Mind the Gaps

IN MEASURING HEALTHCARE PERFORMANCE

NATIONAL QUALITY FORUM

AND IT'S ONLY APRIL.

Sixty-two-year-old Jeff Martin is logging his 26th hour in healthcare appointments this year, and it's only April. Recently diagnosed with diabetes, Martin also copes with hypertension, cardiac arrhythmia, and arthritis. Problems in his back from a work accident have brought additional pain and limited mobility. Martin keeps a list of his medications, tests, and caregivers, which he hands to each new health professional he must see. He knows that all of them want to help him feel well, and yet they work in isolation from each other and often at cross purposes. Doing his best to coordinate his own care, Martin sometimes feels he is falling through the gaps…

Quantity does not equal quality in healthcare. In fact, the patients who spend the most time in our healthcare system are the least well served by it.

More than one-quarter of Americans — and two out of three older Americans — have multiple chronic conditions, forcing them to spend untold hours seeking care. For many reasons having little to do with patients, the "system" is set up to address their conditions one at a time. As the number of a patient's conditions increases, so do the risks of serious complications. Furthermore, the quality of their care will vary widely, depending on where they live, the providers available to them, and choices they must make with too little information.

Enter three promising strategies with the potential to improve care for all patients, including people like Martin: **health information technology, value-based payment, and public reporting of results**. Each strategy represents a pillar supporting better and more consistent healthcare quality. Each depends on accurate and meaningful measures of performance so patients can identify good care, health plans can pay for it, and providers can deliver it.

Currently, we lack key measures that will make these strategies effective. The National Quality Forum believes that filling these gaps in measurement is critical now. Fixing American healthcare will depend, in part, on our collective success.

What Needs to Happen

American healthcare is at a critical juncture. Years of hard work by healthcare's many stakeholders are now reinforced by the Patient Protection and Affordable Care Act (ACA), which places health information technology, value-based payment, and public reporting at the heart of its mandates.

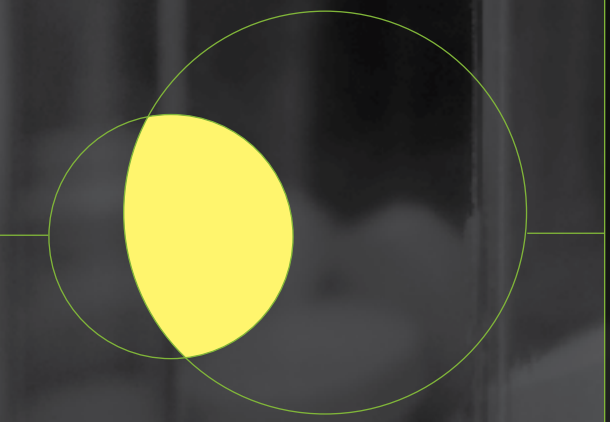
The National Quality Forum has created a two-dimensional framework to focus attention on measures that will have the greatest impact in supporting these strategies. Forming one dimension of the framework are 20 prevalent and costly chronic conditions for which older Americans seek care. The other dimension consists of six priorities of the National Quality Strategy, developed by the U.S. Department of Health and Human Services (HHS) with input from the NQF-convened National Priorities Partnership.

HIGH-IMPACT CONDITIONS FOR OLDER AMERICANS*

- MAJOR DEPRESSION
- CONGESTIVE HEART FAILURE
- ISCHEMIC HEART DISEASE
- DIABETES
- STROKE/TRANSIENT ISCHEMIC ATTACK
- ALZHEIMER'S DISEASE
- BREAST CANCER
- CHRONIC OBSTRUCTIVE PULMONARY DISEASE
- ACUTE MYOCARDIAL INFARCTION
- COLORECTAL CANCER
- HIP/PELVIC FRACTURE
- CHRONIC RENAL DISEASE
- PROSTATE CANCER
- RHEUMATOID ARTHRITIS/ OSTEOARTHRITIS
- ATRIAL FIBRILLATION
- LUNG CANCER
- CATARACT
- OSTEOPOROSIS
- GLAUCOMA
- ENDOMETRIAL CANCER

*Efforts are underway to identify conditions for the under-65 population.

Mind the Gaps



At the conjunction of these conditions and priorities are the gaps that need to be filled with strong performance measures.

NATIONAL QUALITY STRATEGY PRIORITIES

Making Care Safer

Ensuring Person- and Family-Centered Care

Coordinating Care Effectively

Promoting Prevention

Supporting Better Health in Communities

Making Care More Affordable

Health Information Technology

GOOD MEASURES IN, GOOD INFORMATION OUT.

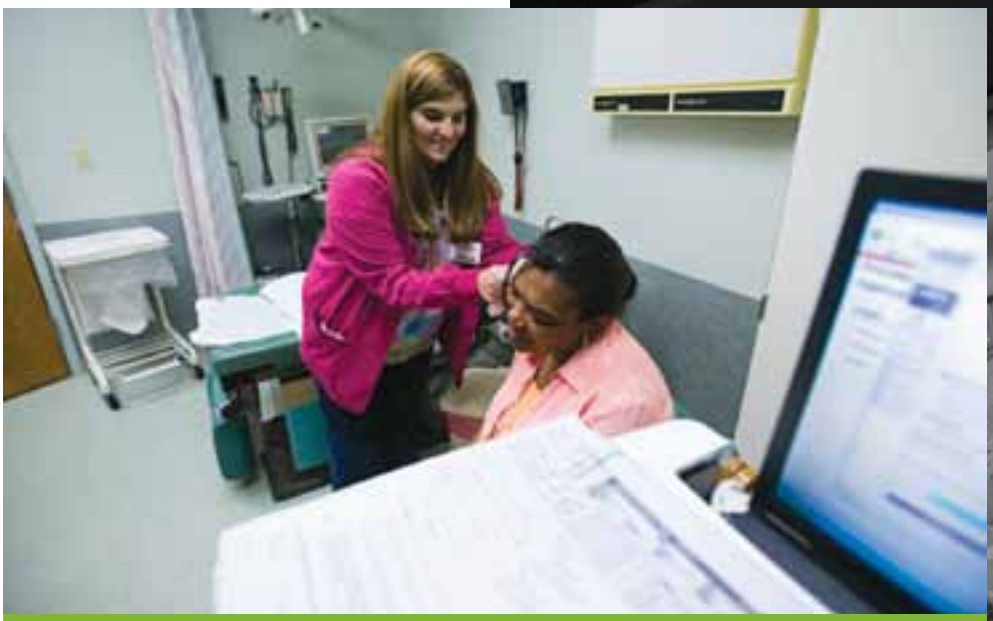
Jeff Martin, his providers, and his health plan often speak different languages, work from different information, and appear to care about different things. With the use of good performance measures, health information technology (health IT) has unique power to focus everyone on the same goals and data. That focus can result in better care for individuals and whole populations.

Clear and careful decisions about what you want to measure are prerequisite to effective health IT. Once those decisions are made, programmers can structure the IT system to collect the data that will support accurate measurement.

Right now, performance measurement relies heavily on claims data, submitted to health plans for payment purposes. Electronic health records (EHRs), with far richer clinical data on individual patients and the care they have received, have the potential to support more accurate and meaningful performance measurement. This potential can be realized only if the performance measures embedded in EHRs will work across IT systems and in multiple settings.

NQF is working with HHS, measure developers, and vendors to ensure that the electronic infrastructure can support performance measurement and improvement. The Quality Data Model, developed by NQF with support from HHS, identifies the types of data that need to be captured in EHRs to measure quality across care settings and types of providers. Another NQF project currently underway, the Measure Authoring Tool, will establish a standardized language and format for eMeasures, so they will work in varied systems and settings.

Currently, most health IT projects focus on capturing data from doctors, nurses, and other clinicians and making it available to a patient's entire care team. In the future, the growing use of personal health records (PHRs), maintained by patients themselves, will result in more data about health outcomes, health risk behaviors, adherence to treatment plans, and experience of care.



MIND THE GAPS: REDUCING RACIAL DISPARITIES

Performance measures offer a powerful tool for health plans battling racial disparities in their members' health, but measures can only serve that purpose when paired with good data on race, ethnicity, and language. Direct methods of collecting data, like asking patients themselves, don't work well for health plans, which lack face-to-face contact with their members. In 2008, WellPoint, Inc., an Indiana-based plan, received the "Recognizing Innovation in Multicultural Health Care Award" from the National Committee for Quality Assurance (NCQA) for its indirect method of estimating race and ethnicity. Using surnames in conjunction with geographic information from the U.S. Census, WellPoint's model was able to accurately predict race more than 90% of the time. In a pilot project, direct mailings to more than 3,000 African-American and Latino members resulted in only two people reporting error. But better data are only the beginning. In March 2011, WellPoint began a randomized control trial to study the effects of financial incentives and culturally tailored materials on diabetes over time among African-American, Hispanic, and white patients. Performance measures embedded in electronic health records will allow WellPoint to gauge whether these strategies improve diabetes control among different racial groups. WellPoint is partnering with medical groups across five states. "We need to get lab data on HbA1c levels, one of our measures for diabetes control, so we need to work with medical groups that have EHRs," says Grace Ting, director of health services in the Health Equity, Cultural and Linguistics Program Office at WellPoint. With its robust data and ability to measure impact, WellPoint will now be able to focus on the heart of the matter: finding strategies that close racial gaps in health.

Pay for Performance

FOLLOW THE MONEY.

Right now, Jeff Martin's health plan pays his caregivers for every visit he makes and every test he receives. Soon, his ambulatory practice team might receive payments that vary depending upon the quality of care provided and the outcomes achieved by their patients. They will then have added incentive to coordinate his care; provide the most effective services; and eliminate unnecessary tests, drug interactions, and wasted time that cost them resources they could otherwise put toward practice improvements.

Across the land and in different ways, public and private health plans have been migrating to value-based purchasing of healthcare. Using a variety of models, they are paying providers for patient outcomes and proven practices rather than volume of care. Performance measures play a key role in determining payments and in detecting potential harms caused by cost cutting.

The ACA gives new impetus to this trend by testing new types of value-based models. In 2012, for instance, one Medicare demonstration will bundle payment to providers for treating a particular condition, such as diabetes, rather than paying for the number of visits made by a diabetic patient. Another HHS demonstration will test payment incentives for home-based primary care teams. A third program will measure the success of accountable care organizations (ACOs), which bring together providers, physicians, and other groups to care for patients like Martin who have multiple conditions.

These programs are just a beginning under the ACA. For each, Medicare will need to determine what outcomes to measure to ensure patients are receiving good care, and what threshold providers will need to cross in achieving that outcome to receive payment.

Anticipating the focus in the ACA on value-based payment, NQF commissioned the RAND Corporation to identify key areas where measures are needed for payment reforms that reward value over volume. The findings signal the need for more measures focused on outcomes, care coordination, and patient engagement, as well as measures that allow a longer view of the patient's experience over time.

"Measures will be important not only to ensure that payment rewards the right care, but also to prevent unintended consequences that could result from hand-picking the healthiest patients to achieve a higher payment."

THOMAS VALUCK, MD, JD, SENIOR VICE PRESIDENT, NATIONAL QUALITY FORUM

SUMMARY OF CURRENT AND PROPOSED PERFORMANCE MEASURES FOR PAYMENT REFORM MODELS

	1. GLOBAL PAYMENT	2. ACO SHARED SAVINGS PROGRAM	3. MEDICAL HOME	4. BUNDLED PAYMENT
Care delivery organizations and/or providers that would typically receive payment	Integrated delivery system, multispecialty group practice, other aggregated provider groups and organizations	Integrated delivery system, multispecialty group practice, other aggregated provider groups and organizations	Ambulatory group practices and/or individual physicians (primary care)	Hospitals, ambulatory group practices, and/or other providers
Types of measures in use in one or more highlighted payment programs	• Mortality • Morbidity (disease and treatment complications) • Safety outcomes* • Patient experience* • Preventive services • Healthy behaviors • Clinical care processes • Care coordination* (patient survey) • Safety practices* (infection control) • Inappropriate resource use (e.g., imaging, antibiotic prescribing)	• Morbidity (disease and treatment complications) • Clinical care processes • Care coordination* (patient survey) • Preventive services	• Clinical care processes • Preventive services • Access* • Patient experience* • Patient engagement* • Care coordination (survey) • Organizational capabilities, including care management practices and meaningful use of health IT	• Episode cost (predicted) • Mortality • Morbidity (treatment complications) • Functional status (change) • Safety outcomes* • Patient experience* • Preventive services • Healthy behaviors • Clinical care process (episode-specific) • Patient engagement* • Care coordination (survey) • Safety practices* • Service use
Types of measures that have been proposed for use in a highlighted payment program but not used	• Functional status (longitudinal change) • Quality of life (longitudinal change)	• Mortality • Functional status (longitudinal change) • Quality of life (longitudinal change) • Structure (ACO criteria) • Management	• Morbidity (disease complications) • Functional status (change) • Quality of life (change) • Staff satisfaction	• None currently

*Measures of this type may be used to monitor for unintended adverse consequences of the payment model.

RAND Corporation, "Payment Reform: Analysis of Models and Performance Measurement Implications," 2011.

For the full report, http://www.qualityforum.org/News_And_Resources/Press_Releases

Public Reporting

NEED TO KNOW.

Jeff Martin is lucky when it comes to public reporting of healthcare performance. Because he lives in the region of the Puget Sound Health Alliance, he is able to check a consumer-friendly website to see how medical groups, clinics, hospitals, and even health plans compare in achieving benchmarks very relevant to his care. The Alliance is one of 17 communities in *Aligning Forces for Quality*, the Robert Wood Johnson Foundation's signature effort to align local players around improving the quality of care.

Public reporting creates a feedback loop. Patients ask more questions about providers that look weaker in clearing a common benchmark. Board members, attending physicians, and staff themselves unite in asking tough questions when their organizations don't perform as well as others. Providers strive to improve their performance as they find themselves compared to their peers. The bar is raised community wide, and patients end up with better, more consistent care.

While providers need internal measures of the processes they use to develop more consistent care, patients want to know about outcomes and what other patients experience. Do doctors listen? Do hospitals report low rates of infections? How many patients get pneumonia before they leave? The best public websites report the data patients care about in language they can understand.

In 2003, HHS started providing performance information for providers nationwide on its Healthcare Compare websites, all of which use NQF-endorsed measures. Under the ACA, these websites will report on a broader array of providers and include more information on their performance over the next several years.

In recent years, NQF has endorsed more outcomes and composite measures that can help patients get the information they want. NQF endorses only those measures that are available for all to use.

MIND THE GAPS: A PRESCRIPTION TO GET BETTER

When leaders at the Puget Sound Health Alliance created a website to report on healthcare in the region, they made sure their Community Checkup would lead to a prescription for healthcare improvement. They designed their report, which eventually included the performance of hospitals, medical groups, health plans, and clinics, to be not only useful but also actionable. At the outset, physician buy-in was key. From there, the Alliance knew that consumers would follow. "Consumers are going to trust their doctors more than a nonprofit that is new to the community," says Diane Stollenwerk, one of the founding directors of the Alliance. Purchasers and consumers in the Alliance were especially eager for measures that would help them drive down costs. "For so many communities, that is where the gap is," Stollenwerk points out. "They need more measures that will help them control costs while they strengthen quality." To address the problem, the Alliance created its own measure of the rates at which patients filled prescriptions by medical groups and clinics for generic drugs in four groups — non-steroidal anti-inflammatories, antacids, cholesterol-lowering statins, and antidepressants. According to the Alliance's research, for every 1% increase in the generic fill rate for all of those drugs, consumers and purchasers could save $2.6 million in the five Puget Sound counties alone (www.wacommunitycheckup.org). Anyone can search the Community Checkup to compare fill rates. Now vice president for community alliances at NQF, Stollenwerk is pleased to note that several measures currently being considered for endorsement will help fill the yawning gap for measuring costs. Meantime, Puget Sound's Community Checkup is changing the way people think about their healthcare. Before public reporting, "people never thought about variations in quality," notes John Gallagher, the director of communication and development at the Alliance. As the Community Checkup evolves, it continues to serve as a valuable tool for lowering costs, increasing transparency, and driving change to strengthen the quality of healthcare.

COMMUNITY CHECKUP

BETTER than average	the rating is above the regional average.
AVERAGE	the rating is at the national average.
BELOW average	the rating is below the regional average.
*	there wasn't enough data to report.

MEASURE:	Cholesterol Test (LDL-C or bad cholesterol)	Blood Sugar (HbA1c) Test	Eye Exam	Kidney Disease Screening
REGIONAL AVERAGE:	79%	86%	70%	84%
MEDICAL GROUP 1:	■	■	●	■
MEDICAL GROUP 2:	●	■	▼	■

The Evolving Role of NQF

Since 2000, NQF has convened consumers and communities, providers and payers, purchasers, policy-makers, and regulators to come together around quality improvement in American healthcare. We have retained steady focus on building consensus on national priorities and goals, endorsing measures, and educating the healthcare community about performance measurement. At the same time, each aspect of our work is evolving as the quality movement gains momentum.

DEVELOPING MAP

Measure Applications Partnership (MAP), established by NQF in 2011, creates an important new forum for promoting good performance measurement. Fulfilling a requirement of the Affordable Care Act, MAP will provide input to the Secretary of Health and Human Services on the choice of measures for use by Medicare and other public programs in public reporting, value-based payment, and other initiatives.

MAP will give the Secretary guidance on measures to use in gauging and rewarding performance in ambulatory practice settings, hospitals, post-acute settings, and some cancer hospitals. MAP will also offer guidance on measures related to care for dual-eligible beneficiaries and reduction of readmissions and healthcare-acquired infections. Like the National Priorities Partnership, MAP encompasses a broad cross-section of stakeholders in American healthcare to ensure that input to HHS represents a full range of perspectives.

ENCOURAGING MEASURE DEVELOPMENT

NQF can only endorse measures that are submitted for its consideration. In recent years, NQF has worked actively to encourage the development of measures that will fill the pipeline in areas where they are most needed by:

- Creating an agenda in 2010 for measure development.
- Commissioning the RAND report, published in 2011, to identify gaps in measurement for a wide range of value-based payment models.
- Identifying measurement gaps in specific areas in the course of endorsement projects.
- Gathering information on measurement gaps as part of a study, currently under way, to examine how communities, states, and others are using NQF-endorsed measures.

In reviewing measures for endorsement, and again when endorsed measures come up for regular review, NQF provides feedback from expert panels and public comment to the developers of the measures. NQF has also been working especially closely with developers on its health IT projects.

WALKING THE TALK OF CONTINUOUS IMPROVEMENT

Walking its own talk, NQF has made changes in its endorsement process to ensure more rapid review for measures that will fill the biggest gaps and to review currently endorsed measures on a prioritized schedule. Other changes include more measures that focus on patients' own views of their care and a longer time horizon that captures whether patients get and stay better. For example, NQF's "Multiple Chronic Conditions Measurement Framework" project seeks to identify measures that determine whether and how patients with many health complications are being served. Such measures will be an important test of care provided by multiple specialists over longer periods of time.

MIND THE GAPS: MAKING PUBLIC REPORTING EASIER

Although each community's healthcare delivery system has unique characteristics and challenges, community collaboratives have common needs when it comes to measurement and public reporting. For example, many would like to benchmark results and get practical insight from other communities as they start or expand into new areas of measurement. To help meet these needs, NQF is developing a Dashboard of suggested NQF-endorsed measures in areas in which even highly divergent communities are already measuring and publicly reporting. The Dashboard will help communities focus on measures that align with HHS' National Quality Strategy and with national reporting requirements and value-based payment reform. "With the Dashboard, communities interested in starting or expanding public reporting can quickly identify measures that have been evaluated and endorsed by NQF, and proven useful in other communities," says Anisha Dharshi, a senior program director leading the Dashboard project at NQF. To shape the Dashboard, NQF gathered information on public reporting in states and communities nationwide and took recommendations from a multi-stakeholder advisory group. For the first version of the Dashboard, NQF is gathering input from many communities, starting with Cincinnati, Detroit, and Maine — chosen for their diversity of healthcare-reporting levels and progress. In addition to measures, the Dashboard will include information on success factors and impacts observed when reporting the measure results. "Community collaboratives seem to be excited about having access to a big-picture approach to public reporting with suggested measures to align around," says Dharshi. Over time, communities using the Dashboard will be able to compare their results for certain measures in their public report with those of their peers, while meeting local needs and priorities.

Why the Time is Now

Like Jeff Martin, patients whose several conditions force so much contact with the healthcare system represent its greatest challenge and opportunity to improve. They more than anyone else need to be treated as whole people, not a series of parts that correspond to care settings or payment codes. They more than anyone else will benefit from better-coordinated care, each aspect adhering to national standards.

But these patients stand for all of us who are looking for a health system that uses technology to strengthen care, payment to reward value, and public reporting to communicate results. Such a rational system depends greatly on accurate, useful measures to tell us how we are doing and what still needs to happen.

At local, state, and national levels, American healthcare has reached a turning point. We must close the gaps in measurement if we are to connect the dots from hospital to specialist to lab to home and back for follow-up care. And we must close those gaps to ensure the right care at the right time in the way patients want it delivered for every American.

What You Can Do

- Take part in choosing performance measures in your community that will support quality improvement.
- Encourage your community to adopt the National Quality Strategy, focus activities on the priority areas, and make a commitment to achieve the goals.
- Use public reporting sites to make your healthcare decisions, and encourage your friends, family, and neighbors to do the same.
- Urge your healthcare plan to use value-based payment.
- Get involved in NQF. Nominate someone for, or serve on, an NQF steering committee.
- Participate in NQF's public comment periods and attend public meetings (in person or virtually).
- Nominate candidates for the National Priorities Partnership and its workgroups when vacancies occur.
- Nominate candidates for the Measure Applications Partnership coordinating committee and workgroups when vacancies occur.
- Participate in public comment periods on the Measure Applications Partnership's proposals for measures to use for value-based payment, public reporting, and other programs.

For information visit: www.qualityforum.org

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