

Quality Alliance Steering Committee: Expansion Workgroup: Recommended Value Exchange Chartering Terms February 22, 2007

These recommendations reflect the deliberations of the Expansion Workgroup as well as comments received from the Quality Alliance Steering Committee (QASC) and many stakeholders across the country. The Workgroup has reached consensus recommendations on a number of critical areas. This report summarizes the Workgroup's agreements regarding "Chartering Terms" for Value Exchanges (VEs) in eight core functional areas. In addition, three major issues that will be ongoing during the implementation of VEs are highlighted at the end of the document. Organizations that are selected to be VEs will have the benefit of participating in a Learning Network being managed by the Agency for Healthcare Quality and Research (AHRQ). This document is being presented to AHRQ as input.

The report is organized in the following sections:

- I. Core Functions of Value Exchanges (VEs)
- II. Core Functions: Principles and Chartering Terms
- III. Selection Criteria and Chartering Benefits
- IV. Major Ongoing Issues (National/Local Aggregation; Balancing Urgency with Need for Standardization; and Need for Business Model)

Appendix: Summary List of Chartering Terms: Expectations and Conditions of Designation

Overall Comment from the Expansion Work Group:

The Workgroup believes there will be ongoing tension between the desire to act on the core purpose of bringing rationality, harmonization and standardization to measurement efforts and having innovation – whether local or national – that is needed to develop new endorsed measures. Just as there is an effort to harmonize performance measures, there needs to be a concerted effort to harmonize the work of transparency initiatives by having a clear, agreed upon destination and accompanying road map. As a nation, we need far greater clarity and coordination both among the national committees, government entities and private organizations. Furthermore, we need far better coordination of roles at the national level and clarification of how those roles relate to local community efforts. These roles need to be communicated to local communities to support the implementation of measures. While this is out of the scope of the Expansion Work Group, it is essential to the success of the Value Exchanges as well as our broader common goal of fostering the efficient collection and use of performance measures throughout the country.

I. Core Functions of Value Exchanges (VEs)

- A. Facilitate collection of provider-level (e.g., physician, practice site, medical group, hospital) measurement across the six IOM performance domains (safe, timely, effective, efficient, equitable, patient-centered)
- B. Use (or promote use of) performance measures and consumers' cost for public/consumer reporting
- C. Use (or promote use of) performance measures to reward and foster better performance
- D. Use (or promote use of) performance measures for improvement directly by providers
- E. Foster collaboration across multiple stakeholders (e.g., physicians, hospitals, consumers, private and public purchasers, quality improvement providers, and local information exchanges) in the community of interest and serve as a hub for sharing information and dialogue
- F. Promote the use of interoperable health information technologies for measurement as appropriate and collaborate with health information sharing processes and in the adoption of these technologies
- G. Support knowledge transfer -- share lessons learned and participate in learning collaboratives with other similar projects
- H. Conduct evaluation of efforts

II. Core Functions: Principles and Chartering Terms

To ensure the rapid national implementation of core consensus performance measures, while fostering local use of that performance information for consumer reporting, rewards and quality improvement the Workgroup recommends the "Hybrid Model". The Hybrid Model consists of collecting or exchanging provider-level data at the local level to generate performance information and having some centralized data aggregation at the national level. This model must provide for local-to-local and local-to-national comparisons and identifying "benchmark" performance. Performance results by provider will be made available to Value Exchanges as numerators and denominators (or other appropriate method), assuring the security and privacy of patient information.

The Hybrid Model gives local communities the flexibility to collect data in a manner that reflects the capacity of the community and does not necessarily require them to have the expertise in data aggregation. As a result, VEs will need to demonstrate/test the extent to which the development of performance results is most efficiently done through: aggregation of raw data; combining particular performance results; or a distributive model that generates results based on accessing multiple data sources. For example, some VEs may have the capacity for data collection through health information exchange (HIE), while others may need to rely on administrative databases or chart review. This also allows for use of different data collection methods within a community. Some data may be collected through HIE, some through ancillary services (e.g., testing facilities for laboratory or radiology), some through patient surveys, etc.

In addition to collecting core AQA identified measures and using or promoting the use of nationally collected HQA measures, the Workgroup recommends that provisions be made to allow for both national and local measurement activity to address areas where there are gaps in national consensus performance measures (e.g., full episodes of care from the patient's perspective, issues of disparity and equity). VEs should serve as testing grounds for additional measures or methods to inform national standards. However, as testing grounds efforts must be made to coordinate the measures or methods being tested. Such methods and testing should be in line with national priorities and ultimately go through a consensus-based process for endorsement/adoption.

What follows below are the eight core functions along with the principles that are supported by each and the chartering terms. While the goal is that a Value Exchange would be able to meet all the chartering terms, we recognize this might not initially be the case. While all Value Exchanges need to meet minimum expectations, the Expansion Committee has set forth a high-bar that captures all we would want them to be. Given that candidates to be Value Exchanges will represent a spectrum of capacities there needs to be some flexibility in allowing entities to grow into meeting all of the chartering terms.

A. Facilitate collection of provider-level (e.g., physician, practice site, medical group, hospital) measurement across the six IOM performance domains (safe, timely, effective, efficient, equitable, patient-centered)

Principles:

- Commitment that performance measures and results are a “public good” – generally available for use
- Collection of measures should be done in the context of what is feasible and does not place unnecessary burden on providers, especially when measuring episodes of care and across different providers
- “Local use” of performance measures collected at higher levels (e.g., statewide or nationally)
- Processes need to be in place to promote benchmarking of local communities to state or national comparisons
- Efficiency of methods of measurement should be tested and most efficient methods promoted. In particular, two critical questions that need to be addressed collectively by the VEs are:
 - Should the generation of performance results occur through mechanism of actual aggregation of raw data; through aggregation of summary performance results; through a distributive model that provides for accessing elements of data needed from various sources to generate performance results.; and
 - To what extent should (or should not) collection include actual manual provision for extracting data from medical records; if it does include such abstraction, what are the methods, audit processes and financial models so support physicians' collection of this information.
- Phase-in measurement of additional providers/delivery sites

Chartering Terms: Expectations and Conditions of Designation

1. Seek to measure at the most granular and appropriate level (e.g., physician, practice site, medical group and hospital)
2. Seek to measure across and inclusive of all of the IOM six performance domains (safe, timely, effective, efficient, equitable, patient-centered)
3. Promote local use of HQA measures collected nationally assuring there are not redundant collection demands placed on hospitals
4. Where statewide collection is more efficient (e.g. using statewide private health plan, Medicaid and Medicare data), provisions must be made to make performance results available to local communities
5. Seek to reflect care provided under federal, state and private payers (e.g., combining as possible Medicare, Medicaid, employment-based and individual coverages), and as possible the Veterans Administration and Department of Defense
6. As needed, conduct legal review to assure that anti-trust issues are considered
7. Actively engage all stakeholders in processes being used (physicians, health plans, hospitals, consumers, purchasers), and as appropriate for the community local QIO, health information exchanges, medical societies, and public health departments
8. Agree to share performance results as a “public good” to promote use of standard measures
9. Be fully transparent (e.g., posting on web, sharing in open meetings, etc.) on all measurements and measurement processes
10. Demonstrate/test the extent to which it is possible to efficiently collect all AQA chart-based consensus measures (selected sites)
11. Implement tested processes for physician or hospital measure collection/aggregation
12. For measures that have not been through consensus:
 - a. Apply national standards to measure selections (e.g. AQA Principles for Measure Selection and Consumer-Purchaser Disclosure Project Principles of Measure Selection)
 - b. Seek to answer core questions identified by AQA and others (e.g. risk adjustment; sample size; transition to clinical/outcome measures; when administrative versus other source data is appropriate)

B. Use (or promote use of) performance measures for public/consumer reporting

Principles:

- At whatever level of collection, performance information created is a “public good” that should be available for any users
- Where performance reporting is done by a third-party using measures aggregated nationally or by a Value Exchange, there should be mechanisms to assure that the basis of any reporting is transparent and subject to review
- There needs to be support for linking consumers’ cost of care with the performance information collected

Chartering Terms: Expectations and Conditions of Designation

1. Develop or foster development of useable reports for consumers on performance information in all of the major performance domains collected
2. Consumer reports should be at the most valid and appropriate “granular level” (e.g., physician, then practice site), with aggregation “up”
3. Disseminate performance information to consumers, seeking to promote access to performance information at “teachable moment” for consumers
4. Develop or foster reports that link quality and other performance information with costs relevant to consumers based on their circumstances
5. Provide the underlying performance information to entities that will use and distribute that information to consumers (e.g., health plans, state/local public agencies, private vendors)
6. Identify how relevant and actionable cost information – such as actual cost exposure of a patient for a total episode of care – can best be linked to performance information by those entities to which consumers are most likely to turn (e.g. health plans that have benefit and network design information)
7. Assess use of reports by consumers
8. Agree to follow AQA Principles for Public Reports on Health Care
9. To the extent Value Exchanges make performance information available to third-parties to present to consumers, they should make that release conditioned upon agreement to comply with consumer reporting principles (e.g., AQA Principles for Public Reports on Health Care)
10. Value Exchanges should agree that they will only be reimbursed for direct cost of providing performance information to requesting third-parties

C. Use (or promote use of) performance measures to reward and foster better performance

Principles:

- Measures, methodologies, and incentives/payment used in pay-for-performance programs should be as consistent as possible across plans and payers
- While there will be a diversity of performance information use by health plans and others to support improvement, those being measured should fully understand and provide input into such programs

Chartering Terms: Expectations and Conditions of Designation Exchange

1. Provide performance information to payers and purchasers (public and private) to support rewards programs and promote the use of standard performance measures and make that release conditioned upon agreement to comply with consumer reporting principles (e.g., AQA Principles for Public Reports on Health Care)
2. Assist programs implementing rewards programs in the design of appropriate severity/risk adjustment addressing both patient health risks and patients’ non-compliance related to physician’s orders evidenced by no-show appointment data or non-compliance with medical advice data
3. Agree to foster coordination in the use of performance information for payment or other reward programs across private health plans, purchasers and public purchaser

D. Use (or promote use of) performance measures for improvement directly by providers

Principles:

- Multiple disparate quality improvement efforts should be encouraged to be coordinated, use standard performance measures and to integrate their efforts

Chartering Terms: Expectations and Conditions of Designation

1. Provide performance information to support provider-level quality improvement
2. Foster coordination of quality improvement efforts among providers and across those delivering QI (e.g., physicians, hospitals, consumers, private and public purchasers, quality improvement providers, and local information exchanges)

E. Foster collaboration across multiple stakeholders (e.g., physicians, hospitals, consumers, private and public purchasers, quality improvement providers, and local information exchanges) in the community of interest and serve as a hub for sharing information and dialogue

Principles:

- Engagement of all major stakeholders is needed for optimal collaboration and success in meeting the goals principles outlined in this document

Chartering Terms: Expectations and Conditions of Designation

1. Engage all key stakeholders in the community in planning and implementation of measurement and use of performance measures. Key stakeholders should include representatives of the perspectives of physicians, hospitals, consumers, private and public purchasers, and quality improvement providers. Other stakeholders that may be engaged include local information exchanges or public health departments.
2. Promote adoption of common national measures and frameworks for use of those performance measures
3. Agree to “terms of engagement” that assure active dialogue, information sharing and participation from representatives of all stakeholders
4. Demonstrate the following organizational capacities:
 - Non-profit status
 - Staff/consultant arrangements to provide needed expertise
 - History of raising funds or in-kind support from multiple stakeholders
 - Ability to manage projects and finances

Additional dimensions of organizational history or structure that may be considered include: history of the entity, Board composition, and committee composition

F. Promote the use of interoperable health information technologies for measurement as appropriate and collaborate with health information sharing processes in the adoption of these technologies

Principles:

- Central goal of VEs and the national performance measurement enterprise should be to promote migration to routinely capture data elements for performance measures as part and parcel of care delivery process through electronic means (EHRs, etc)
- Technology (e.g., HIE, EHRs, PHRs, etc) needs to be structured to support data elements for performance measures

Chartering Terms: Expectations and Conditions of Designation

1. Leverage electronic information as available
2. Assess how data collection can be done more effectively by working in coordination with local regional health information exchanges or local IT efforts
3. Assess how local information exchanges/RHIOs are or are not actively facilitating performance measurement
4. Agreement to use and comply with relevant HITSP standards as applicable
5. Seek to work with information exchanges, RHIOs, QIOs and other groups integrally engaged in promoting local health IT initiatives

G. Share lessons learned/participate in learning collaboratives with other similar projects

Principles:

- Learning from each other is essential to having the best program in all communities and nationwide

Chartering Terms: Expectations and Conditions of Designation

1. Agree to share lessons learned on all functions and aspects of being a VE
NOTE: Specifics being developed by the Infrastructure Workgroup and AHRQ

H. Conduct evaluation of efforts

Principles:

- Evaluation of processes of each core function is essential to how VEs will be expanded in the future

Chartering Terms: Expectations and Conditions of Designation

1. Agree to participate in evaluation of VEs

III. Selection Criteria and Chartering Benefits

A. Selection Criteria for Value Exchanges.

The Expansion Workgroup recommends three “core” capacities that entities must demonstrate:

1. Measurement/auditing and aggregation - for those conducting or overseeing, the ability to do so **or** for those using from a source (e.g., national aggregators) the ability to implement use of measures effectively
2. Managing collaborative processes that engage all stakeholders
3. Organizational capacity to meet one and two above

For each of these areas, there should be clear measures to document how effectively an entity has or would fulfill each function.

The Expansion Workgroup recommends that capacity in other functional areas (e.g., Consumer Reporting; Rewards; Quality Improvement; and Integration with Health IT), are important capacities and the ability of a local group to implement them should be considered in assessing any potential program. Entities should either demonstrate capacity or provide information on where, how, and on what timeline they would acquire the expertise to conduct each function.

B. Benefits of Being Chartered

While the ultimate benefit is to provide higher quality and more efficient health care, the Expansion Workgroup noted many enabling benefits of being a VE– some of which would entail agreement from a range of entities or organizations. The major potential benefits identified were:

- Funding
- Performance Information or Data
- Support from Learning Network
- Imprimatur

	Sources/Implications	Issues
Funding	<ol style="list-style-type: none"> 1. CMS/AHRQ <ul style="list-style-type: none"> • May be limited to benefiting Medicare beneficiaries • Funding potential of 0 to unknown amounts 2. Private Funders (e.g., foundations, health plans, collaboratives) <ul style="list-style-type: none"> • Need to identify/arrange for agreements <p>For any funders, consider:</p> <ul style="list-style-type: none"> • Flat funding or funding of particular function • Limitations and restrictions on funding (by activity, region, population) • Mix of funding 	<p>To what extent can additional federal support from Medicare Trust Fund support expansion of VEs?</p> <p>How can the benefits of VEs be demonstrated to support public and private funding?</p> <p>How can business models be created such that national health plan support is not fractured?</p>
Performance Information or Data	<ol style="list-style-type: none"> 1. Data <ul style="list-style-type: none"> • Actual aggregation of results 2. Performance Results <ul style="list-style-type: none"> • Access to results from various sources 3. Sources: Medicare; Commercial Plan; Medicaid Plan; direct from Provider 	<p>What performance information sharing processes can avoid actual transfer of data?</p> <p>How can national health plans participate in processes that enable “single” submission or that make their allowing for access to data on agreed upon terms?</p> <p>How can local collaboratives have access to all payer performance information or data?</p>
Learning Network	<ol style="list-style-type: none"> 1. AHRQ or other national umbrellas 	<p>Note: See recommendations from Infrastructure Workgroup</p>
Imprimatur	<ol style="list-style-type: none"> 1. Rigor of selection will boost value 	

IV. Major Ongoing Issues

What follows are three issues that the Workgroup has discussed to which there are no “easy answers.” While the Workgroup feels the Chartering Terms partially address these issues, they will need to be reviewed on a regular basis as the measurement enterprise evolves.

Issue 1. National versus local aggregation. While the collection and use of measures will certainly be local (e.g., consumer reporting, payment and quality improvement), in many cases actual submission of data may be better done nationally. This national repository may then aggregate data from both local and national efforts. Many stakeholders expressed concern that rapid “expansion” to have many inconsistent local aggregation efforts would not foster the common goal of promoting rapid adoption of national performance standards. In particular, while there is agreement that collection of performance information should be done as efficiently as possible, there is not agreement regarding whether the “ideal” end state for aggregation of performance information is national, state or local. Also, there is significant concern about not meeting the reporting needs of national stakeholders (e.g., national employers and health plans).

Issue 2. Urgency to get better measures in use with few national standards. There is an inherent tension between the urgency felt by many stakeholders, the desire to promote a coherent national framework and the interest in allowing for local innovation that can foster the development of new national standards. Given the gap between ideal and real, how should the scope of potential Value Exchanges and their “Community of Interest” be defined? In the meantime, how can BQIs, new Value Exchanges or other entities address the needs of large national health care purchasers (including Medicare and Medicaid) for nationwide-consistent solutions and the need to fill key gaps in the array of measures in use?

Issue 3. Lack of demonstrated national “business model” to support performance measurement. While demonstration of a credible business plan to support performance measurement is noted as a core organizational criteria, the Workgroup recognizes that there are few national models of sustained performance measurement. The goal is to establish an ongoing measurement infrastructure that will be national in scope and local in implementation and use of measures. Assuring national consistency in how measures are collected may be challenged by local variation by differential capacity of the Value Exchanges to develop financing models for long-term sustainability.

Appendix

Chartering Terms: Expectations and Conditions of Designation

- A. Facilitate collection of provider-level (e.g., physician, practice site, medical group, hospital) measurement across the six IOM performance domains (safe, timely, effective, efficient, equitable, patient-centered)**
- A1. Seek to measure at the most granular and appropriate level (e.g., physician, practice site, medical group and hospital)
- A2. Seek to measure across the IOM six performance domains (safe, timely, effective, efficient, equitable, patient-centered)
- A3. Promote local use of HQA measures collected nationally assuring there are not redundant collection demands placed on hospitals
- A4. Where statewide collection is more efficient (e.g. using statewide private health plan, Medicaid and Medicare data), provisions must be made to make performance results available to local communities
- A5. Seek to reflect care provided under federal, state and private payers (e.g., combining as possible Medicare, Medicaid, employment-based and individual coverages), and as possible the Veterans Administration and Department of Defense
- A6. As needed, conduct legal review to assure that anti-trust issues are considered
- A7. Actively engage all stakeholders in processes being used (physicians, health plans, hospitals, consumers, purchasers), and as appropriate for the community local QIO, health information exchanges, medical societies, and public health departments
- A8. Agree to share performance results as a “public good” to promote use of standard measures
- A9. Be fully transparent (e.g., posting on web, sharing in open meetings, etc.) on all measurements and measurement processes
- A10. Demonstrate/test the extent to which it possible to efficiently collect all AQA chart-based consensus measures (selected sites)
- A11. Implement tested processes for physician or hospital measure collection/aggregation
- A12. For measures that have not been through consensus:
 - a. Apply national standards to measure selections (e.g. AQA Principles for Measure Selection and Consumer-Purchaser Disclosure Project Principles of Measure Selection)
 - b. Seek to answer core questions identified by Pilot Project Description and through other processes (e.g. risk adjustment; sample size; transition to clinical/outcome measures; when administrative versus other source data is appropriate)

Appendix (cont.)

Chartering Terms: Expectations and Conditions of Designation

B. Use (or promote use of) performance measures for public/consumer reporting

- B1. Develop or foster development of useable reports for consumers on performance information in all of the major performance domains collected
- B2. Consumer reports should be at the most valid and appropriate “granular level” (e.g., physician, then practice site), with aggregation “up”
- B3. Disseminate performance information to consumers, seeking to promote access to performance information at “teachable moment” for consumers
- B4. Develop or foster reports that link quality and other performance information with costs relevant to consumers based on their circumstances
- B5. Provide the underlying performance information to entities that will use and distribute that information to consumers (e.g., health plans, state/local public agencies, private vendors)
- B6. Identify how relevant and actionable cost information – such as actual cost exposure of a patient for a total episode of care – can best be linked to performance information by those entities to which consumers are most likely to turn (e.g. health plans that have benefit and network design information)
- B7. Assess use of reports by consumers
- B8. Agree to follow AQA Principles for Public Reports on Health Care
- B9. To the extent Value Exchanges make performance information available to third-parties to present to consumers, they should make that release conditioned upon agreement to comply with consumer reporting principles (e.g., AQA Principles for Public Reports on Health Care)
- B10. Value Exchanges should agree that they would only be reimbursed for direct cost of providing data to third-parties requesting performance information

C. Use (or promote use of) performance measures to reward and foster better performance

- C1. Provide performance information to payers and purchasers (public and private) to support rewards programs and promote the use of standard performance measures and make that release conditioned upon agreement to comply with consumer reporting principles (e.g., AQA Principles for Public Reports on Health Care)
- C2. Assist programs implementing rewards programs in the design of appropriate severity/risk adjustment addressing both patient health risks and patients’ non-compliance related to physician’s orders evidenced by no-show appointment data or non-compliance with medical advice data
- C3. Agree to foster coordination in the use of performance information for payment or other reward programs across private health plans, purchasers and public purchaser

D. Use (or promote use of) performance measures for improvement directly by providers

- D1. Provide performance information to support provider-level quality improvement
- D2. Foster coordination of quality improvement efforts among providers and across those delivering QI (e.g., physicians, hospitals, consumers, private and public purchasers, quality improvement providers, and local information exchanges)

Appendix (cont.)

Chartering Terms: Expectations and Conditions of Designation

E. Foster collaboration across multiple stakeholders

- E1. Engage all key stakeholders in the community in planning and implementation of measurement and use of performance measures. Key stakeholders should include representatives of the perspectives of physicians, hospitals, consumers, private and public purchasers, and quality improvement providers. Other stakeholders that may be engaged include local information exchanges.
- E2. Promote adoption of common national measures and frameworks for use of those performance measures
- E3. Agree to “terms of engagement” that assure active dialogue, information sharing and participation from representatives of all stakeholders
- E4. Demonstrate the following organizational capacities:
 - Non-profit status
 - Staff/consultant arrangements to provide needed expertise
 - History of raising funds or in-kind support from multiple stakeholders
 - Ability to manage projects and finances

F. Promote the use of interoperable health information technologies for measurement as appropriate and collaborate with health information sharing processes in the adoptions of these technologies

- F1. Leverage electronic information as available
- F2. Assess how data collection can be done more effectively by working in coordination with local regional health information exchanges or local IT efforts
- F3. Assess how local information exchanges/RHIOs are or are not actively facilitating performance measurement
- F4. Agreement to use and comply with relevant HITSP standards as applicable
- F5. Seek to work with information exchanges, RHIOs, QIOs and other groups integrally engaged in promoting local health IT initiatives

G. Share lessons learned/participate in learning collaboratives with other similar projects

- G1. Agree to share lessons learned on all functions and aspects of being a VE
NOTE: Further specifics being developed by the Infrastructure Workgroup and AHRQ

H. Conduct evaluation of efforts

- H1. Agree to participate in the evaluation of VEs
Note: specifics being developed by the Infrastructure Workgroup and AHRQ