



QReport SPECIAL EDITION: 2013 Annual Conference Review

NQF Members Welcome CEO-Elect Dr. Chris Cassel

NQF was honored to welcome President-elect Dr. Chris Cassel to the 2013 Annual Conference. Dr. Cassel has served as President and CEO of the American Board of Internal Medicine (ABIM) and the ABIM Foundation for the past 10 years, where she has spearheaded efforts to promote physician professionalism and certification, quality improvement, and the important role physicians play in stewarding limited resources wisely.



An expert in geriatric medicine, medical ethics, and quality of care, Dr. Cassel is past President of the American Federation for Aging Research and the American College of Physicians. She also formerly served as Dean of the School of Medicine and Vice President for Medical Affairs at Oregon Health and Science University, Chair of the Department of Geriatrics and Adult Development at Mount Sinai School of Medicine, and Chief of General Internal Medicine at The University of Chicago. She is board certified in internal medicine and geriatric medicine.

Dr. Cassel kicked off the second day of the conference, where she offered remarks on the rapidly changing U.S. healthcare system, and how her background ultimately led her to NQF. Her work with geriatric populations—and the complex challenges these populations presented to clinical medicine—made her increasingly aware of and interested in quality and safety issues. She was soon appointed by President Clinton to serve on the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, where the idea that an entity like NQF should exist was officially born.

Reflecting back on her 25 years in academic medicine and 10 years at ABIM, Dr. Cassel spoke of her desire to move beyond the clinical perspective and take a broader view of the healthcare system at this time of important and substantial change. These changes have the potential to make quality improvement easier and more seamless. Yet the country has an overextended and underappreciated primary care workforce, growing challenges in the biomedical world, and fewer and fewer people who can actually afford to take advantage of them. Therefore, the time for meaningful quality standards—for patients, providers, and payers—is now, and NQF is positioned to lead.

NQF is beyond thrilled for Dr. Cassel to join the organization in July 2013. Until then, Dr. Cassel and the Board of Directors will be working together to shape a strategic vision for NQF, one where members, staff, and the broader healthcare community work collaboratively to build a higher-quality healthcare system.

MEETING NEEDS: Accelerating Measurement and Improvement Work Through Collaboration

The quality community has accomplished a great deal in the last decade to help undergird our healthcare system with a way to measure its performance, helping providers deliver better care and consumers make more informed decisions. Yet despite so much progress, there is broad recognition that significant work remains to be done to achieve a healthcare system of the highest value.

Today, the quality measurement enterprise is truly at the cusp of change. As quality measurement has evolved, stakeholders are asking the questions: how do we move toward measures that focus on value? How do we incorporate the patient voice into measurement to better influence outcomes? How do we reduce measure burden and continue to drive improvement? And how do we make measure development more collaborative, book-ended with better information upstream and a faster and more nimble NQF measure review process downstream?

NQF is eager to work across the healthcare community to help answer these questions and bring about the next generation of performance measures. Helen Burstin, senior vice president of performance measures at NQF, discussed NQF's strategic priority of facilitating more collaborative measure development. She presented how NQF is preparing to take on a more facilitative role in measure development via a measure “incubator” space, where developers can come together to fill critical gaps, access new test beds, and ultimately develop national standards for improvement in a streamlined, collaborative fashion. As part of this incubation work, NQF will begin prospecting for innovative measures to bring into the pipeline, while at the same time seeking input from end-users on needed measures.

NQF is also examining the possibility of moving to a “single flow process” for evaluating measures, as well as standing review committees so developers can bring forth measures for endorsement consideration whenever they are ready. A more nimble endorsement process is critical to filling measure gaps faster and getting endorsed measures into market.

Conference discussion also touched on alleviating measure burden. Many perceive measure burden to be focused on a notion of too many measures, or misaligned use of measures as presented by Liz Mort, Senior Vice President, Quality and Safety, and Chief Quality Officer at Massachusetts General Hospital. Yet for some measure burden goes beyond the idea of too many measures. Bill Kramer, Executive Director for National Health Policy at the Pacific Business Group

on Health, commented, “consumers and purchasers don't see a burden, they see a measurement desert.” Ten years later, consumers and purchasers don't have the measures they need to make informed decisions—measures that deal with outcomes, patient experience, cost, and appropriateness. The measure incubator concept and single flow endorsement process will be essential to helping the healthcare field get to these measures.

Measure burden also extends to electronic measures, or eMeasures, given the complexity involved in developing and implementing such measures. As a result, several conference sessions focused on how best to advance



Helen Burstin, Senior Vice President, Performance Measures, National Quality Forum

electronic measurement, and how measure users can play a role in developing eMeasures. Participants agreed that the electronic quality enterprise is not where it should be, given the rapid influx of electronic health records that have been implemented across the healthcare system in the past two years. Electronic health record experts and the quality community need a dynamic, collaborative learning network to help them work together to advance eMeasurement. Furthermore, measure users must help set the measure development agenda, and providers must be given appropriate tools—such as eMeasure calculation engines—to help them implement such measures. Finally, many panelists

agreed that local or national test beds for eMeasures would be extremely helpful in advancing the field. Kristine Martin Anderson, Senior Vice President at Booz Allen Hamilton, reminded participants not to forget the consumer as the quality field works together to advance eMeasurement; as she noted, the quality community must ask how the outcome of this work can be translated so consumers ultimately understand and can use this information.

While there are many challenges the quality measurement field has yet to overcome, there are telling signs of progress from the ground level. Several panelists shared their experiences and lessons from the frontline—reporting back from esteemed medical centers, neighborhood clinics, and a diverse collaborative of medical groups, physicians, and health plans, among others—in turn showing how critical measurement is to quality improvement.

Center, spoke of organizational efforts to use and collect patient-reported outcomes. Her advice for implementing patient-reported outcomes into routine care included finding senior leader champions, working with frontline clinicians to make sure they understand the value it brings to them, and focusing on patients—making sure they can respond via user-friendly interfaces and they receive a thank you for responding—among others. Dartmouth’s efforts have resulted in 15 practices actively working to incorporate patient-reported outcomes into care decisions.

Finally, Peter McGough, Associate Clinical Professor of Family Medicine and Chief Medical Officer at University of Washington (UW) Neighborhood Clinics, focused on his organization’s efforts to ensure patients receive outstanding visits and improve medication reconciliation. UW outlined specific roles for staff during patient visits to ensure all needs were met, and developed medication reconciliation checklists for staff



Bill Kramer, Executive Director for National Health Policy, Pacific Business Group on Health



Liz Mort, Senior Vice President Quality and Safety, Chief Quality Officer, Massachusetts General Hospital



Jim Chase, President, Minnesota Community Measurement

Jim Chase, President of Minnesota Community Measurement, spoke of a cesarean section measure included in a public reporting initiative in the past year. He acknowledged that all measures may not be ready for “prime time,” but by putting them into play, the community can learn valuable information and take action at the local level.

Similarly, Carolyn Kerrigan, Professor of Surgery and The Dartmouth Institute Residency Program Director, Plastic Surgery, at the Dartmouth-Hitchcock Medical

to use. The greatest lesson he and his staff learned was the power of involvement; full staff engagement led to better processes, and ultimately, better outcomes.

As much of the conference illustrated, the future of performance measurement lies in collaboration across the healthcare community. Reconciling these measurement challenges—measure gaps, measure burden, and the complexity of eMeasurement—will be difficult, but NQF and the broader quality community are well prepared to lead the way forward together.

How Reporters are Using Quality Measures to Talk About Quality

A CONVERSATION WITH KAISER HEALTH NEWS' JORDAN RAU

Kaiser Health News senior correspondent Jordan Rau kicked off the 2013 Annual Meeting, offering a journalist's perspective on healthcare quality reporting, and how the work of NQF and its members is helping transform the news landscape.

Jordan began with the history of healthcare journalism, noting that the field has typically focused on 'extremes'—tragic accidents, breakthrough drug developments, new medical technologies—as newsworthy material. What measurement data has done, however, is help journalists tell more about everyday healthcare experiences, where routine and local patient episodes can now be shared within the context of national trends.



Today, the media is increasingly turning its attention to Medicare's pay-for-performance programs—which can reward or penalize based on performance against quality measures. Readmissions stories have proven very popular with readers who are trying to better understand this trend. Soon, measures focused on hospital-acquired infections will also be included in Medicare pay-for-performance programs; journalists are already eager to see the dynamic between these measures and hospital payment.

Following Jordan's remarks, attendees posed some interesting questions, including:

How can the people who live and breathe in the measurement world help journalists get the story right?

Jordan stressed that taking the time to talk to and educate reporters when they call will go a long way in helping get the story right. As he noted, Jordan has seen many PR professionals so keen to stay on message that they don't fully engage with reporters or really answer their questions. When these people take the time to explain, the resulting story is much more rich and informative.

How is journalism properly educating consumers on what quality measures actually mean?

There's no one answer to this question, Jordan notes. Many journalists are writing about measures as "news you can use," but it's up to readers to judge how good of a job they are doing. With that said, many measures are difficult to explain, and given shrinking space for news stories, many measures are simply used as a gateway for larger policy pieces. But when journalists are allowed to focus on one specific issue, such as readmissions, they can help flesh out that level of comprehension that many readers crave.

An ultimate goal of quality measurement is for consumers to use this information to make decisions in healthcare, but that hasn't happened yet. What's holding journalism back from helping consumers to do so?

In his opinion, Jordan doesn't believe that measures will in fact ever be used to directly help patients make healthcare decisions. Individual measures are too hard to parse out and decipher to figure out what you're really looking for. However, he hopes measures will be integrated more into insurers and health plan networks, where they can ultimately help steer people to informed healthcare decisions. Furthermore, as health insurance exchanges come along, hopefully quality measures will become a part of these plans to help patients choose a plan that's best for them. In that sense, measures can and will influence patient choice, but they won't have a direct effect.

NATIONAL QUALITY HEALTHCARE AWARD WINNER

For 19 years, first through the National Committee for Quality Healthcare and now through NQF, the National Quality Healthcare Award has recognized exceptional organizational leadership and innovation in achieving national goals for quality improvement. The focus for the award is updated annually to reflect the evolving national quality agenda. Accordingly, this year's award recognized an organization providing patient-centered care and achieving better health outcomes at lower per capita costs: Mountain States Health Alliance (MSHA).

Based in Johnson City, TN, MSHA serves a largely rural community. Their commitment to excellence and quality can be seen in all aspects of the system, particularly through the creation and adherence to a set of ten Patient-Centered Care Guiding Principles illustrating the importance of safe, customized care provided in a transparent manner and openly communicated with the patient, family, and caregivers throughout the course of treatment.

In an interview with NQF, MSHA President and CEO Dennis Vonderfecht offered his perspective on his organization's efforts to drive performance improvement and create a high-quality, patient-centered health system.



Rep. Phil Roe, MD (R-TN) presents the National Quality Healthcare Award to Dennis Vonderfecht, president and CEO of Mountain States Health Alliance

What are the essential elements to building a culture focused on patient safety and quality? Why are these important?

I think the first essential element is having a culture that's focused first on patient-centered care, which is clearly defined, clearly communicated, and thoughtfully implemented throughout the organization. The second essential element is having a set of clearly identified guiding principles within that patient-centered care philosophy, which we do within Mountain States. One of our guiding principles of patient-centered care is "Patient safety is a visible priority," which reinforces the idea that safety is one of our customers' key requirements. The next step is to clearly identify and understand the metrics that are associated with quality and patient safety and make sure those metrics are transparent to those within and outside of the organization. The last piece should be accountability for performance against those metrics. I think if you do all those things, you provide a clear line of sight for each team member as to how they can personally contribute to the organization's progress in the areas of quality and patient safety.

What quality and safety challenges remain within our existing healthcare system? What steps can we take to overcome these challenges to help ensure safer, more effective care for all patients?

There are three challenges, in particular, that I think are very important.

The first one has been a problem for a long time, and I'm hoping that the Affordable Care Act will begin to address this. It is the lack of alignment of reimbursement between physicians and the other parts of the delivery system. That lack of alignment results in a lack of clear, consistent focus on achievement of metrics around patient safety and quality. I believe we need a reimbursement structure that aligns the interests of physicians and hospitals so that we're working collaboratively for the benefit of patients.

The second piece, which I think needs considerable improvement, is the reduction in variation within care processes. Variation needs to be eliminated as much as possible. If we do that, we're going to improve quality and reduce cost, which takes us a long way toward

achieving the Institute for Healthcare Improvement's Triple Aim.

The third one is a lack of transparency in performance against quality and safety metrics, particularly among physicians. I think the more we can engage physicians in this process and put visibility to their outcomes and processes, the more we will be able to improve quality and patient safety.

What does winning the National Quality Healthcare Award mean to you? What has inspired you and your organization to become such an advocate for patient safety and quality?

I think it's affirmation of the progress that we've made on our journey toward performance excellence, recognizing the fact that that journey has no endpoint. But when we get this type of recognition along the way, I think that it does help affirm to our organization, and to our team members and physicians, that we are making progress along that journey.

The answer to the last half of this question really revolves around our focus on patient-centered care. If we're advocating for the patients, then I think we're automatically advocating for patient safety and quality on their behalf. I think our journey that we've had towards patient-centered care in the last ten years has really helped us stay focused on the patient and has helped us stay focused on metrics that are truly meaningful to the care of those patients.

The other thing that has been beneficial to us is being able to convert those patient safety metrics to faces and lives saved as opposed to just ratios and numbers. It really helps you realize that these are people and not numbers that you're having an impact on by improving your quality and patient safety.

We appreciate the recognition that we received from NQF. It truly is a team effort that results in awards like this. It's not just the leadership; we have to have everyone working together in the same direction to be able to receive this type of recognition.

PAST NATIONAL QUALITY HEALTHCARE AWARD WINNERS

- 2011** Norton Healthcare, Louisville, KY
- 2010** North Shore-LIJ Health System, Great Neck, NY
- 2009** Memorial Hermann Healthcare System, Houston, TX
- 2008** Baylor Healthcare System, Dallas, TX
- 2007** HealthPartners, Bloomington, MN
- 2006** Brigham and Women's Hospital, Boston, MA
- 2005** Northwestern Memorial Hospital, Chicago, IL
- 2004** Trinity Health, Novi, MI
- 2003** Leigh Valley Hospital and Health Network, Allentown, PA
- 2002** Carilion Health System, Roanoke, VA
- 2001** Catholic Health Initiatives, Denver, CO
- 2000** Munson Medical Center, Traverse City, MI
- 1999** BJC Health System, St. Louis, MO
- 1998** University of Pennsylvania Health System, Philadelphia, PA
- 1997** St. Luke's Hospital, Kansas City, MO
- 1996** Intermountain Healthcare, Salt Lake City, UT
- 1995** Evanston Hospital Corporation, Evanston, IL
- 1994** Henry Ford Health System, Detroit, MI

2012 EISENBERG AWARD WINNERS



Each year NQF, together with The Joint Commission, recognizes outstanding individuals and programs dedicated to improving patient safety with the John M. Eisenberg Patient Safety and Quality Awards. The Eisenberg Award recognizes major achievements of individuals and organizations in improving patient safety and healthcare quality, consistent with the aims of the National Quality Strategy—better care, healthy people and communities, and affordable care. Better care in particular focuses on improving the overall quality by making healthcare patient-centered, reliable, accessible, and safe.

SAUL N. WEINGART, MD, PhD DANA-FARBER CANCER INSTITUTE, BOSTON, MASSACHUSETTS

Dr. Weingart was presented with the Eisenberg Award for Individual Achievement in recognition of his longstanding commitment and national contributions to patient safety through publication, education, research and leadership. Examples of his many accomplishments include creation of the Harvard Executive Sessions on

Medical Error; extensive research in understanding the role that patients and families can play in advancing patient safety; development of a web portal-based incident reporting system for patients; and development of novel curricula in patient safety and online patient safety courses.

KAISER PERMANENTE, OAKLAND, CALIFORNIA

Kaiser Permanente was presented with the Eisenberg Award for Innovation in Patient Safety and Quality at the National Level in recognition of the pioneering innovations of their implant registries, which have shown unsurpassed and proven benefits for patient safety, quality, outcomes, and cost effectiveness in

their integrated healthcare system. The registries are models of seamless integration across medical centers in nine states and represent unprecedented partnerships among health plan administrators, hospitals, and physician medical groups.

MEMORIAL HERMANN HEALTHCARE SYSTEM, HOUSTON, TEXAS

Memorial Hermann Healthcare System was presented with the Eisenberg Award for Innovation in Patient Safety and Quality at the National Level in recognition of their High Reliability Journey from Board to Bedside initiative. This initiative focuses on providing compassionate, operationally and financially efficient

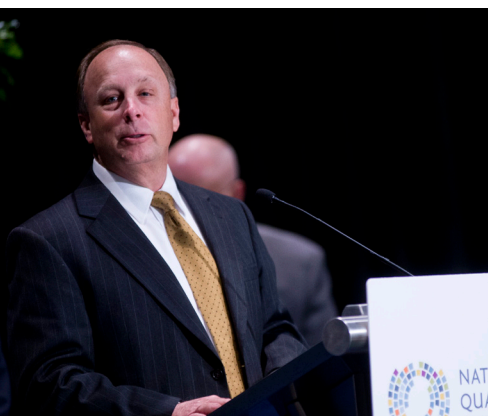
care by concentrating leadership and employee attention on high-reliability behaviors, evidence-based care, and harm prevention across 12 hospitals, 19 ambulatory surgery centers, clinics, and other ambulatory care locations.

THE VOICES OF QUALITY: Perspectives on Patient Safety

Improving patient safety has long been a part of NQF's mission to advance high-quality healthcare. The wider healthcare community has embraced this idea as well—from the National Priorities Partnership to the National Quality Strategy, the nation's commitment to reducing harm and preventing medical errors is clear.

The 2012 Eisenberg Award winners—representing diverse and innovative healthcare organizations and systems from across the country—epitomize what it means to put safety at the forefront of patient care. NQF asked the winners to share their thoughts on the importance of patient safety: what it means to inspire change, what challenges we still face, and why they are such advocates for quality improvement.

We invite you to learn about their stories.



Dan Wolterman, president and CEO,
Memorial Hermann Health System



Jed Weissberg, MD, Senior Vice President,
Hospitals, Quality and Care Delivery, Kaiser Permanente



Saul N. Weingart, MD, PhD, Dana-Farber
Cancer Institute, Boston, Massachusetts

What are the essential elements to building a culture focused on patient safety and quality? Why are these important?

Memorial Hermann Healthcare System: Memorial Hermann's leadership is committed to providing the highest quality and safest care in operationally and financially efficient ways. Quality, safety, and operational efficiency work just as well in accountable care, bundled care or fee-for-service environments, and will always be the right thing to do. Our journey to high reliability is no small challenge, as MHHS includes nine acute care hospitals, a children's hospital, two rehabilitation hospitals, 18 ambulatory surgical centers, over 100 other ambulatory facilities, 21,500 employees, and 5,000 physicians who provide 732,000 days of inpatient care for 135,000 patients annually. In spite of our size, it is imperative that we remain agile enough to conform to new regulations, payment mechanisms, evidence-based

practice innovations, physician relationships, and techniques for managing the health of our community and employees.

Kaiser Permanente: *Clinical quality has always been at the forefront at Kaiser Permanente, where we look at it from the perspective of individual patient care, as well as population care. We've developed great tools and approaches to both, which have resulted in us doing very well in all the public accountability measures that we report, the way our health plan is ranked, and the way our hospitals are evaluated. That has been our core—we understand the relationship between the traditional view of clinical quality and the evolving understanding of patient safety.*

We really started learning about patient safety when the IOM reports came out, starting in 1999, after which we created programs that were a testament to our organization's commitment to the principles of patient

safety and building a patient safety culture.

Vital to this work is our strategic partnership with the Institute for Healthcare Improvement (IHI) for the last seven years. We've sent many physicians and staff to their patient safety officer training programs.

All our work is underpinned by data—and the feedback of that data to the people who know about it and care. We routinely track our patient issues so we can aggregate our experience to enable better understanding of the gaps in our defenses and the opportunities to design safeguards, more efficient processes, and safer processes.

Saul Weingart: In my view, safety culture and initiatives that improve quality and safety are two sides of the same coin. Organizations that vigorously pursue risks and mitigate them in a systematic and effective way communicate a clear message to staff, patients, and the community. This commitment to quality and safety—in word and deed—reinforces shared norms and aspirations and at the same time creates a climate where staff feel a personal responsibility to act in ways that promote safety and quality.

What quality and patient safety challenges remain within your system? What steps can we take to overcome these challenges to help ensure safer, more effective care for all patients?

Memorial Hermann Healthcare System: We are aware that we can never truly eliminate all variances from patient care; i.e., we cannot make imperfect humans perfect. However, we attempt to create resilient processes that, combined with “mindfulness,” provide multiple opportunities to “catch” potential errors before they produce harm. As healthcare evolves, the principles of high reliability—100% quality performance and 0% incidents of avoidable harm mean that performance challenges will continuously present themselves. Our ongoing challenge as a healthcare system is to be ready to address them in the most efficient and effective ways possible.

While the principles of high reliability are endorsed from the top, they are implemented every day and night by the thousands of MHHS employees and physicians that work closest to the bedside. We are seeking new ways to spread the commitment to high reliability virally throughout our organization. We want those at the bedside to inoculate their peers with the HRO principles that empower us to achieve consistency and eliminate variation across our system: preoccupation with

failure, reluctance to simplify, sensitivity to operations, commitment to resilience, and deference to expertise (from Weick and Sutcliffe, *Managing the Unexpected*).

Kaiser Permanente: *As healthcare gets more complicated in terms of the sources of information, technologies, devices or monitors, classic patient histories, advancing medical knowledge, or self-reported functional status and outcomes, it's too much for just one person or even one system to keep straight. We are continuing to develop new skills in device, system, and knowledge management and integration into our practice guidelines and electronic health records in order to keep our patients safe while providing the best in current medical care.*

Saul Weingart: Quality and safety are ongoing challenges in healthcare. Even as we improve our performance in medication safety or infection control, for example, that sets the bar higher for the next round of improvements. I see a lot of critical work ahead in understanding diagnostic errors, improving electronic systems, measuring disease-specific outcomes, and building care models that support patient engagement.

Although the work is never done, there are some important challenges ahead. Providers and healthcare organizations are asked to do more and more with less and less. Increasingly complex care is delivered by multiple professions and specialists across diverse care settings. These features create conditions where communication and coordination are critically important. I see challenges and opportunities over the next few years to create models of care that provide continuity and ensure seamless care across the continuum.

What does winning the Eisenberg Award mean to you? What has inspired you and your organization to become such an advocate for patient safety and quality?

Memorial Hermann Healthcare System: Receiving the Eisenberg is a great honor for MHHS and is accepted on behalf of our patients and staff. We take the award as an acknowledgement that all 25,000 employees and physicians are moving in the right direction. We also consider the award as a responsibility to continuously improve and be worthy of it. So in one sense there is great satisfaction in receiving the Eisenberg award. In another sense, there is a great obligation to live up to it now and in the future. We sincerely intend to do so.

Houston has a “can-do” culture enhanced by an influx of the best and brightest from all over the U.S. and the

world. Our lay and physician board membership reflects that mix. Some lay members come from high reliability industries, such as energy. Our 2012 hospital board chair also leads the Houston Zoo, which operates as a high reliability organization with lives at stake. Our board members ask questions about subjects that healthcare workers might take for granted such as: why do we have any patient falls at all, or is there any acceptable rate for medication errors. Our board members think we can do better, and so do we.

That's why we call it continuous evolution. And even when we reach zero—as we have with transfusion reactions for many years—there is the challenge of sustaining that...forever. That's high reliability. We must never stop improving. We must never lose attention to detail. We must never become complacent. After all, it's what we would want for ourselves, our family, and our friends and neighbors. At MHHS, it's what we want for all our patients as well.

Kaiser Permanente: *The Eisenberg Award has really been very powerful internally. We had a mutual commitment from our organizational leadership and our professionals to collect data—information on how and with what we were practicing, looking at implants, etc.—which was critical to informing current and future clinical practice, and contracting for the inputs (implants, devices, medical products) to clinical practice. So the recognition from the award has been hugely validating and has made everybody—the clinicians, scientists, the data analysts, the project managers who work on the registry—feel very proud of what they've created and the benefit that it's brought our members and, of course, the recognition! And being recognized by NQF, in concert with The Joint Commission, which are two of the most respected organizations in healthcare—we love it!*

The other thing is that we're in the company of Saul Weingart, who is fantastic and a true leader in safety, and Memorial Hermann, which is a hospital system we truly respect.

Saul Weingart: This is an enormous honor. I remember Dr. Eisenberg as a charismatic and inspiring leader, and hope to live up to his ideals. The award recognizes my own work and that of my organization, Dana-Farber Cancer Institute, for our efforts to work closely with patients to create safer and better care. Patients and their families have a tremendous amount to teach us about how healthcare can and should be delivered. It is our personal and professional responsibility to listen and learn.



NQF THANKS CAROLYN CLANCY

NQF was honored to welcome Dr. Carolyn Clancy, director of the Agency for Healthcare Research and Quality (AHRQ), to the annual Eisenberg Awards luncheon this year, where she helped recognize our esteemed winners.

As Dr. Clancy prepares to step down from AHRQ, NQF would like to thank her for her years of tireless service to improve the health and healthcare of all Americans. Her leadership and achievements have left a lasting legacy on the quality community that will not be soon forgotten.

Policy Perspectives:

PATRICK CONWAY ON THE FUTURE OF PERFORMANCE IMPROVEMENT AND QUALITY MEASUREMENT

Patrick Conway, chief medical officer at the Centers for Medicare & Medicaid Services (CMS) and director of the Center for Clinical Standards and Quality, gave conference attendees a high-level look at CMS' vision for quality measurement and federal performance measurement programs in the coming years. In his remarks, he emphasized the remarkable progress the nation has made over the past decade to promote and improve quality measurement, and declared that the future looks promising.

Much of the conversation focused on the idea of implementing a set of electronic clinical quality measures (eCQMs) and e-reporting requirements to align CMS quality programs and reduce provider reporting burden. CMS' ultimate goal is for participants to report on measures just once, with the resulting data available for use in multiple programs. For hospitals, this includes the Inpatient Quality Reporting Program, the Hospital Value-Based Purchasing Program, and the EHR Incentive Program for Meaningful Use. Physicians and other eligible professionals could also choose to report from their EHRs and get credit for the Physician Quality Reporting System, the Physician Value Modifier, Accountable Care Organizations, and the EHR Incentive Program for Meaningful Use.

As Dr. Conway noted, the ultimate goal for these hospital and physician quality reporting programs is to bring about improvement via measurement. Yet there are still inherent challenges in EHR-enabled measurement. To begin with, the quality field still faces many major measure gaps. Developing eMeasures presents special challenges of its own, with regard to feasibility and e-specifications. The issues of data element standardization, as well as cross-vendor reliability in calculation, remain major obstacles. Finally, how to best structure data collection within practices and report and collect measures remains unclear. However, CMS, NQF, and the healthcare community are prepared to tackle these challenges together, and are already beginning to make promising inroads.

Dr. Conway also expressed his thanks to NQF and their members for their work to rethink the current measure endorsement process to maximize its effectiveness and efficiency, as well as efforts to develop, test, and evolve the process for endorsement of eMeasures. Furthermore, CMS is eager to work with NQF and the quality community to actually start filling measure gaps, as opposed to just talking about them. He also reiterated how helpful the recommendations of the Measure Applications Partnership (MAP) have been to CMS in their decision-making, and the organization looks forward to extending MAP review of measures to other programs. Ultimately, Dr. Conway stressed that NQF has played a critical role in bringing the public and private sectors together to address these issues, and must continue to play that role.

“How do we really push data transparency even farther and faster? Perhaps CMS becomes the supplier of data. This will come at a cost, and we must make our case on the Hill, but available data will help providers and communities across the country dramatically improve.”



VIEW FROM THE FIELD: Understanding Measure Use and Usefulness

As use of performance measures proliferates, many in the quality community are increasingly interested in understanding the experiences, impact, and results of measure use. How can we work together as a group to evaluate measure use and take advantage of those learnings to inform the quality improvement field?

One possible solution discussed at this year's conference is the establishment of 'feedback loops'—regular exchanges of information between those who develop, endorse, and use measures. Recommended by the IOM as essential for continuous learning and system improvement in their report, *"Best Care at Lower Cost: The Path to Continuously Learning Health Care in America,"* feedback loops show promise for meeting many of the needs of the measurement community.

Some of the key goals for feedback loops—creating better, more useful measures, filling measure gaps, and encouraging data sharing and increased collaboration—were major points of discussion amongst panel members and attendees.

Elizabeth Mitchell, CEO of the Maine Health Management Coalition, discussed how feedback loops could offer significant assistance around the concept of getting those in the public and private sector to use the same, best measures. Mitchell commented, "Fewer measurements are fine, but make them as meaningful and valid as possible. Please align!"

A future measurement-focused feedback loop could also prove useful in better identifying measure gaps—areas where measures are needed and don't exist. During a breakout session, participants discussed three high priority gap areas identified in a pre-conference survey—care transitions, shared decision making, and overuse and waste—and discussed how to best address these gaps. Potential barriers and strategies for overcoming them were discussed.

Conference sessions also delved into the importance of bringing forth innovative measures, such as cost and resource use measures, to help the healthcare community learn and improve care quality. Resource use measurement can show variation in care and key drivers such as avoidable services, preventable readmissions, and avoidable emergency department use. Implementing such innovative measures that

address healthcare cost requires collaboration between stakeholders, and getting buy-in can be difficult. As a participant stated, "looking at cost is an important trust exercise." Open communication, transparency, and sharing of common goals can help build the trust that will lead to successful collaborations and improved quality down the road. Patient-reported measurement falls into the innovative measurement category as well, and lends itself well to the feedback loops concept—interactions between patients and providers can play a critical role in care delivery and patient outcomes.



Elizabeth Mitchell,
CEO, Maine Health Management Coalition

Ultimately, cross-sector collaboration throughout the healthcare community is needed to facilitate learning, implement change, and bring about improvement. The National Priorities Partnership (NPP) has worked to encourage this collaboration, as evidenced by the success of their Maternity and Readmissions Action Teams. The Action Teams have helped build broad consensus around clearly defined goals and processes for reducing early elective deliveries and rates of



Michael Lepore, PhD, Director of Quality, Research, and Evaluation, Planetree



Cynthia Pellegrini, Senior Vice President, Public Policy and Government Affairs, March of Dimes



Dr. M. Michael Shabot, Chief Medical Officer, Memorial Hermann Health System

readmissions, and have experienced a great deal of success. As Michael Lepore, PhD, Director of Quality, Research, and Evaluation at Planetree, noted, “the opportunity to engage with patients through the Action Team really was transformative.”

Similar positive changes are taking place across the nation. As Cynthia Pellegrini, vice president for Public Policy and Government Affairs with the March of Dimes, shared, a March of Dimes Toolkit focused on reducing early elective deliveries and accompanying public education campaign have led to 48 state health officers signing on to reduce preterm birth by 8 percent. “Nothing breeds success like success. The more partners you bring in proactively, the more you bring in over time,” remarked Pellegrini.

There is broad agreement that the healthcare community has a long way to go before we can effectively harness our collective measurement experiences to build a higher-quality healthcare system. Yet we have made positive inroads, as seen through the work of our colleagues. The concepts discussed at the conference—building feedback loops, bringing innovative measures into play, and collaborating across sectors to learn from each other—will be integral to this effort, and NQF is eager to play a leading role in bringing about this change.

There may have been a day in the past when a single organization could drive change. That day is gone.”

CYNTHIA PELLEGRINI, VICE PRESIDENT FOR PUBLIC POLICY AND GOVERNMENT AFFAIRS WITH THE MARCH OF DIMES

BRINGING MEMBERS TOGETHER FOR SHARED LEARNING

Through a variety of feedback channels, NQF members expressed strong interest in having more networking opportunities, chances to work across councils, and more time to work with another on important healthcare issues. This year's annual conference was designed to address this feedback.

During the member lunch on the first day of the conference, NQF shared results from a February 2013 member survey focused on activities members were undertaking to advance the priorities and goals of the National Quality Strategy (NQS). The results, which represented feedback from across the country and from each of the NQF councils, indicated a high level of activity in the patient safety (60%) and care coordination priority areas (54%), with the least activity reported around the person- and family-centered care (35%) and health and well-being priority areas (27%).

Following a presentation of the survey results, NQF staff facilitated small group, cross-member discussions about the success factors and challenges they had encountered while implementing the NQS in their own organizations. Two key barriers expressed by the groups included the difficulty of collecting and distributing

partake in new 'NQF Dinners around Town,'—voluntary dinners organized by NQF for members to get more chances to meet other members they may not know. Each dinner was hosted by a member of the NQF Board of Directors and an NQF senior staff member, and allowed members from across councils to meet and socialize outside of the confines of the conference agenda. While some “shop talk” occurred, attendees were able to get to know one another in a relaxed atmosphere over dinner, making new connections that they could take with them in the weeks and months following the conference.

Elected council leadership met for breakfast on day two to continue discussions on how the councils can more optimally work together, on NQF projects and work beyond NQF. Council leaders discussed a variety of strategies that have helped them stay connected, and



meaningful data, particularly across settings; and the challenge of balancing the benefits of standardization of measures such as the ability to consistently compare results with customization of measures to meet the specific needs of local communities. Overwhelmingly, multi-stakeholder collaboration and alignment were identified as critical strategies for overcoming these barriers. As one participant noted, “members of NQF, as a group of committed action leaders, could start to model cooperation and coordination.”

Later that evening, members enjoyed a networking reception where the National Quality Healthcare Award was presented (see page 5). 80 members then chose to

new ways to get the eight groups more meaningfully engaged with one another on issues such as patient reported outcomes, pursuit of the National Quality Strategy, and collaborative measure development. Leaders also discussed NQF staff ideas to enhance the member experience.

By all indications, attendees made ample use of the extended networking time over the course of the conference and appreciated the opportunity to engage more fully with their peers. NQF looks forward to hearing more about members' experiences at this event, and welcomes any feedback on new ways in which we can better engage with our members.

WHERE WE GO NEXT

The 2012 Annual Conference gave members many chances to work with one another. Member input is particularly helpful as NQF works to better meet its members' needs and help solve major healthcare challenges.

The sessions produced a series of takeaways and next steps that NQF is committed to following through on. Here is what you can anticipate:

BETTER MEASUREMENT THROUGH COLLABORATION

Facilitate creation of high-impact measures in highest priority need areas by :

- identifying measure gaps
- working with developers to fill gaps
- building a faster, more nimble measure review and endorsement process.

> Underway now, spring 2013—remainder of year

Focus on reviewing measures that matter to our constituents, and can make a difference in improving value. NQF has already started on a “Cost and Resource Use” measure review project.

> Underway, see project. We anticipate tackling other important measure areas starting in late spring—early summer.

WORKING WITH THE FRONT LINE TO UNDERSTAND MEASURE USE AND USEFULNESS

Develop the ‘measurement feedback loops’ concept as a way to learn from the field, help inform future measure development, and share valuable information with members.

> Anticipated work starting summer 2013

Continuation of cultivating stories from the field via the National Priorities Partnership, Measure Applications Partnership, NQF member councils, and tools such as NQF’s interactive ‘Quality Positioning System’ and its ‘Action Registry.’

BRINGING MEMBERS TOGETHER/MEETING MEMBER NEEDS

Creation of a member-only, online library of charts, tables, graphics and other items that members can download and use in their own work

> May 2013

Creation and roll-out of new project alerts offering members a heads-up when work they care about is starting, a plain English description of the work, and how they can get involved.

> May 2013

Launch of a pilot program to match members with their own NQF staff liaison, to facilitate more connections and easier access to help.

> June 2013

More frequent calls between all elected council leadership, to offer strategic guidance and find ways to connect councils more routinely

> April 2013, monthly moving forward



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