

Buying Value's Recommendations for a Multi-Stakeholder, Multi-Level Consensus Model for Improving Healthcare Quality Measure Alignment

A Measure Alignment Workgroup convened by The Buying Value Project met on March 20th with three objectives:

1. to develop a common understanding of the different dimensions and problems in measure alignment and of what better alignment would look like;
2. to develop a draft consensus strategy to achieve the future state vision, and
3. to develop a draft action plan with specific and feasible means to implement the strategy.

The discussion focused on the alignment of measures for value-based purchasing, transparency and quality improvement.

The workgroup explored the possibility of a strategy that would fit across the range of entities subject to performance measurement: a) hospitals and other facility-based care organizations, b) health plans, and c) ambulatory care providers, including individual physicians (primary and specialty) and behavioral health clinicians; groups of physicians and behavioral health clinicians, and d) integrated delivery systems and ACOs. The Workgroup premised its discussions on:

Consequences of Current Misalignment in Quality Measurement:

- Requiring clinicians, health care organizations and health plans to report and/or be accountable for performance relative to multiple variations of similar measures is extremely burdensome and wasteful.
- Requiring them to be accountable for an excessive number of measures means that they choose to either focus on a subset, dilute quality improvement efforts over many measures, and/or fail to identify and meet achievable benchmarks.
- The lack of comparable data that stems from measure misalignment makes it more difficult to accurately assess progress in quality improvement efforts and in public reporting.
- Measure misalignment adds unnecessary costs for purchasers and payers that are ultimately born by patients and taxpayers.

Operating Principles for Improved Measure Alignment

- Agreement on specific performance measurement priorities within clinical areas or domains (e.g., diabetes, asthma, care coordination, access) across care settings at the national, regional, and state levels would improve the likelihood of focused and effective performance improvement.
- Such priorities should be consistent with overall national quality improvement priorities, as identified in the National Quality Strategy¹ and as may be further specified by appropriate authoritative reports, e.g., the IOM Committee on Core Metrics for Better Care at Lower Cost and the annual Healthcare Quality and Disparities Report.

¹ The National Quality Strategy defines a set of national priorities. This initiative, led by the Agency for Healthcare Research and Quality of the U.S. Department of Health and Human Services, establishes the national priorities for health care system improvement, and identifies both measurement priorities across the system and priorities for filling gaps in measurement due to a lack of appropriate or adequate measures.

- Consumer organizations, public and private purchasers, national provider and health care organization associations, health plans, regional and local quality initiatives, and state and federal agencies, all need to be involved in and take responsibility for, aligning measurement.

The meeting concluded with a strong consensus that work should proceed as quickly as possible to develop and implement a concrete alignment strategy based on three types of measure sets – national core, state/region-specific supplemental, and optional innovative.

The workgroup acknowledged that the current high degree of variation in health care quality measurement makes forging a successful alignment strategy highly challenging. But it believes that significant improvement can be made now. In the words of one participant, “moving rapidly towards the best alignment we can achieve will be a great relief to a lot of folks.”

The workgroup recommended core measure sets be created at the national and regional (state, multi-state, or sub-state) levels in an interactive and iterative process:

1. A broad multi-stakeholder group should be convened at the national level to recommend a **national core set of measures**, for use in all areas of the country and in both the private and public sectors.
 - a. The group should follow the charter developed in the planning subgroup (see cover note) and clarify its measurement priorities, criteria for inclusion of measures, and principles for attribution.
 - b. Work of the national group should be informed by input from state and regional groups responsible for measure set development.
 - c. The national core measure set should be narrowly drawn at the outset, with the option for expansion over time. The group should recommend priorities for creation of new measures to fill measure gaps, e.g., functional status measures, population-based measures, and patient-generated measures, taking into account recommendations of the Measures Application Partnership (MAP) and,
 - d. The group should make recommendations on how to determine whether core measures could allow for variation in metrics and still be “equivalent”.
 - e. The group should recommend a timetable for creation and phased implementation of the national core measure set and state/regional core measure sets, using an initial benchmark date of September 30, 2014.
2. Similarly broad multi-stakeholder groups should be convened at the state, or regional (multi-state or sub-state) level – initially six to eight such groups – to develop **state or region-specific core measure sets** that would be voluntarily adopted at the state level and serve to supplement the national core measure set. These groups would be built on multi-stakeholder efforts already in existence at the state/regional level, e.g., the committee appointed by the Massachusetts Governor to establish a Standard Quality Measure Set and regional broad-based multi-stakeholder collaboratives.
 - a. The groups should also follow the charter developed in the planning subgroup and clarify their measurement priorities, criteria for inclusion of measures, and principles for attribution.
 - b. The state or regional core measure sets would supplement the national core measure set with measures that reflect regional needs, interests, and priorities; these sets would not replace the national measure set, in whole or in part.
 - c. The groups could adopt a limited number of innovative measures for testing.

- d. The groups should take responsibility for periodic review and modification of their state or region-specific core measure set.



3. Core measures would be uniform and specified by:
 - a. Source, i.e., claims, clinical data, EHR, or some hybrid
 - b. Condition within which care providers would be measured by specialty
4. Core measures, and their denominators, could vary by uniformly-defined setting, and/or population.
5. Core measure sets should incorporate the needs of patients/consumers, purchasers, all payers and reflect:
 - a. The current state of measurement, i.e., be composed mostly of widely-used measures and
 - b. A strong preference for NQF measures, and
 - c. Measures required by federal programs, e.g., Medicare Advantage, Medicaid and CHIPRA core measure sets, Exchange/Marketplace Quality Reporting System and by states, and
 - d. Recommendations on a core measure set coming from work by commercial health plans and CMS (2014);
 - e. Recommendations of the IOM Committee on Core Metrics for Better Care at Lower Costs, when available;
 - f. Recommendations on a Common Measures List by the Buying Value Project (2013);
 - g. Recommendations of the Measures Application Partnership (MAP), in general, and its recommendations on Families of Measures and Core Measures;
 - h. Standard definitions of measure data elements, e.g., time intervals, ICD codes, under development by the National Library of Medicine and others, e.g., post-acute care community re: pressure-ulcers;
 - i. A priority for measures which easily “roll up” from the micro-system level to organization-wide, state and national levels, and
 - j. The principle that measures should be auditable, actionable by the accountable entity, and externally benchmarked.

Implementation of the system of core measure sets would:

1. Be based on specific commitments of government at all levels, providers and healthcare organizations, health plans, consumer organizations, purchasers;
2. Be done in collaboration with healthcare quality organizations, e.g., NQF, NCQA, QASC, NASHP, PQA, measure developers and HIT vendors;
3. Be phased-in overtime and employ benchmarks for alignment and measures of success, based on recommendations of the multi-stakeholder groups, beginning this fall and,
4. Be coordinated by a national healthcare quality organization or combination of national quality organizations, with dedicated funding, which would:
 - a. Be responsible for monitoring and auditing implementation;
 - b. Be responsible for periodic review and modification of the core measure set;
 - c. Provide technical assistance to those creating measure sets;
 - d. Convene leaders of measurement organizations for peer-to-peer learning, and
 - e. Create and maintain a national, searchable and interactive database of all measures in use at the national and regional levels that would build on existing databases and facilitate identifying measures in multiple databases, e.g., NQF's and AHRQ's quality measures clearinghouse.
 - f. Require dedicated funding.