

**Testimony**  
**Joachim Roski, PhD MPH, Managing Director, Engelberg**  
**Center for Healthcare Reform, Brookings Institution**  
**Quality Measures Workgroup**  
**October 28, 2010**

8:00 a.m. to 1:00 p.m./Eastern Time  
Sheraton National Hotel – 900 S. Orme Street  
Arlington, VA 22204 – PH: 703-521-1900

---

My name is Joachim Roski and I am a Managing Director at the Engelberg Center for Healthcare Reform at Brookings. The Center provides data-driven, practical policy solutions that foster high-quality, innovative care – care that is both more affordable and more effective in actually improving patient health. The recently-enacted health care reform legislation presents important opportunities to improve the way that America’s health care system works, and reforms to expand coverage hold the potential to help millions of Americans.

Through a variety of projects, the Engelberg Center promotes the broad-based exchange of ideas to develop consensus around practical steps for health care reform. It also provides technical support for both collaborative work among a wide range of health care stakeholders and actual implementation of reforms. The Center’s overall focus is on key priority areas that are critical to the kind of reform that will improve not just the health care system, but the health of individual patients. Efforts are focused on six areas: quality and value; payment and delivery reform; evidence-based health care; medical innovation; state health reform; and health reform implementation.

Over the last several years the Center has focused among other areas on meaningful use of health IT and developing effective, efficient, and scalable means to collect and aggregate electronic data to measure health care performance across the country. Such information can support clinicians in improving care, support payment reforms, and aid consumers in smart decision-making. Through those efforts we have worked extensively with physicians and provider organizations, health plans, consumers, employers, representatives of regional measurement and improvement collaborative, quality measurement experts, and many others. The Quality Alliance Steering Committee, co-chaired by Drs Carolyn Clancy and Mark McClellan, has provided guidance and oversight to these activities to ensure that relevant performance information can become quickly much more widely available than it is today.

The Center has also focused on opportunities to support private and public sector payment reform efforts by linking health care system performance results to reimbursement schemes. To that end, the Engelberg Center is working closely with Elliott Fischer and his team from Dartmouth's Center for Health Policy Research. Among others, we have for example worked over the last few years with a learning network of approximately 90 aspiring accountable care organizations and others to address and pilot-test how accountable care organizations can be assessed for their performance on quality, cost, and the experience of care. To that end, we have laid out a potential trajectory how such organizations should be expected to measure performance that is increasingly outcomes-focused and patient-centered.

In order to support progress on making performance results available quickly the Center has focused intensively on more effectively accessing already available electronic data from administrative data sources, laboratories, internal and external clinical registries, electronic health or medical records, etc. Such data is often widely available in electronic format today but not accessed or connected in the right way to compute performance results and to make it more widely available today. At the same time, even by taking full advantage of the available data today, many important performance results and outcomes of care cannot be computed because some of the relevant data is not available in electronic formats.

For example, information about the stage or biomarkers for cancer is not generally available electronically available today in a timely fashion. While such data is eventually entered and stored in state-based tumor registries, it can take up to 12 months and longer for the complete information to be available in these registries to support disease surveillance. Hence, this information is often not available today in a timely fashion to drive patient-care as effectively and efficiently as possible. Furthermore, since the stage of cancer and other biomarkers are key input factors for treatment decisions based on evidence-based cancer care guidelines, performance results documenting the effectiveness, efficiency, and patient-centeredness of cancer treatments are very difficult to assess today in the absence of this data.

To plan for a more integrated and functional HIT environment that supports and incentivizes better care in the future, we should focus on harnessing all learning from

data that is already available while formulating how we would like the system to evolve. As we design the architecture of our evolving quality improvement and measurement efforts, we should keep in mind that additional electronic data should be collected to support optimal, real-time decision-making needs of patients and their physicians or other clinicians. As a by-product of supporting direct patient care, the same data can also be useful to measure and improve care and support a “learning” health care system. Measures or data that are not able to serve that primary purpose should be avoided.

This basic premise and our experience at the Center suggests a number of key elements we should keep in mind as we set out to improve the electronic availability of data and measures to support patient care, care improvement, measurement, and enable necessary performance feedback loops.

- First, in order to be able to measure if health is improving we should primarily focus on a set of outcomes and associated data elements that are either broadly applicable across conditions (e.g., health risk, functioning) or specific to prioritized, high-impact conditions (e.g., cardiovascular disease, cancer, etc.). Moreover, such outcomes should address the quality, cost/efficiency, and experience of care. Outcome measures will allow patients’ and physicians to focus on the desired results of care and how to achieve them. Measures of specific, clinical practices or measures of the mere documentation of the care process itself (e.g., completeness of records) should be de-emphasized and ideally already be reflected in properly chosen outcomes.

- Second, measurement should be patient-centered by reflecting the total episode of care experienced by patients. Among others, this suggests a focus on measuring results of care across the care continuum as experienced by patients. Such an approach should replace or augment previous measurement approaches that have largely focused on specific care processes delivered by specific groups of specialty care physicians.
- Third, care coordination, management of “hand-offs”, and care transitions represent chief areas of concern for many patients and known opportunities for improvement. Hence, identifying or developing suitable measures that allow for an assessment of successful care coordination and transitions not only reflects a patient-centric point of view but also allows for a focus on current major defects in achieving desired results.
- Fourth, it is hard to imagine a patient-centric view of care that does not reflect patients’ values, preferences, and other input. Hence, patient-generated data reflecting these and other domains should be captured to be able to be effectively considered during the care process including shared decision-making processes.

Finally, future measures should not only tell us about the “meaningful use” of IT by specific clinicians. Instead they should be useful in supporting care decision-making processes, payment reform, and consumer needs by addressing all of these objectives through a common, parsimonious set of measures.