

# **Invitational Meeting on Performance Measurement, Data Aggregation, and Reporting November 8–9, 2004**

## **Introduction**

The meeting on performance measurement, data aggregation, and reporting was convened by the Agency for Healthcare Research and Quality (AHRQ), America's Health Insurance Plans, the American Academy of Family Physicians (AAFP), and the American College of Physicians (ACP). The purpose of the meeting was to identify critical issues in ambulatory care performance measurement in response to public demands for accountability, purchasers' sense of urgency with respect to public reporting of quality, and a shared goal of uniformity in performance measurement to facilitate both reporting and improved care delivery.

The timing of this meeting coincides with a growing interest in rewarding high quality providers (through "pay for performance" or "p4p") and clinicians' burgeoning interest in adopting health information technology to enhance the quality, safety, and efficiency of care delivery. AHRQ Director Carolyn Clancy chaired the meeting, and Centers for Medicare and Medicaid Services (CMS) Administrator Mark McClellan delivered some keynote remarks.

## **A Status Report on Quality Measurement —Elizabeth McGlynn, RAND Health**

Elizabeth McGlynn opened the meeting by highlighting the advances that have been made in measuring quality and reporting on quality. These include good tools and a wealth of information. At the same time, she stressed that the available information is often difficult to find and interpret and said that much of it offers different answers to the same questions. McGlynn also said that American adults receive only about one-half of the recommended care, and that number drops considerably when it comes to care for geriatric conditions.

McGlynn said the question for this meeting is, "How do we get from where we are to where we want to go?" She said the "next frontier" for quality measurement and reporting is at the physician practice level (either individually or in larger groups).

In order to frame the discussion, McGlynn reviewed the work of the Strategic Framework Board (SFB), which was formed in December 1999 to develop a strategy for national quality measurement and reporting. The aim of the board's work is to improve the health of the American public through the use of quality measurements. The SFB is also charged with articulating the guiding principles and priorities for a national system and identifying potential barriers to successful implementation of any proposed solution. McGlynn discussed the SFB's conceptual framework for a quality measurement and reporting system, saying that the aim is to

- evaluate the degree to which the U.S. health care system is providing safe, effective, timely, and patient-centered care

- assess whether the delivery of high-quality health care is efficient and equitable
- enable substantial progress to be made toward achieving established national goals
- provide easily accessible information on quality to a variety of audiences (including consumers, purchasers, health plans, and providers) in order to facilitate individual and collective decision making
- provide information that regulators, purchasers, health plans, and providers can use to support continued improvement and the achievement of goals

McGlynn said the system must be evidence-based and that in order to have an evidence-based system, you must have data. She said a major product of a national quality measurement and reporting system must be evidence about quality. She noted that it was also necessary to develop strategies to take action when evidence is weak or absent, and to routinely identify gaps in evidence and develop strategies to fill in the gaps. Overall, stressed McGlynn, the challenge is to find a balance between absolute certainty and the need to treat patients on a day-to-day basis.

The SFB has advocated a simultaneous top-down (goal setting) and bottom-up (frontline care delivery) approach to selecting measures and reporting strategies. McGlynn said that common measures were the currency of exchange that links what happens on the front lines of care with efforts to achieve national goals for quality improvement. Effective reports, she said, will “provide the right information, in the right form, at the right time, for the right people to make the decisions that are right for them.”

McGlynn stressed that it was important to recognize the tension between national goals (which provide a focal point for leadership and action) and local concerns. She cautioned that while the choice of these national goals would shape the choice of quality measures and reports, adopting goals is ultimately a local issue—and one that requires buy-in if they are to be adopted and result in quality improvements. A strategic plan for adoption is needed, she said, and it must include public awareness, an improved product, and systems that reward high-quality providers. In addition, although leadership at all levels of the system is essential, local advocates and channels for connecting participants must also be developed. McGlynn added that without a strategic plan for adoption, quality measurement and reporting as a tool to drive improvement may not realize its potential.

The purpose of a national quality measurement and reporting system, stressed McGlynn, is to improve quality. She noted that

- *transparency* is the goal of information generated for accountability and selection
- *change in care delivery* is the goal of information generated for improvement

McGlynn added that everyone’s skills— those of consumers, patients, providers, and purchasers— need to be improved in order to use this new information effectively.

We are at a critical juncture, said McGlynn, with a national focus on expanding the use of health information technology. Health information technology is a huge tool, but we need to figure out how to use it effectively. In addition, McGlynn said that while there were multiple experiments under way to reward providers for reporting and for improved performance, it is important that people not draw conclusions too quickly. She added that while there were very exciting activities

under way, including engagement by specialty societies in a dialogue around physician-level measurement, there is currently no strategic plan to coordinate these activities.

The SFB contends that the key dimensions of a strategy must include

- selecting national goals
- conducting a leverage analysis
- choosing measures
- reporting results
- using the information to design a data system and the infrastructure to allow these activities to take place

Regarding national goals, McGlynn said that the Institute of Medicine priority areas represent a starting point for discussion. The issue, she said, is whether the presence of national goals (or the process of developing them) would facilitate the engagement of individual physicians.

McGlynn took meeting participants through some examples of what a national goal might look like. These included such objectives as “improve the quality of life for persons with depression” and “reduce mortality from heart disease” as well as “improve the coordination of care for patients with multiple health care needs” and “ensure the safe and effective use of medications.”

The political reality, said McGlynn, is that no activity will occur unless there is a centralized funding mechanism. Operationally, she said, while it is possible to develop a starter set of goals, testing them in multiple clinical areas across the continuum of care will be necessary to evaluate the credibility of the information technology and to assess the credibility of pay-for-performance measures. McGlynn also acknowledged that agreeing on a starter set of goals for clinical areas is likely to be easier than developing a mechanism for updating them and for ongoing revision.

In order to develop national goals, it is essential to conduct leverage analyses. This is useful for determining what set of actions is most likely to make a difference and where the locus of control for action resides, said McGlynn. She took meeting participants through the steps of a leverage analysis for the goal of reducing mortality from heart disease. The example outlined the steps that take place after a heart attack (from on-the-scene CPR to the adequacy of the trauma system), as well as the events that precede a heart attack. The leverage opportunities are primary and secondary prevention—because the best way to survive a heart attack is not to have one in the first place.

Next, McGlynn said that under the SFB “rational” design, measures will flow from the leverage analysis. She said the measures designed for hospitals and health plans likely cannot also be used at the individual physician level.

The SFB has recommended integrating performance measurement for accountability and for improvement. There are two approaches—an internal measurement model and a transparency model—and the option you select will drive the health information system you create, said McGlynn. The first model argues that data should be used internally to measure improvement and guide care and assumes that individual physicians aren’t really in a position to make major quality improvements. Under the transparency model, if people knew how well a hospital, health plan, or physician were performing, said McGlynn, they would use this information to make choices about

providers. In other words, they would make rational decisions on where to go for care. McGlynn said that the SFB tried to make the point that both approaches can operate from the same set of data.

Looking again at the political realities, McGlynn noted that beliefs about the availability of data (now and in the future) drive perspectives on measurement opportunities. She noted that there has been considerable debate about whether measures should be proprietary or in the public domain. In addition, she pointed out the tension between those urging deliberateness and those urging speed and said that it was important to find a balance between the two. McGlynn added that there was a lot of work to be done to align measures to multiple uses.

Turning to data aggregation and reporting, McGlynn stressed that for data to be used for accountability, pay for performance, quality improvement, and other decision making, they must be assembled, processed, packaged, and delivered to multiple sources. They must also be collected from multiple sources. If not, we will end up with suboptimal or potentially misleading information, she warned.

Collecting good data, McGlynn noted, will not be easy. Not only do physicians see multiple patients, but patients see multiple physicians and physicians have multiple contracts. Coordinating the information from these multiple sources will be a challenge.

The political and operational reality, said McGlynn, is that data are power. This means you “have to give to get,” she said. McGlynn said that some pooling of data—especially at the physician level—will be necessary, and that this raises a number of challenges and concerns. What data elements will be pooled? Who holds the pooled data? Is that person trustworthy and competent? In addition, who decides how the data will be used, and will there be opportunities for review prior to the release of those data to health plans, purchasers, and the public? And how does this get paid for?

Prior successes offer some lessons, said McGlynn. She highlighted several:

- those being measured have to be at the table and have a clear role in policy making
- starting where there is common ground allows for more rapid progress
- a trusted, neutral broker is essential
- initial efforts probably will not please anyone
- progress will be too slow for some, too fast for others
- the availability and nature of funding will drive the process
- people, not technology, will need to solve the critical problems

Finally, McGlynn noted that while there are a lot of lofty visions about where we would like to go, we need to figure out how to get there from where we are today.

## **Discussion**

During the discussion that followed, there was a follow-up question on trust and competence. Elizabeth McGlynn said that trust depends upon each person’s perspective, and that it would be necessary to find data brokers who are trusted across diverse segments of the health care community. She added that the competence issue has to do with processing the data—and that even good companies can mess that up from time to time.

So who holds the polled data? McGlynn said that, in her opinion, this was not something that should be handled by a single entity. At the same time, she reiterated that there is a lot of waste now in how data are collected, and that the lack of data pooling and data sharing is placing a huge burden on the system.

Another participant noted the need to intersect the discussion on quality with a conversation about the data. One way to get started, suggested McGlynn, was to build the ideal Web site. Depending on your perspective (physician, provider, hospital, and so forth), what information would you like at your fingertips?

Another participant suggested that there was a missing element in the discussion to date: technical assistance to help physicians implement health information technology.

There was also discussion about whether structures can be “imposed.” While one person noted the need for a multi-stakeholder forum, another said there were structures in place already and questioned whether a larger group could effectively be put in place. One participant cautioned that all the stakeholders must be at the table if viable solutions are to be achieved. There was discussion about whether the National Quality Forum (NQF) is the appropriate vehicle for this process or whether a different group could accomplish more. One person observed that the people represented in the room were “not natural bedfellows” and said that the real question wasn’t *who* would undertake these activities but *whether* everyone could commit to focus on figuring out how to measure quality, report on it, and advance the public health.

We need to think about the different structures in place and how we do business, said one participant, so that physicians feel these are credible measures (versus merely being imposed on them). Another person suggested focusing on efforts already under way and identifying what each stakeholder can do to advance common objectives.

While the NQF brings together stakeholders to discuss what to measure, said another participant, the harder question is how to translate measures into day-to-day patient quality of care. This was followed by a comment about how to get agreement on a handful of measures (given the large number of measures out there). McGlynn said that, in her opinion, the issue was not the number of measures, but rather having an information technology system that allows ease of data collection and analysis. She compared this to an airline black box, which collects information from multiple sources.

## **Remarks**

### **—Mark McClellan, Centers for Medicare & Medicaid Services**

Mark McClellan said that now is the time to make progress in using quality measurements to get a better health care system. He said that stakeholders are getting behind the effort to put in place performance measures for ambulatory care, and said that it was time to collaborate more closely than ever to make quality improvements and close the quality gap. He warned, however, that if you cannot measure quality, it will be hard to achieve a system that rewards quality care.

McClellan committed to taking a leadership role in working with key stakeholders to push forward with ambulatory performance measures, and his remarks focused on CMS' goals and activities in this arena. He noted that the Medicare Modernization Act gave the agency new tools, including purchasing power. At the same time, he said, there are better ideas floating around today and better support than ever for quality improvement efforts based on quality measurements—and even pay for performance.

The goal to improve quality and safety underlies all of our goals, stressed McClellan. He noted the urgent need for more broadly accepted quality measures that are results-oriented. He also noted that despite many advances in technology and medical science, the American health care system too often fails to translate these efforts into better patient care. Too many patients receive the wrong treatments or fail to receive the right ones, said McClellan. He added that we need a better strategy to come up with innovative, high-quality care—and ways for delivering this care.

McClellan stressed that the tools exist now to put in place better medical practices and to provide every patient the right care at the right time. The goal is a “patient-centered, personalized, equitable, safe, quality care system,” he said.

McClellan pointed to the work of the CMS Quality Council, which includes four working groups. The Quality Council is designed to give patients and providers the tools they need to make the best decisions, he said. It also strives to ensure that we have an environment for medical practice that supports the best use of these tools (including information technology tools and information on effectiveness of treatment options and effectiveness of provider performance). One working group is focused on performance measurement, including the possibility of pay for performance, he added.

The CMS administrator said that it was very important to have in place a collaborative process in order to get to a common set of meaningful and valid ambulatory care measures that are outcomes-oriented. He noted that the NQF has played an important role in helping to establish a consensus process, adding that NQF is currently conducting a review of the effectiveness of ambulatory care measures. McClellan stressed that CMS is supporting the refinement of these measures.

Next, McClellan cited some of the challenges ahead. These include

- development of the data for the measures themselves (and he noted the debate on the use of claims-based data)
- questions about funding and ownership of measures (which he said he thought were really about providing adequate financial support)
- privacy questions (he noted the need to ensure the privacy of patient data) and the need to look at secure data measures
- technical issues regarding the development of reliable and valid measures (he suggested that there would be a robust starter set in each of the specialties by next year)

Noting that addressing these challenges would be hard work, McClellan expressed confidence that progress on performance measurement in the ambulatory care area was achievable. He pointed to the broad alliance that came together to make progress in the hospital arena. McClellan noted that CMS has used a variety of tools to standardize reporting requirements and to prioritize and standardize quality measures for hospitals. As a result of these efforts, he said, there is now

voluntary reporting on 10 starter measures for all patients being treated for three common health problems.

We want to emulate this collaboration with the active involvement of all key stakeholders in the ambulatory care arena, said McClellan. We need your help, and we hope we can start today, he said.

While CMS wants broad stakeholder input, McClellan stressed that the agency was going to keep moving forward on its own with pilot programs. He cited as one example a Medicare pilot program on fee-for-service chronic care coordination, in which the agency will pay physicians for improving quality and lowering costs at the same time. In other words, CMS will pay for sharing the gains that will come from more efficiency within the system, he said.

We are also pushing forward on other ambulatory care demonstrations, said McClellan. This includes a Medicare performance demonstration in which physicians are given incentives to put in place new information technology, including health information technology, and to make improvements in quality. The program thus rewards better quality of care and improvements in health outcomes. Another pilot project incorporates a subset of the ambulatory care measures in a pay-for-performance demonstration that rewards large practices that are able to influence services and improve health outcomes. The practices will receive bonuses if they save Medicare money while at the same time improving quality of care and health outcomes.

In concluding his remarks, McClellan reiterated that he would like to see the establishment of an alliance of key stakeholders in ambulatory care around initiatives that encourage and reward improvements in health outcomes and quality of care. “As we strive to make improvements,” he said, “I believe there are opportunities to provide better support and an environment that encourages us to get it right the first time.”

## **Discussion**

During the discussion that followed, someone asked McClellan about his top three priorities for getting started. He cited three items:

- providers must be at the table (he also noted that providers are tired of facing cuts in Medicare payments and want the flexibility to be innovative)
- all key stakeholders, including consumers, must be at the table and ready to agree to reward, encourage, and even pay for better results
- the stakeholders must have a concrete goal

There was also a question about how CMS was addressing the problem of a “dysfunctional payment system” that does not reward outcomes or improvements in quality. How is CMS looking at the issue of pay-for-performance incentives and fee for service?

It is too often the case that the providers who know most about how to improve care are feeling frustrated, said McClellan, because they are swimming against the tide in an environment that pays hospitals and physicians more when they have complications and dispense more care. He said the problem right now is that higher quality means fewer dollars for hospitals and other health care providers. He said that while the CMS demonstration projects are fairly modest, they should offer some guidance on what does and does not work.

McClellan added that a major change within Medicare is the availability of more PPO plans, which offer the opportunity to lower costs and coordinate care more effectively. He said CMS was looking to expand its PPO offerings in the next year, especially as the agency moves to a system that will support the use of PPOs at the regional level. At the same time, he once again emphasized that without meaningful ways to measure how well the system is doing, it will be very hard to support and reward improvements in quality of care.

Finally, there was a question about the accessibility of Medicare data and whether it could be merged with other data sources. McClellan noted that there were currently real limitations on his agency's ability to share patient-level data. But this is not insurmountable, he said. He noted that CMS was looking at the use of aggregated data. McClellan added that it was necessary to find ways to either get rid of the need for patient-level data or ways to ensure its protection—and he asked meeting participants for their help in addressing this problem.

### **A Framework for Performance Measures —Kevin Weiss, American College of Physicians**

Kevin Weiss offered a framework for discussing clinically relevant, standardized performance measurements for ambulatory care. Urging quick action, he said that the lack of agreement on performance standards and data conventions has resulted in confusion about the validity of measures, imposed a burden on providers, and created confusion among patients over which provider or institution to select. Weiss endorsed the work of the Strategic Framework Board in setting up an evidence-based conceptual framework for quality measurement and reporting.

Weiss noted two pathways for quality improvement—intrinsic motivation (i.e., must be ready to engage in change) and extrinsic motivation (i.e., pay for performance)—and said that everyone must be mindful of the tension between the two. For example, there is concern that physicians can be driven to do too much if the incentives are set too high.

Weiss noted that the Institute of Medicine's priority levels are evidence-based, which he said should help to narrow the number of potential measures. If there are 20 priority areas, he said, there will probably be 3–4 good evidence-based ones and 10–20 performance measurements.

Weiss said that performance measures must be

- evidence-based
- scientifically sound (including a clear linkage between clinical process and outcome; and valid, reproducible, responsive, and risk adjustable as warranted)
- clinically relevant (to providers, purchasers, and consumers)
- transparent (i.e., open source and fully disclosed)
- feasible (i.e., of reasonable cost and precise specification, and they must not add an undue burden on providers)

Feasibility, said Weiss, is probably the most difficult of these elements. How do we facilitate measurement so providers aren't burdened?



Next, Weiss looked briefly at existing processes, and noted that the National Quality Forum provides a national forum for developing consensus-based performance measures. The American College of Physicians, meanwhile, has a policy that supports well-designed demonstration projects on the use of performance measures for accountability.

It is time to move forward with accountability, said Weiss, adding that it was important to be careful about how accountability is rewarded. Weiss also noted that performance measures should have the same attributes for quality improvement and accountability.

The ACP's recommendation, he said, is "that pay for performance should become a top national priority, and that Medicare payments should lead to this effort."

Weiss also noted a couple of elements that he said have been largely missing from the discussion:

- the need for continuous review (to find the benefits of the improvement and to be mindful of the unintended consequences of bad measures)
- recognition of the vulnerabilities of performance measures (including the need to ensure that each measure promotes not only quality, but also equity and access)

Finally, Weiss offered a road map to change. He said this road map involves raising public awareness, redesigning measures and reports, delivering information in a timely fashion, public reporting, leadership, and a system that rewards quality. Most important, he said, is to recognize that the Institute of Medicine has already provided the goals, and that the work ahead involves enhancing the evidence-based process, improving accountability, and making sure there is a surveillance cycle in place.

## **Discussion**

The discussion opened with a remark about health disparities among uninsured Americans and the need to balance access along with quality and equity. A second person suggested that there will be even more uninsured in the next 2–3 years as insurance costs rise, thus increasing the urgency to act now.

One participant suggested that there already existed a broad consensus on performance measures, and that what was really needed to move forward was to put in place the right measures (including system metrics), the right levers (the stakeholders in the room), the right incentives (aligning professionalism with payment), and the right supports at the office level.

The discussion quickly moved into the area of accountability. Without accountability, performance measurements will have no meaning, said one participant, who added that any changes must also reduce the administrative burden on physicians. This concept of reducing the administrative burden on physicians was echoed by several other participants during the course of the discussion. Another, however, suggested that quality improvement need not be burdensome and challenged the provider community to improve the coding in order to pay for the interventions that provide the highest quality of care. Similarly, another participant said that the burden on physicians will disappear once measurement is incorporated into a practice and becomes part of the work flow. He added a challenge to the health plans: Is there a way to collect and aggregate data in local communities and

give physicians one report that is credible? Someone else noted that the health plans have a great deal of data that can provide a window into some aspects of performance.

The way to get new codes approved is through the American Medical Association process, said one participant. He cautioned, however, that the problem with building on the existing system is that it is a per-procedure/per-visit model. We need to be looking more broadly at how we change the payment system to reward performance and quality care over time (for management of chronic disease), he said. He added that little progress would be made, however, unless the Medicare system is revamped at the same time.

Still regarding accountability, one participant asked how to engage physicians on quality improvement and accountability. These measures don't require sophisticated information technology, but they do require implementation. Another person suggested that there needed to be joint accountability (and better data coordination) at the physician level to address gaps in care, since patients often see more than one physician for their care.

How quickly can a better health information technology system be put in place? One participant noted that it will take a while for smaller private practices to acquire, manage, and report data on quality of care—since physicians would be doing this in addition to their current duties. The participant suggested progressively incentivizing practices to do this. Another stressed that health information technology will enable physicians to be more efficient—especially at the small-practice level. Another suggested that the answer to the “when” question will come after there is an answer on how to finance new information technology systems.

One participant said that there was work that could be done before an electronic medical records system was put in place. The participant noted that most physician systems are currently set up for billing, not for managing patient data. He suggested that it would be very helpful if the insurance plans, which do receive patient data, could act as a registry around a few, agreed-upon performance-based measures.

From a purchaser perspective, said one participant, it would be helpful to have a set of recommendations that were tiered based on the level of evolution of a physician's practice. For example, level one would be a practice that is unwilling to collect data for medical records; level two, those who are willing to collect information; level three, those who have implemented at least a minimal health records system; and, level four, measures that are geared to physicians who have put in place an advanced, interoperable electronic medical records system.

One participant suggested that the various Medicare pilot projects under way would provide a lot of useful data on quality improvement and information technology over the next three years. He suggested that private payers also set up similar pilots. The participant noted a sea change in the way that physicians were managing small offices, and stressed the need to learn from their efforts before rolling out new systems for improving quality.

One big question that came up repeatedly was: How are we going to put in place new health information technology and pay for changes to the system? One participant said there was no question that there were considerable costs to developing and implementing evidence-based performance measures. Another participant suggested that the costs must be shared by private and public payers.

Regarding payment models, one participant suggested that quality improvement needed to be thought about in two different pathways: one for those “at the top of the class” and another for those at the bottom. If we really want to improve quality for those at the bottom of the class, said the participant, then this implies a different incentives model. Another participant suggested that some of the existing pilot projects would offer a logical, reasoned, and measured way to deal with some of these issues.

One participant noted that there is no unanimity in what constitutes a pay-for-performance program. She noted three basic versions (including the CMS model) and said she felt that none is sustainable as a business model over the long haul. The challenge for those assembled here today, she said, is not to fall into a trap and think the versions on the books today are the only options.

There was also discussion about how to provide individual physicians with the flexibility to take the steps they want to address quality improvement. The current system is not allowing them to do this, said one participant. Another person, meanwhile, noted that a section of the provider community has already demonstrated success in managing chronic conditions and disease management, and is already adopting electronic health records and other automated technologies. Perhaps we should begin where successes have already taken place and try to build on these, he said.

One participant suggested that there are already agreed-upon measures at the physician level for prevention (of diabetes, hypertension, etc.) and that his organization was ready to move forward with demonstration projects to validate and show that these measures can be implemented in small practices.

Another participant expressed concern that the current system is not helping to create the uniformity that every provider says it needs. If we can’t get uniformity on what we’re measuring, it is hard to figure out how we can move forward, she said.

There was also concern raised about proprietary care programs. One participant noted that physicians are being offered incentives to compete in proprietary care programs rather than incentives for improving quality. We need to communicate that proprietary care programs aren’t the right way to go, he said, but how do we do this given existing market forces?

Regarding a timetable for action, one participant said that it was critical to think about near-, medium-, and long-term horizons. It is extremely important that we have these different time horizons, he said.

In wrapping up the discussion, AHRQ’s Carolyn Clancy asked each participant to write down two suggestions that reflect short-term priorities.

## **Improving Data Reporting —Randy Johnson, Motorola speaking on behalf of the Consumer Purchaser Disclosure Project**

Randy Johnson said he wanted to leave participants with two points:

- We have a need for nationwide measures, reflected by consensus around the National Quality Forum
- We have the need for data aggregation initiatives, including provider-identifiable information from the Centers for Medicare & Medicaid Services

Johnson highlighted Motorola initiatives in the health care arena, including a series of focus groups in the early 1990s; development of a measurement tool in 1994 to evaluate HMOs on quality of care, cost effectiveness, and patient satisfaction; development of an incentive program in 1996 on health risk assessments; introduction of disease management strategies in 1997; and the introduction of incentivized disease management participation in 2001.

Johnson noted that a little more than three years ago, his company started looking to synchronize its health care purchasing, and came to the conclusion that it needed to focus on quality reporting and disclosure. The Consumer Purchaser Disclosure Project was formed in 2001 with a goal that by 2007 Americans would be able to select hospitals, other providers, and treatments based on public reporting of nationally standardized measures for clinical quality (safe, timely, and effective), consumer experience, equity, and efficiency.

Johnson said there were four major steps toward reengineering the health care system:

- measurement, transparency, and disclosure using nationwide standards
- a focus on consumerism
- pay for performance
- healthy people (we need to focus on healthy people in order to bring about the best-quality system that we can, he said)

Johnson stressed that increased transparency is already being demanded by patients, who need better tools to make good business decisions. More important, he said, we need to make improvements in quality of care. We make decisions about toasters and cars based on price, quality, and customer satisfaction, said Johnson, and we've decided we must have the same ability to make decisions about our health care.

**Peter Lee, Pacific Business Group on Health**, another member of the Consumer Purchaser Disclosure Project, added that there is urgency in moving forward today—not three years from now when CMS pilot programs are complete. There are huge stresses on the health care system today, he said, and employers are facing double-digit inflation. He added that the business community is already thinking about health plans for 2006. The question is whether there will be good high-deductible health care plans or bad ones, said Lee. If we don't do something soon, he warned, we'll have a lot of people in high-deductible plans, and this runs counter to what most physicians feel is needed for good preventive care.

Lee reiterated the need to provide better, more useable information that is based on sound science. Transparency is absolutely critical, said Lee. We'd like to go through the NQF process, but we won't wait. The employer perspective is that the drive is there now to move forward, he concluded.

## Discussion

There was some discussion about the Hospital Quality Alliance (HQA) and how it had evolved. Three hospital associations recognized that they needed to work together to get better information out to the public. The message was, said the participant, Get us a common agenda and a standard set of measures that can be turned into real information for the public and real information for providers. She noted the need to move the dialogue beyond just putting out measures and toward putting real information in the hands of providers, purchasers, and consumers. This is a much more difficult task, she said, but one we should not shrink from.

Also regarding the HQA, one participant noted that stakeholders agreed that the issue was not one of aligning measures but rather one of putting in place identical measures. Another person stressed that the alliance has pledged to work through the NQF.

There was also criticism of the HQA—specifically that many people did not find out about its work until the alliance brought performance measures before the NQF.

Purchasers and consumers felt that their interests had not been as robustly represented as perhaps might be desirable, said the participant. Whatever we do on the ambulatory care side, we must have purchaser and consumer input from the very start, he said. There was also concern expressed about the lack of initial input into the HQA process by rural and specialty hospitals.

One issue that really divides those pushing the hardest for measurement and quality reporting is how accurate and reliable measures have to be before they can be used, said another participant. From the physician's standpoint, we want to be judged as fairly as possible and as accurately as possible. But, as a consumer, I'm okay with information that's only 70 percent predictive of which hospital or provider is better, he said. Other participants echoed the point that people need the right tools to make the right health care decisions.

There was considerable discussion about what data to use and how to get started. Several participants suggested starting by looking at existing claims data. Another asked where to go to get access to credible claims data. Someone representing a health insurer said the plans can give information now to physicians that is actionable and patient-specific. While this wouldn't solve everything, it would be a start.

Another participant suggested not setting too lofty a set of performance measures given the claims and administrative data available today. Yet another said that physicians were concerned about using claims data for quality reporting and evaluation because they were collected based on very different criteria.

One participant noted that the barriers to rapid implementation of performance reporting and disclosure clearly center around data aggregation and ownership. We need to start figuring out the solutions and addressing the barriers to moving forward, he said. Another participant asked: How do we take the data and aggregate it in some format that is appropriate from the point of view of different constituencies, and bring it together in objective, neutral ways that protect patient privacy?

There was also some discussion about how to develop information technology collection systems in physicians' offices, and how to set up a system in which information flows through regional health data exchanges.

One participant noted that health care is local, and so is the need to aggregate data. At the same time, there is a need for coordination at all levels (local, regional, and national). Having data is okay, said the participant, but only if we are using them. The barriers to progress revolve less around the measures and more around who is aggregating the data and how the results will be acted upon, he said.

Another participant remarked that the discussion on data aggregation was very exciting. The person said that the health care community needed to construct something that can be effective in communities and that people can use to benchmark and make real improvements. We've been measuring and testing pay for performance over the last decade, he said, but these efforts have not achieved what we want.

As employers, said one participant, we try to communicate as effectively as we can to our employees. We'd like best-in-class measurements regardless of where a person resides. The person added that he'd like to see less bureaucracy and a system that is less confusing for those who deliver care on a nationwide basis. Another person suggested looking at the Veterans Affairs system, and how it tracks people as they move from region to region.

Another participant noted that there appeared to be a struggle between what can be done quickly as opposed to what can be done right. He said there seemed to be genuine consensus among the payer and purchaser communities on what to measure, adding that the real challenge was in figuring out how to measure and what to do with the results. Another person said that it was not possible to work exclusively with office-based data (that claims data were also needed). As a result, it was necessary to discuss what it means to aggregate, refresh, and report these data, said the participant.

There was also a question raised about whether there were activities that the health care community needed to stop doing in order to get traction. For example, should we stop pursuing measurement agendas? Another participant said that the goal of the Consumer Purchaser Disclosure Project guidelines was to be guided by Institute of Medicine priorities. But we also want a cost-efficiency performance measure, which doesn't currently exist, he said.

One participant suggested that efforts not start with pay-for-performance measures, because these are the most problematic from a health plan perspective. Another person said that, from an employer perspective, pay for performance is essential, as is quality improvement, if costs are to be reduced.

Bringing the conversation back to the subject of data reporting, one participant suggested building on the work of the NQF. If the goal isn't just cost containment, but also quality improvement, then this is about more than selecting a hospital or a physician. So why can't we make sure the patient gets feedback from some of these data (such as, "you forgot to refill your antidepressant" or "you're scheduled to get blood testing done")? she asked.

## **Creating a Strategy for Data Aggregation and Stewardship —David Kibbe, American Academy of Family Physicians**

David Kibbe said that the country was long overdue for a national strategy for data collection, aggregation, measurement, and reporting on quality processes and outcomes for common expensive, chronic illnesses. If the next frontier is data collected from the physician and practice levels, he said, then we must address barriers and opportunities that exist at the physician and practice levels. These include trust and competency; adoption of technology; and new models for data exchange (and new skills for managing health information) that include the patient as part of the data supply chain.

Regarding trust and competency, Kibbe said that if data are to be collected from physicians, then data stewardship must be practiced with complete transparency. He added that issues of data ownership and rights of use must be addressed, and he warned against data arbitrage.

Regarding the adoption of technology, Kibbe said that performance and quality data must become the routine by-product of the delivery of care using an electronic health records (EHR) system. It is too expensive to get the data any other way, he said. Kibbe also said that certification of electronic health records, which includes data collection and submission standard features, must be completed nationally. In practices that do not have electronic health record-keeping systems in place, he said, technology must lead in the direction of electronic health records along pathways that are not dead ends (so people don't have to throw away their existing systems and start all over).

We are further along with electronic health record keeping in physician practices than many people assume, said Kibbe. He stressed that these early adapters are not innovators, nor do they care about the technology—but they want it to help their practices survive and thrive. The return on investment is becoming clearer every day, he said.

Kibbe noted that there were several key barriers to the deployment of a national electronic health record-keeping system. These include

- high prices (solution is affordability and price transparency)
- risk of implementation failure (solution is evidence-based technical assistance)
- lack of connectivity and interoperability (solution is for EHRs to be the “central nervous system” of the practice)
- confusion about the product and company reliability (solution is EHR product certification, which is well under way)
- wide variability in contracts and business practices (solution is standard contract language and clarity about business practices after sale)
- access to capital (solution is low-interest loans)

Regarding new models for data exchange, Kibbe noted that new and more efficient models of data exchange are required, along with new skills for managing them. It's not just about data producers and users, he said. Rather, he said, we need to have a health data supply chain (and a market for these data) that involves almost everyone. Among these are physicians, patients, hospitals, emergency departments, long-term care facilities, and researchers. We need to recognize that there is a market for data that have multiple uses, are recycled, and pay for themselves, said Kibbe.

We can stage a national data submission implementation standard, said Kibbe. To do this first requires agreement—which we have—that standard measures are essential. Now we need to develop a blueprint for electronic health record certification and find the capital to enable national

deployment of health information technology in small medical practices. And, of course, we need data, he added. Kibbe said that what was needed was a uniform architecture for data collection, management, analysis, and reporting that takes into account the complexity of the data supply chain.

Kibbe stressed that data are just data (and thus that people should not make a distinction between administrative and claims data). The question, he said, is how to use data from multiple sources. He added that the continuity-of-care record is a basket, and that there was no reason why one particular entity should be responsible for populating the whole thing. Instead, it would make sense to have multiple entities filling it out and providing useful information, Kibbe said.

Finally, Kibbe stressed that a key question that remains is how to engage physicians. When they complain about accuracy, he said, then tell them we'll work on it to improve the data reporting. As long as physicians are engaged, then we can make big strides, said Kibbe. Right now, he said, they don't see much in this for them.

### **Discussion**

The discussion started with a comment about the “artificial dichotomy” between claims and administrative data. The data that are critical to care come from all over the place, including other physicians, said one participant. We have to be very careful about how we think about using the data. If we are trying to judge the competency of a physician, he said, that's one thing. But if we are interested in the functioning of the physician within the system he or she is imbedded in, then we want to know whether a test that was ordered was done, and that's a different usage.

I think we need research, thinking, and demonstration projects on how we record clinical data in the office, added the participant. While I like the idea of electronic medical records, we need to rethink how we record data because we are, over time, losing a lot of the critical clinical information we receive.

In response, Kibbe noted that there has been a tendency to transfer the paper documentation model to a computerized system. He said that the continuity-of-care model has thrown a wrench into this approach because the summary health information is built differently. There's a real struggle going on that will have profound implications on how we measure quality in the future, he said.

One participant noted that the health care community is in the process of transitioning to electronic health records, and noted that health plans have much more administrative data available than do individual doctors. A second person echoed the latter comment and asked whether the data available through the health plans could be accessed to inform physicians and patients. Someone else suggested that it was necessary to rethink the whole issue of data ownership.

Another participant stressed that the health care community should not wait until there is a critical mass of electronic medical records before doing something with the data. Instead, we should talk about using administrative data so we can get started by January 2006 with some degree of initial credibility.

There was a question for Kibbe about what he thought American Academy of Family Physicians (AAFP) members wanted to see done next. Also, what would make AAFP members comfortable regarding data stewardship?



In response, Kibbe said his members would like to get rid of all the paper, and they would like to make their practices financially successful. But they aren't really all that interested in submitting quality data, he cautioned. To the extent that we can provide reasonable, financial incentives to submit these data, he said, I think we could get considerable interest.

There was a follow-up question about how to make it “worth it” to providers to submit data. The participant noted that she had counted 86 existing incentives programs, and that most are considered poor. If these incentives aren't good, then what would be an attractive motivation? she asked. In response, Kibbe said the first step was to provide help in purchasing and implementing electronic data recording systems. Once a certified system is up, he said, then the physician can submit data (and become engaged, and get extra money to do so). Next, he said, provide additional incentives for physicians to reach their quality-of-care targets.

One person asked about trust, and how to structure the custodial function (vis-à-vis the data) to give everyone a much-needed level of comfort. Another person observed that gaining trust was going to be difficult. Yet another focused on credibility. Any time you hide things, even if for a good reason, it causes concern (i.e., even though we expect the public will find a composite measure most useful, consumers should be able to click down and locate the details), said the participant. The person added that there was also a difference between disclosing measures and disclosing all the data in the database (i.e., multiple stakeholders may agree on the measure, but perhaps not all will agree on disclosing all the data so someone else can put it together as they see fit).

It sounds like we need short-, medium-, and long-term data aggregation strategies, said one participant. There is a lot going on, and the question is whether we can light a fire and find the two or three models that can be applied everywhere in the country.

A lot of the focus is on the Medicare population, noted one participant, who said his focus was on chronic diseases (versus, for example, employers, who are likely to prioritize different measures). The person noted that progress on the health information technology front is coming quickly, because both plans and payers have committed to help fund adoption of electronic health technology. But the question is: What do we get if we help fund it? (Quality data, replied someone else.)

One participant noted that the American College of Surgeons (ACS) is working with the Department of Veterans Affairs on Web-based data collection and management. With AHRQ support, ACS is in the process of making the program available to any hospital (both VA and other) that wants to use it. The system is totally secure (because the data are encrypted), and data are only given to the hospitals that report data, he said. The data include preoperative, postoperative, and operative data. Another person noted that ACS was one of several groups that have maintained databases, adding that the real issue is one of data aggregation. How many of these separate systems will be mainstreamed? he asked.

In response, another participant noted that both access to data and public disclosure are critical. She urged everyone to think about multiple uses. “Collect once and use many different ways,” she said.

One person raised the related issue of creating composite measures and massaging data for different uses. I need high-level aggregate data for some stuff, said the person, and I need to package data in different ways. He added that it was important to pay attention to how data, after they have been

aggregated and analyzed, are further aggregated and manipulated. Most consumers, he said, don't want to look at 25 measures when choosing a physician.

Another participant suggested that this discussion was really about two separate things: building roads (the infrastructure) and building houses. We need to recognize that each needs to be funded, he said. First we need to get there (data aggregation), then we need to address what we are going to do with the information once we have it.

Finally, there was a remark about the need for synergy at each level, and the need for “vertical parsimony” (so that we have the same measures for reporting, quality, and national tracking). This is easier said than done, cautioned the participant, because the availability of data is different at different levels.

## Next Steps

**Carolyn Clancy** wrapped up the meeting by noting that a lot of people had spoken with some urgency about the need to move forward in the ambulatory care arena. While there is a lot of work to be done, she noted, there did not appear to be any interest in creating new performance measures.

Clancy suggested creating three workgroups:

- performance measurement
- data reporting
- data aggregation

Clancy noted that the workgroup on performance measurement would set out short-, medium-, and long-term options and look at recommending performance measures. We need to look at the performance measures that are out there, she said, and come up with criteria that can be implemented in various time frames. She said she hoped the workgroup would also look at what it would take to accomplish this goal.

On data reporting, Clancy said she would like the workgroup to look at how to report on dimensions of performance, as well as how to use data in ways that are meaningful and useable. In other words, she said, this gets back to the idea of “collect once and use multiple times.” How do we successfully report to multiple audiences? Clancy added that the broad issue of accountability also fell under this workgroup's purview.

Regarding data aggregation, Clancy said that she hoped group members would array the options for data aggregation and report back.

**Invitational Meeting – November 8 and 9, 2004**  
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