



The High-Value Health Care Project

Building an infrastructure for performance measurement and reporting

SUMMARY

In the United States, patients get significantly different care depending on where they live, which doctors and hospitals they use and the patients' race and ethnicity. The cost of that care also varies significantly by provider and region.

Through its High-Value Health Care Project, the Quality Alliance Steering Committee (QASC) built the initial infrastructure for a nationwide performance measurement and reporting system. The overarching purpose of the three-year project was to:

- Help health care providers improve the quality of patient care.
- Help consumers make informed choices about health care providers.
- Help ensure that payments support provider efforts to improve quality and efficiency, rather than simply covering ever-more-intensive treatments.
- Help reduce racial and ethnic disparities in care.

QASC—composed of top executives from more than 30 health care and business organizations—is based at the [Engelberg Center for Health Care Reform](#) at the Brookings Institution in Washington. Brookings coordinated the project and spearheaded the implementation of several of its components.

[America's Health Insurance Plans Foundation](#) in Washington, and the [American Board of Medical Specialties Research and Education Foundation](#) in Chicago, also developed key components of the project.

Key Results

In journal articles, issue briefs and reports to the Robert Wood Johnson Foundation (RWJF), project staff cited these results:

- The Engelberg Center:
 - Identified strategies for combining administrative and clinical data for use in performance measurement, focusing on cancer, cardiovascular disease and diabetes
 - Developed models for collecting and reporting on patients' race, ethnicity and language and incorporating that information into performance measures, and shared best practices with stakeholders from across the country
 - Assessed how nine vanguard health care organizations across the country collected and aggregated data for the implementation of clinically-enriched performance measures (i.e., measures requiring both administrative and clinical data) and identified recommended practices
- America's Health Insurance Plans Foundation implemented 22 measures of physicians' performance in preventing and managing chronic conditions; pilot-tested a methodology for aggregating information on those measures across health plans; communicated with and obtained input from physicians about the findings.
- American Board of Medical Specialties Research and Education Foundation developed 22 measures of the cost of episodes of care required to treat 12 high cost medical conditions, and tested the measures on a dataset of commercial health care claims that drew on a pool of 15 million insured people.

Funding

RWJF authorized \$15.8 million for the High-Value Health Care Project, which included grants to three nonprofit organizations:

- Brookings Institution: \$8.7 million from July 2007 to January 2010, and \$399,000 from January to August 2010.¹
- America's Health Insurance Plans Foundation: \$3.55 million from July 2007 to July 2010.²
- American Board of Medical Specialties Education and Research Foundation: \$1.76 million from December 2007 to December 2009.³

¹ Grant ID#s 60177 and 67252.

² Grant ID# 61926.

³ Grant ID# 62609.

RWJF also provided \$474,000 to GYMR and MSL Group (formerly known as Manning Selvage & Lee) to develop communications for the project.⁴

See [Appendix 1](#) for more information on the grants.

CONTEXT

A wide gap separates the health care Americans *should* receive from the care they *actually* receive. Patients get significantly different care depending on where they live; which doctors and hospitals they use; and the patients' race and ethnicity. According to the Engleberg Center, the cost of that care also varies significantly by provider and region, regardless of outcome.

The fragmentation of the health care system has made it difficult to know who is receiving the most appropriate care, and what that care should cost. Given that the United States spends more per capita on health care than any other country, yet ranks 10th in life expectancy and 27th in infant mortality, there is an obvious need to improve the quality of care and get more value for the money spent.⁵

Measurement is a core tool for assessing the timeliness, effectiveness and appropriateness of care. “Most policy reforms that can really make a difference—such as changing how providers are paid, and how health care benefits are designed—require rich measures of how we are actually doing in providing better-quality care and avoiding unnecessary care,” said Mark McClellan, M.D., Ph.D., M.P.A., director of the Engelberg Center and the High-Value Health Care Project.

“We have to make progress in measurement for any health care reform to move forward in a meaningful way.”

Performance Measurement Initiatives

A number of initiatives collect data and report on performance in public and private health care settings:

- AQA (formerly Ambulatory Care Quality Alliance)—an alliance of 135 organizations representing physicians, consumers, employers, government agencies, health insurance plans and accrediting and quality organizations—promotes strategies to implement performance measurement, collect and aggregate data in the most

⁴ Contract ID#s 63740 and 67659.

⁵ *OECD Health Data 2008*. France: Organisation for Economic Co-operation and Development, and Institute for Research and Information in Health Economics.

appropriate way and report meaningful information to consumers, physicians, other clinicians and other stakeholders.⁶

- The Hospital Quality Alliance—a coalition of hospitals, nurses, physician organizations and accrediting agencies—facilitates the implementation of measures and reports on quality in the nation’s hospitals.⁷
- Medicare publishes key information on the quality of hospitals, nursing homes, home health agencies and kidney dialysis facilities.
- Some 70 regional efforts generate data and report on efforts to improve health care quality.⁸

However, there is much variation in measurement approaches among these pioneering initiatives, leading to the inability to compare performance measure results within and across public and private sectors. Thus performance measures results are not easily understood by consumers, and health care providers involved with multiple initiatives are burdened with disparate reporting demands. Developing a nationally consistent, technologically sound and efficient approach to gathering and reporting information on health care performance is a key step to delivering high-quality care.

About the Quality Alliance Steering Committee (QASC)

AQA and the Hospital Quality Alliance created QASC in 2006 to advance high-quality, cost-effective, patient-centered care by coordinating and expanding efforts to measure its quality.

QASC is a multistakeholder collaborative with members that include executives from more than 30 organizations, such as the Chamber of Commerce, the American Medical Association, the Blue Cross and Blue Shield Association, the Joint Commission, the National Business Coalition on Health and the Robert Wood Johnson Foundation (RWJF). (See [Appendix 2](#) for a membership list.) A number of QASC members are also active in the National Quality Forum (NQF) (see [RWJF’s Interest in This Area](#)).

Soon after its launch, QASC members took stock of the field. “What was apparent is that lots of people were developing measures, but there was no national strategy for implementing them. The insight was that no one was in charge,” said RWJF Senior Program Officer Michael Painter, M.D. QASC therefore took on the process of coordinating and building components for an infrastructure to better implement measures as its primary focus.

⁶ See www.aqaalliance.org.

⁷ See www.hospitalqualityalliance.org.

⁸ Descriptions of these initiatives are available on the Quality Alliance Steering Committee [website](#).

RWJF's Interest in This Area

RWJF has made a \$300 million commitment to improve the quality and equality of U.S. health care, with *Aligning Forces for Quality (AF4Q)* as its flagship program. *AF4Q* works to improve health care quality in 17 participating communities by engaging patients in their care and publicly reporting on the performance of physicians and hospitals.

RWJF has also awarded more than a dozen grants to the [NQF](#), based in Washington, which builds consensus on national priorities for improving health care quality, and endorses standards for measuring and reporting on performance. Endorsement by NQF signifies that a measure is the best in its class.⁹

NQF members include consumer organizations, public and private health care purchasers, health care providers and accrediting bodies. Organizations typically submit performance measures to the NQF in response to one of its periodic calls for measures in a specific aspect of health care.

Hospitals, physicians and other providers have traditionally played the dominant role in developing health care performance measures. To shift that balance, RWJF gave almost \$3 million to the Consumer-Purchaser Disclosure Project, a coalition of more than 50 employer, consumer and labor organizations. Their efforts gave those groups a greater voice in developing performance measures, including through NQF. (See [Program Results Report](#).)

RWJF has also been providing support to test and estimate the effect of implementing the Prometheus Payment system, which calculates the cost of care for an entire course of treatment. It improves quality of care for the patient by removing conflicting goals inherent in existing payment systems by increasing transparency and equalizing risk between health care and insurance providers. See the [RWJF website](#) for more information.

THE PROJECT

Through its High-Value Health Care Project, the QASC built the initial infrastructure for a nationwide performance measurement and reporting system. The overarching purpose of the three-year project was to help:

- Health care providers improve the quality of patient care.
- Consumers make informed choices about health care providers.

⁹ Program Results Reports on NQF's quality measurement work in a number of areas are available online: [ambulatory care](#); [palliative care](#); [nursing sensitive measures](#); [mammography centers](#); and substance abuse (1) and (2).

- Encourage insurers to reward providers’ efforts to improve quality and efficiency, rather than simply paying for ever more intensive treatments.
- Reduce large racial and ethnic disparities in care.

To achieve those goals the project’s strategy was to:

- Develop valid, consistent methods for measuring health care quality by building a national system for aggregating data.
- Develop cost measures for episodes of care—the package of diagnostic, management and treatment services required to address specific conditions such as congestive heart failure, asthma and diabetes.
- Use performance measurement to monitor and reduce racial and ethnic disparities in the quality of care.
- Document regional efforts to measure performance and lessons learned, and ensure that those regional efforts become part of a national strategy.

The project ultimately aimed to inform policy-makers and the public and private sectors about the best ways to collaborate to make critical performance information available.

“We are not just talking about measures that we should be collecting or getting consensus on the measures. We are doing the hard work of actually implementing the measures,” said Project Director McClellan. “And we can’t do that without a collaborative public/private mechanism.”

Project Management and Design

The Engelberg Center coordinated the High-Value Health Care Project and developed several of its components. America’s Health Insurance Plans (AHIP) Foundation in Washington, and the American Board of Medical Specialties Education and Research Foundation in Chicago, also developed key elements of the project. See [Activities & Results](#).

A number of subcontractors provided technical assistance on various components of the project. See [Appendix 3](#).

Communications

Under two contracts managed by RWJF, GYMR and the MSL Group provided communications support to the grantees. Besides editing and producing numerous issue and policy briefs and technical reports, the activities of these consultants included:

- Writing content alerts and press releases on project activities and results, and providing briefings on Capitol Hill and other media outreach.

Coordinating two online focus groups of physicians on the performance reports posted on AHIP Foundation’s physician portal.

See the [Bibliography](#) for more information on the publications.

ACTIVITIES & RESULTS

Combining Clinical and Administrative Data

Many performance measures rely exclusively on administrative data, such as insurance claims for medical, laboratory and pharmacy services. These typically indicate that a medical test was performed or a medication prescribed, but do not provide information on outcomes.

Combining administrative and clinical data can enhance the validity of performance measurement and strengthen efforts to improve health care quality. However, information on outcomes—based on lab results, patient charts and patient registries, which detail patients’ risk factors and medical conditions—is often unavailable, and when it is, it may not be in electronic form.

Researchers at the Engelberg Center “tried to identify a feasible way to get from where we are now, which is just using administrative data, to having performance measures that capture some of the advantages of both systems. And to do it in a way that is not overly costly but still provides added value,” McClellan noted.

Results

Engelberg Center staff:

- **Examined the role that patient registries can play in measuring the quality and cost of health care.** The researchers identified challenges inherent in leveraging registries and identified short- and long-term solutions to adapt and expand registries and the clinical information they provide to better measure quality and cost.¹⁰
- **Recommended ways to build a national cancer data infrastructure to support high-quality, patient-centered outcomes.** For example, researchers proposed creating a tool that would allow providers to exchange diagnostic information more quickly.¹¹
- **Identified the feasibility of linking clinical data on cardiovascular care from registries at the American College of Cardiology and the Society of Thoracic Surgeons with administrative data from several private health care payers.**

¹⁰ *How Registries Can Help Performance Measurement Improve Care*. Washington: High-Value Health Care Project, June 2010.

¹¹ Unpublished study.

While each database had shortcomings, researchers found that linking them produced extensive new and clinically detailed information that could be used to inform patient-focused outcome measurement.¹²

- **Identified technical, regulatory, and financial solutions to linking clinical and administrative data on diabetes care.** Such integration could improve the planning and management of patient care, provide feedback to physicians and help payers create incentives to provide high-quality, cost-efficient services.¹³

Aggregating Performance Data Across Health Plans

The AHIP Foundation developed the Data Aggregation Pilot Project to advance a standard method for compiling information on physician performance across health plans.

“There is broad consensus that getting better data on physician performance is important to improving both the quality and value of health care,” said Steve Pearson, M.D., principal investigator. “There is lots of activity in this field, lots of experiments people can learn from. However, the methods differ. That’s a concern, especially when doctors realize these data will be used to assess their practice.”

The AHIP Foundation convened the Data Oversight Workgroup, composed of physicians, health plan representatives, researchers and leaders at RWJF and America’s Health Insurance Plans (see [Appendix 4](#)). Project staff also drew on regional collaboratives in California, Massachusetts and Minnesota, and worked closely with the Quality Alliance Steering Committee’s Measurement Implementation Strategy Workgroup.

Results

The AHIP Foundation reported these results in *Health Affairs*,¹⁴ the issue brief *Aggregating Physician Performance Data Across Health Plans*¹⁵ and reports to RWJF.

¹² *Combining Claims and Registry Data for Patient-Focused Outcome Measurement*. Technical brief. Washington: High-Value Health Care Project, September 2010.

¹³ *Expert Panel Recommendations: Lab Data Integration for Diabetes Care Improvement*. Technical brief. Washington: High-Value Health Care Project, April 2010.

¹⁴ Higgins A, Zeddies T and Pearson SD. “Measuring the Performance of Individual Physicians by Collecting Data From Multiple Health Plans: The Results of a Two-State Test.” *Health Affairs*, 30(4): 673–681, 2011. Abstract available [online](#).

¹⁵ *Aggregating Physician Performance Data Across Health Plans*. Washington: High-Value Health Care Project, March 2011.

The project team:

- **Selected 22 measures of physician performance in preventing and managing chronic conditions, such as cancer, diabetes, cardiovascular disease, rheumatoid arthritis and depression.** (See [Appendix 5](#) for the measures.)
- **Developed and pilot-tested a methodology for aggregating data on the performance of 21,823 physicians in Florida and Colorado on 18 of the measures.** The pilot-test included health plan data from Aetna, Blue Cross Blue Shield of Florida, Cigna, Humana and United Healthcare.
- **Created an online physician portal that doctors could use to compare their performance to that of their peers, by specialty and region.** Local and state medical societies in Colorado and Florida cosigned a letter notifying physicians about the portal and encouraging them to view the information.

Physicians provided feedback on the portal by completing an instant survey or participating in an online focus group. The responses suggested three overall recommendations:

- *Less is more, given limits on physicians' time.* Clinicians want information in small, easily digestible doses.
- *Formatting is important.* Physicians also want information in formats that are intuitively navigable. However, they sometimes want ready access to more information on a methodology underlying a measure and the rationale for choosing it. Roll-over text or pop-up boxes could provide this information without cluttering the page.
- *To be useful, data on physicians' performance must be current and preferably longitudinal.* That is, clinicians should be able to track their performance over time.

Physicians' response to the performance reports was mostly positive. However, despite the assurance of confidentiality, relatively few actually logged on to view the reports citing practice-time constraints. Staff concluded that the pilot approach could be the “basis for making comparable performance information available nationwide,” but that “additional efforts are needed to find ways to effectively engage providers.”

Measuring the Cost of Episodes of Care

The American Board of Medical Specialties Research and Education Foundation created the Characterizing Episodes and Costs of Care project (known as the C3 project) to develop and test cost-of-care measures. The board convened a technical advisory committee (See [Appendix 6](#) for members.) and 12 condition-specific workgroups to help shape the measures.

The QASC’s Episodes Workgroup, other clinicians, experts in research methodology, and health care economists also provided expertise. Project staff exchanged information regularly with the Centers for Medicare & Medicaid Services. Five subcontractors helped develop and test some of the measures. (See [Appendix 3](#).)

Results

The American Board of Medical Specialties Research and Education Foundation cited these results in the issue brief *Measuring the Cost-of-Care* and a report to RWJF. The project team:

- **Developed 22 measures of the cost of treating 12 high-cost medical conditions, including acute myocardial infarction (heart attack), asthma, colon cancer, diabetes and low back pain.** Staff had initially planned to identify one measure for each of 20 conditions, but decided to develop two measures for most of 12 conditions. (See [Appendix 7](#) for the conditions and their measures.)

To create the measures, workgroups identified all services they could reasonably associate with each medical episode; accounted for differing levels of severity; and identified diagnostic and procedural codes that billers might use. The workgroups also identified the level of accountability for the care—physician, hospital or region.

- **Tested the cost measures on a commercial health care claims dataset (Thomson Reuters MarketScan) that encompassed 15 million insured people.** The researchers tested the acute myocardial infarction measures using insurance claims from 3.3 million Medicare recipients in 12 metropolitan areas, and the diabetes, asthma and low back pain measures using 207 million claims involving 3.4 million people tracked by the Wisconsin Health Information Organization.

The workgroups revised the measures based on these pilot tests and compared the results across populations, finding comparable patterns of resource use.

- **Posted the cost measures, with specifications and technical appendices, on the [QASC website](#).**

Limitations

The researchers acknowledged some limitations to their testing. In particular, they did not test the measures on Medicaid populations (and tested only one on a Medicare population). The measures also covered a short period, and so did not incorporate all clinical outcomes. Nonetheless, the researchers believe the project showed that “transparent and collaborative processes” can be used to develop “reliable and valid episode-based cost-of-care measures,” to help identify variations across institutions and providers.

Enhancing Racial and Ethnic Equity

Hospitals have taken the lead in collecting data on patients' race, ethnicity and language, and 22 states require them to do so.¹⁶ However, only two states, California and Massachusetts, require health plans to gather such information, and health plans that do so rarely achieve robust response rates from patients. For example, although Aetna leads the way in this arena, it has compiled race and ethnicity data on just 30 percent of its members.¹⁷ An additional problem is that four states limit the collection of this data.

“If we don't pay special attention to vulnerable populations in measuring health care performance, providers will look better if they avoid these populations, rather than doing the hard work of improving their quality of care and outcomes,” said McClellan. To close the gap, the Engelberg Center created the Racial/Ethnic Health Care Equity Initiative.

Results

The issue brief *Moving Toward Racial and Ethnic Equity in Health Care* and reports to RWJF from Engelberg Center staff highlighted activities to enhance racial and ethnic health care equity and cited results. Engelberg Center staff:

- **Examined the race and ethnicity data collection practices and health information technology readiness to collect data of nine Massachusetts' health plans, as well as the thoughts of members from varying racial and ethnic groups on their health plan collecting such data.** The researchers uncovered these barriers:
 - Health plans have few direct interfaces with members, limiting their ability to acquire information on race and ethnicity.
 - Consumers are skeptical of the efforts of health plans to collect such information, and member turnover is high.
 - Restrictive, inconsistent and costly information systems present significant challenges to storing, maintaining and effectively using such information.^{18 19}
- **Partnered with RAND to validate new statistical methods for estimating, at a population-level, the racial and ethnic composition of a health plan's membership, based on name analyses and geocoding rather than self-reports.**

¹⁶ Hasnain-Wynia R, Pierce D and Pittman MA. “Who, When, and How: The Current State of Race, Ethnicity and Primary Language Data Collection in Hospitals,” The Commonwealth Fund, 2004.

¹⁷ Hassett P. “Taking on Racial and Ethnic Disparities in Health Care: The Experience at Aetna,” *Health Affairs*, 24(2): 417–420, 2005.

¹⁸ *Lessons in the Acquisition of Race, Ethnicity, and Language Data by Health Plans*. Issue brief. Washington: High-Value Health Care Project, February 2010. Available [online](#).

¹⁹ Husnain-Wynia R, Taylor-Clark K and Anise A. “Collecting Race, Ethnicity, and Language Data to Identify and Reduce Health Care Disparities: Perceptions of Health Plan Enrollees.” *Medicare Care Research and Review*, December 2010.

Although self-reported information is the gold standard for monitoring differences in health care quality, it is often difficult to obtain.

The researchers concluded that, “indirect estimations can provide health care organizations with valid information on which to base improvement strategies.”²⁰

- **Developed a model for measuring and monitoring regional health care disparities by aggregating data on performance across hospitals.** In this pilot, five hospitals in Montgomery County, Md., stratified information on 27 measures of clinician performance in treating four conditions—pneumonia, surgical care, acute myocardial infarction and heart failure—by patients’ self-reported race and ethnicity.

Based on the pilot-test, researchers cited opportunities to improve data collection, for hospitals in regions to standardize data collection to allow for aggregation and analysis of disparities, and to build greater collaboration and engagement among community stakeholders to address disparities in health care.²¹

- **Developed a methodology for analyzing the employer business case for addressing racial and ethnic disparities.** Engelberg researchers assessed the relationship between race and ethnicity, absenteeism and productivity for 17,000 county employees and their dependents in Kings County, Wash.

An analysis of the data revealed that employees received high-quality care overall, but that Black patients were less likely to receive adequate medication for asthma. Because other disparities were not apparent, observing relationships between health care quality, absenteeism and productivity was not possible. However, the researchers concluded that employers, policy-makers and health plans could use the approach to determine whether health care disparities affect workplace performance.²²

- **Shared best practices to help communities collect and use information on patients’ race, ethnicity and language to promote health care equity.** The Engelberg Center sponsored “Charting a Course for Health Care Quality Improvement: Data-Driven Strategies for Eliminating Health Disparities,” a national conference that drew 240 stakeholders, including health plan representatives, providers, advocacy and consumer groups and public officials.

The conference was held at the National Press Club in Washington in March 2010. Key recommendations included:

- Develop health care payment and delivery reforms that incentivize providers who disproportionately treat vulnerable populations.

²⁰ *Indirect Estimation of Race and Ethnicity: An Interim Strategy to Measure Population Level Health Care Disparities.* Issue Brief. Washington: High-Value Health Care Project, March 2010. Available [online](#).

²¹ *Identifying Racial and Ethnic Disparities in Hospital Quality: Montgomery County Hospital Care Equity Initiative.* Issue brief. Washington: High-Value Health Care Project, July 2010. Available [online](#).

²² *Defining a Business Case for Measuring and Addressing Disparities in Health Care: Evidence From King County.* Issue brief. Washington: High-Value Health Care Project, March 2010. Available [online](#).

- Consistently collect data and develop performance measures that can continuously monitor health care and disparities in underserved communities.
- Ensure that minority and vulnerable communities are key stakeholders in developing and implementing reforms.²³

Identifying Best Practices Across the Country

Results

Engelberg Center staff reported these results from their efforts to identify best practices in performance measurement nationwide. The researchers:

Documented more than 50 of the largest public- and private-sector performance measurement and reporting initiatives in the United States, and published their results in the *American Journal of Medical Quality*.²⁴

- **Examined the work of nine vanguard sites to select and construct clinically-enriched performance measures, collect and aggregate data, and analyze and report the results.** Among the findings:
 - Most sites selected performance measures that align with national initiatives, and they modified them to reflect their own needs and capacities.
 - Key sources of clinical data included electronic health records, available at more than half the sites, as well as patient registries and Web portals.
 - More than half the sites had an audit process in place for validating data.
- **Identified recommended practices.** For example, health care organizations can:
 - Develop a step-by-step process for selecting measures and integrating them into an information technology system.
 - Facilitate the transfer of information via electronic health records and other information technology, following standardized procedures and using consistent terminology.
 - Identify alternative solutions for collecting and aggregating data, if sophisticated information technology is not available.
 - Ensure transparency and the comparability of results across organizations.

²³ *Advancing High-Value Health Care: Data-Driven Strategies for Eliminating Health Care Disparities*. Policy Paper. Washington: High-Value Health Care Project, Unpublished.

²⁴ Roski J and Kim GM. “Current Efforts of Regional and National Performance Measurement Initiatives Around the United States.” *American Journal of Medical Quality*, 25(4): 249–254, 2010. Epub September 3, 2009. Abstract available [online](#).

SIGNIFICANCE OF THE HIGH-VALUE HEALTH CARE PROJECT

The High-Value Health Care Project’s emphasis on thinking strategically about how to advance performance measurement was key, according to RWJF Senior Program Officer Michael Painter, M.D. “The project made a huge contribution in stepping in and asking how we move from where we are to where we need to go.”

Gerald Shea, assistant to the president of the AFL-CIO and a member of the QASC, said the project served as a “relied-upon incubator for developing solutions to commonly identified but perennially vexing problems.” Through the RJWF funding and other initiatives, the steering committee has “had the ability to spend significant resources over a period of time, which is what you need to tackle these problems.”

LESSONS LEARNED

1. **The complex, resource-intensive process of developing measures is only the first step.** “After that, you have to think about these measures as being dynamic, living things that need to be nurtured,” said Kevin Weiss, M.D., M.P.H., M.S., president and CEO of the American Board of Medical Specialties and a project director.

Weiss emphasized the importance of identifying a “home” where long-term responsibility for keeping performance measures up to date will reside. Such a home is especially important given continual technical changes that affect such measures, such as new reimbursement codes and an ever-shifting list of pharmaceuticals covered by different health plans.

2. **Tapping stakeholders who are expert in both health care policy and the technical aspects of performance measures can help overcome the challenges of developing the measures.** Developing these kinds of measures, says project director Weiss, “turns out to be not just technically difficult but politically difficult. Getting the insights of a broader set of stakeholders enriched their development.”
3. **Soliciting input from a diverse range of clinicians is crucial to gaining acceptance for episode-of-care cost measures.** Many diseases involve multiple providers. Cancer treatment, for example, might require a surgeon, an oncologist, a radiation therapist, a primary care doctor, a social worker and a home health care worker. Broad representation from clinical teams is essential to implementing measures that capture a true episode of care. (Project Director Weiss)
4. **Getting physicians to pay attention to their performance reports is difficult.** “Doctors are absolutely inundated with data on their practice,” said Steve Pearson, M.D., project director at the AHIP Foundation. “Trying to penetrate that becomes a real problem when what you are giving them is not directly relevant to what they need to do next week.”

5. **Support from local and state medical societies is essential to gaining buy-in from physicians.** “Doctors often distrust quality reporting tools because health plans and purchasers use them to make judgments clinicians are not always happy with,” said Pearson. “Creating a tool that doctors view as trustworthy—not one that becomes a source of frustration—is important.”

Selecting measures that are “valid, reliable and actionable” helps providers see performance measurement as a way to improve their practice, he noted.

6. **Consistent methodology and implementation of tested performance measures are essential to ensuring that comparisons across physicians and health plans are valid.** Identifying clinicians who participate in multiple health plans is also important to ensuring that measures are comprehensive. (Project Director Pearson)

AFTERWARD

RWJF’s Painter expects the High-Value Health Care Project to make a significant contribution to RWJF’s program *Aligning Forces for Quality (AF4Q)*.

For example, the Brookings Institution is helping five of the 16 *AF4Q* communities implement some of the episode-of-care cost measures, through subcontracts with the American Board of Medical Specialties Research and Education Foundation.

Brookings staff members are also working with some *AF4Q* communities to strengthen their capacity to collect information on patients’ race, ethnicity and language. “Those are both nice wins: efforts to take the measures we invested in and apply them practically and immediately,” Painter noted.

Other Activities

A number of other efforts are under way to translate and disseminate information gleaned from the High-Value Health Care Project. For example, the Engelberg Center is working with:

- Accountable care organizations—created under health care reform—to help them use clinically enriched performance measures to improve the delivery of health care.²⁵
- A number of communities funded by the Department of Health and Human Services under its Beacon Community Program, which promotes the use of information technology to transform local health systems.
- QASC to continue to identify concrete performance measurement implementation strategies and serve a developmental role that supports physician payment reform,

²⁵ An accountable care organization is a network of physicians and hospitals that have agreed to manage all the health care needs of at least 5,000 Medicare beneficiaries over a three-year period.

nationally-consistent measure implementation and public-private sector collaborative measurement activities.

The American Board of Medical Specialties Research and Education Foundation:

- Won a contract in February 2012, as part of a team of partners,²⁶ from the federal Centers for Medicare & Medicaid Services (CMS) to develop an episode-of-care system for CMS' bundled payment pilot project. Bundled payments reimburse providers for treating a single episode of illness or injury (from its beginning through testing and treatment) under one negotiated fee.

America's Health Insurance Plans Foundation is engaged in outreach to CMS and the Beacon Communities to:

- Share project results and raise awareness of the benefits of a distributed data model—including the protection of personally identifiable health information, lower infrastructure costs, consistent analytic results and a more flexible, expandable and more rapid approach for responding to new public health inquires.
- Pursue adding Medicare data with data from the two pilot states to increase the population included in the results and further expand the usefulness of results to doctors.

As these and other efforts advance, Engleberg's McClellan emphasizes the need "to move beyond the cycle in which rising costs spur payers to lower payments to providers or restrict access to care. Those do not seem like good solutions for creating a more personalized and prevention-based health care system. The kind of measurement work we are doing is the essential foundation for real reform."

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Reviewed by: Sandra Hackman and Molly McKaughan

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Communications Officer: Alexis Levy

Grant ID #s: QASC and 67252

Program Area: Quality/Equality

²⁶ Team members also included the Health Care Incentives Improvement Institute, Brandeis University, and the American Medical Association's Physician Consortium for Performance Improvement.

APPENDIX 1

Project List

Brookings Institution (Washington, D.C.)

High-Value Health Care Through Better Information and Quality Improvement: A Strategy for the Quality Alliance Steering Committee

ID# 60177 (July 2007 to January 2010): \$8,724,232

ID# 67252 (January 2010 to August 2010): \$399,047

Project Director: Mark B. McClellan, M.D., Ph.D., M.P.A.

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American Board of Medical Specialties Research and Education Foundation (Chicago, Ill.)

Developing and Implementing a Start Set of Episode-Based Cost Measures for Common Types of Health Care Services

ID# 63609 (December 2007 to December 2009): \$1,178,096

Project Director: Kevin B. Weiss, M.D., M.P.H., M.S.

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America's Health Insurance Plans Foundation (Washington)

Developing a Data Aggregation Method to Construct Performance Measures Assessing Quality and Cost-Effectiveness and Differences in Quality Measures

ID# 61926 (July 2007 to July 2010): \$3,557,740

Project Director: Cynthia Wark, R.N., M.S.N.

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Communications contracts related to the High-Value Health Care Project

GYMR (Washington)

MSL Group (formerly known as Manning Selvage & Lee) (Washington)

ID# 63740 (November 2008 to December 2009): \$271,000

ID# 67659 (May 2010 to April 2011): \$203,000

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APPENDIX 2

Quality Alliance Steering Committee

(Current as of May 2011; provided by the program's management; not verified by RWJF.)

Carolyn Clancy, M.D. (Co-Chair)

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APPENDIX 3

Project Subcontractors

(Current as of May 2011; provided by the project's management; not verified by RWJF.)

Brookings worked with eight subcontractors on its components of the project:

- Network for Regional Healthcare Improvement (\$24,711) in Pittsburgh, which provided technical assistance through president and CEO Maulik Joshi, Dr.P.H.
- Milliman, Inc., in Seattle (\$33,000), which helped validate and review performance measure data.
- Katharine London, M.S., in Cambridge, Mass., who produced policy briefs and recommendations related to health plans in Massachusetts and to collecting data on race and ethnicity (\$8,000).
- Summit Health Institute for Research and Education in Washington, which provided technical assistance on efforts to improve the collection of data on race and ethnicity (\$75,000).
- David Nerenz, Ph.D., in Detroit, who analyzed data and produced a report on making the business for collecting race and ethnicity data (\$27,200).
- Northwestern University in Chicago, which provided analytic support and produced an article on consumers' views of health plans collecting race and ethnicity data (\$20,080).
- RAND in Santa Monica, Calif., which provided technical support and training to health plans on indirect estimation (\$399,522).
- American College of Cardiology (\$105,000) in Washington, and Society of Thoracic Surgeons (\$275,00) in Chicago, which produced reports and papers and conducted meetings with stakeholders on how best to use the results of linking administrative and registry data.

The American Board of Medical Specialties Research and Education Foundation worked with five subcontractors:

- Northwestern University in Chicago, which provided input from health economists, programmer analysts and physicians (\$231,960).
- Thomson Reuters Healthcare in New York City, which provided analytic support by testing select measures on a regional dataset (\$124,413).

- National Committee for Quality Assurance in Washington, which provided technical advice on the process of developing measures and submitting them to the National Quality Forum for endorsement (\$57,070).
- University of Illinois (\$39,065) and Loyola University (\$7,252), both in Chicago, which provided input from health economists.

APPENDIX 4

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APPENDIX 5

Areas of Quality Measures Created by the Data Aggregation Pilot

The AHIP Foundation selected these areas for measures to test the methodology for aggregating information on physician performance across health plans:

- Breast cancer screening
- Colorectal cancer screening
- Disease-modifying anti-rheumatic drug therapy for rheumatoid arthritis
- Use of imaging studies for low back pain
- Diabetes
 - Lipid profile for diabetes
 - Hemoglobin A1C testing for diabetics
 - Urine protein screening for diabetics
 - Retinal eye exam for diabetics
 - Diabetes composite measure, including all four individual measures

- Cholesterol management for patients with cardiovascular conditions (includes high-risk procedures and ischemic vascular disease)—LDL screening
- Persistence of beta-blocker treatment after a heart attack
- Annual monitoring for patients on persistent medications
 - ACE/ARB
 - Digoxin
 - Diuretics
 - Anticonvulsants
- New episode of depression
 - Optimal practitioner contacts for medication management
 - Effective acute-phase treatment
 - Effective continuation-phase treatment
 - Depression composite measure, including all three individual measures

APPENDIX 6

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APPENDIX 7

12 High-Cost Conditions and Their Episode-of-Care Measures²⁷

- Acute Myocardial Infraction
 - 30 days following onset
 - Post-acute period (31–365 days post-event)
- Asthma
 - One-year period for patients with asthma
- Breast cancer
 - 60-day period preceding breast biopsy
 - Treatment in newly diagnosed cases over a 15-month period
- Chronic obstructive pulmonary disease (COPD)
 - Management of stable COPD over a one-year period
 - Management of unstable COPD over a one-year period

²⁷ See Table 1 in the issue brief *Measuring the Cost-of-Care* for the formal names of the measures and the level at which accountability for each is lodged.

- Colon cancer
 - 21-day period around colonoscopy
 - Treatment of localized colon cancer
- Congestive heart failure
 - Management of chronic congestive heart failure over a one-year period
 - Management of chronic congestive heart failure following hospitalization over a four-month period
- Coronary artery disease
 - Management of chronic artery disease over a one-year period
 - Management of coronary artery disease following revascularization over a one-year period
- Diabetes
 - One-year period for patients with diabetes
- Gastroesophageal reflux disease (GERD)
 - Twelve months of GERD treatment
 - Twelve weeks of GERD treatment
- Low back pain
 - Care associated with acute/subacute lumbar radiculopathy with or without lower back pain
 - Management of simple nonspecific lower back pain (acute and subacute)
- Pneumonia
 - Management of community-acquired pneumonia requiring hospitalization
 - Management of ambulatory pneumonia
- Sinusitis
 - Ambulatory management of acute/acute-recurrent sinusitis
 - Management of chronic sinusitis

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www.healthqualityalliance.org/about-qasc. Quality Alliance Steering Committee website describes the project and its workgroups, offers links to a resource library, and includes an interactive map of regional performance measurement initiatives.

www.healthqualityalliance.org/hvhc-project/cost-care-measurement-development. Page on the Quality Alliance Steering Committee website provides episode-based cost-of-care specifications for 22 measures.