountability. We will discuss implications of this approach and potential opportunities to refine it to be more useful for quality measurement/accountability purposes.

Next Steps:

- Collaborate with provider groups to get stage on broad population for linkage:
 - ASCO Quality Oncology Practice Initiative
 - American College of Surgeons National Cancer Data Base
 - Integrate with electronic record systems

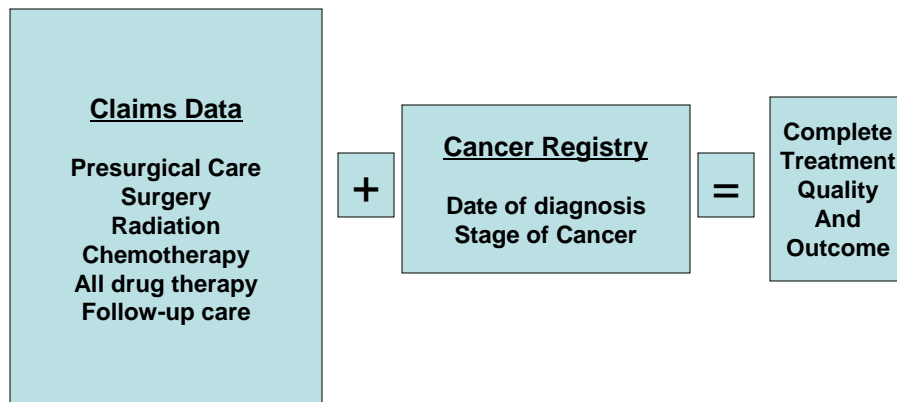
Accuracy of Physician Reported Cancer Stage for Analysis of the Quality of Cancer Care

Edge SB, Watroba N, Miller A, Roistacher J,
Newcomer LN, Dahlberg R, Wilk A, Legnini M

Roswell Park Cancer Institute
UnitedHealthcare
The Brookings Institution

Quality Alliance
Steering Committee

Advantages of Linking Claims and Registry



Quality Alliance
Steering Committee

2

Collecting Stage Data for Claims Linkage

- Cancer registry stage data may not be available for up to two years after diagnosis
- Alternative is to have physicians provide stage data directly to payer for linkage to claims
 - Timely
 - Direct – does not require other agreements

Direct Physician Reporting of Staging Data

- Technique used in 2006 Oncology Demonstration Project from CMS
 - Limited data reported
- Adopted by UnitedHealthcare for linkage to claims
 - Patterns of care
 - Quality benchmarking to NCCN guidelines

Key Issue: Accuracy of Physician Reported Stage

- Inaccurate recording of stage would lead to inaccurate assessment of the quality of care
- There has been no prior test of the accuracy of physician reported stage

Objective

- Compare the cancer stage reported to UnitedHealthcare by physicians for breast, colorectal and non-small cell lung cancer with the stage recorded in the state cancer registry.

Methods: Case Identification

- Beginning 10/1/2007, UnitedHealthcare identified insured persons:
 - Treatment of breast, colon, or lung cancer
- Physician contacted to provide stage and clinical data on “UHC Cancer Status Form”

Cancer Status Form

- Patient information
- Date of cancer diagnosis
- Stage (as of date of diagnosis)
- Current clinical status
 - Adjuvant therapy
 - Clinically disease free
 - Recurrent / metastatic disease
 - Deceased

UHC Cases Matched to State Cancer Registries

- Selected states with largest number of cases in the UHC Program
 - Florida; Georgia; Ohio; Texas

Privacy Protection

- IRB approved at Roswell Park; each state
- Needed fully identified data for matching
- Careful mechanisms to protect PHI

Staging Data Compared

- Physician generated – UHC
- State Cancer Registry

Unadjusted Stage Agreement Rates: State Registry and MD Generated

N=515	Stage Agreement Rate	95% Confidence Limits
Breast	82%	77% - 87%
Colorectal	81%	71% - 89%
Lung	74%	66% - 82%
Overall	80%	76% - 84%

Reasons for Non-Agreement: Use of “Stage IV”

- Stage defined as extent of disease at date of diagnosis
- Physicians often use “Stage IV” to describe any patient with recurrent or metastatic cancer
- Useful in clinical care, but this is inaccurate use of stage

Agreement by Reported Stage: Breast

N cases	Physician Reported Stage					
	0	I	I/II	III	IV	All
Registry- Reported Stage	0	I	I/II	III	IV	All
0	.	.	1	.	2	3
I	2	1	57	2	2	64
II	2	.	72	11	5	90
III	1	.	6	30	4	41
IV	.	.	.	1	19	20
All	5	1	136	44	32	218
Registry Stage 0 – III, MD Stage IV – 13 / 32 cases						

Physician Reported Stage More Accurate on Cases MD Stage I – III and Treated for Adjuvant or NED

Clinical Status	Breast	Colon	Lung	Total
Adjuvant Rx / NED	87%	81%	94%	85%
Metastatic / Dead	66% p=0.005	85% p=0.75	73% p=0.78	74% p=0.009

Conclusion

- Overall agreement between state registry and physician generated stage was 80 percent
- Agreement less for cases coded by physicians as Stage IV
 - Physicians may use Stage IV incorrectly for cases with recurrent cancer

Conclusions

- The level of accuracy is not high enough to use these data for defining reimbursement or physician accountability.
- Linkage of staging data and claims from private and public payers may be done in near real time.
- This strategy warrants further evaluation and broad implementation for quality assessment.

Next Steps

- Collaborate with provider groups to get stage on broad population for linkage
 - ASCO QOPI
 - American College of Surgeons National Cancer Data Base
 - Integrate with electronic record systems

TAB 5

Date: September 15, 2010
To: QASC members
Re: QASC Work Group updates

Action required from QASC:

- *For your information.*

Next Steps:

- QASC members will continue to receive periodic updates from Work Group chairs on the progress of Work Group activities throughout 2011.

Episodes of Care Work Group Updates

In 2010, the Episodes Work Group met on February 5, May 7 and August 13. At the February meeting, the Work Group received updates from Brookings/HVHC regarding the C3 project and from representatives from Detroit and Wisconsin about readmission measures testing. Some of the issues discussed by the Work Group included:

- Review of the C3 activities led by Brookings staff, including progress of refining the measure development, and preparing measure specification for NQF call for measure.
- Reviewed episode-based analysis related with asthma, congestive heart failure, diabetes, low back pain, and colon cancer.
- Review status of efforts in Detroit (with Save Lives Save Dollars) and Wisconsin (with the Wisconsin Collaborative for Healthcare Quality) to test readmission measures in their communities.

At the May meeting, the Work Group received updates on readmission measures testing from Wisconsin as well as Detroit pilot sites. Kevin Weiss from the American Board of Medical Specialties provided updates on the C3 project as well as potential pilot testing of cost-of-care measures.

The Episodes Work Group discussed the following issues:

- Kevin Weiss provided general updates regarding the status of the cost-of-care measure development project and informed the group that plan was under discussion to pilot-test the project's measures with Wisconsin Health Information Organization, and one or two Aligning Forces for Quality communities.
- Mary Gordon of the Wisconsin Collaborative for Healthcare Quality (WCHQ) and Devorah Rich of Greater Detroit Area Health Council (GDAHC) and Save Lives Save Dollars Detroit (SLSD) provided overview of efforts for pilot-testing readmission

measures. WCHQ was planning for reporting measures to participating providers as well publicly (at physician group level), and calculate measures for patients with specific conditions. Ms. Gordon commented on the challenges of getting a readmission rate evaluation process up and running, including getting unique patient identifiers to track readmission information beyond on single hospital level, incorporating additional service information at discharge and etc.

- Devorah Rich of GDAHC discussed multiple ongoing readmission measurement efforts in Michigan, including Michigan State Action on Avoidable Re-hospitalizations (MI STA*AR) and Better Outcomes for Older Adults through Safe Transitions (BOOST). This project was in its initial stages, with initial readmission rate reporting likely to take place in 2011. MI STA*AR, working with two hospitals in southeast Michigan and one in western Michigan, as well as the state's commercial HMO health plans, was looking to calculate readmission measures later in May. Hospitals would review their results in June, and then the project could expand further in subsequent months. BOOST is a collaborative with the University of Michigan and Blue Cross Blue Shield of Michigan to develop a "toolset" by which hospitals can identify high-risk patients, intervene (e.g., through discharge planning programs) to prevent readmissions, and measure the impact of select intervention tools. GDAHC was working with both efforts as a convening organization and to develop public reports for these efforts' computed results.
- The Work Group recommended looking at lessons of public reporting efforts of readmission measures from other states.

At the August 13 meeting, the Work Group received updates on the C3 project as well as pilot testing of cost-of-care measures. Some of the updates shared with the Work Group included:

- Introduction of new addition to Brookings staff – Sophie Shen and Iris Chan.
- Joachim Roski informed the Work Group about the priorities and key issues to be discussed at next QASC meeting:
 - Identify best practices of measure development and disseminate the best practices for broad use.
 - Integrate with and inform other health care reform activities including health IT meaningful use and Cost of Care measures to be led by CMS.
- Dr. Roski also mentioned strategic collaboration between QASC and NQF when one group member asked how QASC's activities relate with NQF's. The objective of the joint task force is to work collectively to make information about measure development and the implementation process available. The NQF-QASC discussion will focus on the following key areas:
 - Steps need to be focused during full endorsement process
 - Developing measures that are easy to implement
 - Defining viable data collection practices
 - Building partnerships with measure stewards
- QASC and NQF have drafted a report on enhancing availability of performance information, which will be shared with the QASC in September.
- Updates on cost-of-care measures including rerunning all the measures except for GERD using 2008 claims and preparing materials to prepare NQF call for measures, which

might take place later this year. Rerunning measures using 2008 claims will improve the internal validity of measure calculation and increase the chance for NQF endorsement.

- Brookings staff provided updates on pilot testing cost-of-care measures with WHIO and RWJF Alliance for Quality communities. The contracts for pilot testing have been in place and would kick off the project in late August and early September.

The next Episodes meeting is scheduled for November 19, from 1:00-2:00 p.m. EST.

Measurement Implementation Strategy (MIS) Work Group Updates:

In 2010, the MIS Work Group met on February 2 and May 17. At the February meeting, the Work Group received updates from American Health Insurance Plan Foundation (AHIPF) staff regarding the data aggregation project and from Brookings/HVHC staff regarding the Racial/Ethnic Health Care Equity Initiative (REHEI). Some of the issues discussed by the MIS Work Group included:

- Review of the data aggregation activities led by AHIPF, including outreach efforts in Colorado and Florida, the status of efforts to beta-test data aggregation and submission software platforms, and the progress of the National Committee for Quality Assurance (NCQA) to validate the methods employed in the project's software tools.
- Review of the planned agenda for the March 25 Racial/Ethnic Equity Conference to be held at the National Press Club in Washington, DC.

At the May meeting, the MIS Work Group received updates on how the QASC is re-orienting itself in the face of health care reform passage. QASC will have a new focus on implementation. Current activities related to cost-of-care and health equity will expand to include collaborations with regional organizations to pilot-test measure methods and to focus on electronic data collection.

The MIS Work Group discussed the following issues:

- Review of an REHEI paper that made recommendations about the collection and use of race and ethnicity data by stakeholders and the public sector. The paper touched on some of the most promising, practical approaches for using these data as well as some of the potential unintended consequences of other approaches.
- Enriching claims data with clinical data. Specifically, the MIS Work Group reviewed an HVHC issue brief that discusses the utility of clinically-enriched data, the feasibility and replicability of the methods, and the financial viability of the methods. The issue brief also discusses considerations that registries face when deciding whether or not to participate in data integration projects.
- Linking hospital discharge data, lab results, and present-on-admission indicators to risk-adjust hospital outcomes measures. Virginia Health Information and the Agency for Healthcare Research and Quality piloted the data linkage project, demonstrating that the data linkage improved risk adjustment and measure quality. HVHC prepared a brief

highlighting the effort, methods, best practices, and how data linkage can improve measure credibility.

The next MIS meeting is scheduled for November 8, from 3:00-4:00 p.m. EST.

National-Regional Implementation Work Group Updates:

The National-Regional Implementation Work Group met in July and September to provide guidance and support to project staff regarding the ongoing efforts of the RWJF-funded Advanced Measurement Best Practices Project (AMP). The AMP Project is intended to identify best practices in measure implementation methods and explore how they may become the basis for nationally consistent data collection and aggregation approaches across the public and private sectors. The Work Group reviewed the preliminary findings and provided input on the recommended practices identified from the project.

Additionally information on the activities of the National-Regional Implementation Work Group is available within this Tab and on the QASC website.

The next meeting of the National-Regional Implementation Work Group is scheduled for October 27, 2010.

Next Steps:

QASC members will continue to receive periodic updates from Work Group chairs on the progress of activities throughout 2010.

Quality Alliance Steering Committee – Episodes of Care Work Group
Meeting Notes – August 13, 2010

Work Group co-chair Chuck Cutler provided opening remarks for the meeting and walked through the call's agenda. New Brookings staff members introduced themselves (Sophie Shen and Iris Chan). Mr. Cutler then turned the call over to Joachim Roski, who provided overview of QASC priorities.

Dr. Roski informed the Work Group about the priorities and key issues to be discussed at next QASC meeting:

- Identify best practices of measure development and disseminate the best practices for broad use; and
- Integrate with and inform other health care reform activities, including health IT meaningful use and Cost of Care measures to be led by CMS.

Dr. Roski also mentioned strategic collaboration between QASC and NQF when one group member asked how QASC's activities relate with NQF's:

The objective of the joint task force is to work collectively to make information about measure development and the implementation process available. The NQF-QASC discussion will focus on the following key areas:

- Steps need to be focused during full endorsement process
- Developing measures that are easy to implement
- Defining viable data collection practices
- Building partnerships with measure stewards

Note: A report has been done between NQF and QASC on these key areas, and it will be shared with Work Group members.

Summary of current Cost of Care activities:

Project staff are now in the final stages of validating the project's 22 episode-based cost-of-care measures and testing most of them using 2008 claims (recently available from Thomson-Reuters). Staff are also preparing technical specifications for measures most likely to be called by NQF, such as diabetes, CHF, and low back pain. NQF's Call for Measures is likely to take place later in 2010.

Two measures are still undergoing revisions by their respective condition-specific work groups: breast cancer and GERD. The next work group calls are scheduled to take place in late August. Issues to be discussed at the next breast cancer work group include reviewing the measure results, including 2008 claims and other remaining issues. Issues to be discussed at the next GERD work group call include reviewing the results of 12-week GERD measures (during the last GERD call, the work group finalized two GERD-related measures: 12-month and 12-week).

Questions from WG members About the Impact of Using 2008 Claims to Test the Measures

- What is the implication of validating the measures using 2008 claims? Some Work Group members expressed concern with the potential impact on the measure results if there are shifts in practices between 2006 and 2008.

Project staff notes the impact will be minimal given all measures look at resource use for episodes identified within a relatively short timeframe (1 year), and patients' characteristics are relatively static within the timeframe. In addition, the exercise of testing the measures on 2008 claims is intended to validate the measure methods. This exercise will enhance internal validity and improve the chance for NQF endorsement. It is not intended to reflect current practice in 2010; as such (and given the absence of patient and provider identifiers) these results will not be used to inform quality improvement or reimbursement for evaluated providers.

Note: the Work Group member should continue with discussion on this topic at next QASC meeting.

Other Questions Raised by WG members:

The importance to differentiate public reporting and use the measure results for internal use by providers.

- This is a good point that the measure implementers should keep in mind and QASC can discuss further during in person meeting.

Brookings staff member Sophie Shen provided summaries on beta testing of Cost of Care measures in two pilot projects:

The beta testing provides field testing results for NQF full measure endorsement; promotes acceptance of cost of care measure among a large collection of stakeholders; and discusses barriers and solutions for measure implementation:

- Test cost of measures at one or two RWJF AF4Q communities beginning from Sept till August 2011, partnering with ABMS
- Test about six measures with WHIO data (07-08), partnering with ABMS and Thomson Reuters

Group members suggested monthly updates about two pilot testing projects share with the group by Brookings staff.

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QASC National-Regional Implementation (NRI) Work Group
July 20, 2010 – Conference Call Notes

Jim Chase welcomed the Work Group participants. Joachim Roski, Ayodola Anise, Sophie Shen, and Iris Chan from Brookings were also on the call.

The following is a review of the discussion points from the July 20 NRI Work Group conference call.

Ayodola Anise discussed preliminary results from the Advanced Measurement Best Practices (AMP) Project. Data collection and aggregation processes for each pilot site were assessed based on surveys, interviews with staff, documentation review, and site visits where necessary.

Preliminary results indicate the following:

- Sites tend to choose quality measures that align with national or regional initiatives, specifically IHA, HEDIS, and PQRI. However, many sites modify the specifications of these measures due to data source and collection constraints.
- Sites use a variety of different data sources and data collection methods when ideal data sources are not available. Some sites have successfully used “work around” solutions, such as web portals or mini patient registries to collect blood pressure and immunizations data.
- Sites favor harmonization of measure specifications and all sites seek to have stakeholder input and buy-in.

Sites also faced a number of challenges, including the following:

- Collecting certain types of information (e.g., immunization status) proved to be challenging, as this information is often not available to physicians.
- Provider-reported data is growing in volume; however, the data is sometimes inconsistent across sites.
- Penetration of EHRs among physicians is low. Additionally, even if a site had an EHR, automatically and electronically extracting data from the EHR to the external aggregator or warehouse was not possible.

Ms. Anise and Dr. Roski reiterated the goals of the conference call: 1) to discuss additional analyses that might be useful; and 2) to develop a framework for identifying recommendations that are useful to data owners, policymakers, and other stakeholders.

Work Group members began by discussing risk adjustment:

- Members expressed frustration with lack of information on case mix and risk adjustment and agreed that they have to find work-around methods.

- Dr. Roski noted that many sites do not risk-adjust because their measures are not going to be used for public reporting or pay-for-performance. In addition, many sites do not have enough data to risk-adjust.
- A Work Group member asked whether there was any way to find standards and compare risk-adjustment methods across organizations.
- Groups that risk-adjust their measures may find risk adjustment helpful for acceptability and buy-in. Work Group members found that adjusting their measures by insurance plan (Medicaid, Medicare, commercial) made them more palatable
- Work Group members agreed that different adjustment schemes have different levels of complexity and that the project should think about what to recommend to whom.

In response to a question from Aetna regarding consistency in patient attribution across sites, Brookings clarified that the analysis would compare site measures to HEDIS and PQRI. Aetna responded that they were curious because their attribution methods vary depending on the purpose of the measure. For example, a measure for payment incentives requires different attribution methods than a measure for quality improvement.

Members next discussed how to make best practice recommendations most useful:

- One Work Group member suggested that the project provide materials on the basics of data collection, including necessary tools, people, and expertise. Another member agreed that tool sets scalable to different data sources, purposes, and organization types would be useful.
- A member suggested that the project ask sites about data collection history, measurement creation processes, and rationales and creation processes for “work-around solutions” in order to get a better sense of what has worked in the past.
- A member suggested that the project stratify recommendations to accommodate organizations with different capabilities and resources for data.
- A member asked that the project include information regarding why particular pilot sites were chosen, including the elements of their data collection processes that made them example for other organizations.
- Work Group members suggested that the project provide benchmarks to help people know if they are doing things correctly. For example, what kind of match rates should be expected? What is very far off? In response, Dr. Roski noted that AHRQ has created an end-user-friendly set of decision points to address this issue.
- One member suggested that the project ask sites whether they thought their data efforts were worthwhile. For example, did sites have to reject bad measures? How much money was required to implement data processes?

- Another member requested that the project ask sites about partners. Work Group organizations have worked with LabCorp and others to gather clinical data.
- Work Group members expressed interest in hearing more about how the project fits with Meaningful Use. Members also asked if the project could point to a new direction from a policy perspective.

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QASC National-Regional Implementation (NRI) Work Group
September 1, 2010 – Conference Call Notes

The following is a review of the discussion points from the September 1 NRI Work Group conference call.

Jim Chase greeted the Work Group and summarized the goals of the call.

Ayodola Anise walked through the background and objectives of the Advanced Measurement Best Practices Project (AMP) and discussed recommendations regarding measure selection, data collection and aggregation, and measure specifications. Ms. Anise also identified areas in which lack of information made identification of best practices difficult. Ms. Anise asked the Work Group for input on additional analyses and recommendations as well as next steps.

Ms. Anise discussed measure selection and maintenance recommended practices, including the following: convening a standing internal measures/quality committee, review of national compendium of measures, alignment of measures with existing national and regional measures, selecting measures based on populations served, and periodic review of measures with the internal measures/quality committee. The Work Group provided the following input:

- Members agreed that measures should better align with areas of health care in which improvement is needed. Alan Glaseroff suggested that population-level data be used as a starting point to identify where problems exist. For example, data from the California statewide cancer registry had shown that his provider network needed to improve in diagnosing colorectal cancer. As a result, his group selected colorectal cancer screening as a performance measure.
- Mr. Chase agreed that measures should lead to change and address a population need rather than simply aligning with existing measures. Denise Love concurred and stated that many health plans already use statewide data to highlight areas where improvements in care are needed.

Work Group members next discussed recommendations for data collection and aggregation, including ensuring that data protection and secure data transfer practices are in place, use of work-around solutions (i.e., registries, web portals) to obtain clinical data when EHRs are not available, and use of a data intermediary. For organizations with EHRs and IT capacity, recommended practices included developing a data warehouse, use of NQF's Quality Data Set, and facilitating the electronic transfer/extraction of EHR data. Work Group members provided the following feedback:

- Mr. Glaseroff emphasized that it is difficult to create work-around solutions without funding. Most groups that create registries to record blood pressure, for example, are enabled by pay-for-performance payments. Recommendations on work-around solutions should therefore be specific to different levels of funding.

- Another Work Group member concurred and suggested that QASC recommend obtaining funding and buy-in as a best practice in the creation of work-around solutions.
- Ann Woo echoed Mr. Glaseroff's comments and suggested that measures be aligned with Meaningful Use in order to ensure funding through performance incentives. Mr. Glaseroff agreed that QASC should focus on Meaningful Use rather than NQF-endorsed measures since Meaningful Use is already aligned with performance incentives and also aligns very well with NQF.
- Mr. Glaseroff suggested that QASC also formulate recommendations on compliance with HIPAA regulations. Health plans can avoid dealing with HIPAA if they receive aggregated data from providers, but aggregate data is not useful for auditing. Patient-level data is useful for auditing but requires HIPAA compliance.
- Mr. Glaseroff stated that more and more health plans are using ASP-based applications. This method, which stores data in the cloud rather than on in-house servers, makes data extraction difficult. Therefore, QASC should tailor its data extraction recommendations to different data storage methods.

Ms. Anise next discussed variation in measure specifications between sites. Sites modified measure specifications based on both user preference and system limitations. Ms. Anise recommended that plans make measure specifications explicit and produce data dictionaries to improve transparency in how measures are calculated.

- Work Group members agreed that measures designed for large health plans may not work for smaller health plans and provider groups, especially for uncommon conditions with small denominators.
- Mr. Glaseroff voiced frustration that quality organizations are turning to rarer and rarer conditions in order to increase the size of the measure set. Preventive screening measures (e.g., breast cancer) have large enough denominators to work for small plans, but most other measures do not. Mr. Glaseroff suggested that QASC recommend ways to identify conditions with too few denominator cases at the outset; this would help providers avoid collecting data only to later realize that the denominator was insufficient for measure submission.
- Aparna Higgins suggested that sites be asked about encountering these sorts of problems with HEDIS measures. Ann Woo stated that HEDIS cardiac measures do not work even in the 300,000-person Hill Physicians plan and recommended that NCQA look at the granular level when designing measures.
- Mr. Chase confirmed that plans often modify measure specifications (e.g., patient attribution) to increase the number of denominator-eligible patients.

- Mr. Glaseroff proposed that groups of measures be combined into composite measures with sufficiently large denominators and recommended that QASC provide guidance on how to avoid producing unreliable data. Mr. Glaseroff also expressed frustration with the lack of pediatric performance measures beyond BMI measurement and immunizations.

Ms. Anise discussed areas in which best practices could not be identified, including physician attribution, member matching, data validation and verification, and case/risk adjustment. Ms. Anise then suggested next steps for QASC and the NRI Work Group, including developing a toolkit to assist organizations with data collection and use, convening a committee on measure harmonization, and supporting further research in areas in which best practices are still emerging. Work Group members discussed these recommendations and additional next steps:

- Mr. Chase recommended that QASC form a user group consisting of individuals from each pilot site to discuss best practices and practices in general. This group would help address the lack of easily-identifiable best practices in certain areas.
- Mr. Glaseroff recommended that measure harmonization occur at the payer level, since plans often select measures based on the availability of pay-for-performance funding. Mr. Glaseroff suggested looking at the work of Integrated Healthcare Association and Mark Smith at the California HealthCare Foundation to harmonize payers in California.
- A Work Group member stated that QASC should focus primarily on best practices for data collection rather than on measure selection and harmonization. QASC should have a translational role, providing guidance on how to make measures work at a regional level for different delivery systems.
- Mr. Glaseroff distinguished health measures (e.g., population-level death rates) from health care measures (e.g., individual patient experience) and suggested that more health measures be included in performance data sets.
- Mr. Glaseroff suggested that QASC provide recommendations on how to collect patient survey measures and proposed looking at the medical home model for guidance in this regard. Mr. Glaseroff also recommended that QASC provide guidelines on how to better integrate patient-collected data with provider-collected data, since certain information (e.g., blood pressure) may be most reliable when collected at home.