

# Performance Measurement

Accelerating Improvement



# Redesigning Health Insurance Project

Ongoing Congressional concern about uneven quality and the slow pace of improvement

# Redesigning Health Insurance Project

MMA (PL 108-173) mandated *two* studies

- Sec 328 – study of performance measures and their use to align payment with performance
- Sec 109 – study of Medicare’s Quality Improvement Organization program

The committee empaneled by the IOM will produce *three* reports:

- Performance Measurement Report
- Payment Incentives Report
- Performance Improvement Report

# Committee Members

Steven A. Schroeder - *Chair*, University of California, San Francisco

Bobbie Berkowitz, University of Washington

Donald M. Berwick,\* Institute for Healthcare Improvement

Bruce E. Bradley, General Motors Corporation

Janet M. Corrigan, National Committee for Quality Health Care

Karen Davis, The Commonwealth Fund

Nancy-Ann Min DeParle, JP Morgan Partners, LLC

Elliott S. Fisher,\* Dartmouth Medical School

Richard G. Frank, Harvard Medical School

Robert S. Galvin, General Electric Company

David H. Gustafson, University of Wisconsin

\*Subcommittee on Performance Measures Co-chairs

# Committee Members

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Alan R. Nelson, American College of Physicians

Norman C. Payson, NCP, Inc.

William A. Peck, Washington University School of Medicine

Neil R. Powe, Johns Hopkins University

Christopher Queram, Wisconsin Collaborative for Healthcare Quality

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William C. Richardson, W.K. Kellogg Foundation

Cheryl M. Scott, Group Health Cooperative

Stephen M. Shortell, University of California Berkeley

Samuel O. Thier, Harvard Medical School and Massachusetts General Hospital

Gail Wilensky, Project HOPE

# Why performance measurement?

- Gap remains wide between the bold vision laid out in the *Quality Chasm* report and the current state of the U.S. health care delivery system
- Performance measurement is believed to be the key to further progress—regardless of approach
  - Public reporting to support payer and patient choice
  - Quality improvement initiatives
  - Professional and institutional accreditation
  - Pay for performance

# Limitations of the current system

- Current approaches—relying on voluntary, consensus-based efforts—are not up to the task
- Bold national goals are unlikely to be established
  - Current entities lack the authority or leadership required to formulate such goals

# Limitations of the current system

## Measures are likely to remain limited

- Bold measures are unlikely if consensus required
- Domains without “owners” will remain unaddressed (e.g. efficiency, equity, and patient-centeredness)
- Measures may be suspect—if perceived to reflect interests of powerful stakeholders rather than the public
- Wasteful duplication and inconsistency will remain—causing confusion in the public and undue burden to providers

# Limitations of the current system

## Key public goods will receive inadequate investment

- Research to address gaps in current measures
- Data collection, validation, and aggregation methods
- Development and release of useful and meaningful reports to all stakeholders, including the public
- Learning how best to use measurement to foster improvement

The committee believes that a well-coordinated, national performance measurement and reporting system is needed to overcome the limitations of the current “non-system”



# Alternatives considered

1. Large federal entity
2. Office within CMS or AHRQ
3. Other stakeholder groups

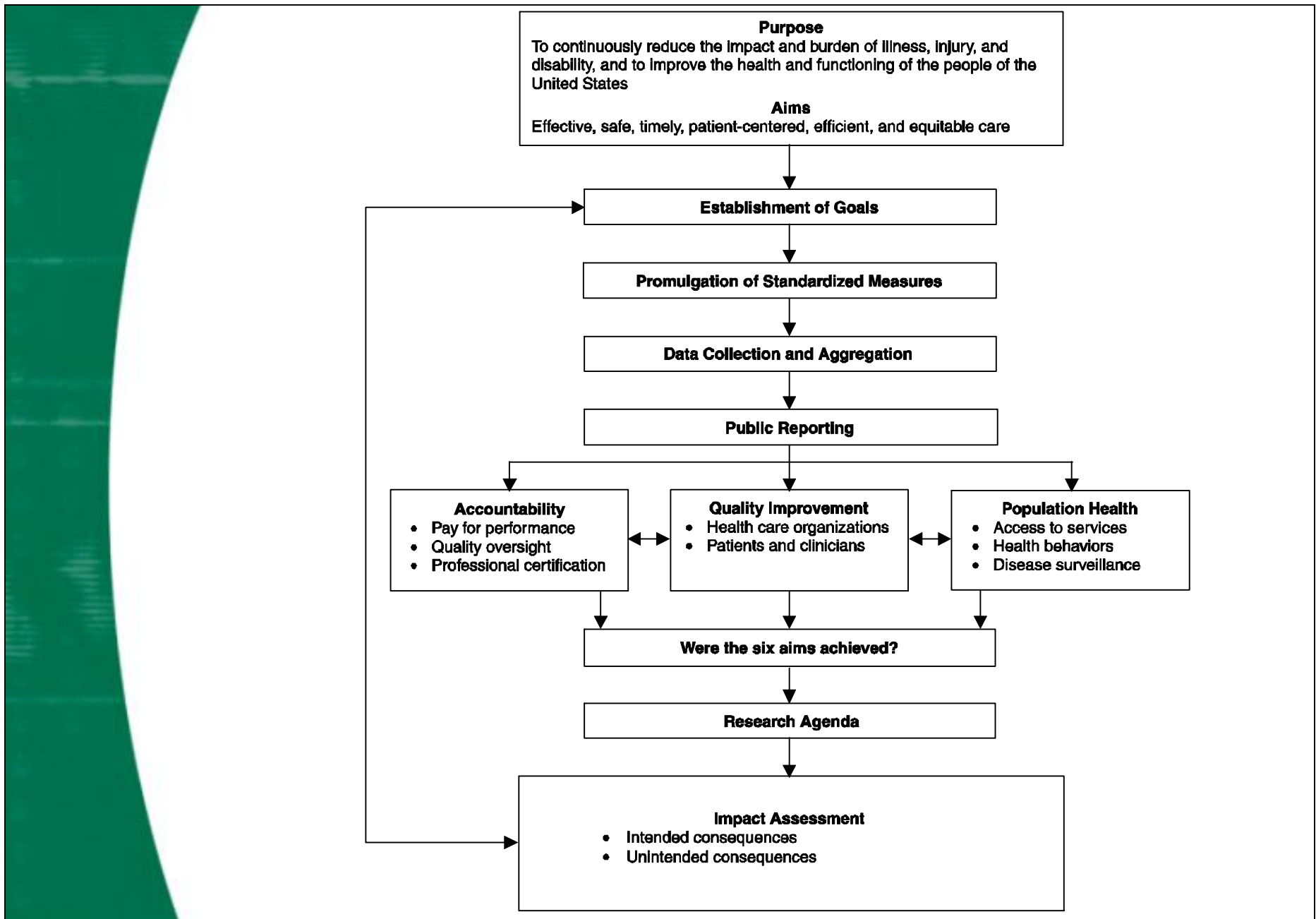
*None felt likely to succeed*


# Best alternative

4. New, independent board—National Quality Coordination Board—housed within the Department of Health and Human Services

# Committee recommendations

1. Establish the National Quality Coordination Board (NQCB) to:
  - Set clear aims and goals for health care system
  - Coordinate and fund development of needed measures
  - Ensure data collection, aggregation, and public reporting
  - Evaluate impact of performance measurement and reporting system



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The National Quality Coordination Board is intended to supplement and strengthen—not replace—ongoing activities in both the public and private sectors

# Committee recommendations

2. Ensure that the NQCB has independence, expertise, integrity, and sufficient resources
3. Foster local innovation in performance measurement aligned with national goals

# Committee recommendations

## 4. Initiate performance measurement and public reporting *now*

- Endorse current consensus based measures
- Ensure creation of data collection and reporting system
- Ensure provision of technical support to providers

# Starter Set

## **Ambulatory Care**

### **Ambulatory care Quality Alliance (26)**

Prevention measures<sup>a</sup> (7), coronary artery disease<sup>a</sup> (3), heart failure<sup>a</sup> (2), diabetes\* (6), asthma<sup>a</sup> (2), depression<sup>a</sup> (2), prenatal care<sup>a</sup> (2), quality measures addressing overuse or misuse (2)

### **Ambulatory Care Survey**

CAHPS Clinician and Group Survey: getting care quickly, getting needed care, how well providers communicate, health promotion and education, shared-decision making, knowledge of medical history, how well office staff communicate

<sup>a</sup>The committee recommends the aggregation of individual measures to patient-level composites for these areas.

# Starter Set

## Acute Care

### **Hospital Quality Alliance (22)**

Acute coronary syndrome<sup>a</sup> (7), heart failure<sup>a</sup> (3), pneumonia<sup>a</sup> (6), smoking cessation<sup>a</sup> (3), surgical infection prevention<sup>a</sup> (from the Surgical Care Improvement Project) (3)

**Structural measures** (computerized provider order entry, intensive care unit intensivists, evidence-based hospital referrals)

### **Hospital CAHPS**

Patient communication with physicians, patient communication with nurses, responsiveness of hospital staff, cleanliness/noise level of physical environment, pain control, communications about medicines, discharge information

<sup>a</sup>The committee recommends the aggregation of individual measures to patient-level composites for these areas.

# Starter Set

## **Health Plans and Accountable Health Organizations**

### **Health Plan Employer Data and Information Set (HEDIS) (61)**

Integrated delivery systems (health maintenance organizations): effectiveness (26), access/availability of care (8), satisfaction with the experience of care (4), health plan stability (2), use of service (15), cost of care, informed health care choices, health plan descriptive information (6)

Preferred provider organizations within Medicare Advantage: selected administrative data and hybrid measures

### **Ambulatory Care Survey**

CAHPS Health Plan Survey: getting care quickly, getting needed care, how well providers communicate, health plan paperwork, health plan customer service

# Starter Set

## **Long-term Care**

### **Minimum Data Set (15)**

Long-term care (12), short-stay care (3)

### **Outcome and Assessment Information Set (11)**

Ambulation/locomotion (1), transferring (1), toileting (1), pain (1), bathing (2), management of oral medications (1), acute care hospitalization (1), emergent care (1), confusion (1)

## **End-Stage Renal Disease**

### **National Healthcare Quality Report (5)**

Transplant registry and results (2), dialysis effectiveness (2), mortality (1)

## **Longitudinal measures of outcomes and efficiency**

1-year mortality, resource use, and functional status (SF-12) after acute myocardial infarction

# Gaps in current performance measures

<u>Gap</u>	<u>Approaches to Address Gap</u>
Lack of comprehensive measures	Equity, efficiency, patient-centeredness
Narrow time window	Longitudinal measurement and care transitions
Provider-centric focus	Composite, population-based, and systems-level measures
Narrow focus of accountability	Shared accountability

# Committee recommendations

5. The NQCB should pursue an aggressive research agenda to fill gaps, address methodological issues, and learn from performance measurement efforts
6. Congress should provide adequate funding to carry out the research agenda

# Potential concerns and responses

The NQCB is too bureaucratic

The NQCB provides central leadership that will reduce the bureaucracy inherent in multiple, uncoordinated efforts and requirements

The NQCB is too complicated

The NQCB will simplify performance measurement by providing clear goals, a phased approach to implementation, and alignment of measures

# Potential concerns and responses

The NQCB is too burdensome for providers

The NQCB is a threat to patient privacy

The NQCB will stifle local innovation

The NQCB will decrease burden by substituting uniform reporting framework

The NQCB will ensure confidentiality in strict compliance with the Health Insurance Portability and Accountability Act

The NQCB will serve as a foundation upon which local efforts can build

# Potential concerns and responses

*Is this a proper role for the federal government?*

No other stakeholder has the authority, resources or leverage to achieve the required degree of coordination

Execution through CMS will catalyze change throughout the system

# NQCB will benefit all stakeholders

- *For Patients*—ensures bold vision of earlier IOM reports translated into aims and goals for improvement and a system to support these goals
- *For Providers*—reduces duplication, inconsistency, and risk that measures won't be sustained

# NQCB will benefit all stakeholders

- *For Payers*—addresses need to improve the quality and efficiency of the system
- *For stakeholders involved in measurement efforts*—coordinates activities and provides additional funding

# Supplemental Slides

# Subcommittee Members

Donald M. Berwick – *Co-chair*, Institute for Healthcare Improvement

Elliott S. Fisher – *Co-chair*, Dartmouth Medical School

Patricia Gabow, Denver Health and Hospital Authority

Lillee Gelinas, VHA, Inc.

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Paul Wallace, Kaiser Permanente Care Management Institute

# Recommendation 1

**Congress should establish a National Quality Coordination Board (NQCB) with seven key functions:**

**Specify the purpose and aims for American health care.**

**Establish short and long-term national goals for improving the health care system.**

**Designate, or if necessary develop, standardized performance measures for evaluating the performance of current providers, and monitor the nation's progress toward these goals.**

**(continues)**

# Recommendation 1 (continued)

- Ensure the creation of data collection, validation, and aggregation processes.**
- Establish public reporting methods responsive to the needs of all stakeholders.**
- Identify and fund a research agenda for the development of new measures to address gaps in performance measurement.**
- Evaluate the impact of performance measurement on pay for performance, quality improvement, public reporting, and other policy levers.**

## Recommendation 2

**The NQCB's membership and procedures should be designed to ensure that the board has structural independence, protection from undue special interests, substantive expertise drawn from the public and private sectors (including not-for-profit entities), contract authority, standards-setting authority, financial strength, and external accountability.**



## Recommendation 3

**Local innovation in pursuit of national goals for improving health care quality should be encouraged. Performance measurement, improvement, and reporting activities—including those of public and private purchasers; accreditation and certification entities; and federal, state, and local government programs—should be substantially aligned with the national goals and standardized measures established by the NQCB, but local communities should also be encouraged to identify and pursue local priorities, in addition to helping to achieve national goals.**

# Recommendation 4

**The NQCB should promulgate measure sets that build on the work of key public- and private-sector organizations. Specifically, the NQCB should:**

**As a starting point, endorse as national standards performance measures currently approved through ongoing consensus processes led by major stakeholder groups.**

**Ensure that a data repository system<sup>1</sup> and public reporting program capable of data collection at the individual patient level are established and open to participation by all payers and providers.**

**Ensure that technical and financial assistance is available to all providers who need help in establishing performance measurement and improvement capabilities.**

<sup>1</sup>The data repository system would collect, validate, and aggregate provider performance data (see Recommendation 1).

# Recommendation 5

**The NQCB should formulate and promptly pursue a research agenda to support the development of a national system for performance measurement and reporting. The board should develop this agenda in collaboration with federal agencies and private-sector stakeholders. The agenda should address the following:**

**Development, implementation, and evaluation of new measures to address current gaps in performance measurement.**

**Applied research focused on underlying methodological issues, such as risk adjustment, sample size, weighting, and models of shared accountability.**

**Design and testing of reporting formats for consumer usability.**

**Evaluation of the performance measurement and reporting system.**

## Recommendation 6

**Congress should provide the financial resources needed to carry out the research agenda developed by the NQCB. The Agency for Healthcare Research and Quality should collaborate with Grantmakers in Health and others that have ties to local foundations to convene public- and private-sector stakeholders currently investing in various aspects of this research agenda for the purpose of identifying complementary investment strategies.**