ENGELBERG CENTER for Health Care Reform at BROOKINGS

Consistent and Timely Measure Implementation

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Changing Measurement Landscape

- Growing use of performance measures (clinically-enriched, longitudinal, outcome-oriented, etc.) for quality improvement, reporting, and payment
- Measures range from AMA-PCPI and NCQA to CMS and AHRQ, both endorsed and non-endorsed by NQF
- Inconsistent measure use across quality initiatives
- Varied operational measure specifications for similar measures used in different health care organizations.
- Lack of measure alignment within and between the private and public sectors.

Where the Measurement Landscape is Headed

- Alignment of measures where possible
  - Similar concepts across payers to support greater performance improvement
  - Similar specifications for concepts to reduce administrative costs and enhance comparability
- Consistent and timely methods for sharing actionable data with providers
- Parsimonious measures in areas that make large-scale consistent implementation feasible
- Broader, faster implementation of comparable, meaningful measures for quality improvement, reporting, and payment

Today's Environment

- National Quality Forum endorsing scientifically valid measures
- Payers selecting measures for monitoring provider performance
- Initiatives underway
  - Measure Implementation across providers and populations (ACOs, AF4Q, Collaboratives, Value Based Purchasing)
  - New data submission approaches across payers (Beacon, HIE, Collaboratives)

Quality Alliance Steering Committee

- Focus on Performance Measurement Implementation Issues related to the Triple Aim
  - Measure selection for determining value
    - Range of concepts that could be applicable
    - Range of measures within concepts
    - Different specifications of same “measure”
  - Data Transfer issues
    - Standardizing provider performance measures across payers
    - Merging data across different IT systems (platforms, sources)
    - Protecting privacy, security, and proprietary information
    - Data governance structures
    - Systems should not be cost-prohibitive
  - Effectiveness of Measures in meeting Triple Aim
    - Requres timely feedback to clinicians to affect performance
    - Measures must be valued by clinicians for them to be actionable
    - Feedback must be interpretable by clinicians

Measures Commonly Used

- Medicare ACO MSSP: 33 required measures of patient experience, care coordination/safety, prevention, and at-risk populations from three sources (CAHPS, claims, clinical)
- Medicare Advantage Star: 36 measures of prevention, chronic care management, patient experience, and customer service from HEDIS, CAHPS, HOS and administrative systems

Measures Commonly Used

- Health Plans: AHIP survey of measures commonly used by 11+ plans found:
  - Measured diabetes, cardiovascular, asthma, URI, pulmonary, transitions, mental health/substance abuse, resource use, prevention
  - Mostly HEDIS or use rates
- Regional Health Collaboratives
  - Wide range of measures being used

Data Sources

- Existing data sources common across programs:
  - Patient experience: CAHPS patient experience measures commonly collected in plans and subset required in MSSP; patient experience and outcome measures may be collected more directly/timely from patients in future
  - Claims: Hospital readmissions, ambulatory sensitive conditions admissions, ER use, inpatient admission rates, diabetes control, resource use and cost measures
  - Clinically enhanced measures: High blood pressure control, screening for HbA1c, LDL, eye exam—HEDIS reporting, electronic record extraction

Selecting Consistent Measures

- Consistent concepts: While common data sources exist, different programs have selected different items to measure different concepts
- Consistent specification: When same concepts are selected, programs may differ in item specification (i.e., screening v. education on falls)

Potential Measures: Cost and Resource Use

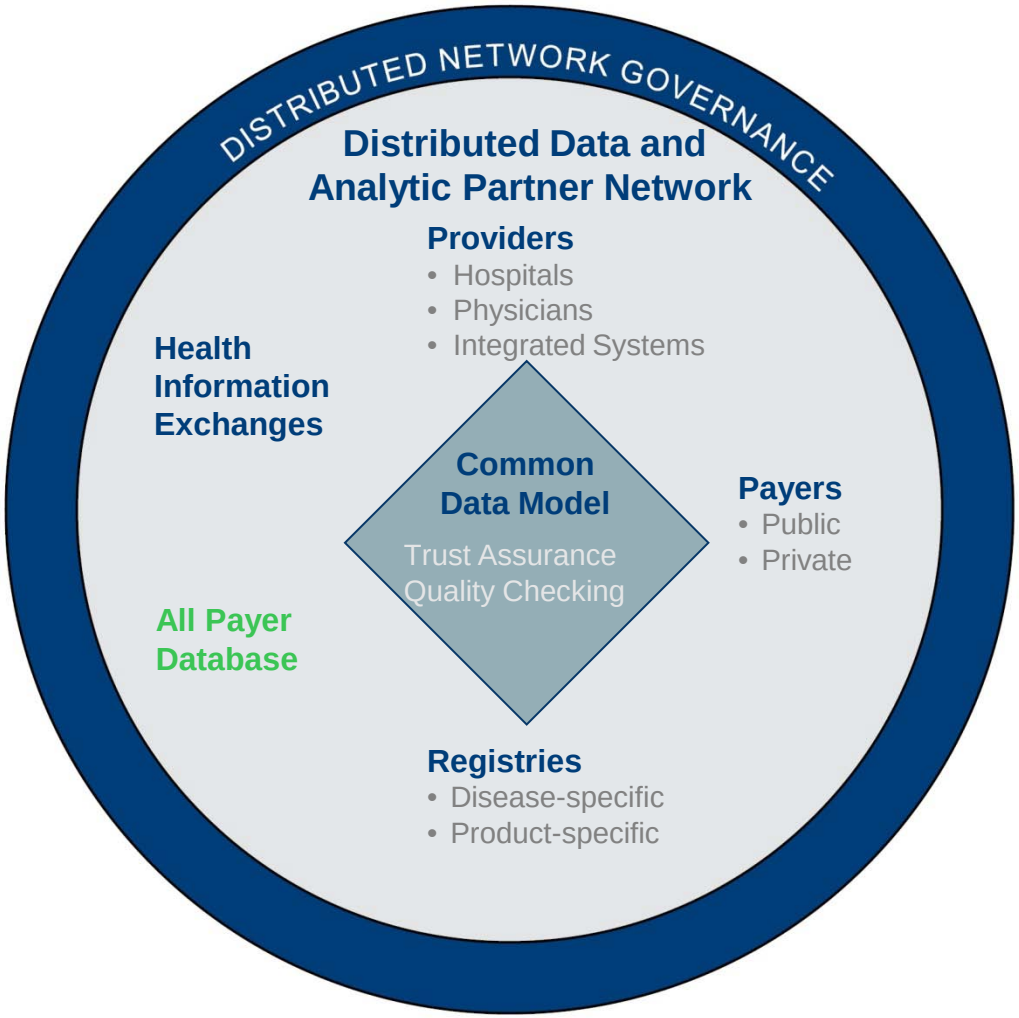
Measure Title	NQF	PQRS	MU	MSSP	AF4Q*	Beacon
Total Resource Use Population-based PMPM Index (HealthPartners)	1598					
Total Cost of Care Population-based PMPM Index (HealthPartners)	1604					
Relative Resource Use for People with Diabetes (NCQA)	1557					
Relative Resource Use for People with Cardiovascular Conditions (NCQA)	1558					
Relative Resource Use for People with Asthma (NCQA)	1560					

* Represents the number of AF4Q communities out of 16 using the measure.

Variations in Cost Measures

- Unit of Analysis –
  - Cost per person year, member month, episode
- Identification of Related Costs
  - Based on diagnosis, types of clinicians, time windows, other
- Risk-adjustment methods
  - Consistent risk adjusters across payers
- Privacy protection
  - Individually identified data
  - Proprietary data

Clinically Enhanced Measures Feedback and Reporting Using Distributed Model



Quality of Care (e.g., HbA1c < 8%)

Sponsors*

Queries

Results

Coordinating Center(s)†

Sponsors initiate and pay for queries and may include government agencies, medical product manufacturers, data and analytic partners, and academic institutions.

†**Coordinating Centers** are responsible for the following: operations policies and procedures, developing protocols, distributing queries, and receiving and aggregating results.

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