# NQF COMMUNITY DASHBOARD PROJECT CONSTRUCTING A FRAMEWORK JANUARY 2011

#### INTRODUCTION

Across the country, many communities have been leaders in measuring and publicly reporting on healthcare performance to motivate improvement in local health and healthcare. Building support and buy-in across local stakeholders while forging new paths forward has resulted in a variety of ways that communities currently measure and publicly report about the quality of local care. This lack of standardization is a challenge for stakeholders (e.g., large employers, health plans, medical groups, hospital systems, state and federal agencies) who want to be able to make direct, meaningful quality comparisons across communities. This disparity also makes it difficult for consumers to use the information in making healthcare decisions. There has been the notion that a set of core measures for public reporting which focuses on encouraging alignment of measures used in local communities around anticipated national reporting requirements and incentives (e.g., payment reform) would be a helpful next phase in making public reporting even more valuable and effective.

As a result, in 2010, the National Quality Forum (NQF) embarked on the Community Public Reporting Dashboard project funded by the Robert Wood Johnson Foundation (RWJF) to bring a multi-stakeholder group together to identify a core set of domains<sup>1</sup> to be used for a dashboard of recommended measures in public reporting. This dashboard of core measures is intended for use by communities interested in moving their public reporting toward consistency with national strategies and incentives using NQF-endorsed<sup>®</sup> measures. Focusing on the "public at large" audience, the dashboard could be used as a starting place for some communities and as an enhancement for other communities in public reporting efforts. While the dashboard may be offered as guidance to encourage standardization and comparison, communities could still report any measures they choose. Each community would also determine the design and format of the public reports that include core measures from the dashboard. Overall, a standardized dashboard

of core measures enables communities to align their programs with national priorities and allows for comparisons of quality initiatives across communities.

As a respected neutral convener and an organization driven by the mission to improve health and healthcare in America, NQF was well-positioned to convene the multi-stakeholder group to develop a dashboard of standard measures for use by interested communities in their public reporting. At a workshop in Washington, DC on October 12, 2010, invited participants were asked to identify a core set of domains to be included in the dashboard to address patient-centered outcomes, key processes of care, cost of care, and essential infrastructure supports. Participants included public and private sector representatives from across the county, at the local, state, and national levels to ensure that the end-product would be a community-focused dashboard that reflected a wide range of interests. Prior to the workshop, NQF subcontracted with Mathematica Policy Research to document the current public reporting landscape as background information for the stakeholder group. This work included an environmental scan of existing public reporting projects, a cataloging of a sample of those public reporting programs along with associated measures, and a mapping of the cataloged measures to the <u>National</u> <u>Priorities Partnership (NPP) National Priorities and Goals</u> and the <u>NQF-endorsed® Patient-Focused Episodes of Care Measurement Framework</u>.

In preparation for the workshop, a web meeting was held to orient participants to the purpose of the Community Dashboard project, discuss the NPP framework and the Department of Health and Human Services (HHS) proposed National Quality Strategy, and provide an overview of the environmental scan conducted by Mathematica Policy Research. Under the leadership of workshop co-chairs, William Golden, MD (Medical Director, Arkansas Medicaid) and Christopher Queram, MA (President and CEO, Wisconsin Collaborative for Healthcare Quality), the multi-stakeholder group then met to discuss and define the domains and subdomains that should be included in a dashboard of core measures for use in public reporting. Workshop participants arrived at a core set to be included in "Right Now" and "In the Future" versions of the dashboard to accommodate current gaps in the development of performance measurement. They also identified key issues relevant to implementation of the dashboard and offered their guidance on issues to address when piloting the "Right Now" dashboard in three or four communities engaged in public reporting and receiving support through the <u>RWJF Aligning</u>

Forces for Quality initiative. The dashboard pilot is expected to begin in these communities in February 2011.

This report is comprised of five sections: 1) Background; 2) Project Components; 3) Constructing a Recommended Dashboard; 4) The Path Ahead; 5) Conclusion. In the Appendices, we provide the following: A) Final Sample of Public Reporting Programs for the Environmental Scan; B) Executive Summary: Environmental Scan of Public Reporting Programs and Analysis Final Report; C) Community Dashboard Workshop Project Participant List; D) Web Meeting Slides; E) Domain and Subdomain Areas used for the Initial Voting Exercise; and F) "Right Now" and "In the Future" Domains and Subdomains from the Community Dashboard Workshop.

## BACKGROUND

The National Quality Forum is a private, nonprofit membership organization committed to improving healthcare quality performance measurement and reporting. Created in 1999 by both private and public sector leaders following the recommendation of the President's Advisory Commission on Consumer Protection and Quality in the Healthcare Industry, NQF has become a recognized standards setting organization working with a full range of stakeholders to influence the U.S. healthcare system by building consensus around national priorities and goals for performance improvement, endorsing national consensus standards for measuring and reporting publicly on healthcare quality performance, and facilitating the attainment of national goals through education and outreach programs.

A focus on public reporting builds on NQF's experience of endorsing performance measures through its consensus driven process and recommending National Priorities and Goals through NPP. With a stronger emphasis on public reporting in recent years, the development of a dashboard to help guide community public reporting and allow communities to align with national priorities and to be compared with one another takes on even more meaning. Since 2006, public and private initiatives have been developed to encourage the field to move toward more transparency in healthcare quality reporting.<sup>2</sup> HHS' development of Chartered Value Exchange communities has encouraged local coalitions to participate in activities related to

measurement and reporting on healthcare quality and cost. In addition, RWJF has provided support to a network of 17 community and/or regional healthcare improvement organizations through a multi-year grant initiative called Aligning Forces for Quality (AF4Q). These communities are given financial support and technical assistance to develop strong public reporting programs that help to educate consumers and other stakeholders on quality healthcare. Finally, the recently-passed Affordable Care Act (ACA) requires that the HHS Secretary develop a strategic framework for public reporting.<sup>3</sup> This framework may include national-level recommendations for data collection, aggregation, and analysis. The development of such a framework will catalyze the expansion of public reporting, especially as healthcare reform moves into the forefront. In addition, as federal and state regulations change to motivate quality improvement, a standard approach to quality measurement will likely be a part of new approaches to payment and other financial incentives (e.g., meaningful use of health information technology).

Knowing that effective public reporting and improvement in health and healthcare are essential to promoting cost effective, patient-centered care in the context of health reform, NQF is committed to equipping communities with the tools and resources to help them gauge and monitor progress. In fact, NQF has recently embarked on the development of a community outreach strategy that will assess how NQF can best support communities in their efforts to improve health and healthcare quality. The dashboard of core measures is intended to be one of many tools offered to communities as they do the tough work of making patient-centered care a reality. Communities that align their work with the dashboard of core measures will also be able to benchmark themselves against other communities of interest.

#### **PROJECT COMPONENTS**

#### **Environmental Scan and Catalog of Public Reporting Programs**

During February-September 2010, NQF contracted with Mathematica Policy Research to conduct an environmental scan of public reporting programs to survey the landscape for characteristics, components, and types of measures included in reports. Mathematica selected a sample of 72 public reporting programs from over 300 scanned. The sampling frame included

those healthcare quality public reports that had been used in previous studies and reports,<sup>4</sup> as well as those recommended by key informants.<sup>5</sup> The final selection of programs was based on a mix of geographic focus (national-, state-, local-level reports), early and late adopters of public reporting (started before or after 2005), and key informant validation (see Appendix A for sample list).

Once the sample was identified, Mathematica cataloged a variety of information about the public reports including overall characteristics (sponsor, reporting format, etc.) and domains where measures were reported (outcome, process, patient engagement, safety, etc.). All of the measures from the sample programs were also entered into a database. The programs and measures were then mapped to the NPP's six National Priorities and Goals, the NQF-endorsed Patient-Focused Episodes of Care Measurement Framework, and a set of conditions used by NQF for classifying measures. Domain areas that had high and low levels of public reporting were outlined through the results reported by Mathematica (see Appendix B for executive summary). This information was then made available as background to the multi-stakeholder workgroup tasked with identifying the domains and subdomains for the community dashboard.

#### **Convening of Multi-stakeholder Workgroup**

Twenty-four people accepted the invitation to participate in the workshop to identify a community dashboard of core measures (see Appendix C for list of workshop participants). Two meetings of the group were held, one via web meeting and one in-person. Over the course of both meetings, co-chairs William Golden and Christopher Queram provided background on the work that had taken place at NQF on the public reporting dashboard, as well as summarized frameworks put forth by NQF, HHS, and others for moving healthcare quality forward (see Web Meeting slides in Appendix D). Results from the environmental scan and catalog of public reporting programs were also discussed to include the mapping of these programs to the NPP framework, the NQF-endorsed episodes of care framework, and other types of measurement areas. During the web meeting, to launch their discussion of what key components should be included in the dashboard of core measures, workshop participants voted on what domain and subdomain areas they thought should be included in the dashboard (the list of domain and

subdomain areas is included in Appendix E). During discussion at both meetings, several issues arose and will be considered as the dashboard continues to be refined:

- 1. **Purpose of Dashboard** Meeting participants suggested that a clear intention be set for use of the dashboard. Overall, the purpose is to encourage and support communities as they move forward along the continuum of performance measurement and public reporting. At the same time, the participants emphasized the importance of striking an appropriate balance between those communities with substantial experience/expertise in performance measurement and reporting and those that are not as advanced. For those communities that have been engaged in measurement and public reporting for a long time, it was suggested that the dashboard could provide a way to focus their efforts in promoting quality improvement; conversely, for those that are new to public reporting, the dashboard could be an example of "best practices" in the field and be used as a road map for where to initiate their efforts. All communities engaged in public reporting can use the dashboard to help ensure that their providers are positioned well for Medicare and Medicaid payment reform and other incentives that will require some degree of standardization to quality measurement and reporting across the country. Having the dashboard identify the key elements of healthcare that should be reported on by communities was seen as a benefit. Others felt that the dashboard could help communities educate consumers and the public on how to identify good quality healthcare. One point of clarification was whether the dashboard should be designed to report on *healthcare* or broader community health. If the dashboard does come to include some public health or population health measures, participants recommended somehow connecting the dashboard to the MATCH (Multilevel Approach to Community Health) reporting system out of the University of Wisconsin and perhaps other existing sources of state or national data (e.g., Agency for Healthcare Research and Quality [AHRQ], Centers for Disease Control and Prevention [CDC]) to help communities easily pre-populate some measurement elements.
- Key Audience for Dashboard Meeting participants discussed the issue of the key audience for the proposed dashboard. Some wanted clarification as to whether the intended audience would be consumers or providers. If the focus is consumers, then the

recommendation was to select dashboard components that resonate with consumers and are communicated in terms that can be understood by the community audience. In addition, the group suggested that the dashboard be consumer tested and validated. Some meeting participants stated that the key audience should be the public at large, which could include consumers, purchasers, and other stakeholders. In this scenario, NQF would furnish a generic template that each community could re-package according to its selected primary audience(s).

- 3. Emphasis on Standardization, but Flexibility in Core Dashboard The dashboard is intended to create an opportunity for standardization around a core set of agreed upon domains, subdomains, and measurements. However, there was also a recommendation by participants that communities have the ability to choose the degree to which they use the dashboard and continue to ensure that what is measured and reported locally is important to the local population. Co-chairs and NQF staff also supported the idea that the aim of the dashboard is to enable progress that will eventually inform: 1) comparisons across communities and 2) comparisons of community progress in measuring and reporting quality within a national framework of priority areas for improving health and healthcare nationwide. Encouraging and supporting the use of a common set of core measures will facilitate these comparisons, while also recognizing the flexibility that communities need in their public reporting efforts.
- 4. Gap Areas in Measurement and Public Reporting Some discussion also took place during the virtual meeting about the gap areas in measurement and their potential impact on public reporting and the idea of a common dashboard. Many participants emphasized the need for more cross-cutting measures (e.g., care coordination, patient-reported outcomes, total costs of care) like those that will be required for accountable care organizations. Others mentioned a need for patient experience measures that can be used in all settings. The question about including population health measures in such a dashboard also came up, with many advocating for a combination of measures that include those which describe the well-being of communities in general and individual outcomes that can be directly influenced by the healthcare system. Many agreed that there were serious gaps in measurement around outcomes and cost. For example, while Mathematica's environmental scan showed that many programs are reporting on

outcomes, participants noted that the measures available to report on outcomes do not adequately address important areas like functional status and health-related quality of life. Co-chairs and the NQF staff provided some background on other NQF efforts that are intended to identify measurement gap areas and provide a starting place for the development of new measures. However, it was noted that some currently available measures can be used across settings and for various stages of a condition, and that those measures should be considered for potential inclusion in the core dashboard.

- 5. Offering a Continuum of Dashboard Options While the deliverables of the meeting were a "Right Now" and "In the Future" dashboard, participants recommended a continuum of options that might include a third dashboard between the two presented that could be implemented in a year. The "Right Now" dashboard would concentrate on using measures that are feasible today and encourage efforts to harmonize the way they are currently reported. The "In One Year" dashboard could push out further the use of measures or measure sets that will be ready for implementation soon. The "In the Future" dashboard would set forth aspirational goals for measurement, which would likely need to be flexible as they will be impacted by health information technology and meaningful use work since additional data will be available for communities with the adoption of this technology.
- 6. Where this Dashboard Fits for Communities Many participants discussed the context of their own public reporting and the influencing factors that impact their final products. Some brought up the national movements in setting goals for healthcare quality like those of the NPP, the Institute of Medicine, HHS, and AHRQ. Participants also noted that some of their public reporting components are mandated by their state legislatures and others are based on feedback from important community stakeholders. The group also discussed the impact that healthcare reform will have on public reporting, especially with regard to the increase in the number of Medicaid patients that will be covered and accessing the system. Finally, a recommendation was made to ensure that the dashboard components link to payment reform efforts, which offer communities incentives for reporting. As a result of this discussion NQF will work to ensure that the dashboard template takes into account the context within which many communities do their public reporting.

## **CONSTRUCTING A RECOMMENDED DASHBOARD**

At the in-person meeting, workshop participants were asked to recommend the components of the core dashboard based on the background materials (environmental scan, draft HHS National Quality Strategy, NPP priorities, etc.) and group discussion through a prioritization exercise. They voted first for the top domain areas to include in the core dashboard. Secondly, they prioritized subdomains within each of the domain areas. They were asked to think about the two dashboards—one that could be implemented "Right Now" and one that could be implemented "In the Future" (or three years from now). A visual representation of the draft dashboards developed during the meeting is included in Appendix F.

#### **Refinements to "Right Now" Dashboard Domains and Subdomains**

In an effort to construct the dashboard of core measures, participants' recommendations for the "Right Now" dashboard domains and subdomains were mapped to the structure that NQF uses to categorize its endorsed measures. This categorization also serves as the backbone for a tool that NQF is creating called the Quality Positioning System (QPS)<sup>6</sup> which will offer a platform for more easily searching and selecting NQF-endorsed measures. Once the QPS is completed, it will be possible to identify the specific NQF-endorsed measures that fit into each domain and subdomain area in the dashboard. To coordinate terms and align categories, the structure and language have been adjusted in the dashboard where necessary to facilitate ease of use for both the dashboard and QPS tools. The recommended "Right Now" dashboard is included in Table 1:

# Table 1: "Right Now" Dashboard – Domains and Subdomains

Domain Area	Subdomains
Outcomes	Intermediate Outcomes
	Functional Status
	Mortality
Care Coordination	Care Transitions
	Appropriate & Timely Follow-up
	Preventable Readmissions
	Avoidable Emergency Department Visits
Cost/Resource Use/Overuse	Cost/Resource Use/Overuse
Safety	Healthcare Associated Infections
	Medication Safety
	Adverse Events
Patient & Family Engagement	Patient Experience
	Shared Decisionmaking
	Self-Management
Population Health & Prevention	Effective Preventive Services
	Healthy Lifestyle Behaviors
	Public Health Outcomes
	Social Determinants of Health
Equitable Access & Disparities	Timeliness of Care
	Access to Primary Care
	Barriers to Needed Care

## Mapping Measures to the Domains and Subdomains: Two Examples

In order to demonstrate what a recommended core dashboard might look like, two examples of domain and subdomain categories mapped to potential measures were presented during the workshop—one for population health and the other for care coordination. These two domain areas are presented here with a list of potential associated NQF-endorsed measures based on workshop participant feedback and further NQF review (see Table 2 for Population Health and

Prevention and Table 3 for Care Coordination). Upcoming work on finalizing the dashboard will involve piloting the dashboard in three or four communities to gather recommendations from these communities about which measures are most realistic to capture and which are most effective at demonstrating improvement in quality of care. Further steps will also incorporate cross-walking selected measures to those included in meaningful use provisions and other public and private sector programs.

Domain Area	Subdomains	Potential Measures
Population Health	Effective Preventive Services	Breast cancer screening
& Prevention		Colorectal cancer screening
		Childhood immunization status
		Pneumonia vaccination status for older adults
		Hypertension (PQI 7)
		Hyperlipidemia (primary prevention)
		Secondary prevention of cardiovascular cvents—use of aspirin or antiplatelet therapy
		Promoting Healthy Development Survey (PHDS)
	Healthy Lifestyle Behaviors	Tobacco use assessment & cessation intervention
		Counseling on physical activity in older adults
		Body Mass Index in adults
		Body Mass Index ages 2-18 years
		Initiation and engagement of alcohol and
		other drug dependence treatment
		Fall risk management in older adults
	Public Health Outcomes	Low birth weight (PQI 9)
		Healthy term newborn
	Social Determinants	Children who live in communities
		perceived as safe
		Children who go to schools perceived as safe

# **Table 2: Population Health and Prevention - Potential Measures**

## **Table 3: Care Coordination - Potential Measures**

Domain Area	Subdomains	Potential Measures
Care Coordination	Care Transitions	3-item care transition measure (CTM-3) 30-day post hospital discharge care transition composite measures for AMI, heart failure, and pneumonia Medication reconciliation post-discharge (MRP)
	Appropriate & Timely Follow- up	Timely transmission of transition record Follow-up after hospitalization for mental illness Proportion of patients with a chronic condition that have a potentially avoidable complication ADHD: Follow-up care for children prescribed attention-deficit/hyperactivity disorder (ADHD) medication.
	Preventable Readmission	30-day readmissions rates for: AMI, heart failure, pneumonia
	Avoidable Emergency Department (ED) Visits	ED visits for children with asthma (pending endorsement)

## THE PATH AHEAD

Next steps in developing the community dashboard of core measures include further refining it with three or four local community alliances over the course of 2011 through a pilot project. Specific objectives for the pilot are to: 1) refine the list of measures or measure sets that can be mapped to the dashboard; 2) select a name for the dashboard that resonates with communities; 3) uncover what factors likely influence success in implementing the dashboard; and 4) reveal what barriers might keep communities from using the dashboard. It is expected that the communities selected for the pilot will reflect different stages of measurement and reporting—i.e., those who have introduced only one public report, those who have issued at least a few public reports, and those who have completed multiple iterations of public reporting.

Refining the list of measures to be included in a recommended core "Right Now" dashboard will be a key activity of the community pilot. Pilot sites will have the opportunity to share information on which measures they feel best reflect quality healthcare in their community and

which have received support from community stakeholders. Other measure reporting issues that might be investigated during the pilot include the type of entities that should be measured in the dashboard (e.g., hospitals, medical groups, health plans, community, etc.) and how easy or difficult it would be for communities to amend current use of measures or incorporate new measures that use the exact numerator and denominator specifications included in the NQF-endorsed measure. It is anticipated that the recommended dashboard coming out of the pilot project will include the domains and subdomains plus sets of identified measures and their technical specifications and recommended data sources. It will also include a cross walk with other important measure sets in place or under development, such as meaningful use guidelines, new healthcare delivery models under ACA (Accountable Care Organizations, Patient-Centered Medical Home, etc.), national reporting efforts (AHRQ, etc.), and a sample of communities' public reports.

Communities that participate in the pilot will also help to select the name that best represents the purpose of the dashboard. During the in-person workshop, participants were asked to provide ideas on an appropriate name for the dashboard. Recommendations centered on ensuring that a description of who is being measured (e.g., community, provider, etc.) be included in the name. Words like "framework" and "template" were also presented as ideas for inclusion. Workshop participants suggested that a date stamp be added somewhere to the name so that people know what timeframe the dashboard represents.

Finally, the pilot work with three to four communities will investigate factors that foster success in using the dashboard and any barriers that may exist for its implementation in a community. As part of their commitment to the pilot, communities will be asked to work with NQF to formally document what circumstances existed during the project to enhance the use of the dashboard and what difficulties created hurdles to its uptake. Common issues among the communities, as well as unique insights will be recorded. These lessons learned will be included in a report that frames a recommended dashboard with core measures intended for broader use. After the pilot work is completed, the dashboard will be rolled out for expanded use.

#### CONCLUSION

During phase one of the Community Public Reporting Dashboard project, there has been much success in taking the initial steps necessary to develop a tool that communities can use to help guide their public reporting. Using the environmental scan of current public reporting programs as a backdrop, stakeholders from community, state, and national organizations came together to discuss what areas are most important to measure and report to improve performance. The result was cross-cutting, patient-centered measurement domains and subdomains. This dashboard sets the stage for a pilot project to take place in three to four communities, which will further clarify the issues that affect the use of such a dashboard to motivate and support greater alignment in the content of measurement and public reporting. In the end, use of the dashboard should generate discussions that motivate expanded and aligned reporting that improves health and healthcare in communities across the country.

#### NOTES

- Throughout this report the word "domain" will be used to mean categories of measurement such as outcome, process, structure, access, safety, patient engagement, care coordination, cost, overuse, population health, and palliative/end-of-life care.
- 2. Christianson JB, Volmar KM, Alexander J, et al., A report card on provider report cards: current status of the health care transparency movement., *J Gen Intern Med*, 2010;25(11):1235-1241.
- United States Government Printing Office (GPO), Public Law 111-148 The Patient Protection and Affordable Care Act, *124 Stat 119, section 3015*. Washington, DC:GPO, 2010. Available at www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf
- 4. Scholle SH, Roski J, Dunn DL, et al., Availability of data for measuring physician quality performance, *Am J Manag Care*, 2009;15(1):67–72. Ambulatory Care Quality Alliance (AQA). *Environmental scan: Physician and other clinician consumer reports*, Washington:DC:AQA, 2009, Available at www.aqaalliance.org/septmeetingmaterials2009/ReportingWgReport.pdf. Last accessed January 2011.
- 5. Key informants were experts from the field of public reporting and included consumer, provider, health plan, and community organization perspectives.
- 6. NQF is currently developing the QPS; it will be available for public use in 2011.

# APPENDIX A—FINAL SAMPLE OF PUBLIC REPORTING PROGRAMS FOR ENVIRONMENTAL SCAN

# TABLE 4

# FINAL SAMPLE OF PROGRAMS (N=72)

		Key Informant		G	eographic	Level		Ado	otion		Other characteristics				
	Program Name	Recommended*	National	State	County	Community	Other	First report prior to 2005	First report 2005 and after	AF4Q	BQI	CVE	NASHP	NAHDO	NRHI
	TOTAL	66	11	46	5	3	7	17	55	13	4	14	2	15	16
1	Alliance for Health (Michigan)	$\checkmark$			~				~	✓		~			
2	Better Health Greater Cleveland	✓			~				✓	✓					
3	Bridges to Excellence	✓		~					✓						
4	Buyers HealthCare Action Group			~					✓						
5	California Advocates for Nursing Home Reform Guide	✓		~					~						
6	California Office of Statewide Health Planning and Development	$\checkmark$		~				✓						~	
7	California Cooperative Healthcare Reporting Initiative	$\checkmark$		~				✓			~				~
8	California HealthCare Foundation	~		~				~							
9	California Office of Patient Advocate	$\checkmark$		✓					✓						
10	CMS Medicare Compare	✓	~						✓						
11	Colorado Business Group on Health	✓		~				✓				✓			
12	Colorado Hospital Report Card	✓		~					✓						
13	Community Health Alliance of Humboldt-Del Norte	✓					~		~	~					
14	Dartmouth Atlas of Health Care		~					~							

		Key Informant			G	eographic	Level		Ado	ption	Other characteristics					
	Program Name	Recommended*		National	State	County	Community	Other	First report prior to 2005	First report 2005 and after	AF4Q	BQI	CVE	NASHP	NAHDO	NRHI
15	Dr. Score	✓	1 [	$\checkmark$						✓						
16	Florida Nursing Home Guide	~			~					~						
17	Greater Boston Quality Coalition (GBQC)	$\checkmark$			~					~	~					
18	Harvard Pilgrim Health Care/Harvard Pilgrim Health Care of New England	~						~		~						
19	Health Grades	$\checkmark$		$\checkmark$						$\checkmark$						
20	Health Improvement Collaborative of Greater Cincinnati	~						~	~		~		✓			~
21	HealthInsight	×		✓						✓						✓
22	HealthPartners	✓			✓					$\checkmark$						
23	Healthy Memphis Common Table	~					~			✓	~		~			✓
24	Illinois Hospital Report Card	✓			~					~					~	
25	Integrated Healthcare Association	1			~					~						~
26	lowa Healthcare Collaborative	~			~				~							~
27	Kansas City Quality Improvement Consortium	~					$\checkmark$			~	~		~			
28	Leapfrog Group	~		✓						~						
29	Long Term Care Consumer Guide	$\checkmark$			~					~						
30	Louisiana Health Care Quality Forum	~			~					~			$\checkmark$			~
31	Maine Health Management Coalition	~			~					~			~			~
32	Maine Quality Forum	~			~					~					~	

		Key Informant		G	eographic	Level		Ado	ption			Other	characteris	tics	
	Program Name	Recommended*	National	State	County	Community	Other	First report prior to 2005	First report 2005 and after	AF4Q	BQI	CVE	NASHP	NAHDO	NRHI
33	Maryland Health Care Commission	~		~					~					~	
34	Massachusetts Health Care Quality and Cost Council (HCQCC)	$\checkmark$		~					~				~		
35	Massachusetts Health Quality Partners	~		~					~		~	~			~
36	Michigan Health & Safety Coalition	~		~					~						
37	Minnesota Community Measurement	~		~				~		~	~				~
38	My Care Compare (GDAHC)	~			~				~	~		~			~
39	My Health Care in Utah	~		~				~						~	
40	NCQA Physician Recognition Program (Medical Home)	$\checkmark$	✓						~						
41	New Hampshire Health Cost	~		~					~					~	
42	New Hampshire Purchasers Group on Health	~		~					~					~	
43	New Jersey Department of Health and Senior Services	V		~				~						~	
44	New Mexico Hospital Association	$\checkmark$		~					~						
45	New York State Department of Health	~		~				~						~	
46	Norton Healthcare	√					~	✓							
47	Ohio Hospital Compare	~		~					~				~		
48	Oklahoma Health Care Authority	$\checkmark$		~					✓						

		Key Informant		G	eographic	Level			Adop	otion			Other	characteris	tics	
	Program Name	Recommended*	National	State	County	Community	Other		First report prior to 2005	First report 2005 and after	AF4Q	BQI	CVE	NASHP	NAHDO	NRHI
49	Oregon Department of Human Services	~		~				Ī	~						$\checkmark$	
50	Oregon Health Care Quality Corporation	~		~						~	~		~			~
51	Pacificare			✓				Ē		✓						
52	Pacific Business Group on Health	~					~			~			~			
53	Pennsylvania Department of Health	V		~						~						
54	Pennsylvania Health Care Cost Containment Council (PHC4)	4		~					~						*	
55	Pittsburgh Business Group on Health						~			$\checkmark$						
56	Premera's 2009 Quality Score Card	~		~					~							
57	Puget Sound Health Alliance	~			~			_		~	~		~			✓
58	Quality Check		~							✓						
59	Quality Quest	$\checkmark$		✓						$\checkmark$						$\checkmark$
60	Rhode Island Department of Health	~		~					~						~	
61	Savannah Business Group on Health	~			~					~						
62	South Central PA	~					~	ſ		✓	~		✓			✓
63	Texas Department of Aging & Disability Services	~		~						~						
64	Texas Health Care Information Council	~		~					~						~	
65	U.S. News & World Reports	~	~					[		✓						
66	UCompare HealthCare	~	~							✓						
67	United Health: Find a Physician	~	~							~						

		Key Informant		G	eographic	Level		Ado	otion			Other	characteris	tics	
	Program Name	Recommended*	National	State	County	Community	Other	First report prior to 2005	First report 2005 and after	AF4Q	BQI	CVE	NASHP	NAHDO	NRHI
68	Vermont Department of Banking, Insurance, Securities, and Health Care Administration	~		v					~					V	
69	Virginia Health Information	~		~					~					~	
70	Wichita Business Coalition on Health Care					~			~						
71	Wisconsin Collaborative for Healthcare Quality, Inc.	~		~					~	~	~	~			~
72	Wisconsin Hospital Association	~		~					✓						

Includes programs from the Ambulatory Care Quality Alliance's environmental scan and NRHI members list. \*

AF4Q = Aligning Forces for Quality BQI = Better Quality Information for Medicare Beneficiaries Pilot Project CVE = Charter Value Exchanges NASHP = National Academy for State Health Policy partner NAHDO = National Association of Health Data Organizations NRHI = Network for Regional Healthcare Improvement

# APPENDIX B—EXECUTIVE SUMMARY: ENVIRONMENTAL SCAN OF PUBLIC REPORTING PROGRAMS AND ANALYSIS FINAL REPORT

# Environmental Scan of Public Reporting Programs and Analysis

Final Report: Executive Summary

September 23, 2010

So O'Neil John Schurrer Sam Simon



Contract Number: NQF2009-07

Mathematica Reference Number: 06738.500

Submitted to: National Priorities Partnership National Quality Forum 601 Thirteenth Street, NW Suite 500N Washington, DC 20005 Project Officer: Christy Olenik

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# Environmental Scan of Public Reporting Programs and Analysis

Final Report: Executive Summary

September 23, 2010

So O'Neil John Schurrer Sam Simon



## **EXECUTIVE SUMMARY**

The many different public reporting initiatives that aim to promote quality and efficiency in the health care system speak to a growing momentum in support of transparency in health care and evidence-based improvement. At the same time, the variety of purposes, audiences, and data sources associated with such initiatives can make it difficult to identify opportunities for coordination in pursuit of a national agenda for quality improvement.

To help identify potential areas for coordination in public reporting, the National Quality Forum (NQF) contracted with Mathematica Policy Research to assess the current landscape of public reporting in health care. The assessment also included the examination of public reporting in the context of a conceptual framework for understanding quality, as public reporting within such a framework can help develop a common understanding of quality in health care among stakeholders (Institute of Medicine 2001, 2006). To enhance and broaden understanding of quality in health care, Hibbard and Pawlson (2004) have promoted the development and use of a framework that is consistent with the Institute of Medicine's six aims for the health care system: ensuring that care is safe, timely, effective, efficient, equitable, and patient centered. The NQF has subsequently developed an integrated framework incorporating these six aims and reflecting national priorities; this integrated framework was reviewed and endorsed through its multistakeholder consensus process. The key elements of the framework, adapted to include the measurement domains used in Mathematica's analysis, are depicted in Figure I.

Figure I. Domains of the NQF Integrated Framework	Figure I.	Domains of the NQF Integrated Framewo	ork
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Phases of Care	National Priority Areas	Measurement Domains
<ul> <li>Population at Risk</li> <li>Initial Evaluation and Management</li> <li>Follow-Up Care</li> </ul>	<ul> <li>Patient and Family Engagement</li> <li>Population Health</li> <li>Safety</li> <li>Care Coordination</li> <li>Palliative and End-of- Life Care</li> <li>Overuse</li> </ul>	<ul> <li>Access</li> <li>Process</li> <li>Outcome</li> <li>Cost</li> <li>Structure</li> </ul>

Note: Phases of care are from the NQF patient-focused episode-of-care measurement framework, which includes the following components: population at risk (health promotion, primary and secondary prevention); initial evaluation and management (onset of clinical illnesses and initial assessment); and follow-up care (coordination and transitional phase) (NQF 2009).

National priority areas were put forward by the National Priorities Partnership, which is convened by NQF and represents a diverse range of high-impact stakeholder organizations focused on health care improvement. The priority areas in the figure described in further detail are (1) engage patients and families in managing their health and making decisions about their care; (2) improve the health of the population; (3) improve the safety and reliability of America's health care system; (4) ensure that patients receive well-coordinated care within and across all health care organizations, settings, and levels of care; (5) guarantee appropriate and compassionate care for patients with life-limiting illnesses; and (6) eliminate overuse while ensuring the delivery of appropriate care.

The objectives of the environmental scan and analysis were to provide an overview of current public reporting efforts, to identify opportunities for harmonization among programs and publicly reported measures, and to identify gaps in measurement in the context of the NQF's integrated framework. Such information can contribute to current knowledge about public reporting in health care and can inform decision making related to public reporting, including the development of a

standardized community dashboard of core quality measures. The objectives of the project centered on four research questions:

- 1. What domains and measures are captured in public reporting activities?
- 2. How do publicly reported measures map to, and converge with, the NQF integrated framework?
- 3. How do publicly reported measures diverge from the integrated framework? What are the gaps in reporting?
- 4. Among the NQF integrated framework areas addressed, what is the convergence (or congruity) between publicly reported measures within specific domains of the integrated framework? What is the divergence between measures within specific domains of the integrated framework?

# Methods for Conducting Environmental Scan and Analysis of Public Reporting Programs

From February to September 2010, Mathematica conducted the environmental scan and analysis of public reporting programs, based on a sample of programs identified in collaboration with NQF. Programs in the initial sample included those identified in previous research by Roski and Kim (2009), Cronin and Shearer (2005), and the Ambulatory Care Quality Alliance (2010); and in the Agency for Healthcare Research and Quality's Report Card Compendium. Members of the following initiatives were also included: Aligning Forces for Quality, the Better Quality Information for Medicare Beneficiaries Pilot Project, Charter Value Exchanges, Network for Regional Healthcare Improvement, National Academy for State Health Policy, and the National Association of Health Data Organizations initiatives. Additional programs were identified by six key informants consulted for the study and through a general literature search.

Through this process, we identified 332 programs, of which 162 met project criteria for public reporting. We defined a public reporting program as one that has information publicly available through either web-based or paper documents without any associated fees. However, for this project, we included only programs with information available through the Internet. Proprietary programs were included, provided they made at least some information available to the general public without subscription. In consultation with our six key informants, we narrowed the sample to 72 programs, stratified by geographic area of focus and date of public reporting initiation, to ensure that it was representative of the larger universe of programs identified.

Information on the 72 identified public reporting programs and their quality measures were collected and entered into a Structured Query Language (SQL) database; SQL is a computer language designed for relational database management systems. The database included fields for data entry related to program and measure domains.

• **Program domains** included audience; availability of information; contact information; first published report date; frequency of reports; geographic level—national, state, county, community, and other (metropolitan statistical area, health service area, hospital referral region); most recent report date; payer type; program description; program name; program website; publication mode; report link; report name; sponsor; type of organization; and time of public reporting adoption.

• *Measure domains* included condition; data source; measure title, measurement domain; national priority area; NQF endorsement; phase of care; denominator; numerator; target population; and unit of analysis.

After cataloging the sampled program and measure information, we conducted four levels of analyses: (1) descriptive analysis of publicly reported programs and measures to provide an overview of public reporting, (2) mapping of unique measures to the NQF integrated framework to assess the types of measures reported in each domain of a framework for understanding quality, (3) analysis of convergence and divergence in public reporting to the integrated framework to provide greater depth of information about reporting within domains of a framework for understanding quality, and (4) analysis of congruity (convergence) among measures within specific domains of the framework to examine key factors affecting the potential for measure harmonization.

## **Descriptive Analysis of Programs and Measures**

The 72 sampled programs reported a total of 4,254 measures, of which 1,685 represented unique (or unduplicated) measures. The total number of measures reported per program ranged from 1 to 261, with a mean of 59.

#### **Characteristics of Sampled Programs**

Although the public reporting programs reviewed exhibited a variety of characteristics, the "typical" program was a state-level initiative begun in the past five years, sponsored by a state agency, and directed at the general public for purposes of accountability or informed consumer choice. Key characteristics of all programs reviewed are summarized next.

- **Date of initiation.** More than 70 percent of programs selected for review began public reporting in 2005 or afterward.
- *Geographic scope.* Most programs reviewed were state-level reporting programs (64 percent). Programs national in scope were the next most common (15 percent), followed by regional programs (10 percent), county-level reporting programs (7 percent), and community-level programs (4 percent).
- **Organizational sponsorship.** State agencies sponsored the largest proportion of programs (33 percent), followed by multistakeholder organizations (24 percent), consumer/advocacy groups (13 percent), employer business groups (10 percent), and the federal government (1 percent). A mix of other organizations (for example, academic institutions, commercial health plans, hospital associations, and provider groups) sponsored the remaining 19 percent of programs.
- *Target audience.* Most public reporting programs targeted consumers or the general public (88 percent). Other identified audiences included health care providers/managers (11 percent), purchasers/benefits designers (11 percent), payers (4 percent), and policymakers/regulators (4 percent).
- *Purpose.* Most of the selected programs reported quality measures for the purpose of informing consumer choice (92 percent) and public accountability (90 percent). The selected programs less often reported measures for purposes of quality improvement (33 percent), accreditation/certification (4 percent), or for payment incentive (3 percent).

## Characteristics of Quality Measures Used in Public Reporting Programs

The measures used by the sampled public reporting programs reflected several different measurement domains. However, the typical program reported facility-specific, NQF-endorsed, hospital quality measures based on administrative claims data from all payers, for chronic cardiovascular and pulmonary conditions affecting people older than 65. Characteristics of the quality measures used across all reporting programs reviewed are summarized next.

- *Sources of data.* Most programs (85 percent) relied on administrative claims as a key data source. Patient surveys (65 percent) were the next most common source, followed by facility surveys (28 percent).
- *Payer type.* Seventy-two percent of programs reported measures relevant to populations covered by all payers. Other programs included data from one or more of the following payer types: commercial (19 percent); Medicare (10 percent); and Medicaid (1 percent). Three percent of programs did not specify a payer type.
- *Unit of analysis.* Eighty-one percent of programs used facility, such as hospital or nursing home, as the unit of analysis. Group practices were the next most common unit of analysis (38 percent), followed by health plan (28 percent), and individual practice (13 percent).
- *Setting of care.* Inpatient hospitals were the most common setting of care for measure reporting (74 percent), followed by clinicians' office (58 percent) and nursing care facility (26 percent). Other settings of care were reported by fewer than 15 percent of programs.
- *Age groups.* The largest number of programs (more than 75 percent) reported measures specific to people older than 65. Measures specific to the general adult population were the next most common (69 percent of programs), but slightly more than half of the programs (51 percent) also reported measures specific to children.
- *Conditions.* Seventy-eight percent of programs reported measures related to chronic cardiovascular conditions, and 71 percent of programs reported measures related to chronic pulmonary conditions.
- **Disparities.** Relatively few of the sampled programs reported measures related to disparities in care, with 6 percent addressing racial/ethnic disparities, 4 percent addressing socioeconomic disparities, and 6 percent addressing some other type of disparity.
- **NQF endorsement.** Seventy-eight percent of programs used NQF-endorsed measures.

# Mapping and Analysis to Assess Convergence and Divergence with a Framework for Understanding Quality

To assess the extent to which public reporting programs align with a quality framework reflective of national priorities, we mapped measures to the NQF integrated framework and examined convergence with or divergence from it. We used both total (including duplicated) measures and unique (unduplicated) measures in the analysis. We defined convergence in terms of the number of programs reporting and the number of measures being reported that corresponded to a specific domain. Divergence from the framework or gaps in public reporting are defined as domains in the integrated framework in which few programs are reporting and few measures are

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being reported. The key domains of the NOF integrated framework assessed for convergence and divergence included the three phases of care, the six national priority areas, and the five measurement domains shown in Figure I.

Our analysis of programs and measures indicates that the degree of convergence varies considerably across domains. Table I provides an overview of the percentage of programs, percentage of duplicated measures, percentage of unique measures, and mean number of measures reported within each domain of the integrated framework. We highlight key findings in the bullets below.

	Programs	Duplicated Measures	Unique Measures	Mean
Total	72	4,254	1,685	59
		% of Total		<pre># of Measures</pre>
Phase of Care				
Population at risk	71	12	8	10
Initial evaluation and management	92	38	40	24
Follow-up care	96	47	46	29
Not classified	78	27	35	20
National Priority Area				
Patient and family engagement	72	11	12	9
Population health	68	13	8	12
Safety	71	16	16	13
Care coordination	83	32	22	23
Palliative and end-of-life care	15	4	7	17
Overuse	60	10	13	10
Measure not classified	74	16	24	13
Measurement Domain				
Access	54	2	3	3

#### Table I. Domains Captured by Programs and Measures

Notes: Not all categories are mutually exclusive, and programs may have measures in more than one category. Therefore, column percentages may add up to more than 100 percent.

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For duplicated measures, several programs may report the same measure, in which case the measure is counted once for each time it is reported. Thus, if two programs report the same measure, the measure is counted twice.

A unique measure is defined as having the same measure description, measurement domain, national priority, and phase of care. Multiple programs may report the same measure, but in our analysis of unique measures, this measure is only counted once.

Mean is calculated among programs that reported measures in the specific category. Programs that did not report any measures in the category were not included in the calculations.

#### Phases of Care

Cost and utilization

Structure

Outcome

Process

Initial evaluation and management and follow-up care were the phases of care with the highest level of convergence. More than 90 percent of programs reported measures associated with these two phases, with 38 percent of measures mapping to initial evaluation and management and 47 percent mapping to follow-up care. Among programs that report in these two phases, the average number of measures reported per program was also high; programs reported an average of 24 initial evaluation and management measures and 29 follow-up care measures. Examination of unique measures also reflects this pattern, as 40 and 46 percent of unique measures are initial evaluation and management, and follow-up care, respectively.

The phase of care with the lowest percentage of programs reporting was the population at risk phase. Seventy-one percent of programs reported one or more measures that could be mapped to this area, and 27 percent of duplicated measures and 8 percent of unique measures mapped to this area. The average number of measures among programs reporting in the population at risk phase was also relatively lower compared with that for programs reporting measures in the initial management and evaluation (24 measures) and follow-up care (29 measures) phases; programs reported an average of 10 population at risk measures.

## **National Priorities**

*Care coordination was the priority area that had the highest level of convergence.* Compared with other priority areas, most programs reported measures in the care coordination area (83 percent); the highest percentage of measures could be mapped to this priority area (32 percent), and the highest average of number measures per program was associated with this area (23 measures per program). Reflecting this pattern, the largest proportion of unique measures mapped to the care coordination priority area (22 percent).

**Overuse measures were reported by more than half of reporting programs.** Sixty percent of programs reported overuse measures, with a mean of 10 measures per program (out of 59) mapping to this domain. Overuse measures also accounted for 13 percent of all unique measures reported.

A majority of programs reported population health measures, but the number of measures they reported was low. Though 68 percent of programs reported at least one population health measure, only 13 percent of duplicate measures and 8 percent of unique measures mapped to the population health priority area.

*Few programs reported palliative and end-of-life care measures.* Fifteen percent of programs reported palliative and end-of-life care measures, and 4 percent of unique measures could be mapped to this priority area. Among unique measures, only 7 percent mapped to palliative and end-of-life care measures. However, among programs that reported within this area, the average number of measures reported per program was relatively high (17 measures).

#### **Measurement Domain**

**Public reporting among sampled programs was highly convergent with measurement domains of outcome, process of care, and cost and utilization.** Eighty-five percent of programs reported process of care measures, 90 percent reported outcome measures, and 82 percent reported cost and utilization measures. The percentage of measures associated with each area was 39 percent for process of care, 33 percent for outcome, and 26 percent for cost and utilization. The average number of measures reported per program in each of these measurement domains was also relatively high, with 27 measures (process), 22 measures (outcome), and 19 measures (cost and utilization)

reported. Examination of unique measure also reflects this pattern, where 26 percent are process measures, 34 percent are outcome measures, and 32 percent are cost and utilization measures.<sup>1</sup>

Access and structure measures were the least reported measures. Only 54 and 47 percent of programs reported access and structure measures, respectively. Access measures included those related to supports for the provision of health care (for example, facility amenities, workforce hours, and availability of health information technology). In addition, only 2 percent of measures could be mapped to the access domain and 6 percent mapped to the structure domain. Among programs reporting access and structure measures, respectively. Although access and structure measures made up a larger percentage of unique measures (3 and 11 percent, respectively), there was still considerably lower reporting within these domains in comparison with other measurement domains.

# Convergence and Divergence Within a Specific Domain of a Framework for Understanding Quality

After assessing the extent to which public reporting maps to a quality framework, our next step was to understand the degree to which it is possible to compare quality across reporting programs. To assess comparability, we conducted an analysis of convergence and divergence of measures within a specific domain of the NQF integrated framework. For the study, we selected two areas of measurement—cholesterol management and heart failure quality of care—to illustrate the process for conducting such an analysis. These two areas were selected because they had several measures that fell into specific domains across the integrated framework: follow-up care (phase of care), care coordination (national priority), and clinical processes of care (measurement domain). For these analyses, we used *convergence* to indicate similarities along key characteristics of measures and *divergence* to indicate differences along these characteristics. The measure characteristics along which we compared measures included measure description, numerator, and denominator; purpose of measurement; data source; target population; geographic level of reporting; use of NQF-endorsed measures; unit of analysis; and setting of care.

Eight cholesterol management and six heart failure quality-of-care measures were identified and analyzed. Overall, the eight cholesterol management measures showed a fair amount of alignment in purpose of measurement, data source, geographic level of program, use of NQF-endorsed measures, and unit of analysis. Similarly, the purposes, data sources, NQF endorsement, unit of analysis (facility), and setting of care (inpatient) were the same for the six heart failure quality-of-care measures. Within both areas of measurement, however, the numerator and denominator differed in instrumental ways, which would make valid comparisons between the measures within an area difficult.

<sup>&</sup>lt;sup>1</sup> Outcome measures were mainly patient safety and outcome measures (55 percent of unique measures), but also included readmission, morbidity, mortality, health-related quality of life, intermediate outcome, functional status measures, and other outcomes. Cost measures included those related to procedure utilization, an episode of care, length of stay, hospital readmission, imaging, per capita costs, emergency department visits, medication prescribing, other service costs, and other cost and resource use. Process measures include those related to clinical care processes, healthy lifestyle behaviors, care coordination, patient and family engagement, prevention services, safety practices, and other processes.

## Implications for Public Reporting in Health Care

Findings from the mapping and analysis of public reporting programs and their measures have several implications for a national quality agenda.

Our analysis suggests that although there is a high degree of convergence between reporting initiatives and several domains of a quality framework reflective of national priorities, relatively less attention has been paid to public reporting of population-based measures (including measures of disparity), public reporting within the overuse and population health national priority areas, and public reporting within the measurement domain of access to care. Given the importance of these issues to the current policy agenda, these might be areas to promote in public reporting. They might also provide opportunities around which to engage consumers and other stakeholders in public dialogue—especially among the state and federal government-sponsored programs that appear to dominate the reporting landscape.

Moreover, as stakeholders have an interest in better coordinating public reporting efforts, our analysis suggests that further effort might be needed to harmonize reporting, through the development of standardized measurement specifications. The sample of programs reviewed for this study showed that the number and types of measures reported vary considerably across programs and among measures within the same topic. Although such variation is expected given differences in resources, purpose, and audience, the ability to make valid comparisons is especially critical to the development of measures that can inform public policy at a national level.

#### Limitations of the Study

Based on our methods, several caveats should be considered in interpreting findings. First, the sample was selected to represent the diversity of public reporting programs according to key informant input and other study criteria (for example, definition of public reporting program, geographic representation, and period of public reporting initiation). Therefore, the sample might not represent the universe of programs. Second, decisions regarding the categorization of programs and measures were subject to team interpretation of definitions and guidance. However, several procedures were undertaken to ensure internal consistency of the data, including routine and comprehensive quality checks and standard training and procedures for data entry. Finally, information cataloged was limited to information available through the public reporting program's website, and how measures were cataloged was subject to how they were presented on the website.

## Conclusion

Our analysis suggests that if current patterns persist there will continue to be considerable variation in measurement and reporting. This variation in practice may well contribute to innovation in this evolving field. However, it also creates challenges to efforts to develop a coordinated national approach to quality and efficiency in health care. Continued assessment of potential areas for development and coordination of efforts will enhance the quality and usefulness of public reporting initiatives.

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APPENDIX C—COMMUNITY DASHBOARD PROJECT

WORKSHOP PARTICIPANT LIST

## COMMUNITY PUBLIC REPORTING DASHBOARD PROJECT

## WORKSHOP PARTICIPANT LIST

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#### Terry Whitson, JD

Assistant Commissioner, Indiana State Department of Health, Indiana

#### **Dolores Yanagihara, MPH**

Director, Pay for Performance Program, Integrated Healthcare Association, California

#### NATIONAL QUALITY FORUM

APPENDIX D—WEB MEETING SLIDES



### **Community Public Reporting Dashboard Project**

### **Orientation Web Meeting**

### September 28, 2010 12:00 pm-2:00 pm ET



The charge of the Community Public Reporting Dashboard Workshop participants is to identify core domains and subdomains of a public reporting dashboard. Where possible, the group will also identify endorsed metrics.

Communities could then adapt the core dashboard to reflect the issues specific to their constituents.

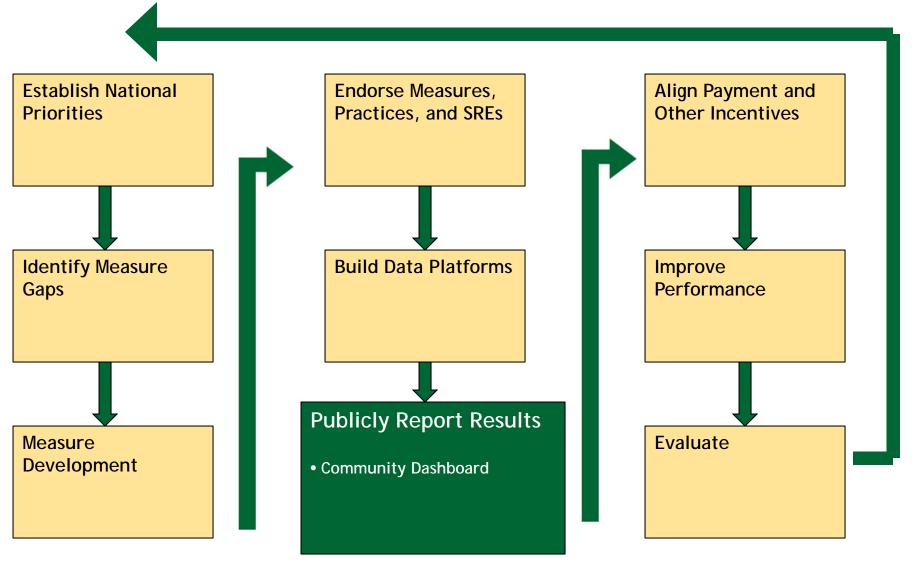
## **Today's Web Meeting Objectives**

- Introduce the Community Public Reporting Dashboard
   Project
- Lay the groundwork through:
  - the National Priorities Partnership priorities & goals;
  - the NQF-endorsed<sup>®</sup> Patient Focused Episodes of Care Framework; &
  - the Department of Health & Human Services
     Proposed National Health Strategy
- Provide results of a public reporting environmental scan
- Explain first step ranking exercise for building Dashboard

# Introduction of the Community Public Reporting Dashboard Project

4

### **Quality Enterprise Functions: NQF Contributions**





### Why a Standardized Dashboard?

- Enable true quality comparisons of a core set of measures, while providing community flexibility
- Give consumers better information to make informed decisions



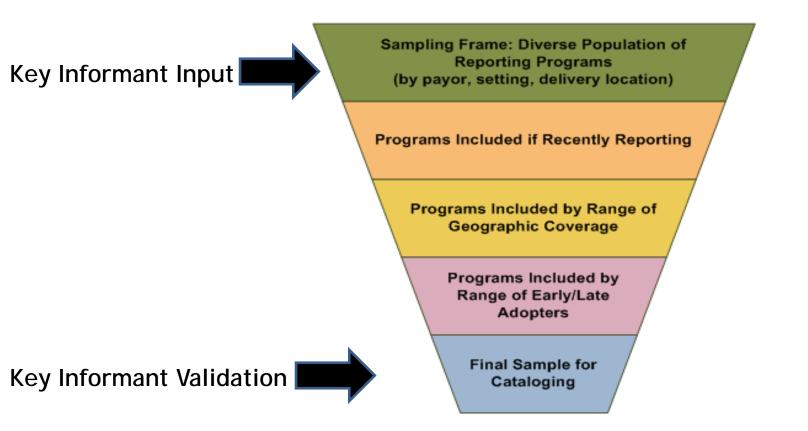
Process: Phase One – March through July 2010

- Conduct an environmental scan of public reporting programs national, state, county, regional
- Catalog sample of public reporting programs & their measures

### Community Public Reporting Dashboard Project



Sampling Strategy for Environmental Scan & Analysis of Public Reporting Programs





Process: Phase Two – July through August 2010

 Map cataloged measures to NQF's integrated Patient-Focused Episode of Care Framework & National Priorities Community Public Reporting Dashboard Project



Process: Phase Three – August through October 2010

- Develop report of scan & analysis results
- Convene stakeholder group to identify a prioritized set of domain and subdomain areas for use in a community-based public reporting dashboard

Community Public Reporting Dashboard Project

Project Deliverables:

- Environmental scan & catalog report that present convergence & divergence of current public reporting programs
- Database that includes scanned & cataloged programs along with their measures
- Guidance document that recommends measure domains & subdomains for public reporting



Next Steps:

- Pilot of dashboard with three communities
- Documentation of lessons learned

# **Questions & Discussion**

- Is the charge of the group clear?
- Do you understand the scope of the work & the objectives?

# Laying the Groundwork: NPP Integrated Framework & Alignment with the HHS National Healthcare Strategy



- National Priorities Partnership:
  - Patient & Family Engagement
  - Population Health
  - Safety
  - Care Coordination
  - Palliative & End-of-life Care
  - Overuse
- Patient-focused episodes of care

### **National Priorities Partnership**



- Consumers
- Purchasers
- Quality alliances
- Health professionals/providers
- State-based associations
- Community collaboratives & regional alliances
- Accreditation/certification groups
- Health plans
- Supplier & industry groups
- Six ex officio non-voting members
  - CMS, CDC, AHRQ, NIH, HRSA, VA

Co-Chairs:

- Bernie Rosof, MD, Physician Consortium for Performance
- Improvement
- Margaret O'Kane, MHS, National Committee for Quality
- Assurance

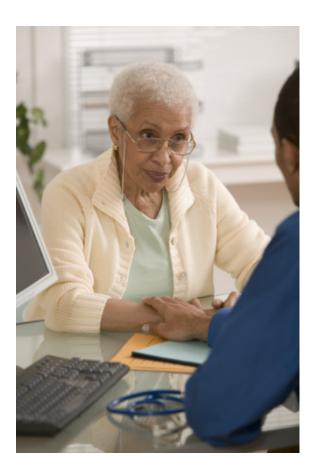
**National Priorities Partnership** 

16

NATIONAL QUALITY FORUM

#### NATIONAL PRIORITY Patient & Family Engagement

- Engage patients & their families in managing their health & making decisions about their care
- Areas of focus:
  - Patient experience of care
  - Patient self-management
  - Informed decisionmaking



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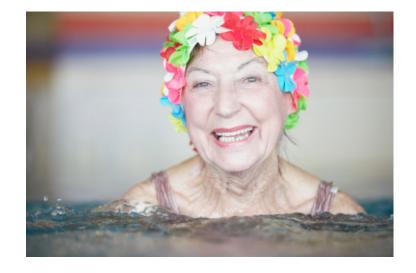
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18

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### NATIONAL PRIORITY Population Health

- Improve the health of the population
- Areas of focus:
  - Preventive services
  - Healthy lifestyle behaviors
  - National index to assess health status





#### NATIONAL PRIORITY Safety

NQF NATIONAL QUALITY FORUM

- Improve the safety & reliability of America's healthcare system
- Areas of focus:
  - Healthcare-associated infections
  - Serious adverse events
  - Mortality



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20

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Care Coordination

- Ensure patients receive well-coordinated care within & across all healthcare organizations, settings, & levels of care
- Areas of focus:

NATIONAL PRIORITY

- Medication reconciliation
- Preventable hospital readmissions
- Preventable emergency department visits





#### NATIONAL PRIORITY Palliative & End-of-Life Care

- Guarantee appropriate & compassionate care for patients with life-limiting illnesses
- Areas of focus:
  - Relief of physical symptoms
  - Help with psychological, social, & spiritual needs
  - Effective communication regarding treatment options, prognosis
  - Access to high-quality palliative care & hospice services



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21

NATIONAL QUALITY FORUM

#### NATIONAL PRIORITY **Overuse**

- Eliminate overuse while ensuring the delivery of appropriate care
- Areas of focus:
  - Inappropriate medication use
  - Unnecessary lab tests
  - Unwarranted maternity care interventions
  - Unwarranted diagnostic procedures
  - Unwarranted procedures
  - Unnecessary consultations
  - Preventable emergency department visits & hospitalizations
  - Inappropriate non-palliative services at end of life
  - Potentially harmful preventive services with no benefit



22





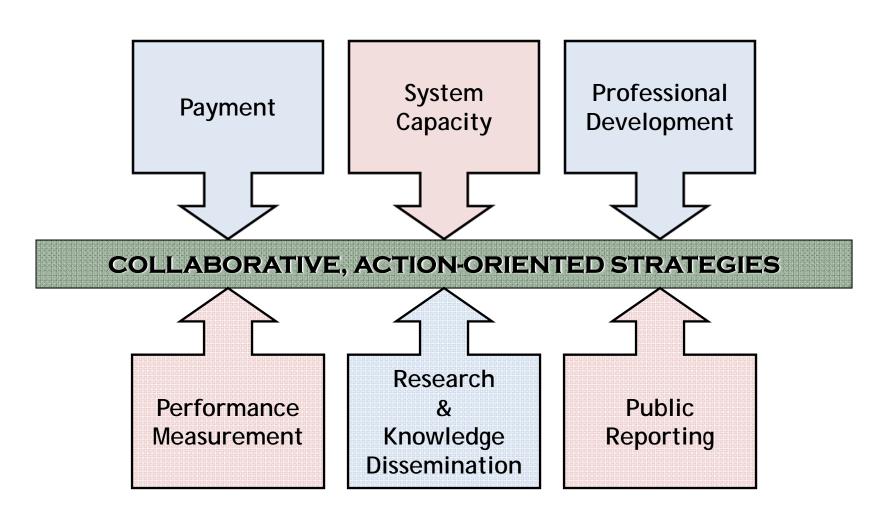


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#### **Driving to achieve results...**



## **Patient-Focused Episodes of Care**

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- Patient-focused orientation
  - Follows the natural trajectory of care over time
- Directed at value
  - Quality, costs, & patient preferences
- Emphasizes care coordination
  - Care transitions & hand-offs
- Promotes shared accountability
  - Individual, team, system
- Addresses shared decisionmaking
  - Attention to patient preferences
- Needed to support fundamental payment reform

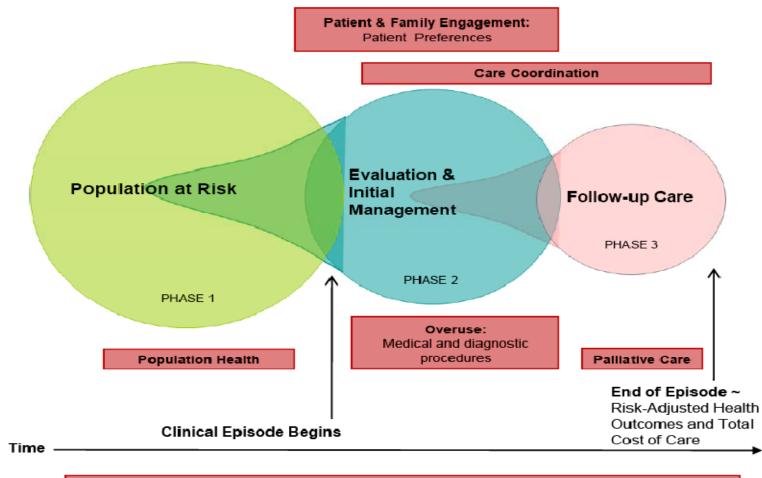
### **Patient-Focused Episodes of Care Domains**

- Patient-level outcomes (better health)
  - Morbidity & mortality
  - Functional status
  - Health-related quality of life
  - Patient experience of care
- Processes of care (better care)
  - Technical
  - Care coordination/transitions /care planning
  - Decision quality care aligned with patients' preferences
- Cost & resource use (less overuse, waste, misuse)
  - Total cost of care across the episode
  - Patient opportunity costs

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#### Integrated Framework: Patient-Focused Episodes of Care & NPP





Safety

Health reform legislation, the Patient Protection & Affordable Care Act (PPACA), requires the Secretary of Health & Human Services to "establish a national strategy to improve the delivery of health care services, patient health outcomes, & population health."

HR 3590 §3011, amending the Public Health Service Act (PHSA) by adding §399HH (a)(1)

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### Measure Development & Endorsement Agenda



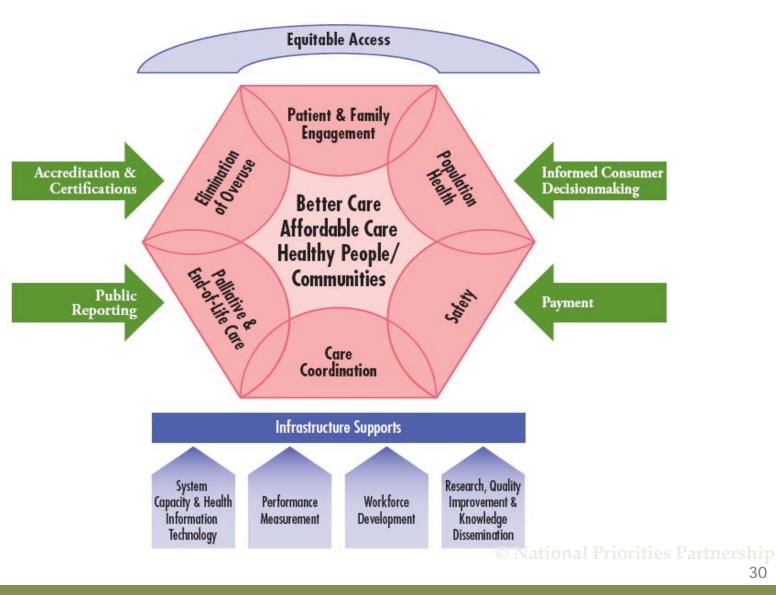
- Alignment with the national priorities & strategy for healthcare quality improvement
- Identification of priority measure gaps to direct development resources to high leverage areas
- Continuous scan of the measure development pipeline to make mid-course corrections, as necessary

#### • HEALTH REFORM LINKS:

- AHRQ and CMS to conduct triennial **assessment of measure gaps** (ACA Section 3013)
- **\$75 million for measure development** authorized, but not yet appropriated (ACA Section 3013)
- Expanded public reporting & new performance-based payment reform models (various ACA provisions)
- Measurement of **HIT meaningful use** (ARRA HITECH provisions)
- Mandate & funding for child health performance measures (CHIPRA quality provisions)

- Domains
  - High-quality care
  - Affordable care
  - Good health
- Principles
  - Patient-centeredness & family engagement
  - Quality care for patients of all ages, populations, service locations, & sources of coverage
  - Elimination of disparities
  - Alignment of public & private sectors

### NPP Input to Secretary of HHS to Inform the National Strategy for Healthcare Quality



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30

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# Questions & Discussion

- Does the integrated framework provide a starting point for thinking about a Dashboard?
- What might be missing?

# Public Reporting Environmental Scan, Catalog, & Mapping Results

# Sample Selection

- Over 300 public reporting programs scanned
- 72 selected for cataloging based on geographic focus, early/late adopter status, & key informant validation
- 4,254 total measures were cataloged for the 72 programs – there were 1,685 unique measures

#### **Environmental Scan & Catalog Results**

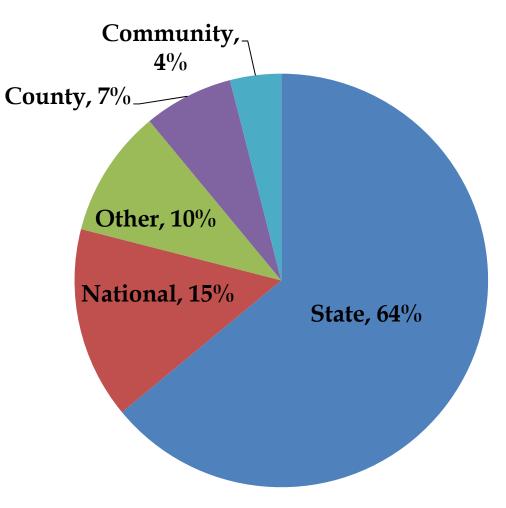
## Characteristics of the 72 Programs

• 71% of programs began public reporting after 2005

• 29% of programs reported before 2005

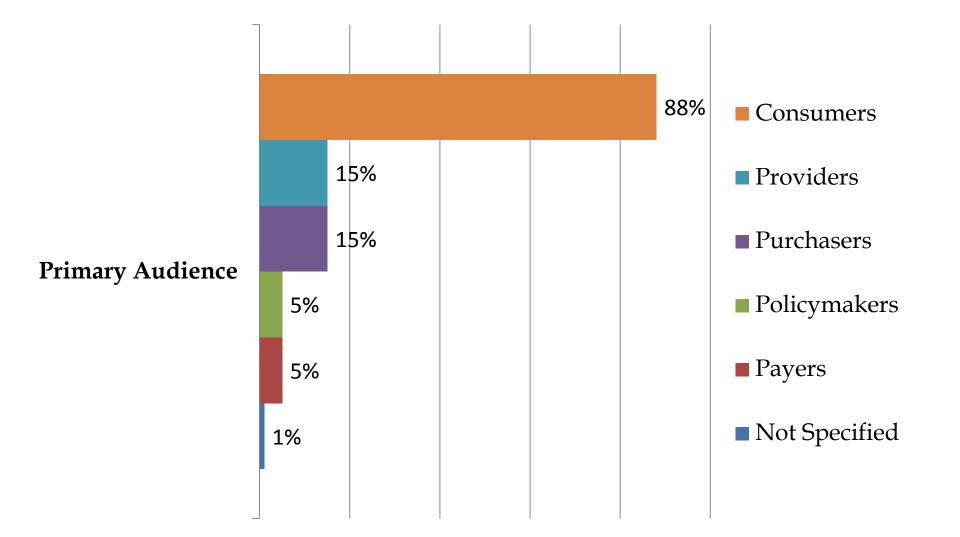


#### **Geographic Focus of Reports**



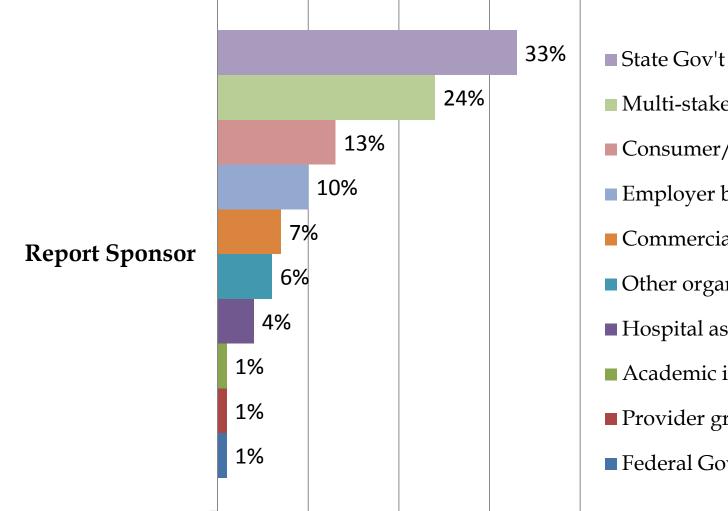
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Note: Categories are not mutually exclusive so numbers add up to more than 100%.



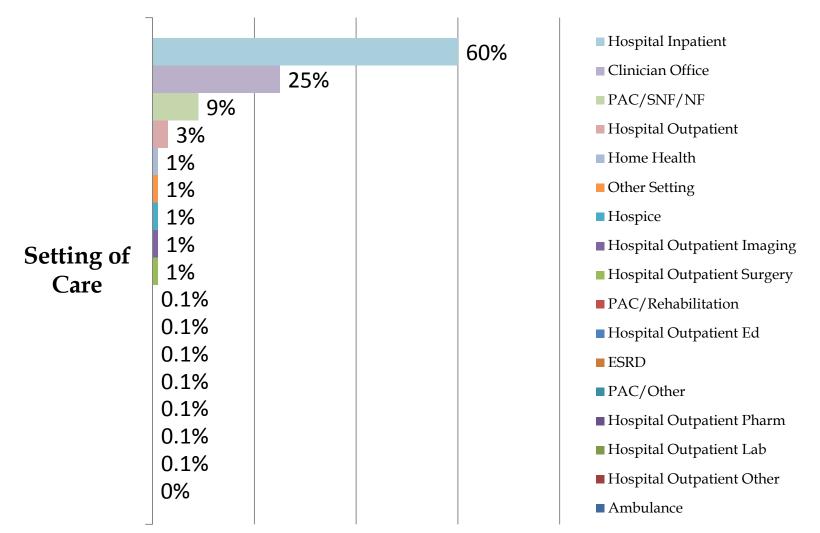


- Multi-stakeholder
- Consumer/advocacy group
- Employer business group
- Commercial health plan
- Other organization
- Hospital association
- Academic institution
- Provider group
- Federal Gov't

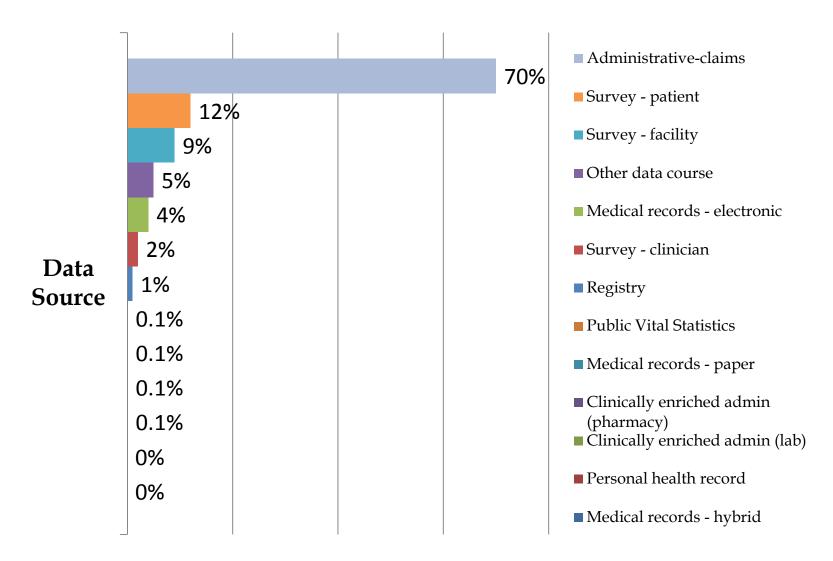
### Characteristics of the Measures

- 71% of the measures cataloged were not NQF-endorsed<sup>®</sup>
- However, 78% of programs did use an NQF-endorsed measure in their reporting

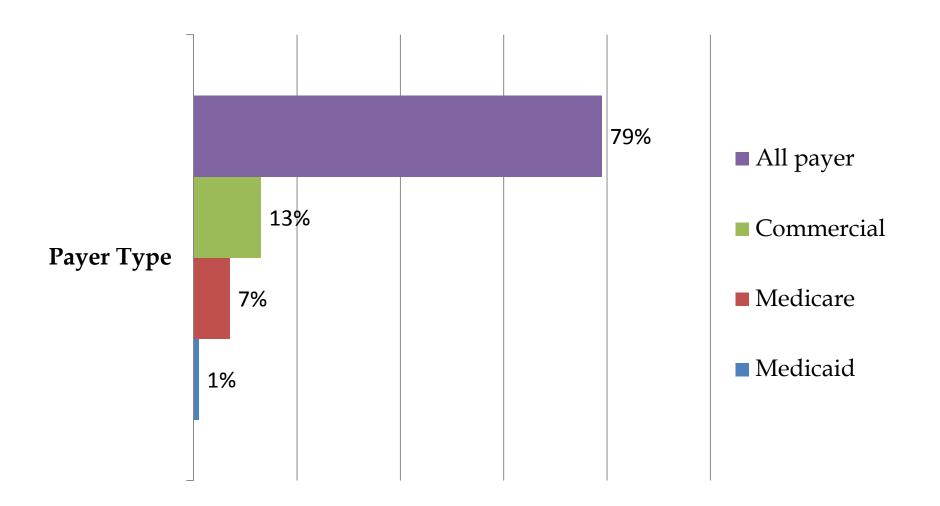
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Note: Categories are not mutually exclusive so numbers add up to more than 100%.



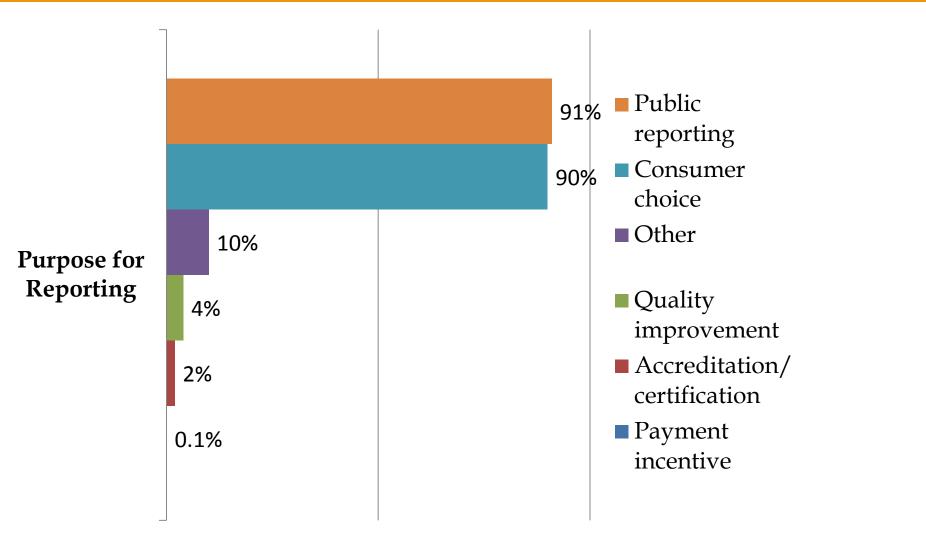
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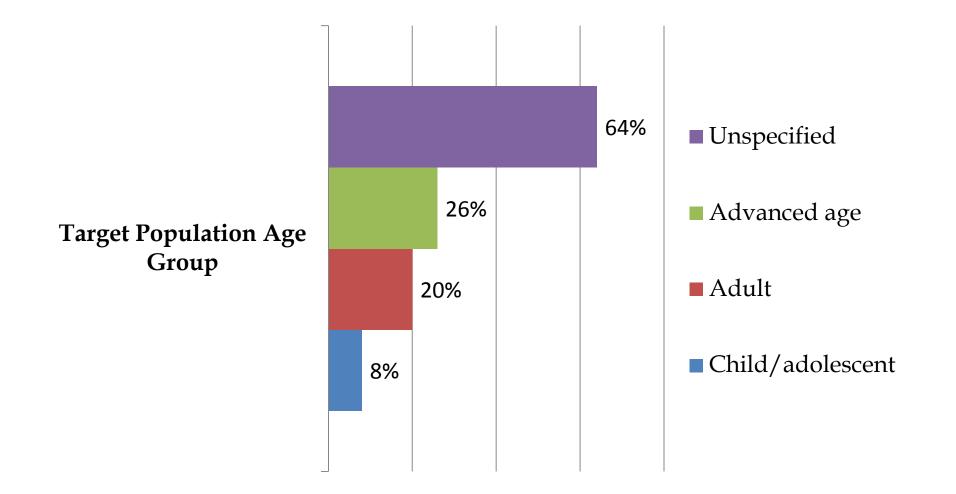


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41





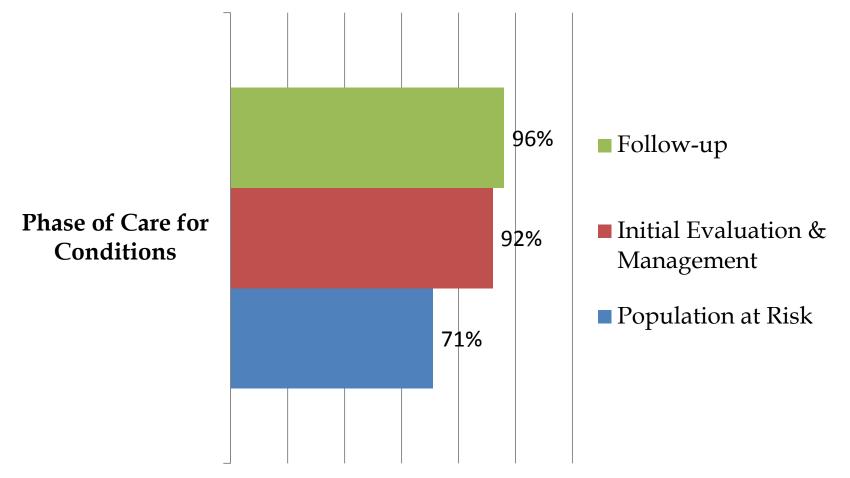


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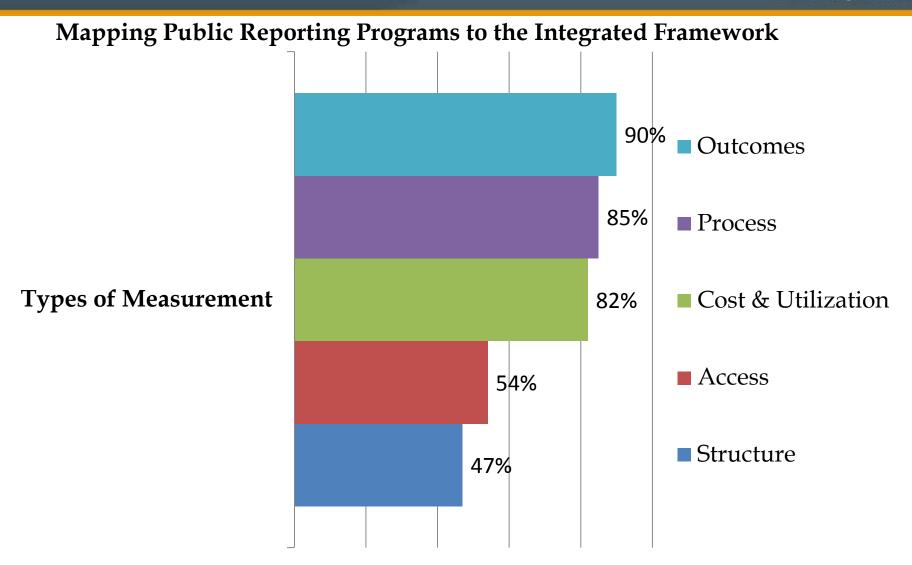
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#### Mapping Public Reporting Programs to the Integrated Framework

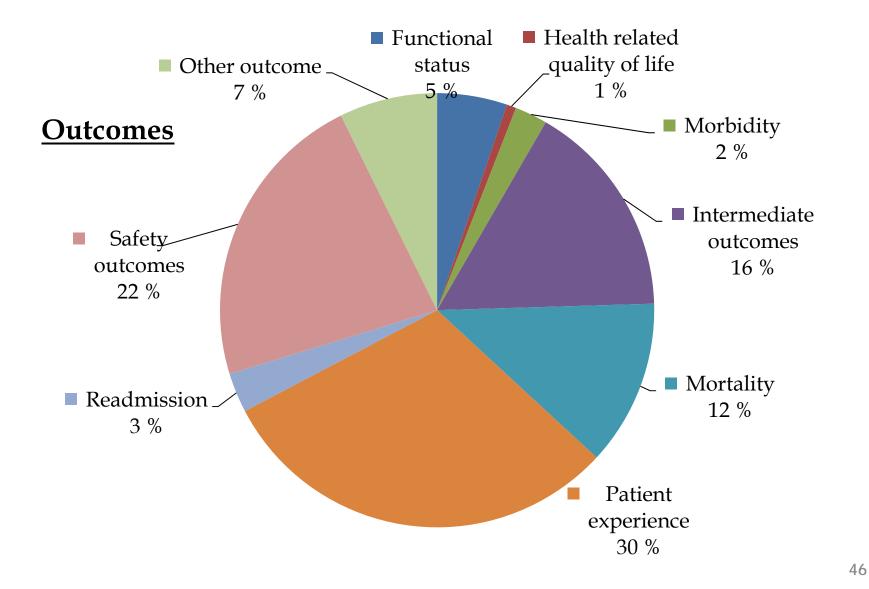


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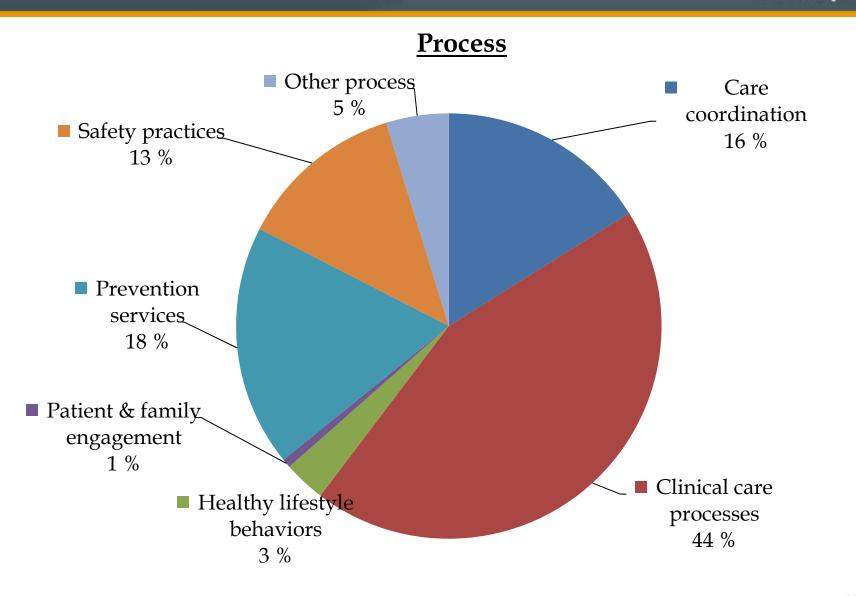


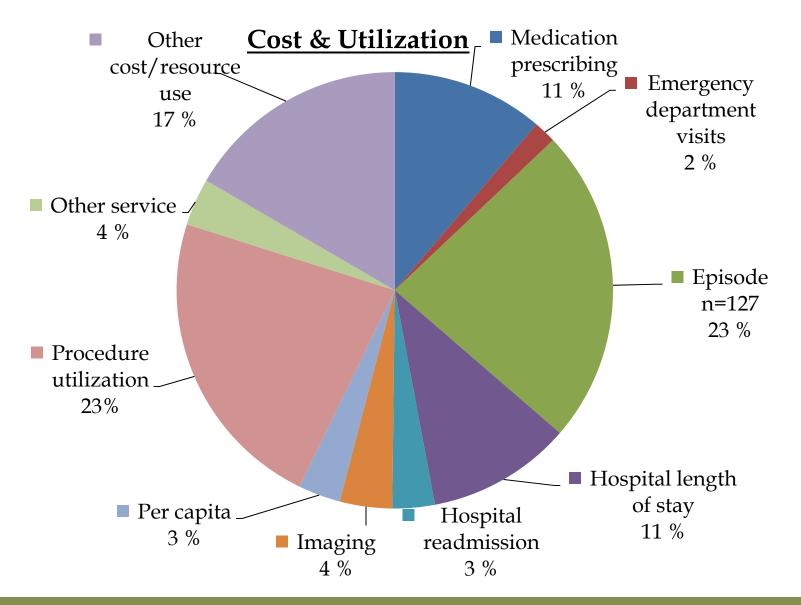
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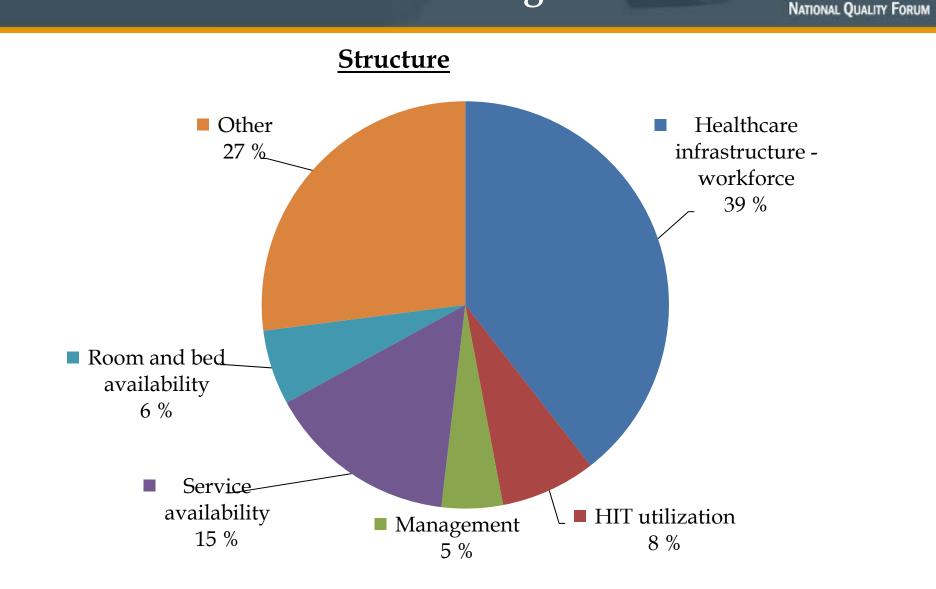
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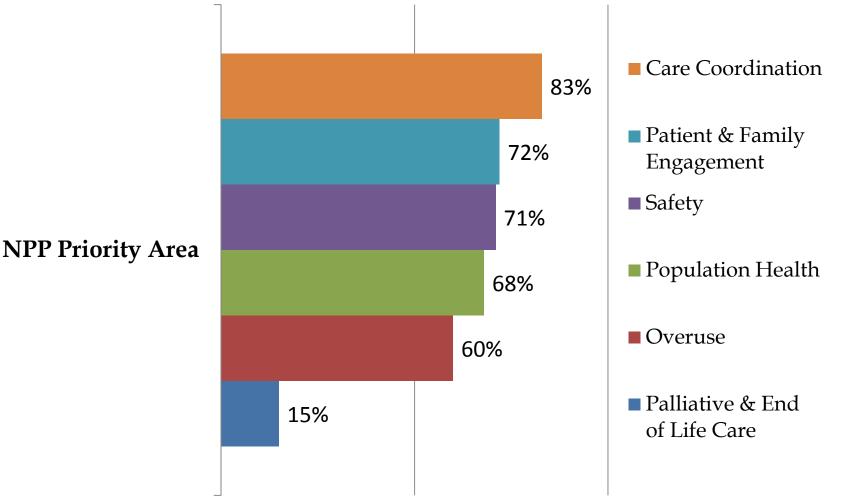
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48



49

#### Mapping Public Reporting Programs to the Integrated Framework



Note: Categories are not mutually exclusive so numbers add up to more than 100%.

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# **Questions & Discussion**

- Does the data resonate with your experience?
- Are there any findings that surprise you?

# Next Steps & Preparation for In-Person Meeting October 12, 2010

- Homework Assignment for Workshop Participants:
- Review Excel sheet with background data on domains and subdomains
- Vote for the <u>five domain areas</u> that are "core" to a public reporting dashboard
- For those five domain areas, name <u>three</u> <u>subdomain areas</u>
- Due October 5<sup>th</sup>!!!

For questions, contact: Christy Olenik at <u>colenik@qualityforum.org</u>



## Questions?

#### NATIONAL QUALITY FORUM

APPENDIX E—DOMAIN AND SUBDOMAIN AREAS USED FOR THE INITIAL VOTING EXERCISE AT THE COMMUNITY DASHBOARD PROJECT WORKSHOP

#### COMMUNITY PUBLIC REPORTING DASHBOARD WORKSHOP DOMAIN AND SUBDOMAIN VOTING

Outcomes	Care Coordination	Cost & Utilization	Safety	Patient & Family Engagement	Population Health
<ul> <li>Patient experience</li> <li>Intermediate outcomes</li> <li>Functional health status</li> <li>Mortality</li> <li>Readmission</li> <li>Safety</li> <li>Pain &amp; function for elective surgery</li> <li>Return to work</li> <li>Prevention services</li> <li>Accountability for improvement</li> <li>Care coordination</li> <li>Accountability for access</li> <li>Health related quality of life</li> </ul>	<ul> <li>Care transitions</li> <li>Appropriate &amp; timely follow-up</li> <li>Medication management</li> <li>Readmission</li> <li>Effective care plans</li> <li>Communication/ education</li> <li>Having medical or health home</li> <li>Percent in meaningful use</li> <li>Help in navigation</li> </ul>	<ul> <li>Cost per episode</li> <li>Hospital readmissions</li> <li>Procedure utilization</li> <li>Overuse, appropriateness, efficiency</li> <li>Emergency department visits</li> <li>Per capita</li> <li>Total risk-adjusted cost of care</li> <li>Contract prices for randomly selected procedures</li> <li>Hospital length of stay</li> <li>Admits per 1000</li> <li>Imaging use</li> <li>Length of emergency wait</li> <li>Episode readmission</li> <li>Prescribing</li> </ul>	<ul> <li>Healthcare associated infection</li> <li>Medication safety</li> <li>Adverse events</li> <li>Ambulatory settings</li> <li>Mortality</li> <li>Cleanliness of environment</li> <li>Medical safety</li> </ul>	<ul> <li>Patient experience</li> <li>Shared decisionmaking</li> <li>Self management</li> <li>End-of-life planning</li> <li>Patient friendly policies</li> <li>Provider communication</li> </ul>	<ul> <li>Effective preventive services</li> <li>Healthy lifestyle behavior</li> <li>Public health outcomes</li> <li>Social determinants</li> <li>Community index of health</li> <li>Environmental assessment (parks, trails, etc.)</li> </ul>

Process	Overuse	Access [& Equity]	Structure	Palliative & End-of-Life Care	Clinical Quality of Care
<ul> <li>Clinical care processes</li> <li>Care coordination</li> <li>Safety practices</li> <li>Preventive services processes</li> <li>Patient &amp; family engagement</li> </ul>	<ul> <li>Appropriateness of diagnostic tests &amp; procedures</li> <li>Direct cost</li> <li>Indirect cost</li> <li>Use of diagnostics, drugs, &amp; procedures</li> <li>Preventable inpatient/ emergency care</li> <li>Per capita costs</li> <li>Patient outcomes</li> <li>Population receiving specific procedures</li> <li>Efficiency</li> </ul>	<ul> <li>Timeliness to care</li> <li>Access to primary care</li> <li>Barriers to needed care, e.g., cost</li> <li>Insurance coverage</li> <li>Follow-up missed due to cost</li> <li>Access to needed specialty referral services</li> <li>Family access to care</li> <li>Continuity of care</li> <li>Telephone availability of doctor</li> <li>Choice</li> <li>Race, ethnicity, language, disparities in outcome</li> </ul>	<ul> <li>HIT use</li> <li>Workforce</li> <li>Management</li> </ul>	<ul> <li>Pain management</li> <li>Access to supportive services</li> <li>Advance preparations defined &amp; honored</li> <li>Family perception of care</li> </ul>	<ul> <li>Outcomes: Clinical data &amp; patient functional status</li> <li>Safety: Avoided events, near misses and care coordination</li> <li>Process: Measures based on evidence of improved outcome</li> </ul>

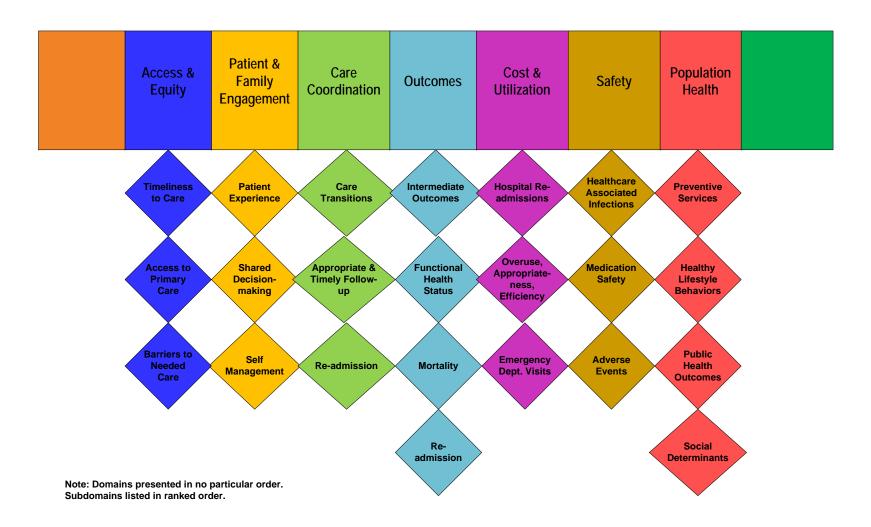
#### NATIONAL QUALITY FORUM

APPENDIX F—"RIGHT NOW" AND "IN THE FUTURE" DOMAINS AND SUBDOMAINS FROM THE COMMUNITY DASHBOARD PROJECT WORKSHOP

#### "Right Now" Dashboard

Future Dashboard Expansion

Flexibility for Additional Domains Selected by Communities



"In the Future" Dashboard

Future Dashboard Expansion

Flexibility for Additional Domains Selected by Communities

