

February 11, 2009

Dear Colleague,

We recently provided you with information on a collaborative effort involving leadership from the Quality Community that has developed recommendations for the Obama Administration and Congress as they tackle health care reform. We are pleased to report that nearly 130 organizations have signed-on in support of the recommendations included in [Building a Foundation for High Quality, Affordable Health Care: Linking Performance Measurement to Health Reform](#). Attached please find correspondence from the Stand for Quality Steering Committee updating you on the progress of this important initiative.

As always, please do not hesitate to reach out with any questions you may have. Please direct all inquiries to info@standforquality.org.

STAND FOR QUALITY

in Health Care

Dear Colleague:

We are writing to update you on the progress and next steps for supporting the recommendations in *Building a Foundation for High Quality, Affordable Health Care: Linking Performance Measurement to Health Reform*. As of today, nearly 130 organizations have stated their support for these recommendations to ensure that health reform builds on existing measurement, quality improvement and public-private partnerships. The groups that have come together represent the broad range of stakeholders who have been working to move our health care system to be one that continuously fosters improvement at all levels, including patient and consumer groups, employers, representatives of physicians, nurses and other clinicians, health plans, hospitals and more. We hope you will join with these groups to endorse the recommendations, which you can do at StandforQuality.org.

Based on the amount of activity focused on the stimulus, we are planning on publicly launching Stand for Quality in early March. We want to ensure that these recommendations get the time and focus they deserve. Here are some additional details:

- Release Stand for Quality and the list of endorsing organizations the first week of March. Until that time, we ask you to refrain from either distributing this document to members of the press or to policy-makers. Obviously, the document is “in circulation,” but it is important that the official launch of the recommendations garner maximum impact. If you are contacted by a member of the press, we suggest the following response:
“There is a draft set of recommendations and interim list of potential organizations that are coming together to support the role of measuring performance in the health reform effort; but there will be no public comment until the recommendations are finalized and made public in early March.”
- Until Stand for Quality is launched this remains a “private” document. The final document may look somewhat different as we format it for readability.
- We currently anticipate a public launch that will include a press event and formal delivery of the Stand for Quality materials in the first week of March.
- We will be developing supplemental materials that we will share with supporting organizations as they are developed.
- We will provide periodic updates to all signatory organizations and welcome your thoughts and suggestions.

We welcome additional organizations to join in endorsing these recommendations and we will provide additional updates until the launch. Thanks again for your interest and support for our work to improve the quality and affordability of care in America. Please don't hesitate to send any questions to info@standforquality.org.

STAND FOR QUALITY
in Health Care

Sincerely,

Stand for Quality Steering Committee:

Janet M. Corrigan, Ph.D., M.B.A., President and Chief Executive Officer, National Quality Forum

Karen Ignagni, M.B.A., President and Chief Executive Officer, America's Health Insurance Plans

Charles N. Kahn, III, M.P.H., President, Federation of American Hospitals

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Mark B. McClellan, M.D., Ph.D., Director, Engelberg Center for Health Care Reform at the Brookings Institution and Leonard D. Schaeffer Chair in Health Policy Studies

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Linda J. Stierle, R.N., M.S.N., NEA-BC, Chief Executive Officer, American Nurses Association

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Richard J. Umbdenstock, FACHE, President and Chief Executive Officer, American Hospital Association

Building a Foundation for High Quality, Affordable Health Care: Linking Performance Measurement to Health Reform

Recommendations

We must improve quality in health care and make it more affordable:

- Health care costs too much, the quality of care delivered is highly variable and many Americans don't have access to needed care. Doctors, nurses and other clinicians strive to deliver high quality care, but they often lack critical support such as the information they need to improve patient care.
- The way we pay for health care encourages more but not necessarily better care. In response to high costs, more and more employers are either not offering coverage any longer or are cutting back.
- There are examples all over the country of high-quality, affordable health care being delivered everyday. We need to create a health care system that builds on these examples to deliver care that is financially sustainable, high quality, patient-centered and satisfying to the millions of clinicians and others providing care. Our challenge and opportunity is to make high quality, affordable care the norm, not the exception.
- Dramatic changes are needed to fix our health care system. Piecemeal approaches that do not build toward comprehensive reform will not suffice. Important elements of reform include: expanding coverage and access to all; reforming payments to promote value; increasing use of health information technologies; supporting clinicians' efforts to reengineer care; and engaging patients in making better choices and managing their health conditions.

Performance measurement is a core building block to provide high quality affordable care:

- Information that is grounded in good evidence will support quality improvement, payment reform, and enable better clinical and consumer decision-making. This information can tell us which care is leading to better outcomes; which treatment options are more cost effective; and which health plans, hospitals and clinicians are delivering safe, high quality, affordable care.

Public investments are needed to support the performance measurement, reporting and improvement enterprise.

- This investment requires dedicated federal support that is not subject to political interference from special interests. The areas and current working estimates of needed public support are:
 - Priority setting, measurement endorsement and maintenance, and evaluation of the efficacy of measures used for improvement (\$50 million annually, which would support expanded work of the National Quality Forum);
 - Support for the Department of Health and Human Services to fund the development of measures to fill critical gaps in areas such as outcomes, episodes of care and cost of care (\$250 million);
 - Support the expanded collection of performance information (\$250 million of public support with potential matching direct and in-kind support from the private sector); and
 - Support research to better understand which quality improvements make the biggest difference in helping clinicians, hospitals and others deliver higher quality, more affordable care (\$100 million for this research function, which is distinct from the far greater public and private resources that directly support actual quality improvement initiatives).

We should build upon the existing public-private performance measurement, reporting and improvement enterprise:

- In recent years, vital public-private partnerships have begun to establish a foundation and become essential to the performance measurement, reporting and improvement enterprise. This enterprise now includes:
 - The National Quality Forum (NQF) which sets priorities and endorses and maintains standardized measures;
 - Sector-specific multi-stakeholder quality alliances including the Hospital Quality Alliance (HQA), the AQA (clinician performance), the Pharmacy Quality Alliance (PQA), and the Quality Alliance Steering Committee (QASC) which promote measurement implementation and effective strategies for collecting, analyzing and reporting performance information;
 - Government agencies including the Agency for Health Research and Quality (AHRQ), the Centers for Medicare and Medicaid Services (CMS), and state agencies which respectively foster measure development, collection and use of measures for improvement, reporting and payment;
 - A network of regional and local multi-stakeholder collaboratives engaged in collecting performance information and improving quality; and
 - A range of measure developers and improvement organizations, such as the Physician Consortium for Performance Improvement (PCPI) convened by the American Medical Association, professional certification boards and societies, accreditors, such as the National Committee for Quality Assurance (NCQA) and The Joint Commission, and quality improvement organizations.
- The common thread running through these efforts is the active collaboration of clinicians, hospitals, health plans, patients, consumer advocates, employers, labor, government and more. Partnership efforts have already made great strides toward their common goal of accelerating measurement, reporting and improvement activities in the health care sector. These same organizations are currently collaborating to even better coordinate their efforts.

Investment in health information technology should be linked to improving care:

- Health information technology represents an important means of advancing quality measurement and improvement which require substantial infrastructure investments. But health information technologies (HIT) can only help improve the quality of care if they are designed to more effectively collect performance information. The link between HIT and performance measurement must be planned and strategic.
- We should ensure that public and private investments in HIT appropriately support delivery at the point of care, improvement, and quality measurement. For example, support for clinicians' use of HIT should be tied to demonstrable improvements in care and efficient use of resources. A condition for funding and support for HIT should be that those systems support the collection of performance information as part of the regular process of delivering care, and have adequate protections for patient privacy and data security as core elements of the technologies.

Performance measurement must be dramatically expanded but measurement alone is not enough:

- Performance measurement is a necessary but not sufficient foundation to drive and sustain improvements in patient care. Improvements in the quality and affordability of care will occur only when this information is actually used. We must make sure that clinicians and facilities can take advantage of the information and have effective assistance to improve performance. There are a wide array of local quality improvement efforts that are helping clinicians and facilities deliver better care using performance information.

- An example of using performance information for public reporting can be found in Hospital Compare, a program in which all hospitals participate that has consistently fostered improvement on aspects of performance being measured and reported.
- There are many examples of pay-for-performance programs in both the public and private sector that reward clinicians and hospitals for delivering higher quality care and for their improvement.
- We need to expand efforts on all fronts to: foster greater use of performance information to support clinical improvements and the delivery of more cost effective care; expand public reporting; and expand the use of performance information to promote changes in payment to promote value. This expansion, however, should be guided by an engaged consultative process that assures input is received from those being measured, as well as representatives of those who receive care and pay for care – patients and employers.

These recommendations are the product of a partnership among patient and consumer groups, employers and public purchasers, representatives of physicians, nurses and other clinicians, health plans, hospitals and more. The composition of this partnership reflects the multi-stakeholder collaboration that we believe should be the locus of the measurement, reporting and improvement activities described in this document. Together we call on the new Administration and Congress to build on the momentum that has been generated by collaborative activities already underway. By expanding the public investment in the performance measurement, reporting and improvement enterprise we can harness the energies of these groups that seek to improve care and lower costs, and, ultimately, achieve our goal of making high quality, affordable health care available to all.

This document outlines the case for supporting the performance measurement, reporting and improvement enterprise in three sections:

1. Core Principles Linking Performance Measurement, Improvement and Health Reform
2. The Key Functions of the Performance Measurement, Reporting and Improvement Enterprise
3. Deliverables of the Performance Measurement, Reporting and Improvement Enterprise

Core Principles Linking Performance Measurement, Improvement and Health Reform

Effective health care reform requires significant improvements in both the quality and affordability of care. Clinicians and hospitals strive to deliver high quality care but more can be done to reduce wide, unwarranted variations in care across the country and to support medical practice based on scientific evidence. Escalating costs are unsustainable for the government, employers and patients. Millions of individuals continue to be uninsured or underinsured. Though all Americans are adversely affected, those with chronic conditions, racial and ethnic minorities, older adults, the poor, and the less educated are disproportionately affected. All stakeholders have to play a role in making sure patients have access to affordable, high quality health care when they need it.

We strongly urge the new Administration and Congress to utilize, build on, and make an expanded public investment in the performance measurement, reporting and improvement enterprise to more quickly advance the efforts of clinicians, hospitals, health plans, employers, patients and others to improve care at lower costs. To achieve sustainable health care reform, we have to significantly accelerate improvements in delivering care. Investing in the capacity to expand and enhance measurement, reporting, and improvement activities is critical to the public interest and essential to the ultimate success of health care reform. Measuring and reporting on the performance of health plans, hospitals and clinicians against robust uniform national standards is a necessary foundation to achieving better patient outcomes, improving patient experience, reducing costs and improving the overall delivery system.

A more robust system of measuring and improving care for all Americans supports many elements of reforming our health care system that are not themselves topics of this document, including:

- expanding access to affordable, effective, safe, quality health care and coverage;
- controlling costs;
- increasing the use of health information technologies;
- developing and applying comparative effectiveness research;
- reforming payment to promote value;
- developing more tools for patients to make better informed decisions;
- reorganizing health care delivery to promote coordination and efficient systems; and
- potential reorganization of the processes by which the federal government considers these and other important policy matters.

Over recent years, vital public-private partnerships have begun to establish the foundation for meaningful measurement, reporting and improvement activities. These partnerships include:

- The National Quality Forum (NQF) which sets priorities and endorses and maintains standardized measures;
- Sector-specific multi-stakeholder quality alliances including the Hospital Quality Alliance (HQA), the AQA (clinician performance), the Pharmacy Quality Alliance (PQA), Patient Safety Organizations (PSOs) and the Quality Alliance Steering Committee (QASC) each of which promote measurement implementation and effective strategies for collecting, analyzing and reporting performance information;
- Government agencies including the Agency for Health Research and Quality (AHRQ) and the Centers for Medicare and Medicaid Services (CMS) at the federal level which respectively support measure development, collection and use of measures for improvement, reporting and payment, and an array of state-based efforts to collect performance information and support local improvement;

- A network of regional and local multi-stakeholder collaboratives engaged in collecting performance information and improving quality; and
- A range of measure developers and improvement organizations, including: accreditors, such as the National Committee for Quality Assurance (NCQA) and The Joint Commission; measure developers such as the Physician Consortium for Performance Improvement (PCPI) convened by the American Medical Association and the American Nurses Association (ANA); professional certification boards, such as the American Board of Medical Specialties (ABMS) and its 24 member boards and boards representing other clinical specialties such as nursing, psychology and dentistry; and quality improvement organizations.

All of these groups, and more, provide essential contributions to the measurement, reporting and improvement enterprise and are currently collaborating to even better coordinate their efforts.

The public-private partnerships have already made great strides. For example these partnerships have led to local improvement initiatives in hospitals, clinics, nursing homes and other settings using standard performance measures to improve care in many areas; have led to better collaboration to reduce redundancies and eliminate unnecessary burdens; spurred the development of more measures; and have resulted in a ground-breaking pilot project supported by AHRQ and CMS which seeks to provide more comprehensive and accurate assessments of physician and other clinician performance by, for the first time, combining both public and private sector performance data. Additionally, Congress recently provided public support for public-private collaboration by appropriating federal funding for measure prioritization and endorsement activities as done by the National Quality Forum. Taken together, these partnerships have laid the foundation for rapid expansion of measurement, reporting and improvement activities in health care.

From experience we have learned that these successful initiatives rely on a number of key principles, including:

Measurement of performance is key to improving quality and reducing costs.

Measurement of performance:

- Enables clinicians and hospitals to improve the quality of care they deliver and health plans to improve the quality of care provided to their members;
- Helps patients and clinicians make better health decisions about care and coverage; and
- Enables employers and public health care purchasers to adopt benefits and payment methods that provide incentives for improvement.

Core building blocks are needed for effective measurement, reporting and improvement.

These include:

- Participation of the full range of stakeholders – including those who receive care, deliver care, and pay for care. Patients, clinicians, hospitals, employers, government and others must be at the table with a common vision, providing input into all elements of developing and using performance information to foster improvement.
- National priorities and goals to ensure quality improvement efforts are focused and reflect the urgent need for more effective, efficient care.
- Nationally endorsed, standardized measures to foster improvement and provide meaningful information to patients, clinicians, hospitals, health plans and employers.
- Use of effective, efficient, and continuously improved upon data collection processes including the development, maintenance, and use of standard terminologies, classifications, collection and validation processes.

- Health information technology that enables efficient collection and reporting of performance information and provides real-time feedback to clinicians as they deliver care.
- Alignment of public and private sector efforts to use performance information to foster improvements through public reporting and payment reforms.
- Effective strategies and infrastructure to analyze and disseminate actionable performance information to clinicians, hospitals, patients, purchasers, including self-funded employers and others.
- Well-designed and supported solutions to help clinicians and hospitals use performance measurement information to improve care are supported by accreditation and board certification which drive measurement, reporting, improvement and accountability.
- Local action to implement improvement strategies has state and national support which recognizes the varying levels of local/regional activity and delivery structures.
- National policies are informed by the learning laboratories of local and regional efforts, and by national demonstration and pilot efforts.

Adequate resources must be allocated to enhance the public-private performance measurement, reporting and improvement enterprise. Adequate public resources are vitally needed to support the six key functions of the public good of an effective performance measurement, reporting and improvement enterprise:

- Setting national priorities and providing coordination.
- Developing measures that address those priorities, help improve quality, inform patients, and guide payment.
- Endorsing, harmonizing and maintaining standardized evidence-based measures through a consensus-based process that involves all stakeholders.
- Providing clear processes for stakeholder input to guide the use of measures for public reporting and payment.
- Collecting, analyzing and making performance information publicly available where appropriate in a manner that is effective, efficient, nationally consistent and locally adaptable. Achieving widespread availability of such information quickly should rely on national, regional, and local implementation experience and substantial collaboration across the public and private sectors through an integrated approach to producing information on outcomes, costs, and care experience across care settings and clinicians.
- Supporting the use of performance measurement to foster improvement.

Wide support and engagement of those being measured is critical to assure effective use of performance information.

- All elements of the performance measurement process, but in particular public and private sector use of performance information for public reporting to inform consumer decision making and payment reforms, should be developed based on structured input from all key stakeholders. This consultation must actively engage the patients who receive care, those who deliver care, those who pay for care, as well as other stakeholders.
- The Quality Alliances or similar structures that may evolve should have a clear and distinctive role in the consultative process to make measurement and reporting more effective and create synergies that help ensure performance improvement and accountability.

The Key Functions of the Performance Measurement, Reporting and Improvement Enterprise

Public resources are needed for the public good of creating, maintaining and implementing measures for improvement. We recommend dedicated federal support that is not subject to the political interference of special interests. While the funding needs are substantial, it is small compared to the more than \$2.1 trillion in total health care spending. The entities charged with conducting these activities should be held accountable for producing performance information that improves the quality of affordable care. Six key functions of the performance measurement, reporting and improvement enterprise are essential to support the drive to improve healthcare quality and affordability.

Function 1. Set National Priorities and Provide Coordination

Function: Establish national priorities through a multi-stakeholder process to guide measure development, reporting and improvement activities and assess progress in achieving them. Through a multi-stakeholder process, define the specific tasks and process for coordinating and assuring ongoing evaluation of all measurement and reporting activities. During this process, key stakeholders, including physicians, nurses and other key health care professionals, hospitals, health plans, patients, and employers, are at the table and fully engaged in the discussions and decision-making.

Deliverables: The multi-stakeholder National Priorities Partnership process has already achieved broad consensus on national priorities and goals that should guide public and private sector quality improvement efforts. There needs to be oversight and monitoring of progress, including annual reports assessing priorities against results and an action plan and coordinated effort involving national, state and local stakeholders. Additionally, broad consensus is needed around which entity(ies) should carry out each function to ensure that there are appropriate checks and balances in place and that the experiences of current efforts are leveraged.

Role(s): The National Priorities Partnership process convened by the National Quality Forum should guide priority setting and monitoring. Look to the National Quality Forum to convene a broad-based multi-stakeholder consortium of all of the key stakeholders to develop an ongoing coordination and self-evaluation process for the measurement, reporting and improvement enterprise.

Function 2. Endorse and Maintain National Standard Measures

Function: Endorse and maintain measures for national use through a multi-stakeholder consensus process.

Deliverables: Endorse performance measures that are valid, reliable, evidence-based, feasible to collect and actionable and that can be used consistently by all clinicians, hospitals, health plans, consumers and purchasers. Measures will match areas designated as national priorities, are increasingly outcomes/results focused, be effective for quality improvement, support clinician and patient decision making, and enable reforming payment to promote value. Beyond initial endorsement, similar measures will be harmonized across clinicians, settings and sponsors of measurement initiatives. There will also be formal mechanisms for learning from the experience of using measures to improve the measurement portfolio. There will be a process

by which measures are systematically updated against new science and continually assessed as to whether they are being used and that their use is indeed leading to performance improvement.

Roles: Use the National Quality Forum's existing multi-stakeholder consensus process for endorsement, and expand National Quality Forum processes to assure measure harmonization, assessment and refreshing of measures used.

Function 3. Develop Measures to Fill Gaps in Priority Areas

Function: Develop measures in the critical areas in which they do not now exist. Examples of the types of measures needed are:

- Measures that address critical priorities for improvement identified by the National Priorities Partnership, including care coordination and transitions, palliative/end-of-life care, overuse and waste, individuals' adoption of healthy lifestyles and communities' contributions to promoting better health;
- Comprehensive measure sets for common care episodes (e.g., diabetes, congestive heart failure) that assess patient outcomes (e.g., functional status), care processes, efficiency and cost; and
- Measures of disparities in health and health care for ethnic and racial minorities.

All measures, both existing and newly-developed, must be designed to be collected concurrent with care delivery as part of new health information technologies supporting better care delivery.

Deliverables: Measures that are credible to those being measured, will be collected without undue burden, and used by clinicians, hospitals, patients, health plans, employers and others to support improvements in quality and affordability. Standardized measures of total cost and resource use at all levels of the health care system must be made available just as quickly as new measures of quality, safety and outcomes. Measures will be assessed against evidence-based standards and show a clear linkage to improving quality and making care more affordable. The development of performance measures is integrally linked to the development of clinical practice guidelines and adequate support for comparative effectiveness research.

Roles: The Department of Health and Human Services (DHHS) should receive new and dedicated funding of \$250 million to engage appropriate entities (such as regional collaboratives, academia, accreditation organizations, medical specialty boards and societies, the societies, boards and organizations representing other clinicians) to develop measures for national endorsement. In identifying measures for development, DHHS should be guided by the National Quality Forum and the priorities established through the National Priorities Partnership, the public-sector and input from the range of stakeholders, the quality alliances and community collaboratives. All should be held to high standards and tight deadlines for action.

Function 4. Effective Consultative Processes So Stakeholders Can Inform Policies on Use of Measures

Function: There should be clear, open and engaged consultative processes by which public and private policy makers will receive input and guidance from clinicians, representatives of health plans, hospitals and other care settings, patients, labor, employers, and others. This consultation will not take the place of any required formal policy-making authority, but it should be a required element of the policy development process and assure that those clinicians,

hospitals or others being measured, consumers, employers and other stakeholders are actively solicited, engaged and their views considered.

Deliverables: Multi-stakeholder input processes identify critical tenets and issues for public and private policy makers around the use of performance information for payment and public reporting purposes. Input will ensure that perspectives of those who receive care, those who deliver care and those who pay for care are duly considered. Processes should be established to assure that input can be provided in a timely and comprehensive fashion, and duly considered before policies are ultimately adopted.

Roles: The range of quality alliances, including the Hospital Quality Alliance (HQA), the AQA (clinician performance), and the Pharmacy Quality Alliance (PQA), should provide the building blocks for this consultative input process. However, as measures increasingly bridge across specific clinicians or settings, it is important to evolve these processes while still adhering to the principle that input should be sought and considered from those being measured, as well as by those who receive care and pay for care.

Function 5. Collect, Analyze and Make Performance Information Available and Actionable

Function: Collect and combine data for identified quality measures and performance information from health plans, clinicians, nursing homes, hospitals, community clinics and other providers. This should be done through the most efficient national, state and local means in order to generate valid performance information to improve care. Assure that implementation results in valid, fair, and actionable performance information.

Deliverables: Relevant data and actionable information needs to be collected and made available and actionable for use at local, state and national levels. Data collection should rely on consistent methods based on best practices, minimize burden, promote comparability and protect the privacy and security of patient information. Better information on patients' functional status, clinical outcomes and costs are vital to promoting accountability and fostering improvement across clinicians and care settings. Furthermore, measurement needs to encompass population-based, community and worksite measures that assess lifestyle, exercise and diet that support movement to promoting a wellness-based instead of disease-based health care system.

Data must be integrated across a variety of public and private sources to provide more comprehensive and accurate performance information. This can and must be done while maintaining the security and privacy of patient-level data. The expanded use of clinical registries is one potential path to collect robust process and outcome data, identify gaps in care, standardize collection processes and support research on comparative effectiveness. Data collection should include indicators that impact care such as race, ethnicity, primary language, age, and gender to support aggregate-level analysis of performance by population subgroup and targeted interventions to reduce disparities. Additional collection processes need to be put in place for the widespread, efficient and routine collection of data from patients regarding their experience in receiving care and functional status.

Local, state and national efforts are integral to developing effective strategies for collection of useful information. National collection and reporting can assure that there is a core of national consistency and comparability, and that every community has a common foundation of performance information. Augmented with information collected at the state or local level,

national data allows for local communities to compare their performance to national standards and benchmarks. The collection of additional information enables communities to innovate and respond to local needs and opportunities to improve care.

Currently, there is a great diversity of data collection efforts, with large differences in tools used to collect data and wide variation on data quality. Existing national, state and regional collection efforts for hospitals, nursing homes, home health and other settings should be better integrated with measurement of care provided by the full spectrum of clinicians in ambulatory settings to so performance measurement reflects the care as experienced by patients – received from multiple clinicians and across multiple settings. Health information technologies that support clinicians at the point of care should be designed and implemented to provider for efficient collection of performance information and have adequate protections for patient privacy and data security as core elements of the technologies.

Roles: The implementation of nationally-consistent, locally adaptable mechanisms to produce and improve performance information is a major undertaking. As described in the roadmap for implementation developed by the Quality Alliance Steering Committee, national, state and local/regional roles in data collection and reporting are essential, as is collaboration between the public and private sectors. Such efforts should be guided by public-private partnerships that should bring together many sources of data into information that reflect the consensus-based priorities and standards established through the National Quality Forum. The major elements of the collection implementation strategy should be subject to timely review through a National Quality Forum process. Public-private, multi-stakeholder national and regional initiatives will have to collaborate closely with federal and state agencies to ensure efficient data collection and reporting.

Substantial resources are needed to support this endeavor both nationally and at the local/regional levels. Federal resources needed to support collection processes alone are likely to be well in excess of \$250 million on an ongoing basis (which includes new resources for CMS and other Federal agencies to participate in national level public-private infrastructure, technical support and to provide data and other support for local/regional efforts). Ideally these resources would be matched by direct and in-kind technical support from private sector organizations.

Function 6. Supporting a Sustainable Infrastructure for Quality Improvement

Function: Measurement is not an end unto itself. There needs to be strategic, national consideration of the investments that must be made to improve patient outcomes, processes of care delivery and the cost-effectiveness of care provided. Quality improvement is a complex undertaking that requires investments in tools and methods to help clinicians use performance measures to improve care and clinical practice. There needs to be investment to help clinicians use performance information, including well-designed implementation tools and organizational supports. Similarly, there need to be processes to assess the use of performance measures for patient engagement, public reporting and to revise payments to foster improvements in care.

Deliverables: Direct support for improvement by clinicians in all settings is needed in every community. This support needs to rest on a sound evidence-base, as does the performance measures that guide the improvement work. Support for improvement needs to be anchored in encouraging clinicians to continuously evaluate and, as needed, modify their care delivery to provide high quality and more affordable care. There needs to be assessment and rapid cycle dissemination of lessons learned regarding systems of care that result in better outcomes and more cost-effective care. Similarly, those uses of performance information that may foster

improvements, such as payment reforms and public reporting, need to rest on solid evidence and rapid cycle testing. Research is needed to better understand: the effectiveness of services provided; the relation of patient engagement and adherence to quality improvement; how best to change processes of care delivery; and how systems can be designed to more reliably result in intended outcomes. Since improvement must be anchored in changing patient as well as clinician behavior, there needs to be concerted efforts to develop health literacy, assure the culture and linguistic appropriateness of communications with patients and develop structures that support patients' sharing in decision making about their care.

Roles: Local, regional and national quality improvement collaboratives, private accreditation and certifying organizations, such as NCQA, The Joint Commission, the members of the American Board of Medical Specialties (ABMS) and its 24 member boards and boards representing other clinical specialties such as nursing, psychology and dentistry, professional societies, and others play important roles in driving and supporting quality improvement activities by the range of clinicians, in health plans and in virtually all settings where care is provided. These entities should be recognized for their contributions to date and the continued role they play in helping clinicians better understand and use performance data to improve care. There is a need for public investment in understanding how best to change processes of care and redesign systems to more reliably result in intended outcomes. Additionally, employers, health plans, public payers and others play a pivotal role by redesigning payment models to promote value and making performance information available to the public, which help foster improvement by clinicians, hospitals and others. The Department of Health and Human Services (DHHS) should provide financial support for assessing what improvement methodologies have the greatest impact (estimated annual budget for this key translational research of \$100 million) and conducting rapid cycle testing of payment and public reporting programs. This support is distinct from the far greater public and private resources that support actual quality improvement initiatives.

Deliverables of the Performance Measurement, Reporting and Improvement Enterprise

Performance measurement and reporting are key to efforts to improve quality and reduce costs. The measurement and improvement effort should: generate information that enables clinicians to improve the quality of care they deliver; help patients make better decisions about their care; help employers best meet the needs of their employees; and support employers and public purchasers in creating the right incentives to encourage and support high quality performance and efficiency. Ensuring the capacity to produce useful and accessible performance information must be a central component of any comprehensive health care reform. Below are examples of the kinds of information and processes a strong public-private measurement, reporting and improvement enterprise could yield in the coming years.

Performance Information in 2009

The existing public-private performance measurement, reporting and improvement enterprise has enabled the first steps in the collection of performance information. In 2009, reporting on the performance of health plans, clinicians, hospitals, nursing homes, hospice and palliative care programs, community clinics and others should expand to encompass an increasing array of indicators, clinicians and settings. Specific examples include:

- **Health Plans:** More than 100 million Americans are enrolled in health plans that report clinical quality (HEDIS: Health care Effectiveness Data Information Set) and care experience (CAHPS) results through the efforts of NCQA, CMS, AHRQ, employers and states. These reporting health plans serve Medicare, Medicaid and commercial populations. Increasingly these measures reflect the care provided to those in both Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). In addition, more than 25 states require health plans to report 28 NQF-endorsed adverse events and rates of health-care associated infections. While health plan-level reporting is well developed, almost two-thirds of Americans are enrolled in insurance plans that do not report comparable standardized performance information.
- **Hospitals:** Virtually all hospitals collect and report on patients' experience with their hospital care through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Initiative and more than 25 process measures related to heart attack care, heart failure care, pneumonia care, surgical care and asthma care for children. This information is publicly reported on Hospital Compare. Based on Medicare requirements, new measures to be collected and reported include: healthcare acquired infections and other safety problems, pregnancy/births, palliative care consults, readmissions, and outcome measures related to 30-day risk-adjusted death rates for heart attack, heart failure and pneumonia. States collect hospital discharge data that serves as the platform for much performance reporting.
- **Nursing Homes:** Nursing home measures are expanding to include nineteen measures for short and long-stay patients at high or low risk (e.g., flu and pneumovax vaccinations, use of restraints, patients with pain, etc.). This information is publicly available on Nursing Home Compare and supplements the array of state-level reporting activities on nursing homes.

- **Clinicians:** Existing measures used by Medicare for primary and specialty care include diabetes management (high-blood pressure, blood sugar, and cholesterol management), perioperative care, heart failure management, and many others. Expansion of Medicare's reporting will include 34 new measures on physician and other clinician outpatient care (e.g., pain management, kidney disease, advance care planning, HIV/AIDS). Among private health plans, there is increasing use of nationally endorsed measures to report on clinician performance.

Performance Information in 2010 and Beyond

In the coming years, national, state and local/regional efforts must generate performance information that increases our ability to foster improvements in quality and affordability. Major improvements in collection processes will foster better measures by:

- Enhancing existing and planned measure reporting systems being implemented by CMS, health plans, clinical specialty boards and societies, states and regional initiatives. Examples include:
 - Inpatient and outpatient process and outcome measures should expand to include new information on healthcare-acquired infections and other safety problems, measures of overuse and inappropriate care, indicators of quality end-of-life care, readmissions and hospital-level mortality, and cost of care.
 - Health plan reporting should expand to encompass the 60% of Americans who do not now have comparative plan-level performance information.
- Developing, testing and then implementing broad-scale mechanisms that integrate electronically available performance information across clinicians and settings, including the integration of inpatient and outpatient medical and pharmacy claims data. This initiative should include linking all-payer claims (e.g., Medicare, Medicaid, private health plan data, medical groups) and clinical data (e.g., registries, laboratory data, data from hospices) to provide richer information about outcomes and costs in key disease areas, and it should be informed by pilot initiatives and regional best practices. Examples of the impact of this expansion include:
 - Promoting safer care (implementation of initiatives that lead to large measured improvements in rates of medication errors and postoperative infections); improved population health (use of effective preventive services such as breast and colon cancer screening, the use of individual measures of the adoption of healthy lifestyles and use of community-based measures of the better health promotion); more effective chronic care management and end-of-life care (coordinated care and medication management for patients with asthma, diabetes, heart disease, cancer); and dramatically reduced waste (antibiotic prescribing without appropriate tests, unnecessary imaging for low back pain, and hospital readmission for uncontrolled symptoms at the end-of-life).
 - More accurate outcomes and resource use information by combining medical and pharmacy claims data with clinical registry data on disease severity, complications and surgical outcomes for cardiac surgery and orthopedic patients; and linking of laboratory results with medical and pharmacy claims data to compute intermediate outcome measures for patients with diabetes, heart disease, etc.
 - Episode-based quality and cost information for common conditions will support moving beyond measurement that focuses on "silos" of care and enable tracking outcomes and costs as patients receive care from multiple clinicians and settings.

- Developing, testing and then implementing broad-scale strategies to measure and reduce disparities in health care reliably and efficiently. This will result in improved equity through reduction in the level of disparities in key areas (such as enhanced primary care and hospice access and reductions in high rates of avoidable hospital readmissions for racial and ethnic minorities).
- Developing, testing and then implementing broad-scale strategies to use new health information technologies (HIT), such as electronic health and medical records, to enable providers to routinely collect and exchange performance information based on national electronic standards. Examples of processes that will ensure health information technologies support the delivery of better quality and more affordable care include:
 - Assure HIT supports clinicians providing care with better information at the point of care to support their decision-making;
 - Provide for collection of data associated with incidents that may occur as part of the care delivery process, such as pressure ulcers, falls, infections and other nursing-sensitive measures;
 - Routinely collect information on patients' functional status, medication adherence, self-care ability, cognitive ability and other data critical to delivering effective care;
 - Integrate the collection of data consistent with existing clinical data registries to effectively measure evidence-based processes and outcomes of care;
 - Implement HIT in concert with needed support, training and technical assistance; and
 - Assure the information collection that is part of new information technologies allows for automatic, real-time submission and timely reporting to local and national stakeholders, provides for real-time feedback to the clinicians delivering care, and has adequate protections for patient privacy and data security as core elements of the technologies.
- Assuring wide-scale availability of information about patients' experience of care expands beyond hospitals and nursing homes, to encompass all care settings and all relevant clinicians.
- Establishing an interactive, mutually reinforcing and supportive relationship between the promotion of national consistency in the public-private performance measurement, reporting and improvement enterprise and the need to innovate and respond to local needs and opportunities to improve care by community-based organizations, regional coalitions, and other "front-line" quality improvement initiatives, such as medical boards, specialty societies, hospital organizations, community clinics, hospice and palliative care organizations and others.