

Measurement of Healthcare Quality and Efficiency Resources for Healthcare Professionals Appendix D

Inventory of Programs and Organizations In Alphabetical Order

2013

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Introduction

Healthcare quality and efficiency play an important role for both the overall economy and healthcare consumers. Affordable healthcare is crucial to the financial stability of many workers and retirees making quality and efficiency of programs particularly relevant during periods of economic challenges. Moreover, quality and efficiency measurement occupy a prominent position in ongoing healthcare system reform and pay-for-value efforts. This is particularly true, given the fundamental state of the United States healthcare system, such as the decentralized nature of the healthcare system, often poorly-aligned payment structures and the complexity of roles assumed by service providers.

In light of the current overlap of political, economic, and other environmental factors, the healthcare industry is changing rapidly. As a result, the Society of Actuaries Health Section and Solucia Consulting have co-sponsored this effort to review and inventory the wide range of quality and efficiency measures currently available. Since the original report was published, additional material has become available. But, there is still a need for a two- to four-page summary that offers a unique short overview of a wide range of organizations. So, the inventory has been updated.

The research objective is to survey internet-based resources, and to review and inventory the range of quality and efficiency measures available. The goal was to outline key areas of quality and efficiency measurement and identify future opportunities for actuaries. This Inventory of Programs and Organizations contains the results of that research, and accompanies the project report - *Measurement of Healthcare Quality and Efficiency. Resources for Healthcare Professionals*.

Ready access to web-based quality and performance data has supported an explosion of activity in the use of financial and quality information to improve care. A multitude of organizations have become actively involved in developing ways of determining healthcare quality or quality improvement. Exhibit 1 illustrates the range of organizations focusing on healthcare quality.

This Inventory was updated in the fall of 2013. All web links have been updated. Seventeen new programs are included and discontinued initiatives have been dropped. Many entries have also been updated in full. For some long-standing programs, the previous entries (2008 and 2010) have only been lightly updated. Revised entries include the phrases "Updated in 2013" at the front of the entry.

The material comes directly from websites. It was lightly edited for readability. The authors of this report have not checked or verified the statements on the websites. The statements in the

Exhibit 1. Organizations Focusing on Healthcare Quality & Efficiency



All weblinks were updated in 2013. Written material is extracted from publicly-available material on the websites of organizations - much of the content was extracted in 2013. But, some of the continuing programs come from earlier editions (2008 or 2010). It has not been independently validated and the authors and the Society of Actuaries make no warranty as to its accuracy.

Inventory do not reflect the opinions of the authors. Links are provided for all materials to enable the reader to update information of interest.

The list of organizations in this inventory is by no means exhaustive. The search focused upon canvassing a wide range of organizations active in the field of healthcare quality and then to document a cross section covering the variety of approaches.

Inclusion in the inventory was driven by the primary focus of the measure or activity at a detailed level – does the program help to review specific providers (like each individual hospital). Thus the authors were particularly interested in identifying initiatives and products that measured physician quality, physician efficiency, hospital quality and hospital efficiency. We did not list every state and every insurance carrier; instead the authors pulled examples from states that illustrate particularly interesting approaches or innovations and illustrative programs from various insurance carrier or Blue organizations.

The depth of websites varied widely.

- Some websites offering a comprehensive outline of measures, products or services with downloadable documentation such as technical specifications, white papers and peer reviewed papers.
- Many websites require registration for at least some of their material
- Other websites offered primarily marketing or publicity materials which were short on both descriptive and technical detail.
- Some websites restricted access to members such as health plans or employer sites. In
- A few cases where there was a dearth of information, Internet searches were performed find public presentations. This secondary material was only used to add web links, the entry itself comes entirely from web material from the organization.

The range and focus of materials identified in the research was highly diverse and several different ways of categorizing information were developed to bring a degree of clarity to the information.

Organization

The data has been organized as follows:

Summary	Background and descriptive information of the organization or measure.
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Methodology	Particular procedure or set of procedures used by the organization or product in data collection and/or analysis, technical specifications, methodological constraints, target population and so on that might assist the reader form an opinion about validity and relevance to their particular areas of interest.
Results	Any evidence that the organization or product had achieved its objectives, undertaken any formal or informal evaluations as regards results.
Publications / links	<p>Key links to substantive material</p> <ul style="list-style-type: none"> • Links to searchable data bases • The main summary page (which includes many sublinks) • Peer reviewed materials, white papers and other analyses. <p>In general, this excludes marketing materials other than summary product brochures.</p> <p>Websites are increasingly including videos and/or webcasts. These links are not included.</p>

Two further classifications were used based upon the focus or the intent of the program or measure.

PQ = measures that focus upon physician quality

PE = measures that focus upon physician efficiency

HQ = measures that focus upon hospital quality

HE = measures that focus upon hospital efficiency

Risk = risk adjustment and/or risk assessment measures

Other = primarily for organizations that serve as clearinghouse for information

The following categories are defined in the Appendix.

1. Accreditation, Certification
2. Analytics, Decision Support, Healthcare Data Technology
3. Incentives, Rewards Programs (many new entries fall into this category, for example Accountable Care Organizations)
4. Performance Ratings, Reports, Scorecards, Benchmarking (report actual performance)
5. Standards Setting, Industry Organizations
6. Summary for Public, Consumer, Infomediaries
7. Value based payment / Payment reform

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Organization	Quality Products or Measures	Category	PQ PE HQ HE	
1. 3M Health Information Systems	3M ClinTrac Quality Manager Software	Proprietary/Analytics/Decision Support/Healthcare Data Technology	PQ	14
2. 3M Health Information Systems	3M APR-DRG 3M outpatient grouping software	Proprietary/ Analytics/Decision Support/Healthcare Data Technology	HQ HE	15
3. 3M Health Information Systems	Clinical Risk Grouping (CRG)	Proprietary /Analytics/Decision Support/Healthcare Data Technology	Risk	18
4. ABIM Foundation	Choosing Wisely	Standards Setting, Industry Organizations	PE PQ	20
5. Active Health Management	Care Engine System Care Considerations Performance Measures	Proprietary/Analytics/Decision Support/Healthcare Data Technology	PE	22
6. Aetna	Accountable Care Solutions	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking Value based payment / Payment reform	PQ PE	25
7. Aetna	Aexcel Network Institutes of Excellence™ (IOE) Institutes of Quality® (IOQ)	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	HQ HE PQ PE	28
8. AHRQ – Agency for Healthcare Research and Quality	CAHPS. Consumer Assessment of Healthcare Providers and Systems Family of Surveys National CAHPS Benchmarking Database	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	PQ HQ	31
9. AHRQ – Agency for Healthcare Research and Quality	Evidence-Based Practice Centers (EPC)	Standards Setting, Industry Organizations	Other	34
10. AHRQ – Agency for Healthcare Research and Quality	Innovations Exchange	Standards Setting, Industry Organizations	HQ HE PQ PE	36
11. AHRQ – Agency for Healthcare Research and Quality	National Healthcare Quality Report (NHQR)	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	HQ	39
12. AHRQ – Agency for Healthcare Research and Quality	Quality Indicators	Standards Setting, Industry Organizations	HQ	41
13. American Medical Association (AMA)	Physician Consortium for Performance Improvement (PCPI)	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	PQ	43

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14.	American Medical Group Association (affiliate)	Accountable Care Collaborative	Standards Setting, Industry Organizations	PE PQ HE HQ	45
15.	American Medical Group Association (affiliate)	Council of Accountable Physician Practices (CAPP)	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	PQ	47
16.	Anthem (examples from one state)	State-specific networks Enhanced Personal Health Care Program	Incentive/Reward Programs	HQ HE PQ PE	49
17.	AQA Alliance	Physician Practice Measures	Standards Setting, Industry Organizations	PQ	52
18.	Archimedes Healthcare Models	Archimedes	Risk assessment	Risk	53
19.	Arkansas (State government and other organizations)	Arkansas Health Care Payment Improvement Initiative	Incentive/Reward Programs	PQ PE	55
20.	ASC Quality Collaboration (Ambulatory Surgical Centers)	ASC Quality Measures	Standards Setting, Industry Organizations	HQ	58
21.	BlueCross Blue Shield Association (BCBSA)	Hospitals: Blue Distinction Centers of Medical Excellence	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	HQ HE	60
22.	Blue Cross of Massachusetts	Alternative Quality Contract	Contract Model; Incentive/Reward Programs	PQ PE HQ HE	62
23.	BlueCross Blue Shield of Michigan	Value Partnership Initiatives	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	PQ HQ	66
24.	Brookings Dartmouth ACO Learning Network	Accountable Care Organization Learning Network	Value based payment / Payment reform	Other	69
25.	Brookings Institution – Engelberg Center for Health Reform	Quality Alliance Steering Committee High-Value Health Care Project (HVHC)	Standards Setting, Industry Organizations	Other	71
26.	Californian Association of Physician Groups (CAPG)	Standards of Excellence (SOE) Program	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	PQ	73
27.	California Healthcare Foundation	Various including California Hospital Assessment and Reporting Taskforce – CHART CalHospitalCompare	State focus; Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	HQ	75
28.	Cave Consulting Group	Cave Grouper: Marketbasket System	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	PE	78
29.	CIGNA	Collaborative Accountable Care	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking Value based payment / Payment reform	PQ PE HQ HE	80
30.	CIGNA	Quality initiatives Provider Recognition Directory	Performance Ratings/Reports/Scorecards/Data	HQ HE	82

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		bases/Benchmarking		
31.	CMS Medicare & Medicaid	Bundled Payments for Care Improvement	Incentive/Reward Programs	PQ PE HQ HE 85
32.	CMS Medicare & Medicaid	Comprehensive Primary Care Initiative	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	PQ PE HQ HE 88
33.	CMS Medicare & Medicaid	Dual Eligible - State Demonstrations Financial Alignment Initiative	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	PQ PE HQ HE 91
34.	CMS Medicare & Medicaid	(FQHC) Advanced Primary Care Practice	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	PQ PE 94
35.	CMS Medicare & Medicaid	Hospital Compare	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	HQ 96
36.	CMS Medicare & Medicaid	Measures Management System (MMS)	Standards Setting, Industry Organizations	PQ PE HQ 98
37.	CMS Medicare & Medicaid -	Medicare Hospital Value-Based Purchasing (VBP)	Standards Setting, Industry Organizations, Incentives, Rewards Programs	HQ HE 100
38.	CMS Medicare & Medicaid	Medicare Quality Improvement Organization (QIO) Program.	Incentive/Reward Programs	HQ 102
39.	CMS Medicare & Medicaid	Patient Protection and Affordable Care Act (2010) – provisions on measurement	Value based payment / Payment reform	Other 104
40.	CMS Medicare & Medicaid	Physician Group Practice Demonstration project	Incentive/Reward Programs	PQ 107
41.	CMS Medicare & Medicaid	Pioneer ACO	Incentive/Reward Programs	PQ PE HQ HE 110
42.	CMS Medicare & Medicaid	Physician Quality Reporting System (PQRS)	Incentive/Reward Programs	PQ 113
43.	CMS Medicare & Medicaid	Shared Savings ACO	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking Incentive/Reward Programs	PQ PE HQ HE 116
44.	The Commonwealth Fund	WhyNotthe Best.org	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	HQ 120
45.	The Commonwealth Fund Commission on a High Performance Health System	Multiple papers National Scorecard on U.S. Health System Performance	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	Other 122
46.	Dartmouth Atlas Project	Dartmouth Atlas Project	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	HQ HE 125

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47.	Deloitte Center for Health Solutions	Episode and Payment Reform Papers; Comparative Effectiveness	Value based payment / Payment reform	Other	128
48.	Dr Foster Intelligence. United Kingdom	Dr Foster Intelligence Good Hospital Guide	International	HQ	131
49.	The Fraser Institute. Canada.	Hospital Report Card	International, Performance ratings, Reports, Scorecards, Databases, Benchmarking	HQ	134
50.	Geisinger Health System	Proven Care Model	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	PQ PE HQ HE	136
51.	HCI ³ - Bridges to Excellence	Physician Incentive and Reward Program Endorsement	Incentive/Reward Programs	PQ	139
52.	HCI ³ - Bridges to Excellence	Prometheus Payment System	Value based payment / Payment reform	PQ	142
53.	HealthGrades	Hospital Quality in America	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	HQ	146
54.	HealthInsight	Rankings for Hospitals, Home Health, and Nursing Homes	State focus; Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	HQ	149
55.	Healthnet	Silver Network Decision Power	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	PQ PE HQ	151
56.	HealthPartners	Partners in Excellence Program (PIE) Total Cost of Care and Resource Use (TCOC)	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	PQ PE HQHE	153
57.	The Health System Performance Research Network (HSPRN) Canada	The Hospital Report Series (through 2008)	International	HQ	155
58.	The Hearst Corporation	Map of Medicine Healthguides	International, Standards Setting, Industry Organizations; Summary for Public, Consumer	PQ	156
59.	The Hearst Corporation	MCG (formerly Milliman Care Guidelines)	Proprietary/Analytics/Decision Support/Healthcare Data Technology	PQ PE HQ HE	159
60.	Highmark	QualityBLUE	Value based payment / Payment reform	HQ	162
61.	Hospital in Pursuit Of Excellence (HPOE)	Guides and reports	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking Value based payment / Payment reform	HQ HE	165
62.	IMS Health	IMS MDsource 360°	Proprietary/Analytics/Decision Support/Healthcare Data	PQ PE	168

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Technology

63.	Institute for Healthcare Improvement (IHI)	The Improvement Map	Accreditation/Certification	HQ	170
64.	Integrated Healthcare Association (IHA)	Bundled Payment Project	Value based payment / Payment reform	HQ	173
65.	Integrated Healthcare Association (IHA)	Definition of Financial Responsibility (DOFR)	Value based payment / Payment reform	HQ	175
66.	Integrated Healthcare Association (IHA)	California Pay for Performance Collaboration	Incentive/Reward Programs	PQ PE	177
67.	The Johns Hopkins University	Adjusted Clinical Groups Aggregated Diagnosis Groups	Proprietary/Analytics/Decision Support/Healthcare Data Technology	PQ PE	180
68.	The Joint Commission (JHACO)	Improving America's Hospitals: The Joint Commission's Annual Report on Quality and Safety Top Performers	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	HQ	183
69.	The Joint Commission (JHACO)	ORYX Initiative	Accreditation/Certification	HQ	185
70.	Leapfrog Group	Top Hospitals Survey Top Hospitals	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	HQ	187
71.	Maine Health Management Coalition	Pathways To Excellence Get Better Maine	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	PQ HQ	191
72.	Massachusetts Group Insurance Commission (GIC)	Clinical Performance Improvement (CPI) Initiative	Incentive/Reward Programs	PQ PE	194
73.	Massachusetts Health Care Quality and Cost Council (HCQCC)	Myhealthcareoptions	Summary for Public; Consumer; Infomediary	PQ HQ	196
74.	Massachusetts Health Quality Partners (MHQP)	Quality Insight Others including Consumer Reports and Choosing Wisely	State focus; Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	PQ	198
75.	MEDai, Inc.	Pinpoint Compliance® Risk Navigator Solutions	Risk assessment	HE HQ	200
76.	Milliman	Health Cost Guidelines Suite MedInsight MedInsight Waste Calculator	Proprietary/Analytics/Decision Support/Healthcare Data Technology	PE HE	202
77.	Milliman	Hospital Performance Index	Proprietary/Analytics/Decision Support/Healthcare Data Technology	HE	205
78.	Milliman	Milliman Advanced Risk Adjusters (MARA)	Proprietary/Analytics/Decision Support/Risk Adjustment	Risk	207
79.	Minnesota Health Action Group (previously Buyers Health Care Action Group)	Multiple programs	Standards Setting, Industry Organizations	PQ PE HQ HE	209
80.	Minnesota Hospital Quality	Minnesota Hospital Quality Report	State focus; Performance	HQ	211

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Partnership			Ratings/Reports/Scorecards/Data bases/Benchmarking		
81.	National Academy for State Health Policy (NASHP)	Multiple papers Medicaid Incentive/Reward Programs (by State)	Standards Setting, Industry Organizations	PQ PE HQ HE	213
82.	National Cardiovascular Data Registry (NCDR)	CathPCI™ Registry ACTION Regist ^{TY} ®-GWTG™ CARE Registry™ IMPACT Registry™ IC3	Performance Ratings/Reports/Scorecards/D atabases/Benchmarking	PQ	217
83.	National Committee for Quality Assurance (NCQA)	HEDIS - Healthcare Effectiveness Data and Information Set	Accreditation/Certification	PQ	221
84.	National Committee for Quality Assurance (NCQA)	Patient Centered Medical Home	Value based payment / Payment reform	PQ	223
85.	National Committee for Quality Assurance (NCQA)	Physician and Hospital Quality (PHQ) certification	Accreditation/Certification	PQ HQ	225
86.	National Committee for Quality Assurance (NCQA)	Other Recognition Programs (for physician) Diabetes Recognition Program Heart/Stroke Recognition Program Physician Practice Connections Patient-Centered Specialty Practice	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	PQ	227
87.	National Committee for Quality Assurance (NCQA)	Relative Resource Use (RRU)	Accreditation/Certification	Other	230
88.	National Institute of Health and Clinical Excellence NICE, UK	Evidence-based clinical guidelines, Technical guidelines	International	PQ	232
89.	NQF – National Quality Forum	NQF Endorsed Standards Measure Applications Partnership Quality Positioning System (QPS)	Standards Setting, Industry Organizations	PQ HQ	235
90.	New York State Department of Health	Cardiac Surgery Reporting System (CSRS)	State focus; Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	PQ HQ	238
91.	New York State Department of Health	New York State Hospital Quality Ratings	State focus; Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	HQ	242
92.	New Zealand Ministry of Health	Various District Reports	International	HQ HE	244
93.	OptumInsight	Hospital Benchmarks Hospital Insights	Proprietary/Analytics/Decision Support/Healthcare Data Technology	HE	246
94.	OptumInsight	Symmetry EBM Connect	Proprietary/Analytics/Decision Support/Healthcare Data	PQ	248

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Technology

95. OptumInsight	Symmetry Episode Risk Groups Symmetry Pharmacy Risk Groups	Proprietary/Analytics/Decision Support/Healthcare Data Technology	Risk	250
96. OptumInsight	Symmetry Episode Treatment Groups Symmetry Procedure Episode Groups	Proprietary/Analytics/Decision Support/Healthcare Data Technology	PE	253
97. OptumInsight	Symmetry® Provider Cost & Quality Connect (PCQ Connect) Benchmark Solutions	Proprietary/Analytics/Decision Support/Healthcare Data Technology	HQ HE PQ PE	257
98. Oregon Health Authority	Coordinated Care Organizations Oregon Health Plan (Medicaid)	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking /Analytics/ Incentive/Reward Programs	HQ HE PQ PE	259
99. Organization for Economic Cooperation and Development (OECD)	Health Care Quality Indicator (HCQI) Project	International	Other	262
100. Pacific Business Group on Health California Cooperative Healthcare Reporting Initiative`	California Healthcare Performance Information System Formerly California Physician Performance Initiative (CPPI)	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	PQ	265
101. Patient Centered Medical Home (supporting organization)	American Academy of Family Physicians American Academy of Pediatrics American College of Physicians Center for Medical Home Improvement Primary Care Development Corporation Patient-Centered Primary Care Collaborative TransforMED	Standards Setting, Industry Organizations	Other	268
102. Patient Centered Primary Care Collaborative (PCPCC)	Multiple papers Medical Home material Pilots	Standards Setting, Industry Organizations Value based payment / Payment reform	Other	271
103. Premier Healthcare	Hospital Quality Incentive Demonstration (HQID)	Standards Setting, Industry Organizations	HQ	273
104. Premier Healthcare	QUEST: High Performing Hospitals	Standards Setting, Industry Organizations	HQ	276
105. Puget Sound Health Alliance	Community CheckUp	State focus; Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	PQ PE HQ HE	279
106. RAND Corporation	Multiple papers Rand Health	Standards Setting, Industry Organizations	Various	281
107. Resolution Health	Physician Quality Profiler Personal Health Scan™	Proprietary/Analytics/Decision Support/Healthcare Data Technology	PQ	284

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108. Robert Wood Johnson Foundation Rewarding Results Demonstration Projects	Multiple papers Cost and Value, Payment Reform, Quality Reporting	Incentive/Reward Programs	PQ HQ	286
109. Robert Wood Johnson Foundation	Aligning Forces for Quality Learning from Effective Ambulatory Practices (LEAP)	Standards Setting, Industry Organizations	Other	289
110. Truven Health Analytics (previously Thomson Reuters Healthcare)	100 Top Hospitals	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	HQ	292
111. Truven Health Analytics (previously Thomson Reuters Healthcare)	CareDiscoveryTM CareDiscovery® Quality Measures Micromedex® 360 Care Insights Suite	Proprietary/Analytics/Decision Support/Healthcare Data Technology	PE	296
112. Truven Health Analytics (previously Thomson Reuters Healthcare)	Medical Episode Groups	Proprietary/Analytics/Decision Support/Healthcare Data Technology	PE	300
113. 120. Truven Health Analytics (previously Thomson Reuters Healthcare)	Physician Performance Assessment	Proprietary/Analytics/Decision Support/Healthcare Data Technology	PQ PE	302
114. UnitedHealthcare	Premium Physician Designation Program Primary Care Physician (PCP) Incentive Program	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	PQ	304
115. UnitedHealthcare (UHCWest)	Quality Index Profile (Medical Groups)	State focus; Performance Ratings/Reports/Scorecards/Data bases/Benchmarking; Incentive/Reward Programs	PQ PE HQ HE	307
116. U.S. News & World Report	America's Best Hospitals	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	HQ HE	310
117. Verisk HealthCare	DxCG Intelligence	Proprietary/Analytics/Decision Support/Healthcare Data Technology	PE PQ HQ HE	313
118. Vermont Health Care Reform	Blueprint for Health	Standards Setting, Industry Organizations Value based payment / Payment reform	Other	315
119. Virginia Mason Hospital & Medical Center	Virginia Mason Production System (VMPS)	Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	HE	318
120. Wakely Consulting Group	Wakely Risk Assessment Model	Risk assessment / predictive modeling	Risk	321
121. WebMD	WebMD Quality Care Select Quality Care - Consumer Select Quality Care - Professional	Proprietary/Analytics/Decision Support/Healthcare Data Technology	PE PQ HQ HE	324
Summary for Public; Consumer;				

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Infomediary

122. Wisconsin Collaborative for Healthcare Quality (WCHQ)	Performance and Progress Report	State focus; Performance Ratings/Reports/Scorecards/Data bases/Benchmarking	PQ HQ	327
123. Zynx Health	ZynxEvidence and ZynxOrder	Proprietary/Analytics/Decision Support/Healthcare Data Technology	PQ	329

APPENDIX - Definitions of Secondary Classification Categories

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Organization	3M Health Information Systems
Category	Proprietary/Analytics/Decision Support/Healthcare Data Technology
Source	www.3Mhis.com
Measure	3M ClinTrac Quality Manager Software http://solutions.3m.com/wps/portal/3M/en_US/3M_Health_Information_Systems/HIS/Products/ClinTrac_Quality_Manager/

Summary

3M Health Information Systems delivers comprehensive software and consulting services to help organizations worldwide improve documentation, quality, and financial performance across the healthcare continuum. 3M offers integrated solutions for transcription, speech recognition, clinical documentation improvement, documentation management, computer-assisted coding, quality, and revenue cycle management.

3M ClinTrac Quality Manager Software - Ability to precisely design reviews and studies, monitor their progress and document the results. Integrates key quality, clinical and case management data to support performance improvement.

Methodology

Capability to trigger specific review screens during chart abstracting based on any number of parameters such as diagnosis code, patient type, and others. Supports comprehensive root cause analysis processes via in-depth analysis, peer review processes, assessment and documentation of patient care issues or sentinel events. Ability to design quality reviews by patient, non-patient, provider or facility and ability to assist in the implementation and documentation of regulatory corrections

Results

Enables compliance with The Joint Commission, Centers for Medicare and Medicaid Services, and state-mandated quality reviews.

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Organization	3M Health Information Systems
Category	Proprietary/Analytics/Decision Support/Healthcare Data Technology Benchmarking
Source	http://www.3m.com/
Measure	3M APR-DRG http://solutions.3m.com/wps/portal/3M/en_US/Health-Information-Systems/HIS/Products-and-Services/Products-List-A-Z/APR-DRG-Software/ 3M outpatient grouping software http://solutions.3m.com/wps/portal/3M/en_US/Health-Information-Systems/HIS/Products-and-Services/Products-List-A-Z/Outpatient-Groupers/

Summary

3M Health Information Systems delivers comprehensive software and consulting services to help organizations worldwide improve documentation, quality, and financial performance across the healthcare continuum. 3M offers integrated solutions for transcription, speech recognition, clinical documentation improvement, documentation management, computer-assisted coding, quality, and revenue cycle management.

3M™ APR DRG Software - Flexible health benchmarking database. Focus is on risk adjustment methodologies and selected hospital norms to meet quality and performance improvement goals. Uses 3M APR DRG Classification System to classify patients according to severity of illness and risk of mortality. Compares the severity-adjusted patient population to severity-adjusted normative group averages to assess outcomes and quality. Claims to provide the most-requested health services industry benchmarking functions to help organizations meet quality and performance improvement goals; and to meet potential regulatory and reimbursement changes.

Methodology

The 3M™ APR DRGs offer:

- Updated clinical logic that reflects recent changes in healthcare practice
- The addition of relative weights allowing for comparisons across the 3M APR DRG classifications
- The ability to calculate a severity-adjusted casemix index
- Identification of secondary diagnoses that impact severity of illness, risk of mortality, or both.

Internal or external comparative profiles, expected values, and relative variance can be created for:

- Mortality rates
- Length of stay
- Charges
- Trend analysis

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3M outpatient grouping software

3M outpatient grouping software simplifies the analysis and reporting of ambulatory visits. It identifies key procedures and determines which items are covered within an outpatient prospective payment system (OPPS). 3M classification and grouping functionality is available as integrated components within other 3M products and as embedded solutions for business partners.

The Ambulatory Patient Group (APG) classification system is used as the basis for prospective payment by some state agencies and third-party payers for reimbursing hospitals for outpatient care. 3M's proprietary software, 3M™ Enhanced APG (EAPG) Grouping Software incorporates significant changes to bring APGs current with clinical, coding and billing practices. It also describes a broader, non-Medicare population.

3M™ APC Grouper Plus Software handles the complex OPPS regulations by grouping diagnosis and procedure codes, applying prescribed edits, calculating reimbursement, and interfacing with in-house billing or other hospital information systems.

3M™ Patient-focused Episodes Software

The 3M Patient-focused Episodes (PFE) Software gives a patient-centric view into your organization's costs and outcomes. 3M PFE Software considers all of a patient's conditions and treatments, both acute and chronic, during the specified period and then assigns episodes of treatment to that patient. And with more than 500 definable episodes across inpatient and outpatient care settings, the 3M PFE Software accounts for the wide variety of patient conditions and populations you serve.

Results

Provides accurate performance data to reflect the clinical complexity of patient population. Severity-adjusted benchmarking tool improves performance by:

- Delivering enhanced quality of care
- Reducing costs and LOS
- Comparing actual outcomes to expected outcomes
- Generates LOS reports with a *Potential Savings* column which calculates the cost savings of eliminating the last day of a patient stay which is a more accurate approach than using the average cost per day of a patient stay, as hospital charges are typically front-loaded.

Publications / links

Fact sheet: 3M APR DRG Classification System/3M APR DRG Software

http://multimedia.3m.com/mws/mediawebserver?mwsId=SSSSuH8gc7nZxtUN8meNx_9evUqe17zHvTSevTSeSSSSS--&fn=aprdrgrg_fs.pdf

All weblinks were updated in 2013. Written material is extracted from publicly-available material on the websites of organizations - much of the content was extracted in 2013. But, some of the continuing programs come from earlier editions (2008 or 2010). It has not been independently validated and the authors and the Society of Actuaries make no warranty as to its accuracy.

Fact sheet: Vanderbilt Medical Center

http://multimedia.3m.com/mws/mediawebserver?mwsId=SSSSSufSevTsZxtUN8txP8_BevUqevTSevTSeSSSSSS--&fn=aprdrg_vanderbilt_cs.pdf

Fact sheet: 3M Enhanced Ambulatory Patient Group System

http://multimedia.3m.com/mws/mediawebserver?mwsId=SSSSSuH8gc7nZxtUN8mvPY_1evUqe17zHvTSevTSeSSSSSS--&fn=apgs_enhanced_fs.pdf

Fact sheet: 3M APC Grouper Plus Software (for mainframes)

http://multimedia.3m.com/mws/mediawebserver?mwsId=66666UF6EVsSyXTtI8Ty58TyEVtQEVs6EVs6EVs6E666666--&fn=apc_gplus_fs.pdf

Fact sheet: 3M™ Core Grouping Software (includes APC groupers for PC)

http://multimedia.3m.com/mws/mediawebserver?mwsId=66666UF6EVsSyXTtIxMVOXT_EVtQEVs6EVs6EVs6E666666--&fn=core_grouping_fact.pdf

3M™ Patient-focused Episodes

Software http://multimedia.3m.com/mws/mediawebserver?mwsId=66666UgxGCuNyXTtoxMaoxM_EVtQEcuZgVs6EVs6E666666--&fn=patient_focused_episodes_fs.pdf

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Organization	3M Health Information Systems
Category	Proprietary/Analytics/Decision Support/Healthcare Data Technology
Source	www.3Mhis.com
Measure	Clinical Risk Grouping (CRG) http://solutions.3m.com/wps/portal/3M/en_US/3M_Health_Information_Systems/HIS/Products/CRG/

Summary

3M Health Information Systems delivers comprehensive software and consulting services to help organizations worldwide improve documentation, quality, and financial performance across the healthcare continuum. 3M offers integrated solutions for transcription, speech recognition, clinical documentation improvement, documentation management, computer-assisted coding, quality, and revenue cycle management.

Clinically precise tool for longitudinal disease management

- Provider profiling, quality measurement, and outcomes improvement
- Aligns payment incentives with clinical goals
- Essential basis for effective chronic disease risk adjustment using diagnosis and procedure codes
- Classify patients into severity-adjusted clinically homogeneous groups

The CRG classification system can be used prospectively and retrospectively for both inpatient and ambulatory encounters. Uses demographic data, diagnostic codes and procedural codes to assign each individual to a single mutually exclusive risk group that relates the historical clinical and demographic characteristics of the individual to the amount and type of health care resources that individual will consume in the future.

3M Clinical Risk Grouping Software can:

- Determine and track chronic disease prevalence and progress over time
- Analyze clinical efficacy of treatment patterns
- Determine costs associated with medical services and assess the level of risk for particular groups of individuals
- Track quality of care
- Profile utilization patterns and the appropriateness of capitation rates
- Address both chronic and multiple medical conditions and the level of severity

Methodology

Population based. Uses administrative claims data, diagnosis codes and procedure codes. 3M™ Clinical Risk Groups are a categorical clinical model that uses standard claims data to assign each patient to a single mutually exclusive risk category. Each 3M CRG is clinically meaningful and can predict prospective and retrospective healthcare utilization and costs.

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Results

3M CRGs quantify the total resources used in relation to a specific individual in the future, or in the past, over an extended period of time. 3M CRGs help to:

- Provide increased incentives for health plans to treat those patients at high risk
- Promote financial and clinical efficiency in healthcare delivery
- Provide a methodology to group patients for retrospective analysis such as benchmarking, rate setting, epidemiological analysis and population risk profiling, especially for chronic care where patients may have multiple hospital and doctor visits over a long span of time
- Minimize financial incentives for adverse patient selection

Publications / links

FAQs: Using 3M CRGs for vulnerable populations

http://multimedia.3m.com/mws/mediawebserver?mwsId=66666UgxGCuNyXTtoxfVMxMXEVtQEcuZgVs6EVs6E666666--&fn=crg_vulnerable_populations_faq.p

Data Sheet: Using 3M CRGs with incomplete data

http://multimedia.3m.com/mws/mediawebserver?mwsId=66666UgxGCuNyXTtoxfVMxMyEVtQEcuZgVs6EVs6E666666--&fn=crgs_incomplete_data_ds.pdf

Data Sheet: Applying the 3M Clinical Risk Groups to pharmaceutical data

http://multimedia.3m.com/mws/mediawebserver?mwsId=S555SufSevTsZxtU5xmvLY_9evUqevTSevTSevTSe55555--&fn=crg_pharma_data_sheet.pdf

FAQs: 3M Clinical Risk Groups (CRGs)

http://multimedia.3m.com/mws/mediawebserver?mwsId=S555SufSevTsZxtU5x2eNx_SevUqevTSevTSevTSe55555--&fn=crg_faqs_with_pagination.pdf

Fact sheet: 3M Clinical Risk Grouping Software

http://multimedia.3m.com/mws/mediawebserver?mwsId=66666UF6EVsSyXTtlxfco8TyEVtQEVs6EVs6EVs6E666666--&fn=crgs_for_payers_fs.pdf

White paper: 3M CRGs: Measuring Risk, Managing Care

http://multimedia.3m.com/mws/mediawebserver?mwsId=66666UF6EVsSyXTtOxf_oXMXEVtQEVs6EVs6EVs6E666666--&fn=crg_white_paper.pdf

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Organization	ABIM Foundation
Category	Standards Setting, Industry Organizations
Source	http://www.abimfoundation.org/
Measure	Choosing Wisely http://www.choosingwisely.org/

UPDATED IN 2013

Summary

Choosing Wisely® aims to promote conversations between physicians and patients by helping patients choose care that is:

- Supported by evidence
- Not duplicative of other tests or procedures already received
- Free from harm
- Truly necessary

In response to this challenge, national organizations representing medical specialists have been asked to “choose wisely” by identifying five tests or procedures commonly used in their field, whose necessity should be questioned and discussed. The resulting lists of “Five Things Physicians and Patients Should Question” will spark discussion about the need—or lack thereof—for many frequently ordered tests or treatments.

This concept was originally conceived and piloted by the National Physicians Alliance, which, through an ABIM Foundation Putting the Charter into Practice grant, created a set of three lists of specific steps physicians in internal medicine, family medicine and pediatrics could take in their practices to promote the more effective use of health care resources. These lists were first published in Archives of Internal Medicine.

Recognizing that patients need better information about what care they truly need to have these conversations with their physicians, Consumer Reports is developing patient-friendly materials and is working with consumer groups to disseminate them widely.

Methodology

United States specialty societies representing more than 500,000 physicians developed lists of Five Things Physicians and Patients Should Question in recognition of the importance of physician and patient conversations to improve care and eliminate unnecessary tests and procedures.

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These lists represent specific, evidence-based recommendations physicians and patients should discuss to help make wise decisions about the most appropriate care based on their individual situation. Each list provides information on when tests and procedures may be appropriate, as well as the methodology used in its creation.

Choosing Wisely recommendations should not be used to establish coverage decisions or exclusions. Rather, they are meant to spur conversation about what is appropriate and necessary treatment. As each patient situation is unique, physicians and patients should use the recommendations as guidelines to determine an appropriate treatment plan together.

Results

In response to the National Physicians Alliance “Top 5” lists, research published in Archives of Internal Medicine found a cost savings of more than \$5 billion could be realized if the recommendations were put into practice.

Lists

<http://www.choosingwisely.org/doctor-patient-lists/>

Download a pdf of all specialty society lists

<http://www.choosingwisely.org/wp-content/uploads/2013/02/Choosing-Wisely-Master-List.pdf>

All weblinks were updated in 2013. Written material is extracted from publicly-available material on the websites of organizations - much of the content was extracted in 2013. But, some of the continuing programs come from earlier editions (2008 or 2010). It has not been independently validated and the authors and the Society of Actuaries make no warranty as to its accuracy.

Organization	Active Health Management Company acquired by Aetna in May 2005
Category	Proprietary/Analytics/Decision Support/Healthcare Data Technology
Source	http://www.activehealth.com/
Measure	Care Engine System Care Considerations Performance Measures

Summary

ActiveHealth Management is a leading provider of health management services, including disease management, clinical decision support and personal health records. Solutions, powered by CareEngine System, help to improve care for 18 million people nationwide and help health plans and employers lower costs.

1. CareEngine System gathers and absorbs any and all available data (e.g. member claims, pharmacy, lab data, patient-derived, physician-derived, HRA/PHR, EMR) and analyzes this information against up-to-date evidence-based medical standards. Identifies specific opportunities to improve the care of individual members.
2. Once an issue is identified, the CareEngine System generates a clinical alert, called a Care Consideration, which describes the opportunity to improve care. Care Considerations usually suggest the addition of a treatment, the stopping of a treatment, or a procedure that hasn't been conducted. Care Considerations may be sent to physicians or patients. A distinguishing feature of the CareEngine is its ability to review data and issue care considerations in real time (less than a few seconds) thus being embeddable in PHRs, DM software, EMRs etc
3. Performance Measures - A quantitative assessment
 - of quality of care across networks and physicians compared to evidence-based standards
 - to improve the standard of healthcare and supports pay-for-performance tiered network
 - focused upon coordination of individual care management

Methodology

Using CareEngine technology, organization constantly analyzes an entire population, to identify specific, evidence-based opportunities to improve care for individual members. The **Clinical Development Center's** team of full-time, board-certified physicians, pharmacists and registered nurses develop and maintain evidence-based rules, algorithms and matrices. Evidence-based sources are reviewed daily to develop, test, and implement clinical rules arising from their literature review. Rules are designed to reflect the evidence-based medical literature as closely as possible and to also incorporate exclusionary logic to maximize specificity and thereby decrease the incidence of "false positive" alerts. All programs and clinical guidelines are formally reviewed annually.

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Performance measures are nearing completion of a major overhaul and encompass measures at both the population and physician level. To the extent reasonable, the performance measures mirror the Care Considerations. Some adjustments must be made for the fact that performance measures are issued on a static basis periodically (12 monthly) whilst Care Considerations can be issued almost in a continuous stream as new data becomes available.

In November 2008, American Well™ and ActiveHealth Management announced a strategic collaboration to offer an innovative real-time technology that combines ActiveHealth's CareEngine analytics, with American Well's Online Care System. A web based physician alert/online care system. When CareEngine identifies a medical issue (or gap in care) for a patient, the physician will receive an alert when they are actively consulting with the patient in an Online Care session. The physician can consider such information as well as the corresponding literature reference while offering guidance to the patient or suggesting a course of treatment. Alert is issued when opportunities for better care or potential medical errors are identified. American Well's Online Care enables live communication between physicians and patients. By leveraging CareEngine, physicians providing Online Care are made aware of individualized, specific opportunities to enhance or improve care. In addition, patients who receive a CareEngine alert through their health plan portal, PHR or other online platform will have the opportunity to address the issue immediately by connecting to an Online Care session with an appropriate physician. The CareEngine continuously gathers the medical, pharmacy and laboratory claims data for members and compares it against the latest findings in evidence-based literature.

Refer also entry to American Well.

Results

Clinical alerts based on evidence-based medical guidelines have been found to be effective - were followed at a greater rate (a 12.7% increase- Am J Managed Care 2008 below) when they were sent to both patients and their physicians, compared to when they were sent to physicians alone.

Publications / links

Overview <http://www.activehealth.com/solutions>

Clinical Analytics

CareEngine® and Clinical Decision Support <http://www.activehealth.com/node/27>

Population Health Analytics & Reporting <http://www.activehealth.com/node/28>

Clinical Quality Measures <http://www.activehealth.com/node/29>

Savings Estimator calculator <http://activehealth.com/impact-lifestyle-risk-factors-generate-savings>

Javitt, et al. "Using a Claims Data-based, Sentinel System to Improve Compliance with Clinical Guidelines: Results of a Randomized Prospective Study," American Journal of Managed Care Feb. 2005; 11:93-102

http://s3.amazonaws.com/aetnaeb-cms-staging/QualChoiceStudy_AJMC.pdf

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Juster, I. "Technology-Driven Interactive Care Management Identifies and Resolves More Clinical Issues than a Claims-Based Alerting System," *Disease Management* June 2005; 8:188-197

Rosenberg SN, Shnaiden TL, Wegh AA, Juster IA. Supporting The Patient's Role In Guideline Compliance: A Controlled Study. *American Journal of Managed Care*. 14(11):737-44, 2008 Nov.

Javitt JC, Rebitzer JB, Reisman L. Information Technology and Medical Missteps: Evidence From a Randomized Trial. *Journal of Health Economics*. 27(3):585-602, 2008 May.

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Organization	AETNA
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	http://www.aetnaacs.com
Measure	Accountable Care Solutions

UPDATED IN 2013

Summary

Accountable Care Solutions from Aetna enhances the health care experience for patients, improves quality of care and reduces costs by:

- Empowering providers to effectively manage all patient populations and improve clinical outcomes through an optimal infrastructure for value-based care and patient engagement
- Offering incentive alignment that allows providers to jointly share in the rewards of a successful transition from reactive, encounter-based care to proactive, value-based care
- Establishing scalable clinical business models to support market share growth and efficient, high-quality care delivery to patient populations

Methodology

Measuring and Reporting Success - analytics and outcomes reporting

We offer analytics and reporting tools that measure your progress toward achieving your established clinical and financial goals and — help you meet reporting requirements for state and federal initiatives.

Our technology:

- Delivers reports to detect trends and opportunities, reduce costs, increase efficiencies and successfully manage risk
- Tracks quality of care across networks and physicians compared to evidence-based medical standards
- Helps you identify barriers to compliance with quality metrics

Advanced analytics and reporting for value-based health care - to choose from more than 120 analytics templates across several categories, Executive Summary Provider Analysis, Program Evaluation, Population Management, Financial Analysis, Benchmarking

Customize to meet your unique reporting and analysis needs, including:

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- Interactive data analysis and self-serve ad hoc reporting – You can build reports and analysis on the fly. Users can drill into the data down to the lowest level of detail.
- Custom Dashboards and Reporting – We work with you to define specific requirements and create custom reports with selected quality and financial performance measures.
- Required reporting for federal initiatives such as:

Clinical Analytics for Population Health Management

Transform health information into targeted analysis and insight

Accountable care is evidence-based and data-driven. Its about the big picture – identifying population health trends and treating high-risk patients before their care becomes costly. That’s what our analytics solutions are designed to deliver. As clinical and claims data flow into the system, our software analyzes it against the current evidence base and delivers it to you as actionable information. This information helps you:

- View population health trends and patterns
- Identify individual health risks and high-risk populations
- Find opportunities to improve care at the population and individual level

The resulting intelligence is presented to the care team in a format that meets the needs of each care team member. This intelligence helps the care team:

- Target the right preventative medicine priorities
- Identify gaps in care, medical errors and quality issues
- Devise care plans and tailor outreach and communications
- Personalize care for each patient’s specific needs and characteristics

Tools to assist clinical decision-making

The power of our solution lies in its ability to:

- Continuously aggregate and analyze information about your population
- Apply accepted evidence-based medical standards
- Deliver the information to care team members when and where they need it

Whether it’s a reminder in a physician’s Electronic Medical Record or an alert in the care manager’s population health dashboard, our solution delivers up-to-date information to meet the needs of each member of the care team as they manage individual patients and the population as a whole.

Results

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A study for Medicare Advantage Patients showed

- 45% Reduction in hospital admissions
- 50% Fewer patient hospital days
- \$600 Annual savings per patient

Publications / links

Building a Medicare ACO

<http://s3.amazonaws.com/aetnaeb-cms-staging/ACS/Medicare-Shared-Savings-022013.pdf>

Partnering for Success in the Medicare Shared Savings Program

<http://s3.amazonaws.com/aetnaeb-cms-staging/ACS/ACS%20Shared%20Savings%20Program%20Fact%20Sheet%20FINAL.pdf>

Payer-Provider Collaboration In Accountable Care Reduced Use And Improved Quality In Maine Medicare Advantage Plan doi: 10.1377/hlthaff.2011.1141 *Health Aff September 2012 vol. 31 no. 9 2074-2083*

“Accountable Care Payers 2013: Partners in a Changing Paradigm,” June, 2013. © 2013 KLAS Enterprises, LLC.

<http://www.klasresearch.com/Login.aspx?ReturnUrl=%2fmyklas%2f#/krms/41/0>

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Organization	AETNA
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	www.aetna.com
Measure	Aexcel Performance Network http://www.aetna.com/plans-services-health-insurance/detail/medical-insurance/aexcel-performance-network-plans.html Institutes of Excellence™ (IOE) Institutes of Quality® (IOQ) http://www.aetna.com/healthcare-professionals/quality-measurement/institutes.html

UPDATED IN 2013

Summary

Founded in 1853 in Hartford, Connecticut, Aetna is one of the nation's leading providers of health care, dental, pharmacy, group life, and disability insurance, and employee benefits.

Aetna seeks out and recognizes clinical quality and efficiency among health care providers. We promote quality care at all levels. And we work with health care providers to measure and improve care quality and safety. Two programs recognize certain hospital and surgeons.

Methodology

Aexcel-designated specialists

When you need healthcare, finding the right doctor is critical. It can also be a challenge. Aetna's physician performance network makes the search easier. Members get access to specialists who have met certain industry-accepted practices for clinical performance and Aetna measures of cost-efficiency. These are health care specialists who:

- Are part of Aetna's network
- Meet industry-accepted practices for clinical performance
- Meet Aetna's efficiency standards

Our clinical performance criteria are based on nationally-recognized standards, consistent with leading associations such as:

- National Quality Forum
- National Committee for Quality Assurance

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- American Board of Medical Specialties
- American Osteopathic Association
- American Heart Association
- American College of Obstetricians and Gynecologists
- Society of Thoracic Surgeons
- Centers for Medicare & Medicaid Services

Members can choose specialists from 12 categories, usually without a referral. They may even lower out-of-pocket costs by choosing an Aexcel specialist. Physicians have a dedicated Aexcel page on NaviNet, the secure physician website, which provides them with access to reference materials and a detailed description of our methodology.

Aexcel information we offer you is intended to be only a guide for when you choose a specialist within the Aexcel specialist categories. There are many ways to evaluate doctor practices and you should consult with your existing doctor before making a decision. Please note that all ratings have a risk of error and, therefore, should not be the sole basis for selecting a doctor.

One of the clinical criteria for Aexcel designation is e-Prescribing. The Allscripts ePrescribe Platinum Edition is one of the e-Prescribing options available to Aetna participating doctors and it is free of charge through our agreement with CVS Caremark.

Institutes of Excellence™ (IOE)

A designation for health care facilities that offer highly specialized clinical services to members with complex or rare conditions; a member's clinical care in these cases is coordinated nationally by Aetna (for example, transplant care).

Aetna's National Medical Excellence Program coordinates care and provides access to covered transplant treatment through the national Institutes of Excellence™ network. Hospitals that have met extensive quality, as well as cost-effectiveness criteria have been selected by Aetna to participate in our Institutes of Excellence™ Transplant Network for solid organ transplants and bone marrow transplants. These facilities have been contracted on a transplant-specific basis and are considered participating only for the transplant type listed in our network directory.

Institutes of Quality® (IOQ) facilities

A designation for health care providers who offer clinical services for prevalent health conditions to our Aetna members, served through integrated clinical management at the regional level (for example, bariatric surgery, infertility Clinics, cardiac Care, and orthopedic Care)

Publications / links

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Overview of the Aexcel program

<http://www.aetna.com/plans-services-health-insurance/detail/assets/documents/Member-brochure.pdf>

How we chose specialists

<http://www.aetna.com/plans-services-health-insurance/detail/assets/documents/Aexcel-Methodology.pdf>

Program criteria - Transplants

<http://www.aetna.com/healthcare-professionals/documents-forms/Aetna-Institutes-of-Excellence.pdf>

Aexcel_Physician_Clinical_Performance_Evaluation.

http://www.aetna.com/plansandproducts/health/medical/Aexcel_Physician_Clinical_Performance_Evaluation.pdf

Understanding Aexcel Brochure

<http://www.aetna.com/plansandproducts/health/medical/understandingaexcel.pdf>

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Organization	AHRQ - Agency for Healthcare Research and Quality
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	https://cahps.ahrq.gov/
Measure	<p>CAHPS - Consumer Assessment of Healthcare Providers and Systems Family of Surveys (Ambulatory Care and Facility Care Surveys) National CAHPS Benchmarking Database (CAHPS Database) https://cahps.ahrq.gov/Surveys-Guidance/HP/index.html Hospital Survey Health plan survey https://cahps.ahrq.gov/surveys-guidance/hp/index.html Clinician & Group Survey https://cahps.ahrq.gov/surveys-guidance/cg/instructions/index.html Benchmarking Database https://cahps.ahrq.gov/cahps-database/about/index.html</p>

Lightly updated in 2013

Summary

Initiated in 1995, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) family of surveys is used by many public and private purchasers to

- Assess the patient-centeredness of care;
- Compare and report on performance; and
- Improve quality of care.

A comprehensive and evolving family of standardized surveys that ask consumers and patients to report on and evaluate their experiences with ambulatory and facility-level care health care. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. CAHPS originally stood for the Consumer Assessment of Health Plans Study and was initially focused on developing measures of health plan performance. This evolved to cover the full spectrum of health care services. Considered to be the ‘gold standard’ of patient information and experience regarding quality of hospitals and health plans. The Centers for Medicare & Medicaid Services (CMS) partnered with the Agency for Healthcare Research and Quality (AHRQ) to develop HCAHPS. In May 2005, the HCAHPS survey was endorsed by the National Quality Forum (NQF) and in 2007 the Clinician and Group Survey was endorsed by the NQF.

The CAHPS program is funded and administered by the U.S. Agency for Healthcare Research and Quality (AHRQ), which works closely with a consortium of public and private organizations All CAHPS instruments are in the public domain.

- **Health Plan Survey:** The industry standard for obtaining consumers’ assessments of their health plans. The CAHPS Health Plan Survey is used by commercial, Medicaid, State Children’s Health Insurance Program (CHIP), and Medicare plans representing more than 120 million enrollees. Results of these surveys are used for public reporting, accreditation, quality monitoring at the Federal and State levels, and quality improvement at the plan level. The National Committee for Quality Assurance (NCQA) incorporates CAHPS results into its health plan performance reports as well as its accreditation process for health plans. A version of the survey is also used by CMS, which surveys Medicare beneficiaries enrolled in managed care plans as well as in the traditional Medicare program, and reports the scores in a

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public Web site surveys that assess the experiences of health care consumers in various ambulatory settings, including physician offices, managed behavioral healthcare organizations, dental plans, and tribal clinics.

- **Hospital Survey:** Patients' perspectives on the care delivered in health care facilities, such as hospitals, nursing homes, and dialysis centers. Focuses on the experiences of adult inpatients with hospital care and services. Hospitals voluntarily report data to the CMS. Other facility based surveys include CAHPS In-Center Hemodialysis Survey and the CAHPS Nursing Home Surveys for long-term residents, recently discharged short-stay residents, and the families of residents.
- **Clinician & Group Survey:** Asks patients to report on and rate the quality of care received in physicians' offices. Available in both English and Spanish, it consists of 41 core items, which ensure standardization across survey sponsors, as well as over 50 supplemental items that sponsors may choose to add to the survey instrument to meet their specific needs. For patients who are commercially insured, the visit must have occurred in the last 12 months; for patients who are covered by Medicaid or Medicare, the visit must have occurred in the last 6 months. Covers adult primary and specialty care and child primary care. A visit-specific version of the Adult Primary Care Questionnaire is currently under development.
- **National CAHPS Benchmarking Database:** National repository for data from the CAHPS family of surveys. Created in 1998 as a resource for survey sponsors, researchers, and others interested in using comparative CAHPS survey results and detailed benchmark data. Contains respondent-level survey data, characteristics of entities surveyed (e.g., health plans and hospitals), and other information related to survey administration. Database has two major components - CAHPS Health Plan Survey CAHPS Hospital Survey. A third database component is under development for the CAHPS Clinician & Group Survey.

Methodology

Standardized survey instrument and data collection methodology for measuring patients' perspectives of hospital care. CAHPS surveys ask consumers for both overall ratings and reports about specific aspects of care, providers, and systems. Patients also are asked to report whether, or how often, specific events or behaviors that are indicators of health care quality occurred. Reports about events and behaviors are more specific, actionable, understandable, and objective than general ratings. CAHPS questions about specific aspects of care allow users to identify areas of care that are strong and those that need improvement. CHAPS collects data on communication with staff, cleanliness, pain management, discharge information and attentiveness.

Health Plan Survey - a core set of questions covering enrollment/coverage, access, global ratings, utilization, communication, plan administration, health status, chronic conditions, demographics,

Hospital Survey – a core set of questions that can be combined with customized, hospital-specific items to produce information that complements the data hospitals currently collect to support internal customer service and quality-related activities. Composed of 18 patient rating and patient perspectives on care items that encompass seven key topics: communication with doctors, communication with nurses, responsiveness of hospital staff, cleanliness and quietness of hospital environment, pain management, communication about medicines, and discharge information. It also includes four screener questions and five demographic items, some of which may be used for adjusting the mix of patients across hospitals and for analytical purposes. The survey is 27 questions in length.

Clinician & Group Survey - consists of four instruments:

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- Adult Primary Care Questionnaire 1.0 – 18 topic areas including wait time, health improvement, communication, knowledge of specialist care, cost, doctor thoroughness
- Adult Specialty Care Questionnaire 1.0 – 6 topic areas including care received, shared decision making, cost, procedures
- Child Primary Care Questionnaire 1.0 – 7 topics including scheduling, health improvement, knowledge of specialist care, shared decision making
- Child Primary Care Questionnaire 2.0 (beta) – 9 topic areas including after hours care, chronic conditions, communication, thoroughness, shared decision making.

Results

Various reports and case studies have been developed over the years. A weblink is available below.

Publications / links

Site relaunched in October 2013

Comparative data <https://cahps.ahrq.gov/cahps-database/comparative-data/index.html>

Access Comparative Data in CAHPS Database Online Reporting System <http://www.cahpsdatabase.ahrq.gov/>

Frequently asked questions <https://cahps.ahrq.gov/apps/faq.aspx>

Reports and Case Studies <https://cahps.ahrq.gov/quality-improvement/reports-and-case-studies/index.html>

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Organization	Agency for Healthcare Research and Quality (AHRQ)
Category	Standards Setting, Industry Organizations
Source	http://www.ahrq.gov/
Measure	Evidence-Based Practice Centers (EPC) http://www.ahrq.gov/clinic/epc/

Summary

Launched in 1997 - 5-year contracts to institutions in the US and Canada to serve as EPCs. The EPCs review all relevant scientific literature on clinical, behavioral, economic and organization and financing topics to produce evidence reports and technology assessments - particularly interested in issues that are common, expensive, and/or significant for the Medicare and Medicaid populations. EPC reports and assessments emphasize explicit and detailed documentation of methods, rationale, and assumptions. These scientific syntheses may include meta-analyses and cost analyses. All EPCs collaborate with other medical and research organizations so that a broad range of experts is included in the development process. The resulting evidence reports and technology assessments are used by Federal and State agencies, private sector professional societies, health delivery systems, providers, payers, and others committed to evidence-based health care.

These reports are used for informing and developing coverage decisions, quality measures, educational materials and tools, guidelines, and research agendas. Topics are nominated by non-federal partners such as professional societies, health plans, insurers, employers, and patient groups. Initially 12 EPCs were funded. There are currently 11 centers.

The EPCs review all relevant scientific literature on clinical, behavioral, and organization and financing topics to produce evidence reports and technology assessments.

- Cancer and Blood Disorders
- Complementary and Alternative Care
- Dietary Supplements
- Ear, Nose, and Throat Conditions
- Heart and Vascular Diseases
- Infectious Diseases
- Kidney and Urological Conditions
- Laboratory Testing
- Lung Conditions
- Mental Health Conditions and Substance Abuse
- Metabolic, Nutritional, and Endocrine Conditions
- Musculoskeletal Disorders

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- Nerve and Brain Conditions
- Obstetric and Gynecologic Conditions
- Oral and Gastrointestinal Disorders
- Pediatric Conditions

Publications / links

EPC Evidence-based Reports <http://www.ahrq.gov/research/findings/evidence-based-reports/index.html>

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Organization	AHRQ - Agency for Healthcare Research and Quality
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	http://www.ahrq.gov/ .
Measure	Innovations Exchange http://www.innovations.ahrq.gov/

UPDATED IN 2013

Summary

The Agency for Healthcare Research and Quality's (AHRQ) mission is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. The Innovations Exchange helps you solve problems, improve health care quality, and reduce disparities.

- Find evidence-based innovations and QualityTools.
- View new innovations and tools published biweekly.
- Learn from experts through events and articles.

Methodology

The AHRQ has collected and reviewed an extensive set of innovations and has organized them in a searchable data base using multiple, cross-referenced categories

Disease or Clinical Category: Asthma, Cancer, Diabetes, Heart failure, Hospital-acquired infections, Pressure ulcers

Setting of Care: General hospital, Health plan, Physician office, Worksite wellness

Stage of Care: Acute care, Chronic care, Emergency care, Preventive care

Organizational Process: Intake/Admissions, Organizational culture change, Staffing, Team building

Quality Tool Topics: Benchmarking/Comparative data, Disease/Condition-related, Prevention and wellness, Quality improvement strategies

Patient Care Process: Chronic-disease management, Infection control, Medication reconciliation, Disparity reduction

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Patient Population: Children, Frail elderly, Rural populations, Uninsured

IOM Domains of Quality: Effectiveness, Efficiency, Equity, Patient-centeredness, Safety, Timeliness

Quality Improvement Goals and Mechanisms: Avoidable hospitalizations, Cultural competence, Medical home, Patient satisfaction

To give a sense of the scope of the site, the number of references are recorded below (on August 28, 2013)

IOM Domains of Quality

- Effectiveness (1565)
- Efficiency (343) **Authors note: AHRQ Innovations material based on the IOM definition of efficiency This is different from the business definition used within this report.**
- Equity (458)
- Patient-centeredness (1280)
- Safety (596)
- Timeliness (213)
- Not within an IOM domain (18)

Authors note: AHRQ Innovations material on the web is based on the IOM definition of efficiency (within a clinical context) This is different from the broader business definition used within this report.

Quality Improvement Goals and Mechanisms

- Avoidable hospitalizations (118)
- Confidentiality/HIPAA compliance (24)
- Cultural competence (192)
- Length of stay reduction/management (37)
- Medical home (52)
- Patient satisfaction (80)
- Rapid response teams (17)

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Disease or Clinical Category

Allergy and immunologic care (77)	Gynecologic/Obstetric care (144)	Nephrologic care (30)	Respiratory/Pulmonary care (148)
Cardiovascular care (238)	Hematology/Oncologic care (230)	Neurologic care (101)	Skin and soft-tissue care (41)
Dental health care (33)	HIV/AIDS care (96)	Ophthalmologic care (17)	Substance abuse (164)
Diet and nutrition (201)	Infectious disease care (239)	Otolaryngologic care (15)	Surgical care (40)
Endocrinologic/Metabolic care (196)	Mental health care (237)	Pediatric care (150)	Urologic care (6)
Gastroenterologic care (31)	Musculoskeletal care (179)		

Results

The various sets of material within the Innovations site provide substantial and timely background on many initiatives. The summaries for any particular initiative are typically three to five pages. It includes:

- Summary Evidence rating (overview of published articles)
- Date first implemented
- Patient population
- Problem addresses
- Description of the Innovative Activity
- Reference / related articles

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Organization	Agency for Healthcare Research and Quality (AHRQ)
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	http://www.ahrq.gov/research/findings/nhqrdr/nhqr12/nhqr12_prov.pdf
Measure	National Healthcare Quality Report (NHQR)

Summary

The National Healthcare Quality Report (NHQR) is the first comprehensive national effort to measure the quality of health care in America. It includes a broad set of performance measures that can serve as baseline views of the quality of health care and presents data on services for seven clinical conditions. Commenced in 2003. Sought to develop a set of indicators appropriate for profiling health care quality for the nation, including trends over time. Examine differences at the sub-national level and variations by socioeconomic status. Developed with technical and substantive input of nine federal agencies and organizational units within the Department of Health and Human Services & a range of state public partners and private sector organizations.

In 5th year (2007 report), NHQR offers a consensus-based set of health care quality measures across four dimensions of quality — effectiveness, safety, timeliness, and patient centeredness. Examines effectiveness of care across nine clinical condition areas— cancer, diabetes, end-stage renal disease, heart disease, HIV/AIDS, maternal and child health, mental health, respiratory diseases, and nursing home and home health care.

Methodology

NHQR is built on 218 measures categorized across four dimensions of quality—effectiveness, patient safety, timeliness, and patient centeredness. Measure specifications included in national quality measures, clearinghouse development of condition-specific and state-specific reports. Group of 41 core report measures that represent the most important and scientifically credible measures of quality for the Nation, as selected by the HHS Interagency Work Group. Effectiveness of care is presented under nine clinical condition/care setting areas: cancer; diabetes; end stage renal disease (ESRD); heart disease; HIV and AIDS; maternal and child health; mental health and substance abuse; respiratory diseases; and nursing home, home health, and hospice care.

Results

The NHQR was legislatively mandated as an annual report on trends in health care quality. Purpose is to summarize the current state of health care quality in terms that are understandable and relevant to a broad audience including providers, consumers, researchers, and policymakers. Report focus is systematic reporting on (i) trends and change over time, (ii) differences at the sub-national level by state, and (iii) variations by selected socio-demographic characteristics.

Major findings in 2007

- Health care quality continues to improve, but the rate of improvement has slowed.
- Variation in quality of health care across the Nation is decreasing, but not for all measures.
- The safety of health care has improved since 2000, but more needs to be done

Publications / links

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National Healthcare Quality & Disparities Reports <http://www.ahrq.gov/research/findings/nhqrdr/index.html>

National Healthcare Quality Report http://www.ahrq.gov/research/findings/nhqrdr/nhqr12/nhqr12_prov.pdf

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Organization	Agency for Healthcare Research and Quality (AHRQ)
Category	Standards Setting, Industry Organizations
Source	http://www.ahrq.gov/
Measure	Quality Indicators http://qualityindicators.ahrq.gov/

Summary

Recommended performance measures to help hospitals identify a range of areas for improvement in the form of software and user guides for quality indicators covering four modules. Available free of charge to assist users in applying the quality indicators to their own data. The Quality Indicators (QIs) are measures of health care quality that use available hospital inpatient administrative data. This data measures quality associated with processes of care that occurred in an outpatient or an inpatient setting & highlights potential quality concerns, identifies areas that need further study and investigation, and track changes over time.

First introduced in 2001. Developed by investigators at Stanford University and the University of California under a contract with AHRQ.

The **four modules of indicators** are: Prevention Quality, Inpatient Quality, Patient Safety, and Pediatric Quality.

Prevention Quality Indicators 14 ambulatory care sensitive conditions in adult populations. Identify hospital admissions that evidence suggests could have been avoided, at least in part, through high-quality outpatient care. Are population based and adjusted for age and sex.

Inpatient Quality Care Indicators reflect quality of care inside hospitals and include:

- Inpatient mortality for medical conditions & surgical procedures.
- Utilization of procedures for which there are questions of overuse, underuse, or misuse
- Volume of procedures for which there is evidence that a higher volume of procedures maybe associated with lower mortality
- Reflect the rate of hospitalization in the area for specific procedures
- Mortality Rates for Medical Conditions (7 Indicators), Mortality Rates for Surgical Procedures (8 Indicators), Area-level Utilization Rates (4 Indicators), Volume of Procedures (6 Indicators)

Patient Safety Indicators Reflect quality of care inside hospitals, but focus on potentially avoidable complications and iatrogenic events. Identify adverse events that patients experience as a result of exposure to the health care system Hospital-level. Patient Safety Indicators (20 Indicators), Area-level Patient Safety Indicators (7 Indicators).

Pediatric Quality Indicators Reflect quality of care inside hospitals and identify potentially avoidable hospitalizations among children. Screen for problems that pediatric patients experience as a result of exposure to the healthcare system and that may be amenable to prevention by changes at

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the system or provider level. Four factors—differential epidemiology of child healthcare relative to adult healthcare, dependency, demographics, and development—are considered. Provider-level Pediatric Quality Indicators (13 Indicators), Area-level Pediatric Quality Indicators (5 Indicators)

Methodology

Indicators developed after a comprehensive literature review, analysis of ICD-9-CM codes, review by a clinician panel, risk adjustment and empirical analyses. Measures developed and regularly updated by a consensus process.

Results

Indicators provide a comprehensive picture of the level and variation of quality within four components of health care quality—effectiveness, safety, timeliness, and patient centeredness.

The AHRQ Quality Indicators are now being used for applications beyond quality improvement. Some organizations have used the AHRQ Quality Indicators to produce web based, comparative reports on hospital quality, such as the Texas Health Care Information Council and the Niagara Coalition. Other organizations have incorporated selected AHRQ QIs into pay for performance demonstration projects.

Publications / links

Publications weblink <http://www.qualityindicators.ahrq.gov/Resources/Publications.aspx>

Toolkit weblink <http://www.qualityindicators.ahrq.gov/Resources/Toolkits.aspx>

Webinars and presentations are also available

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Organization	American Medical Association (AMA)
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	www.ama-assn.org
Measure	Physician Consortium for Performance Improvement (PCPI) www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/physician-consortium-performance-improvement.shtml

Lightly updated in 2013

Summary

The AMA convenes the Physician Consortium for Performance Improvement (PCIP) which focuses on clinical quality improvement and patient safety. This physician-led Consortium is composed of national clinical and methodological experts who develop tools and programs designed to help physicians improve care for specific, measurable areas of their practice. The PCPI comprised of over 100 national medical specialty and state medical societies; the Council of Medical Specialty Societies; American Board of Medical Specialties and its member-boards; experts in methodology and data collection; the Agency for Healthcare Research and Quality; and Centers for Medicare & Medicaid Services taking the lead in the development, testing, and maintenance of evidence-based clinical performance measures and measurement resources for physicians. PCPI activities are carried out through cross-specialty work groups established to develop performance measures for physicians from evidence-based clinical guidelines for select clinical conditions

Members of the Consortium have created 14 evidence-based performance measurement sets, to assist physicians analyze their performance and improve the quality of treatment their patients receive. The Consortium supports building quality improvement tools into electronic health records, which make medical care more efficient and safe, as physicians, nurses, pharmacists, and other health professionals have constant access to patient data.

Methodology

The Measures are intended to assist physicians in enhancing quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. These performance Measures are not clinical guidelines and do not establish a standard of medical care.

Currently there are hundreds of PCPI measures. Descriptions and specifications for PCPI performance measures are available for over forty clinical topics or conditions. Measures with descriptions and specifications have been developed by an expert committee, approved by PCIP and published. Format includes a statement of the purpose of the measure, accountability measures, specification of intended audience and patient population, measure specifications (process and outcomes), data capture and measure calculation.

Publications / links

Overview <http://www.ama-assn.org/resources/doc/cqi/pcpi-overview-flyer.pdf>

PCPI Approved Quality Measures <http://www.ama-assn.org/apps/listserv/x-check/qmeasure.cgi?submit=PCPI>

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Measure Testing Protocol for Physician Consortium for Performance Improvement Performance Measures
<http://www.ama-assn.org/resources/doc/cqi/pcpi-testing-protocol.pdf>

Measure Testing Protocol for Physician Consortium for Performance Improvement Performance Measures
<http://www.ama-assn.org/ama/pub/physician-resources/physician-consortium-performance-improvement/knowledge-center.page?>

Position Papers and Resources <http://www.ama-assn.org/ama/pub/physician-resources/physician-consortium-performance-improvement/knowledge-center/position-papers-resources.page?>

Proceedings from the National Summit on Overuse <http://www.ama-assn.org/resources/doc/cqi/overuse-proceedings-paper.pdf>

Physician Consortium for Performance Improvement (PCPI) Performance Measure Status Report.
<http://www.ama-assn.org/ama1/pub/upload/mm/370/measures.pdf>

Technical Specifications for AMA Physician Consortium for Performance Improvement measures endorsed by the National Quality Forum
http://www.ama-assn.org/ama1/pub/upload/mm/370/nqf_hb.pdf

A Framework and Empirical Strategies for Assessing Healthcare Efficiency
http://www.ama-assn.org/ama1/pub/upload/mm/370/exec_summ_efficiency.pdf

Physician Consortium for Performance Improvement Position Statement. The Linkage of Quality of Care Assessment to Cost of Care Assessment
<http://www.ama-assn.org/ama1/pub/upload/mm/370/linkagequalitycost.pdf>

Physician Consortium for Performance Improvement Work Group on Efficiency and Cost of Care. A Framework for Measuring Healthcare Efficiency and Value
http://www.ama-assn.org/ama1/pub/upload/mm/370/framework_meas_efficiency.pdf

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Organization	American Medical Group Association
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	www.amga.org
Measure	Accountable Care Collaborative http://www.amga.org/AboutAMGA/ACO/index_aco.asp

UPDATED IN 2013

Summary

AMGA believes that our current system of health care delivery does not adequately hold providers accountable for the care they provide, nor for providing the full spectrum of care. Creating accountability is impossible until we transform the current volume-based system into one that pays providers based on outcomes (quality) and value (efficiency). Once a link has been made between compensation and results, provider accountability will grow. To promote accountability, and build on existing medical practice patterns, Congress has taken an important step in the creation of Accountable Care Organizations (ACO) in health reform law.

Accountable Care Organizations (ACOs) are one of the key efforts of the recent healthcare reform legislation that address the two greatest challenges facing US health care: unsustainable escalation of costs that threaten the affordability of care and care that is fragmented, poorly coordinated with little accountability for the outcomes of care. It is widely believed that the current volume-based payment system is part of the problem and needs to be restructured to support paying for value rather than paying for delivering services and procedures. The ACO concept couples payment and delivery systems reforms that may have the opportunity to bend the cost curve while improving access and quality.

In 2011, AMGA launched two collaborates focused on practical steps toward creating high-performing organizations and systems of care termed Accountable Care Organizations: a Development Collaborative and an Implementation Collaborative. AMGA collaborative offer access to content experts and provide a forum in which peer organizations can learn from one another as they begin to build and refine business and care processes to develop high-quality, efficient, and sustainable systems of care that provide high-value care to their patients and communities.

In 2012, AMGA is launching the next phase of its Accountable Care Collaborative: Transforming to a Value-Based System of Care. Medical groups are invited to join this yearlong shared learning program. Phase II of the Collaborative will focus on the fundamental organizational, systems, and culture changes necessary for successful transformation to a value-based system of care, regardless of the path chosen—CMS’s Shared Savings Program, the Pioneer ACO Program, commercial ACOs, or other models yet to emerge. Our goal is to create a rich collaborative experience providing participants with practical solutions and strategies specific to their situation.

Methodology

Readiness Assessment Tool

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The Readiness Assessment Tool will be a guide for a structured assessment regarding organizational capacity and readiness including:

- Structure and governance components to support a culture of accountability
- Alignment of incentives both internally and with payers
- Clinical integration across providers and settings
- Care coordination and population management
- Technical support systems to account for cost and quality

A Development Collaborative and an Implementation Collaborative start with improving transitions through True Person-Centered Care. When moving a patient from the hospital to home or from the ER to an assisted living facility, crossed wires and misaligned perceptions and priorities—between providers and patients, across care facilities and among members of the health team—can hinder quality and efficiency during this crucial stage in health delivery. ACOs can create more aligned, effective patient transitions by:

- Getting patients more engaged in their own care:
- Elevating family caregivers to essential members of the care team
- Appreciating each facility’s cultures, strengths, and limitations
- Defining accountability during transitions
- Building professional competency in care coordination
- Implementing strategies to improve cross-setting communication
- Aligning financial incentives to promote cross-setting collaboration

Publications / links

Research guide

http://www.amga.org/research/research/ACO/index_aco.asp

ACO Report FINAL

http://www.amga.org/AboutAMGA/ACO/Articles/AMGA%20ACO%20June%202012%20Report_FINAL.pdf

Readiness Assessment Tool

<http://www.amga.org/research/research/ACO/assessTool.pdf>

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Organization	American Medical Group Association (affiliate)
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	www.amga.org
Measure	Council of Accountable Physician Practices (CAPP) http://www.amga-capp.org

Summary

A research project that seeks to demonstrate that accountable physician practices deliver effective, efficient health care that improves clinical outcomes, enhances quality of life, and satisfies patients.

Methodology

1. Group Practice Performance Study - test the feasibility of linking three data sources:

1. Data from CAPP multispecialty group practices identifying physicians within their groups
2. Medicare claims data from Dartmouth's Medicare fee-for-service claims database; and
3. National Survey of Physician Organizations (NSPO) - NSPO1 and NSPO2 data on organizational attributes and care management processes at these organizations.

Data will be analyzed to provide insight into differences in performance across these organizations and the association between better performance and the presence of specific organizational attributes and specific care management processes.

2. Degree of Integration and Care Management Processes - Collect best practices in

1. Use of IT and the EMR in the care of chronic conditions,
2. Capabilities to provide feedback and guidance on the overall performance of a practice and its physicians,
3. Capabilities to provide patient-centered care.

The study will summarize the current capabilities across the CAPP groups and examine the relationship between the degree of integration and use of care management processes.

Results

Aim is more efficient care through:

- Shared costs
- Better coordinated care
- Shared information and communications system = use of electronic medical records and implement best practices
- Multispecialty medical groups also practice preventive medicine

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There are case studies for various categories:

- Prevention
- Team-based Care
- Health Information Technology
- Evidence-based Treatment
- Day And Night Access
- Value

And, for these ACO Types:

- Integrated Delivery System (IDS)
- Multispecialty Medical Group
- Independent Physician Association (IPA)
- Physician-hospital Organization (PHO)
- Hospital
- Health Plan

Publications / links

Current projects <http://www.amga-capp.org/projects/projects-2013.aspx>

Case studies http://www.accountablecarefacts.org/case_studies/

Partners in Health: How Physicians and Hospitals Can Be Accountable Together, eds. Francis J. Crosson and Laura A. Tollen; Jossey-Bass, 2010

Many Large Medical Groups Will Need To Acquire New Skills And Tools To Be Ready For Payment Reform *Health Aff September 2012 31:91984-1992*;

<http://content.healthaffairs.org/cgi/content/full/31/9/1984?ijkey=Bq3D.HCkM6OII&keytype=ref&siteid=healthaff>.

Health Care Reform Requires Accountable Care Systems. Stephen M. Shortell, PhD, MBA, MPH; Lawrence P. Casalino, MD, PhD *JAMA*. 2008;300(1):95-97.

Reforming the Delivery System. Report to Congress. MedPac. June 2008.

http://www.medpac.gov/documents/Jun08_EntireReport.pdf

Does Affiliation of Physician Groups with One Another Produce Higher Quality Primary Care? Mark W. Friedberg, Kathryn L. Coltin, Steven D. Pearson, Ken P. Kleinman, Jie Zheng, Janice A. Singer and Eric C. Schneider . *J of General Internal Medicine*, Volume 22, Number 10 / October, 2007 pp 1385-1392

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Organization	Anthem (example from one state)
Category	Incentive/Reward Programs
Source	www.anthem.com
Measure	<p>Examples of various state-specific programs</p> <p>Networks</p> <p>Enhanced Personal Health Care Program</p> <p>Access to employer and provider portals for specific states</p> <p>www.anthem.com/ca/home-providers.html</p> <p>http://www.anthem.com/ca/home-employers.html</p>

Updated in 2013

Summary (example from one state)

Overview from authors: Anthem works in multiple states and some material is available only to members or local providers. So, their material is hard to summarize.

- There are multiple Anthem programs related to measurement across each of the states.
- Many states offer multiple networks to their members at different price points. This is based on both quality and efficiency metrics.
- Patient centered medical home programs are available in Colorado and other states.
- Hospital quality incentive programs are offered in some states
- Some states offer links to state-wide data bases. quality or performance in particular states.
- Various programs offered through the Blue Cross Blue Shield Association are available in most of their states. This includes the Blue Distinction, Center of Medical Excellence, Blue Precision Physician Performance Recognition Program, and eQuality Improvement Program. These are discussed in separate entries.

Highlights of public material from one of the larger states (California) is below.

Methodology

HMO Pick-a-Network

The entire HMO portfolio¹ of plans can be sold using any of our three HMO networks:

Traditional HMO Network — with more than 35,000 California physicians and specialists, and more than 370 hospitals

Select HMO Network — our high-performance network, which has demonstrated its commitment to cost efficiency, with locations in 23 counties

All weblinks were updated in 2013. Written material is extracted from publicly-available material on the websites of organizations - much of the content was extracted in 2013. But, some of the continuing programs come from earlier editions (2008 or 2010). It has not been independently validated and the authors and the Society of Actuaries make no warranty as to its accuracy.

And now, introducing Select Plus HMO Network — our new statewide provider network that offers more access than the Select HMO Network at a lower cost than the traditional HMO

Enhanced Personal Health Care Program

This Program empowers primary care physicians (PCPs) to engage in those comprehensive primary care functions that move us toward a coordinated, evidence-based care model that has the greatest impact on achieving the triple aim of improved quality, patient experience and affordability.

We believe the doctor-patient relationship is the most important in health care. Every patient should have a relationship with a primary care physician who knows and understands their individual health care needs, can provide comprehensive “whole patient” health care services, and will serve as their champion, helping them navigate the complex health care system to ensure they get the care they need when and where they need it. This is the key to improving quality and outcomes and, subsequently, lowering costs.

The Program is based on a simple principle – that primary care physicians and their practice team, provided with the right tools, information, and resources, are best equipped to optimize the health of their patients and improve the affordability of health care.

- Make a significant investment in primary care
- Provide primary care physicians with tools, resources and meaningful information that promote (1) access, (2) shared decision making, (3) proactive health management, (4) coordinated care delivery, (5) adherence to evidence based guidelines and (6) care planning.
- Redesign the current payment model to move from volume based to value based payment, aligning financial incentives and providing financial support for activities and resources that focus on care coordination, individual patient care planning, patient outreach and quality improvement.
- Improve the patient experience by creating better access to a primary care physician and making them active participants in their health care.

Results

The networks outlines above are offered a different price points in the market. In some parts of the state, the differences between the various HMO and PPO networks are very larger. Many of these network options have been offered for years.

Publications / links

Medical plans and networks (one of many networks descriptions for specific types of buyers – this is small group)

http://www.anthem.com/wps/portal/ca/employer?content_path=employer/f3/s2/t0/pw_a116798.htm&label=Large%20Group%20Plans%20%2851%20or%20more%20Employees%29&rootLevel=2

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Patient-Centered Primary Care Program

http://www.anthem.com/wps/portal/ca/provider?content_path=provider/f0/s0/t0/pw_e191020.htm&label=Patient-Centered%20Primary%20Care%20Program&rootLevel=3

Solutions for the future

http://www.anthem.com/agent/va/f4/s0/t0/pw_a034764.pdf

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Organization	AQA Alliance
Category	Standards Setting, Industry Organizations
Source	http://www.aqaalliance.org/
Measure	Physician Practice Measures

UPDATED in 2013

Summary

The AQA is a major contributor to achieving the National Quality Strategy through a multi-stakeholder approach which embraces patient-centered team-based care. The AQA alliance, founded in 2004, is a broad-based national coalition working together on a strategy to measure, report on and improve physician performance.

Methodology

There are two main workgroups.

AQA Measures and Improvement Workgroup has evolved from a focus on measures to a focus on improvement efforts with demonstrated success. The workgroup will look at measurement in the context of facilitating and leveraging improvement.

Reporting Workgroup focuses on promoting best practices to report meaningful information to consumers, individual clinicians, and other stakeholders to inform decision-making and improve outcomes.

One report is a survey of private and governmental agencies engaged in reporting on physician performance to physicians and consumers. The report presents results of the survey and recommendations and policy considerations to guide future workgroup efforts.

Publications / links

Survey on Physician Reports http://www.aqaalliance.org/Files/AQAReport_022412_final.pdf
<http://www.aqaalliance.org/Files/CommentsAQAReportingWGDraftPaper.pdf>

Measurement and Improvement Workgroup (includes summaries of monthly calls)
<http://www.aqaalliance.org/measuresimprov.htm>

Principles for Reporting to Clinicians and Hospitals <http://www.aqaalliance.org/files/ProviderPrinciplesMay06.pdf>

AQA Compendium of Approved Performance Measures. 2008
www.aqaalliance.org/files/CompendiumofApprovedMeasures.doc

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Organization	Archimedes Healthcare Models
Category	Risk assessment
Source	http://archimedesmodel.com/
Measure / Initiative	http://www.ncbi.nlm.nih.gov/books/NBK22837/

UPDATED IN 2013

Summary

The Archimedes Model, is a clinically realistic, validated mathematical model that simulates human physiology, diseases, interventions, and care delivery. Through innovations such as IndiGO, Archimedes empowers consumers to become better engaged in their healthcare—leading to improved adherence, better outcomes, and reduced costs.

The practice of medicine has become extraordinarily complex. Managing that complexity requires good information about the effects of different courses of action on health, logistic, and economic outcomes. The preferred method of obtaining that information is through empirical clinical research. Unfortunately, in medicine the ability to conduct clinical research is severely limited. A typical clinical trial comparing just two options requires thousands of patients, costs tens or hundreds of millions of dollars, takes 3 to 15 years, and is likely to be outdated before it is completed.

In other fields, mathematical models have been used to help make decisions and design systems. However, the variability of human biology and behavior, the size and complexity of health care systems, and the wide variety of important questions to be addressed all place special demands on health care models. We have designed a new type of model, called Archimedes.

Methodology

The mathematical foundations of the Archimedes model are described elsewhere (Schlessinger and Eddy, 2002). The most difficult part of the model is the representation of physiology. Features correspond roughly to anatomic and biological variables. Examples in the current Archimedes model are systolic and diastolic blood pressures, patency of a coronary artery, cardiac output, visual acuity, and amount of protein in the urine. Features can represent real physical phenomena (e.g., the number of milligrams of glucose in a deciliter of plasma), behavioral phenomena (e.g., ability to read an eye chart), or conceptual phenomena (e.g., the “resistance” of liver cells to the effects of insulin).

In general, several dozen features and 10 to 30 equations are necessary to calculate the occurrence of any particular outcome (e.g., the rate of heart attacks in a specified population). The model currently includes the features pertinent to coronary artery disease, congestive heart failure, diabetes, and asthma. Features relating to other diseases are being added continually.

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The level of detail of the model is determined by the intended users. We build the physiology part of the model to the level of detail clinicians tell us they consider necessary for their decisions. As a result, the physiology model corresponds roughly to the level of biological detail found in patient charts, general medical textbooks, and the designs of clinical trials. Care processes, logistics, resources, and costs are modelled at an equally high level of detail, as determined by administrators. For example, there are 37 different types of outpatient primary care visits.

Archimedes is a person-by-person, object-by-object simulation. It covers a broad spectrum, spanning features from biological details to the care processes, logistics, resources, and costs of health care systems. It includes many diseases simultaneously and interactively in a single integrated physiology, enabling it to address comorbidities, syndromes, and treatments with multiple effects. Our goal is to provide a trial-validated method that can be used to address problems that cannot be feasibly addressed through empirical studies, because of high cost, long follow-up times, large sample size, unwillingness of providers or patients to participate, large number of options, or the rapid pace of technological change. In the way that a flight simulator provides valuable experience, shortens the time needed in real planes, and simulates experiences that are too dangerous or rare to attempt for real (like severe wind shear), the Archimedes diabetes model should be a useful tool for sharpening our understanding of diseases and their management

Results

Archimedes is based on deep review of the clinical literature. Presentations by the organization indicate major changes in behavior by physicians and patients as a result of using these models.

Publications / links

<http://www.ncbi.nlm.nih.gov/books/NBK22837/>

<http://care.diabetesjournals.org/content/31/8/1670.full.pdf+html>

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Organization	Arkansas (State and other organizations)
Category	Incentive/Reward Programs
Source	http://www.paymentinitiative.org/aboutUs/Pages/default.aspx
Measure / Initiative	Arkansas Health Care Payment Improvement Initiative http://www.paymentinitiative.org/aboutUs/Pages/default.aspx

UPDATED IN 2013

Summary

In 2011, Arkansas Medicaid, the Arkansas Department of Human Services, Arkansas Blue Cross and Blue Shield, and QualChoice of Arkansas partnered to transform our state's health care and payment system. The collaboration is called the Arkansas Health Care Payment Improvement Initiative. Together, Medicaid and private insurance companies represent a large enough portion of the market that initiative leaders felt there would be a big enough incentive for providers to shift to a higher-quality and more cost-efficient system of care.

Working closely with hundreds of physicians, hospital executives, patients, families and advocates, the payers worked for nearly a year to design and build the new payment system. The result is a bold initiative tailored to the needs of Arkansas patients and providers. Though some aspects of this initiative have been or are being tried elsewhere in the country, Arkansas is the first to use this approach statewide and with both public and private payers.

The initiative is part of a larger effort to improve the state's overall health care system by improving access to care, increasing the number of people who are insured and improving the quality of care patients receive. For more information about the larger effort, please visit Arkansas Center for Health Improvement.

Methodology

Public and private insurers in Arkansas and across the country are facing a financial crisis as health care costs rise to an unsustainable level. The Department of Human Services, Arkansas Medicaid, Arkansas Blue Cross and Blue Shield and QualChoice of Arkansas are jointly working on an initiative to address this issue in a way that works for providers and patients. The Arkansas Health Care Payment Improvement Initiative is designed to reward physicians, hospitals and other providers who give patients high-quality care at an appropriate cost. The collaborating partners developed and refined the episode model over nine months with significant contributions and comment from hundreds of physicians, health care professionals, patients and other stakeholders.

How it Works

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Patients experiencing one of the medical episodes will schedule office visits and be seen by their physician or mental health provider just as they are today. Providers will file claims as usual and be reimbursed as they are today. The change comes as providers are now able to input some basic information related to the care they provide into a Provider Portal. Medicaid and the private insurers use the information from the portal along with claims data to determine which provider has the most responsibility for a given episode. That provider will be designated the “Principal Accountable Provider (PAP).” At the end of the set time period, each PAP’s average cost per episode will be calculated and compared to “acceptable” and “commendable” levels of costs. If the average cost is above the acceptable level, the provider will pay a portion of the “excess” costs. If the average cost is acceptable but not commendable, there will be no payment changes. If the provider offers high-quality care below the commendable level, then he or she will be eligible to share in the savings with the payer. If you want more details on the state's overall health care transformation effort, you can read our State Innovation Plan.

An episode is the collection of care provided to treat a particular condition for a given length of time. During the first phase of the payment initiative, Medicaid and the private insurers initially introduced five episodes of care: upper respiratory infections (URI), total hip and knee replacements, congestive heart failure (CHF), attention deficit/hyperactivity disorder (ADHD), and perinatal. Providers share in the savings or excess costs of an episode depending on their performance for each episode. For some episodes, providers will submit a small amount of information not currently available through the billing system through the Provider Portal. For each episode, all treating providers will continue to file claims as they have previously and will be reimbursed according to each payer’s established fee schedule. The payer will identify the Principal Accountable Providers (PAP) for each episode through claims data.

Results

These first episodes were introduced July 1 of 2012, with a preparatory period of three to six months that will give providers time to learn about the new model and to adjust their practices, if necessary. During the preparatory period, providers will receive detailed reports on quality, cost, and utilization for their historical episodes

The rules for each episode vary, but in most cases, the episode length is at 12 months. Providers will receive their first full performance report reflecting settlement for risk and gain sharing payments several months later.

The program is also being extended to additional episodes.

There are multiple workgroups plus additional supports is available through a Provider Portal. Using the portal, providers are able to access reports that show the overall quality of care they delivered during a set time period -- typically one year -- and at what average cost. Medicaid and the private insurers use the information from the portal along with claims data to determine which provider has the most responsibility for a given episode.

Publications / links

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Main link <http://www.paymentinitiative.org/aboutUs/Pages/default.aspx>

Overview <http://www.paymentinitiative.org/referenceMaterials/Documents/APII%20overview.pdf>

Episodes of Care <http://www.paymentinitiative.org/episodesOfCare/Pages/default.aspx>

How it works <http://www.paymentinitiative.org/howItWorks/Pages/default.aspx>

State Innovation Plan

<http://www.paymentinitiative.org/referenceMaterials/Documents/SIM%20III.%20%20State%20Innovation%20Plan%202012%2009%2021%20%20FINAL%20-%20TO%20SUBMIT.pdf>

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Organization	ASC Quality Collaboration (Ambulatory Surgical Centers)
Category	Standards Setting, Industry Organizations
Source	http://www.ascquality.org/
Measure	ASC Quality Measures

UPDATED IN 2013

Summary

The ASC Quality Collaboration (ASC QC) is a cooperative effort of organizations and companies interested in ensuring that ASC quality data is measured and reported in a meaningful way. In 2006, leaders from the ambulatory surgery center (ASC) industry joined with accrediting bodies and associations representing physicians and nurses to form the ASC Quality Collaboration. The ASC Quality Collaboration was formed to develop, support and promote specific measures for quality appropriate to ASCs. This leadership group envisioned a set of quality measures that could become the standard across outpatient surgery settings with potential for use in discussions on pay-for-performance, responding to state data collection initiatives, collaborating with payors and others in providing consumer information, and benchmarking for quality improvement in individual ASCs.

Methodology

The Ambulatory Surgery Center measures are focused around patient safety. The measures are outcome and process focused. They include public interest concerns such as medication administration and correct site surgery and address areas of potential operative and post operative complications such as hospital transfers/admissions and patient burns.

The NQF has endorsed various facility-level ASC measures submitted by the ASC Quality Collaboration including:

- Patient Burn
- Prophylactic Intravenous Antibiotic Timing
- Patient Fall within the ASC
- Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant
- Hospital Transfer/Admission Methodology
- Appropriate Surgical Site Hair Removal

Measures were developed through consultation with a wide range of stakeholders. This includes ASC clinical and administrative leaders, health policy researchers, CMS and other key federal and state governmental agency representatives. Existing measures including those in use, required, or under development by industry organizations were reviewed. After review of commonalities between the current measure sources as well as use of these measures across organizations, nine initial measures were identified for standardization of definitions and measurement criteria.

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Results

These measures are endorsed by the National Quality Forum

The ASC QC strongly supports public reporting of quality data. Our commitment to public reporting is reflected in our online publication of a free quarterly report of ASC quality data, made possible entirely through the voluntary efforts of our participants.

Publications / links

ASC Quality Measures: Implementation Guide. Version 1.7

<http://ascquality.org/documents/ASCQualityCollaborationImplementationGuide.1.7.pdf>

Summary

<http://www.ascquality.org/documents/Summary6ASCmeasuresendorsedbyNQF.xls>

<http://ascquality.org/documents/SummaryASCQCNQFEndorsedMeasures2012.pdf>

Quarterly report on results

<http://www.ascquality.org/qualityreport.cfm>

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Organization	BlueCross Blue Shield Association (BCBSA)
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	www.bcbs.com http://www.bcbs.com/innovations/bluedistinction/
Measure	Hospital programs Blue Distinction Centers of Medical Excellence

UPDATED IN 2013

Summary

The Blue Cross and Blue Shield Association (BCBSA) is a national federation of 39 independent, community-based and locally operated Blue Cross and Blue Shield companies. Collectively, the Blue Cross and Blue Shield System provides healthcare coverage for 102 million people or one-in-three Americans. Blue Cross and Blue Shield companies offer a variety of insurance products to all segments of the population, including large employer groups, small businesses and individuals.

Programs include Blue Distinction, Center of Medical Excellence, and other quality improvement programs.

Methodology

When choosing a medical facility, performance counts. Many specialty care providers in the Anthem network have earned one (or more) of the quality awards below. Each award is only presented to facilities that pass a rigorous review of their processes and performance. Over and over, they've proven their expertise at delivering quality care. That could mean fewer complications, fewer readmissions and higher survival rates. Look for these awards as you weigh your health care options.

Blue Distinction

Hospitals or other centers of care that meet tough standards for quality care may earn the title Blue Distinction Center for Specialty Care. We've worked with expert doctors to come up with these standards. Blue Distinction designation is awarded by the Blue Cross and Blue Shield companies to medical facilities that have demonstrated expertise in delivering quality healthcare. Based on rigorous, evidence-based, objective selection criteria. Goal is to help consumers find quality specialty care on a consistent basis, while enabling and encouraging healthcare professionals to improve the overall quality and delivery of care nationwide. This includes:

- Cardiac Care
- Transplant
- Knee and Hip Replacement

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- Complex and Rare Cancer
- Bariatric Surgery
- Spine Surgery

Center of Medical Excellence

Center of Medical Excellence are programs in our transplant network who offer a high quality of care. They must also show that they are well-run and meet certain standards. Various standards are listed on the website.

Blue Distinction Centers for Transplants® consist of a national network of transplant centers that offer comprehensive services through a coordinated, streamlined referral management. All of the Blue Distinction Centers for Transplants meet specific program selection criteria that consider not only provider qualifications and program process, but patient outcomes as well. This examines the following transplant types:

- heart
- lung (single or bilateral)
- combination heart/lung
- liver (deceased and living donor)
- simultaneous pancreas kidney (SPK)
- pancreas (PAK/PTA)
- bone marrow/stem cell (autologous & allogeneic)

Publications / links

Center of Medical Excellence and Blue Distinction Centers
<http://www.anthem.com/centersofmedicalexcellence/>

Blue Distinction Selection Criteria

<http://www.bcbs.com/why-bcbs/blue-distinction/blue-distinction-overview.html>
http://www.bcbs.com/why-bcbs/blue-distinction/BD_selectioncriteriaoverview.pdf
<http://www.bcbs.com/why-bcbs/blue-distinction/>

Blue Distinction Fact Sheet

http://www.bcbs.com/why-bcbs/blue-distinction/BD_selectioncriteriaoverview.pdf

Hospital Measurement and Improvement Program

http://www.bcbsla.com/Docs/blueneews_april_2009.pdf

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Organization	Blue Cross of Massachusetts
Category	Contract Model; Incentive/Reward Programs
Source	http://www.bluecrossma.com
Measure	Alternative Quality Contract http://www.bluecrossma.com/visitor/about-us/affordability-quality/aqc.html

UPDATED IN 2013

Summary

In 2009, Blue Cross Blue Shield of Massachusetts introduced a payment reform model called the Alternative Quality Contract (AQC). The AQC employs a population-based global budget coupled with significant financial incentives based upon performance on a broad set of quality measures. The twin goals of the AQC are to significantly reduce health care spending growth while improving quality and health outcomes. The AQC is one of the largest commercial payment reform initiatives in the United States and includes over three-quarters of Blue Cross Blue Shield of Massachusetts' overall network of contracted primary care providers and specialists who care for about 665,000 HMO members as of October 2012.

At Blue Cross Blue Cross Blue Shield of Massachusetts, we believe the most promising way to slow rising health care costs is to enable the delivery system to improve the quality, safety and effectiveness of care. To address both cost and quality, we need a health care system in which financial and clinical goals are aligned. A key component is to change the way insurers reimburse doctors and hospitals for their services.

The goal of AQC is to reduce the medical expense trend of participating organizations by half over a five year contract term. One big advantage of this system is that because the growth rates for global budgets are set in a five-year contract, premium increases are much more predictable for businesses.)

Methodology

BCBSMA has developed and implemented a model: the Alternative Quality Contract (AQC). The new contract model combines a per-patient global budget with significant performance incentives based on quality measures. The AQC places the focus on what matters most to all of health care's stakeholders—quality, value, and patient outcomes.

Alternative Quality Contract combines a fixed per-patient payment (adjusted annually for health status and inflation) with substantial performance incentive payments (tied to the latest nationally accepted measures of quality, effectiveness, and patient experience). The goal of this restructured model is to enable the delivery system to give the patient the best result from the most appropriate treatment (e.g. based on the best medical evidence), by the

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right kind of provider (e.g. specialist, family doctor, nurse), at the right time (when intervention is most appropriate), and in the most appropriate setting (e.g. hospital, physician office, independent laboratory, home).

A team of physicians, finance experts, and measurement scientists worked to develop a contract model that would give hospitals and physicians meaningful incentives to improve the quality of care while conserving health care resources.

In particular, the AQC incorporates significant financial incentives that encourage physicians and hospitals to meet high standards on a broad set of quality and outcome measures. Starting budgets for organizations in the AQC are based specifically on each organization's historical rate of spending for its patient population and adjusted for changes in that population throughout the contract term.

AQC contracts are generally five-year agreements in contrast to national and historical norms for one-year fixed payment arrangements. The five-year AQC time period enables physicians and hospitals to plan for use of health care services over the life of the contract. Finally, the AQC put in place several features to mitigate financial risk for the groups, including a requirement that all groups carry reinsurance for high cost cases (i.e., covers 70 to 90 percent of cost if medical expenditures exceed a threshold, such as \$100,000), flexibility in the AQC model with respect to the degree of financial risk sharing assumed by the provider organization and a "unit cost corridor" that adjusts AQC budgets if BCBSMA negotiates significantly higher (or lower) fees with network providers than originally projected. Another distinguishing feature of the AQC is the ongoing data and information support provided by BCBSMA to the AQC groups. The broad set of data and reports provided – some daily, others monthly, quarterly, biannually and annually – is designed to support physicians' success at managing to both the quality and efficiency incentives of the AQC model.

The Alternative Quality Contract includes several key components that are dependent on each other to create the necessary alignment of incentives:

- Financial structure
- Performance measures
- Sustained partnership (five-year contract)
- Integration across continuum of care
- Savings opportunities.
- The Alternative Quality Contract also has several means of mitigating risk:
- Risk Adjustment using Diagnostic Cost Groups (DxCG)
- Partial risk sharing (between 50% and 100%)
- Mandated reinsurance for high-cost cases (where a patient's medical expenses exceed \$100,000)
- A "unit cost corridor" which increases or decreases the global budget if BCBS negotiates higher (or lower) fees with providers than originally projected

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Children's Hospital Boston and its two physician groups, Children's Physicians' Organization and the Pediatric Physician Organization at Children's (PPOC), are the latest provider groups to join the AQC. The agreement with Children's and their physician groups is especially important since they are the first pediatric-only hospital and physician groups to sign the contract. This agreement provides further evidence that this innovative payment model can work for a variety of different types of hospitals and physicians, no matter what their size or specialty.

Results

The AQC was designed to address the twin goals of improving the quality and outcomes of patient care while significantly slowing the rate of growth in health care spending. In year one, significant progress was made toward achieving both goals. The AQC's success is attributable to four primary factors: 1) the quality measures contained in the contract are nationally accepted as clinically appropriate so there is wide support for improving performance on these indicators; 2) real dollars are at stake for improvement; 3) performance data is made available regularly which enables provider organizations to track progress and take action to better manage their patients' health; and 4) the participating provider groups have strong support from their leadership to implement new systems and act on the data.

According to Harvard Medical School researchers, the Alternative Quality Contract is improving the quality of patient care while simultaneously slowing the growth in health care spending. The Harvard study analyzed the effect of the AQC on total medical spending over two years. They found that, compared to nonparticipating groups, savings were 1.9 percent in the first year and 3.3 percent in the second year. Savings were achieved through lower prices from shifting procedures, imaging, and tests to providers with lower fees, and through reduced utilization among some groups. The authors also analyzed the effect of the AQC on quality of care, finding that improvements in chronic care management, adult preventive care, and pediatric care were larger in the second year than in the first year.

Publications / links

Main summary site (including videos) <http://www.bluecrossma.com/visitor/about-us/affordability-quality/aqc.html>

Alternative Quality Contract White Paper <http://www.bluecrossma.com/visitor/pdf/aqc-results-white-paper.pdf>

Summary of Harvard's Alternative Quality Contract study <http://www.bluecrossma.com/visitor/pdf/hms-bcbsma-aqc.pdf>

The 'Alternative Quality Contract,' Based On A Global Budget, Lowered Medical Spending And Improved Quality *Health Affairs August 2012 31:81885-1894; published ahead of print July 11, 2012*

<http://content.healthaffairs.org/content/31/8/1885.full>

<http://healthaffairs.org/blog/2013/06/22/health-affairs-article-on-alternative-quality-contract-named-academyhealth-article-of-the-year/>

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*Blue Cross Blue Shield of Massachusetts The Alternative QUALITY Contract -May 2010 (earlier)

<http://www.bluecrossma.com/visitor/pdf/alternative-quality-contract.pdf>

Blue Cross Blue Shield of Massachusetts Announces First-Year Results of Alternative Quality Contract

<http://www.bluecrossma.com/visitor/newsroom/press-releases/2011/newsRelease01212011.html>

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Organization	Blue Cross Blue Shield of Michigan
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	http://www.bcbsm.com/
Measure	Value Partnership Initiatives http://www.bcbs.com/news/bluetvradio/pathway-to-covering-america/blue-cross-blue-shield-of.html http://www.bcbsm.com/provider/value_partnerships/index.shtml http://www.valuepartnerships.com/

UPDATED IN 2013

Summary

A nonprofit health care organization founded in 1939. The largest health insurer in Michigan: 4.4 million members in Michigan and 1.2 million more members in other states. The largest network of doctors and hospitals in Michigan: 156 hospitals, nearly 30,000 doctors.

Blue Cross Blue Shield of Michigan's Value Partnerships program is a collection of clinically oriented initiatives that are significantly improving the quality of patient care throughout the state of Michigan. Through Value Partnerships, Blue Cross Blue Shield of Michigan works collaboratively with physicians, Physician Organizations, and with the majority of the acute-care hospitals in the state to improve the health care provided to all Michigan residents.

Methodology

This innovative, quality-based approach to transforming health care is:

- Enhancing clinical quality
- Decreasing complications
- Managing costs
- Eliminating errors
- Improving health outcomes

Hospital Pay-for-Performance

The Blue Cross Blue Shield of Michigan P4P program rewards hospitals for improvement and achievement in both quality and efficiency. Through this program a hospital earns, on average, an additional 5 percent on all inpatient and outpatient payments. Blue Cross Blue Shield of Michigan also offers a P4P program for small rural hospitals with measures unique to small and critical access hospitals. The structure and measures of both P4P programs are developed in collaboration with hospitals via a Blue Cross Blue Shield of Michigan-Hospital P4P Workgroup.

Sixty percent of each hospital's P4P score is based on quality, including participation in selected collaborative quality initiatives. The remaining 40 percent is based on efficiency. Hospitals must also meet a patient-safety prequalifying

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condition to be eligible to participate in the program. The following table summarizes the program structure and weights.

Physician Group Incentive Program

PGIP is an innovative program that is catalyzing Michigan physicians to create high performing health care systems across the state. This program supports and facilitates practice transformation using a wide variety of initiatives to reward Physician Organizations for improved performance in health care delivery. PGIP is comprised of 34 initiatives aimed at capability building, improving quality of care delivery, and appropriate utilization of services.

PGIP models of care

Patient-Centered Medical Home Program: The number of designated PCMH physicians grew has grown from 1,200 in 2009 to more than 3,200 physicians in 995 practices in 2012.

Provider-Delivered Care Management: PDCM is a promising new model for care management delivered in the context of the doctor-patient relationship, which extends care management into the clinical setting. Through this program, multi-disciplinary teams composed of RNs, diabetes educators, pharmacists and other health care professionals, led by primary care physicians, work with patients to ensure that patients are empowered to self-manage their health, and that all gaps in care are addressed.

Organized Systems of Care: OSC a community of caregivers that has a shared commitment to a defined patient population. OSCs are designed to take Blue Cross Blue Shield of Michigan's PCMH Program to the next level, expanding it to include hospitals and specialists. Together, through the formation and development of OSCs, primary care physicians, specialists and hospitals will work to coordinate services across the health care continuum for a defined patient population.

Collaborative Quality Initiatives

CQIs address some of the most common, costly areas of surgical and medical care by facilitating collaboration between Michigan providers and hospitals. Participating hospitals and providers collect, share and analyze data through the use of clinical registries, then design and implement changes to improve outcomes associated with complex, technical areas of care. CQI registries permit a more robust analysis of the link between processes and outcomes than can be achieved by examining one group or institution alone. As of 2012, Blue Cross Blue Shield of Michigan is providing funding and leadership for 12 hospital-based CQIs.

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Results

\$27 million saved - in 18 months, through the appropriate use of high- and low-tech radiology services.

66% reduced - reduced radiation exposure per procedure for patients undergoing cardiac CT angiography—with no reduction in image quality.

\$85.9 million saved - statewide over two years by reducing adverse events through the Michigan Surgical Quality Collaborative.

\$102 million saved - statewide over three years by improving quality and reducing complications through the angioplasty initiative.

Publications / links

Main website

<http://www.valuepartnerships.com/>

2012 partners in health care report

http://www.bcbsm.com/content/dam/public/Providers/Documents/help/R007532_2012PartnersReport_01WEB.pdf

Physician Group Incentive Program Overview

<http://www.bcbsm.com/content/dam/public/Providers/Documents/physician-group-incentive-program-basics.pdf>

Assessment and Measurement of Patient-Centered Medical Home Implementation: The BCBSM Experience

Alexander, Paustian, Wise, Green, Feters, Mason, El Reda,

http://annfamned.org/content/11/Suppl_1/S74.full.pdf+html

Partial and Incremental PCMH Practice Transformation: Implications for Quality and Costs

<http://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12085/abstract>

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Organization	Brookings-Dartmouth ACO Learning Network
Category	Value based payment / Payment reform
Source	http://www.acolearningnetwork.org/
Measure	Accountable Care Organization (ACO) Learning Network

UPDATED IN 2013

Summary

The **Accountable Care Organization (ACO) Learning Network**, focuses on practical steps toward implementing more accountable health care and building greater value into the care delivery process through the use of ACOs. The Network offers practical guidance and a forum for interested and engaged parties to learn from one another throughout the process of planning and implementation. The program is working to align feasible short-term delivery system policy reforms – including the “medical home” model, patient shared decision-making, and bundled payments – with the long-term goal of developing a high-quality, efficient, and sustainable system.

Methodology

ACOs have received significant attention in the current health reform debate as an especially promising model for reshaping care delivery. ACOs are provider organizations participating in a payment and performance measurement framework that encourages integration and accountability at the local level. This model presents a path for reform that builds on current provider referral patterns and offers shared savings payments to providers willing to be held accountable for quality and costs. The ACO framework offers a basic method of decoupling volume and intensity from revenue and profit and is thus the first step to achieving a sustainable health care delivery system.

Overview of the Learning Network

The ACO Learning Network is a member-driven network that provides participating organizations the tools necessary to successfully implement accountable care. The Learning Network is sponsored by The Brookings Institution with support from The Dartmouth Institute for Health Policy and Clinical Practice. Brookings and Dartmouth have been working together since 2007 to foster the adoption of ACOs and other accountable care processes and payment strategies that will improve care quality and control health care costs.

The number of accountable care arrangements in the United States continues to grow at accelerating pace. In addition to more than 250 Medicare ACO programs and 200 private-sector ACO initiatives, countless other healthcare delivery and payment innovations are developing in all parts of the country. These organizations are looking for strategic advice on implementation strategies and concrete insights and action steps to move their

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organizations forward in the face of a constantly evolving health care environment. The ACO Learning Network fosters the critical exchange of ideas among members and provides key thought leadership in the development of accountable care implementation and policy.

As the accountable care landscape continues to grow and evolve, creating a rich diversity of accountable care providers—public and private sector, big and small, new and old, hospital systems and small IPAs, integrated health systems and small physician practices, those looking to learn and those looking to lead—so we are making an effort to adapt the content and structure of the Learning Network to better meet member needs. This includes segmenting some of our work to ensure that ACOs of all sizes, organization type, and experience receive the information and tools necessary to effectively implement their accountable care strategy. At the same time, we continue to value the important contributions made by related stakeholders such as pharmaceutical and other biotechnology manufacturers, consulting firms, IT developers, and vendors and want to ensure that they can share their insights and take part in practical accountable care solutions. We will also remain a leader in identifying and responding to policy changes that affect all of our members. Overall, these refined goals will lead to a more productive and valuable experience.

Publications / links

The website lists many articles and press releases related to these topics.

Details are only available to members. Including an ACO Toolkit

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Organization	Brookings Institution – Engelberg Center for Health Reform / Quality Alliance Steering Committee
Category	Standards Setting, Industry Organizations
Source	http://www.healthqualityalliance.org/
Measure	Quality Alliance Steering Committee High-Value Health Care Project (HVHC)

Summary

The Quality Alliance Steering Committee (QASC) is a collaborative effort aimed at implementing measures to improve the quality and efficiency of health care across the United States. The QASC is comprised of existing and emerging sector-specific quality alliances, as well as leaders among physicians, nurses, hospitals, health insurers, consumers, accrediting agencies and the public sector. Together, all of these stakeholders are working to ensure that quality measures are constructed and reported in a clear, consistent, and person-focused way to inform both consumer and employer decision-making, as well as the efforts of practitioners to improve care that is delivered.

This program is supported by the Brookings Institution, a nonprofit public policy organization based in Washington, DC.

Methodology

The Quality Alliance Steering Committee, a collaborative effort among a variety of key stakeholders, is working to make consistent and useful information about the quality and cost of health care widely available. The High-Value Health Care Project is a QASC initiative developed to support this goal.

Quality Alliance Steering Committee (QASC) was formed to advance high-quality, cost-effective, patient-centered health care by providing a national framework for implementing quality and cost measures to improve care around the country. QASC participants reflect a very broad range of health care stakeholders including provider groups, consumer groups, business alliances, payer groups, regional collaborations to improve quality and government agencies. QASC was established in 2006 by two established quality alliances – the AQA Alliance and the Hospital Quality Alliance, along with other stakeholders, to help develop an overall framework for the effective use of standard quality and cost measures in physician offices and hospitals nationwide.

High-Value Health Care Project (HVHC) - Major gaps exist between the health care that people should receive and the care they actually receive. Research also shows that health care quality and costs and patient outcomes differ significantly depending on where patients live, which doctors and hospitals provide their health care, and their racial/ethnic status. Consistent information is needed so that better decisions can be made. Such information about the performance of doctors, hospitals and other health care providers, and health care results can help individuals, providers, and payers better evaluate and choose where to get care, how to improve it, and how to pay for it.

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Selected Publications / links

Archive <http://www.healthqualityalliance.org/archive>

How registries can help performance measurement improve care

<http://www.healthqualityalliance.org/userfiles/Final%20Registries%20paper%20062110%281%29.pdf>

Measuring costs of care: a promising strategy for episode-based measurement

<http://www.healthqualityalliance.org/userfiles/COC%20draft%20080410.pdf>

Fostering Accountable Health Care: Moving Forward In Medicare. Elliott S. Fisher, Mark B. McClellan, John Bertko, Steven M. Lieberman, Julie J. Lee, Julie L. Lewis and Jonathan S. Skinner *Health Affairs*, 28, no. 2 (2009): w219-w231

Reforming Provider Payment *Moving Toward Accountability for Quality and Value*. Statement of Mark B. McClellan, MD, PhD Director, Engelberg Center for Health Care Reform. The Brookings Institution. Senate Finance Committee Roundtable on Health Care April 21, 2009

http://www.brookings.edu/~media/Files/rc/testimonies/2009/0421_providerpayment_mcclellan/20090421_sfc.pdf

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Organization	Californian Association of Physician Groups (CAPG)
Category	State focus; Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	www.capg.org
Measure	Standards of Excellence (SOE) Program http://www.capg.org/index.aspx?page=84

UPDATED IN 2013

Summary

CAPG is a professional association representing physician groups practicing in the managed care model and comprised of more than 150 of California's leading physician groups. These groups employ and/or contract with physicians who in turn provide health care services to approximately 13 million Californians. More than fifty percent of California's health care is delivered by physicians employed by or contracted with CAPG members.

Standards of Excellence SOE reviews group capabilities for six domains:

Methodology

The Standards of Excellence survey is a blue print for how to assess the tools and processes CAPG members have in place to meet the escalating expectations of healthcare purchasers and patients. The survey helps set the bar for healthcare consumers to evaluate a physician group's technical quality, responsive patient experience, and affordability.

The goals are:

- Documented the impressive breadth and depth of care management, HIT, accountability, and patient care infrastructure necessary for the coordinated care model to establish a national blueprint for excellent, accountable care
- Stimulated internal group prioritization of development targets
- Channeled dialogue with purchasers, plans, and policy entities to practices and processes of established value, including significant impact upon state and federal interpretations of reform directives
- Strengthened our culture of transparency, measurement, and reporting, complementing the efforts of P4P
- Annually raised the bar for the claim of Excellence.

Domains 1-4 include: Care Management, HIT, Accountability/Transparency, and Patient Centered Care

Domain 5: Advanced Primary Care is new, hoping to stimulate accelerated progress comparable to what we experienced with Management, HIT, Accountability, and Patient Centered Care. This domain seeks information regarding what groups are doing to strengthen their primary care base, foster practice redesign in anticipation of the

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coming workforce constriction, and improve professional satisfaction of this most crucial foundation element for our systems.

However, in this first year, the domain will NOT be scored, nor will any individual group results be published. We will use composite results to guide our environmental awareness and priorities for 2013 and beyond, including CAPG's support of the new California Advanced Primary Care Institute (CAPCI).

Domain 6, Administrative and Financial Capability, remains optional. We believe this has been useful for groups in self assessment, and certainly helpful for organizations contemplating "next level" expansions and formal ACO endeavors. This domain is not scored, and reports are not published.

Results

Participation remained voluntary in 2012. 73 CAPG groups delivering coordinated, comprehensive care to 10.8 million Californians (90% of our HMO covered lives) participated in 2012. These same groups care for an additional estimated 4 million people with PPO, traditional Medicare, and Medi-Cal.

Thirty organizations achieved "Elite" status by surpassing thresholds in each of 4 scoring domains...up from 25 in 2011 and 20 in 2009.

Publications / links

2013 SOE Star Chart	http://www.capg.org/modules/showdocument.aspx?documentid=1155
2013 SOE Survey	http://www.capg.org/modules/showdocument.aspx?documentid=1054
Primary Care Domain V	http://www.capg.org/modules/showdocument.aspx?documentid=1055
Financial and Admin Domain VI	http://www.capg.org/modules/showdocument.aspx?documentid=1057
Frequently Asked Questions	http://www.capg.org/modules/showdocument.aspx?documentid=1056

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Organization	California Healthcare Foundation
Category	State focus; Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	www.calhospitalcompare.org/
Measure	CalHospitalCompare California Hospital Assessment and Reporting Taskforce – CHART http://www.chcf.org/topics/hospitals/index.cfm?itemID=111065&subsection=chart https://chart.ucsf.edu/#

UPDATED IN 2013

Summary

The California HealthCare Foundation is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, the goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford.

The Foundation offers many papers and funds many research projects on healthcare. One major program is the CHART initiative.

California Hospital Assessment and Reporting Taskforce (CHART) was established in 2004 to develop a statewide hospital performance reporting. The result of this collaboration between the California HealthCare Foundation, the University of California at San Francisco Philip R. Lee Institute for Health Policy Studies, and the California Hospitals Assessment and Reporting Taskforce (CHART) was a website - CalHospitalCompare.org. This site includes ratings for clinical care, patient safety, and patient experience for the 220 hospitals rated on the site account for 82% of hospital admissions in California. Participation is voluntary.

CalHospitalCompare.org is a report card of California hospital performance ratings that consolidates information from a number of sources into an easy-to-navigate website. Rates quality of care, patient experience, and safety measures for hospitals by local area. A free service, available in English and Spanish, allows consumers to search for hospitals by location, name, or medical condition.

Ratings cover the various illnesses:

- heart attack,
- heart failure,
- heart bypass surgery,
- hip fracture,
- maternity
- pneumonia.

Additional measures cover to patients admitted to the Intensive Care Unit, and all surgical patients or all medical patients (patients admitted to the hospital for an illness that is not treated with surgery).

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Methodology

This Web site is the result of a partnership between two independent organizations dedicated to improving health care quality: the California HealthCare Foundation (CHCF) and the California Hospitals Assessment and Reporting Taskforce (CHART), a not-for-profit public benefit corporation. This site includes ratings for clinical care, patient safety, and patient experience for all acute care hospitals in the state of California with publicly available information. This represents 332 hospitals, and does not include psychiatric hospitals, rehabilitation facilities, long-term acute care hospitals and specialty only hospitals. CHART has contracted with Truven Health Analytics to provide data support and analysis.

How We Rate Quality on This Website

At CalHospitalCompare.org, we rate hospitals on quality measures that affect health care, so you can compare hospitals. Here are examples of some of the measures that you'll see on this website and why they matter:

- Appropriate timing of antibiotic. Getting an antibiotic within one hour prior to surgery reduces the risk of wound infections. Hospitals should make sure surgery patients get antibiotics at the right time.
- Hospital-acquired pressure ulcers. Pressure ulcers, also called bedsores, are areas of damaged skin caused by lying in one position for too long. This measure shows the percentage of patients who acquired pressure ulcers (stage two or higher) after going into the hospital.
- Aspirin given at arrival to cardiac patients. Aspirin can help keep blood clots from forming and reduces the risk of death for a patient having a heart attack.
- Bilateral cardiac catheterization. Cardiac catheterization is a procedure that tests if blood vessels to the heart are narrowed or blocked, which could cause a heart attack. Most people need the test only on the left side of the heart near the major pumping chamber. The test should be performed on the right side for only a small number of reasons, such as heart valve disease. This indicator reports the proportion of patients who received heart catheterization on both sides of the heart.
- Breastfeeding rate. This rate indicates what percentage of newborns were being breastfed exclusively upon discharge. Although there are many reasons breastfeeding rates vary, it is good practice for hospital staff to help new mothers begin to breastfeed before they leave the hospital.
- Transition to home. The care that patients get after leaving the hospital is important to their recovery. Patients were asked whether doctors and nurses talked with them about arranging needed care after leaving the hospital, and whether they received, in writing, information about which symptoms or health problems to watch for.

Other information includes, ICU Death Rate , various surgical measures (such as infection prevention, use of appropriate antibiotic, appropriate discontinuation of antibiotic) and complication reduction (such as controlled postoperative blood glucose, and blood-clot prevention .

Risk adjustment for patient characteristics and hospital volume includes using a "margin of error," An estimated range of hospital performance for each condition is calculated, with the range wider for hospitals with fewer patients and narrower for hospitals with many patients. The data for the specific condition are then checked to determine

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whether this range includes any of the performance benchmarks (low, middle, or high, where higher means better performance) and a performance score of superior, above average, average, below average, or poor is assigned. Five scores were assigned using the low end (L) of the range of each hospital's estimated performance and the high end (H) of the range and comparing them to the low, middle and high.

In 2011 the CHART board of directors moved to change the source of data collection from participating hospitals to publically available sources, thus making the role of CHART a data aggregator. In this new format CHART collects, analyzes, and scores data from various sources and aggregates it into hospital-specific reports. In doing so, consumers and other users no longer need to use numerous Web sites to obtain performance information when making decisions about their care.

Results

Information is updated each year. The data base is built for consumer searches.

Publications / links

California Hospital Compare

<http://www.calhospitalcompare.org/about-us.aspx#ixzz2juL2gLRF>

Link to hospital specific information

<http://www.calhospitalcompare.org/?v=2>

How we rate quality on this website

<http://www.calhospitalcompare.org/resources-and-tools/why-quality-matters/how-we-rate-quality-on-this-website.aspx>

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Organization	Cave Consulting Group
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	www.cavegroup.com
Measure	Cave Grouper: Marketbasket System http://www.ahrq.gov/qual/efficiency/hcemch3.htm

UPDATED in 2013

Summary

Cave Consulting Group, Inc. (CCGroup) is a software and consulting company focused on improving the efficiency and effectiveness/quality in the healthcare delivery system. We recognize the need to address all components of medical trend (not just service price discounts), if cost-efficiency and effectiveness are to be improved and trend is to be controlled.

We believe market efficiency and effectiveness will be improved once practitioner and hospital efficiency and effectiveness are accurately and reliability measured, practitioners are informed of their performance results, and patients have knowledge of—or are directed to—the most efficient and effective practicing providers. Finally, we believe market efficiency and effectiveness will be improved once patients with unstable chronic medical conditions are accurately identified and properly managed.

Methodology

There are a suite of products

- Cave Grouper™
- CCGrouper EfficiencyCare™
- CCGroup BullsEye™
- CCGroup EffectivenessCare™
- CCGroup MediScreen™

Cave Consulting Group: Cave Grouper Marketbasket System

The Cave Grouper™ groups over 15,000 unique ICD.9 diagnosis codes into 527 meaningful medical conditions. The 527 medical conditions in the Cave Grouper™ account for 100% of all medical conditions and expenditures as identified by ICD.9 medical condition diagnostic codes (as well as ICD.10). An episode of care is defined as all services linked together that are used to treat a patient's medical condition within a specified period of time—including all ambulatory, outpatient, inpatient, and prescription drug experience (when available). Derivations of the Cave Grouper™ have been tested over the past 22 years on over 90 million members and 705,000 physicians nationwide.

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The CCGroup EfficiencyCare™ Module takes the output from the Cave Grouper™ and develops specialty-specific physician (or physician group) efficiency scores. Compare physician efficiency against the efficiency of a peer group of interest using a standardized set of prevalent medical condition with the intent of minimizing the influence of patient health status and methodology statistical errors.

This output is then used with CCGroup BullsEye™

Efficiency scores and drill-down detail may be accessed via CCGroup Analytics™ reporting front end.

Automated CCGroup Batch Reports (pdf) may be produced for each physician or physician group.

Publications / links

Case studies <http://cavegroup.com/wordpress/marketbasket-system/case-studies/>

News (recent findings)
<http://cavegroup.com/wordpress/news/>

Current Patents

Method, System, and Computer Program Product for Physician Efficiency Measurement and Patient Health Risk Stratification

<http://cavegroup.com/wordpress/news/patents/method-system-and-computer-program-product-for-physician-efficiency-measurement-and-patient-health-risk-stratification/>

Method and System for Producing Statistical Analysis of Medical Care Information

<http://cavegroup.com/wordpress/news/patents/method-and-system-for-producing-statistical-analysis-of-medical-care-information/>

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Organization	CIGNA
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking Value based payment / Payment reform
Source	www.cigna.com
Measure	Collaborative Accountable Care http://newsroom.cigna.com/KnowledgeCenter/ACO/

Updated in 2013

Summary

Cigna HealthCare - offering managed medical, pharmacy and dental care services, including integrated indemnity and group life and health insurance, Cigna HealthCare also offers condition management, behavioral health benefits, assistance and work/life support programs, and a range of health and wellness coaching services.

As the health care industry tests new approaches to improve health care delivery, one of the most talked about concepts is the accountable care organization – or ACO. The term ACO means different things to different people.

We call our ACO-like initiatives collaborative accountable care (CAC). Each CAC program is a collaboration between Cigna and a group of health care professionals that’s responsible and accountable for the population it serves. The group must have a substantial primary care component, which can take any of the following forms:

- A large primary care practice (examples: ProHealth Physicians in Connecticut, Medical Clinic of North Texas in the Dallas/Ft. Worth Metroplex)
- A multi-specialty group (example: Holston Medical Group in northeastern Tennessee)
- A fully integrated delivery system, including doctors and facilities (example: Piedmont Physicians Group in Atlanta)
- A Physician Hospital Organization (example: Health Choice in Memphis)
- An Independent Physician Association/Independent Practice Association (example: Renaissance Physician Organization in Houston)

Regardless of practice type, the common thread is that the medical group must be willing to accept responsibility and accountability for achieving the “triple aim” of improved health, affordability and patient experience.

The medical group is rewarded through a pay for value structure if it meets targets for improving quality and lowering medical costs.

A key component to these programs is the care coordinator – typically a registered nurse employed by the medical group who works with individuals, especially people with chronic conditions, to ensure they get the screenings and follow-up care they need and have access to educational materials that can help them manage their health. Care

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coordinators work closely with Cigna's case managers and help their patients access Cigna's clinical support programs, such as chronic condition management (diabetes, heart disease) and lifestyle management programs (weight, stress, tobacco).

Cigna is now engaged in 75 collaborative accountable care initiatives in 26 states. These programs encompass more than 760,000 commercial customers and more than 30,000 doctors, including more than 14,000 primary care physicians and more than 16,500 specialists. Cigna launched its first CAC program in 2008. Our goal is to have 100 of them reaching one million customers in 2014.

Collaborative accountable care is one component of the company's approach to physician engagement for health improvement, which also includes the innovative Cigna-HealthSpringSM care model for Medicare customers. Today, well over one million Cigna and Cigna-HealthSpring customers benefit from 240 engaged physician relationships across 31 states, with more than 58,000 doctors participating, including more than 20,000 primary care physicians and nearly 38,000 specialists. Read more.

Results

Jackson Clinic Improves Quality, Lowers Costs (Aug. 2013) – Press release

Data Published in Health Affairs (Nov. 2012) – Press release

Publications / links

Dr. Salmon's collaborative care insights, FierceHealthPayer, Sept. 13, 2013.

CAC Model: Promising Early Results, Health Affairs, Nov. 2012.

From Volume to Value, published by FierceHealthPayer, Feb. 21, 2012.

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Organization	CIGNA
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	www.cigna.com
Measure	<p>Quality Initiatives http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/health-and-wellness-programs/quality-initiatives</p> <p>Provider Recognition Directory http://cigna.benefitnation.net/cignams/default.asp</p>

Updated in 2013

Summary

Cigna HealthCare - offering managed medical, pharmacy and dental care services, including integrated indemnity and group life and health insurance, Cigna HealthCare also offers condition management, behavioral health benefits, assistance and work/life support programs, and a range of health and wellness coaching services.

CIGNA's website outlines multiple programs related to quality. This includes several programs related to this study.

- Provider Recognition
- Hospital Centers of Excellence
- Physician Quality and Cost Efficiency Profile
- Cigna Care Designation

Methodology

Provider Excellence Recognition Directory

The Provider Excellence Recognition Directory lets you search for participating physicians who have achieved quality-related recognition from the National Committee for Quality Assurance (NCQA) for diabetes or heart/stroke care and for hospitals that meet the Leapfrog Group patient safety standards. The Provider Excellence Recognition Directory includes three types of recognition programs:

- NCQA Diabetes Physician Recognition Program
- NCQA Heart/Stroke Physician Recognition Program
- Leapfrog Group Patient Safety Standards for Hospitals

The search can find a hospital that has fully implemented one or more patient safety standards defined by The Leapfrog Group.

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Cigna Care Designation

Cigna Care Designation (CCD) is a benefit plan option available for Cigna plans in 69 service areas across the country as of January 1, 2013. Developed in response to our customers' requests for more information about physician quality and cost efficiency, the Cigna Care Designation helps distinguish physicians within our provider network based on their performance under specific quality and cost efficiency measures in 3 domains of primary care and 19 areas of specialty care.

Under the Cigna Care Designation benefit plan, a subset of participating physicians in specialties receive the Cigna Care Designation display icon based on specific selection criteria. These specialties include allergy and immunology, gastroenterology, gynecology, orthopedics and surgery and dermatology. Physicians with the designation have a Cigna Care Designation icon displayed next to their name in the Cigna directory. Cigna participating providers are considered in-network whether or not they receive the Cigna Care Designation. However, a lower customer co-payment or coinsurance level may apply if the customer chooses a Cigna Care Designation physician. To learn more about Cigna Care Designation please refer to the 2013 Quality and Cost Methodologies Whitepaper found at the Cigna HCP Portal.

Physician Quality and Cost Efficiency Profile

Customers have online access to quality and cost efficiency displays for 19 physician specialties and 3 primary care specialties. Employers are asking us to help their employees - our customers- make more informed health care choices. To continue to support the industry's movement toward consumerism, we have created programs that align with the Consumer Purchaser Disclosure project, to provide health care quality and price information for consumers. Cigna was the first national health plan to receive NCQA Physician and Hospital Quality (PHQ) Certification of our quality and cost display methodology in 2009 and has maintained the certification since that time.

Profiles for participating physicians in 22 specialties are available in most service areas in the form of quality icons and star (*) designations for cost efficiency. Quality displays are available to consumers via Cigna's public provider directory and secure directory for Cigna customers. Cost efficiency displays are viewable only by customers via the online provider directory on our secure customer website.

The quality and cost efficiency displays represents only a partial assessment of a specialist's quality performance and cost of care. We encourage customers to consider all relevant factors and to speak with their treating physician when selecting a specialist.

Hospital Centers of Excellence

Our program supports the growing consumer demand for information on hospital outcomes and efficiency for specific diagnoses and procedures. Through this program, participating hospitals have both a patient outcomes and cost efficiency score for several procedures/conditions. Based on claims data, we evaluate hospital patient outcomes (quality) and cost-efficiency information through the Cigna Centers of Excellence (COE) program. Participating

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hospitals meeting specific quality and cost-efficiency criteria are designated as a Center of Excellence by procedure and condition.

In 2013, we will make the following updates for 31 new procedures, Cluster procedures in a more meaningful way for consumers, Incorporate industry standard Agency for Healthcare Research and Quality (AHRQ) complications and mortality measures, add readmissions data to the assessment methodology, consider geographic access in the methodology.

Because the Centers of Excellence program reflects only a partial assessment of quality and cost efficiency for select hospitals, it should not be the sole factor used when making decisions. We encourage individuals to consider all relevant factors, and to speak with their treating physician when selecting a hospital.

Publications / links

Centers of Excellence brochure https://secure.cigna.com/health/provider/medical/pdf_coe.pdf

Centers of Excellence/ hospital value tool 2011/2012 methodology
http://www.cigna.com/pdf/COE_WhitePaper.pdf

Cigna Care Designation and Physician Quality and Cost-Efficiency Displays 2013
<http://www.cigna.com/pdf/2013-cigna-care-designation-methodology.pdf>

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Organization	Centers for Medicare & Medicaid Services
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking /Analytics/ Incentive/Reward Programs
Source	https://www.cms.gov
Measure / Initiative	Bundled Payments for Care Improvement http://innovation.cms.gov/initiatives/bundled-payments/index.html

UPDATED IN 2013

Summary

Traditionally, Medicare makes separate payments to providers for each of the individual services they furnish to beneficiaries for a single illness or course of treatment. This approach can result in fragmented care with minimal coordination across providers and health care settings. Payment rewards the quantity of services offered by providers rather than the quality of care furnished. Research has shown that bundled payments can align incentives for providers – hospitals, post-acute care providers, physicians, and other practitioners– allowing them to work closely together across all specialties and settings.

Under the Bundled Payments for Care Improvement initiative, organizations will enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality, more coordinated care at a lower cost to Medicare.

Methodology

Under the Bundled Payments initiative, CMS would link payments for multiple services patients receive during an episode of care. Providers will have flexibility to determine which episodes of care and which services would be bundled together. The Bundled Payments for Care Improvement initiative is seeking applications for four broadly defined models of care, three of which would involve a retrospective bundled payment arrangement, with a target price (target payment amount) for a defined episode of care and one of which would be paid prospectively.

Initiative Details: 2 Payments Types, 4 Models

In these models, CMS and providers would set a target payment amount for a defined episode of care. Applicants propose the target price, which would be set by applying a discount to total costs for a similar episode of care as determined from historical data. Participants in these models would be paid for their services under the Original Medicare fee-for-service (FFS) system, but at a negotiated discount.

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Model 1: Retrospective Acute Care Hospital Stay Only

The episode of care would be defined as the inpatient stay in the general acute care hospital. Medicare will pay the hospital a discounted amount based on the payment rates established under the Inpatient Prospective Payment System (IPPS). Medicare will pay physicians separately for their services under the Medicare Physician Fee Schedule. Hospitals and physicians will be permitted to share gains arising from better coordination of care.

Model 2: Retrospective Acute Care Hospital Stay plus Post-Acute Care

In Model 2, the episode of care will include the inpatient stay in the acute care hospital and all related services during the episode. The episode will end either 30, 60, or 90 days after hospital discharge. Participants can select up to 48 different clinical condition episodes.

Model 3: Retrospective Post-Acute Care Only

For Model 3, the episode of care will be triggered by an acute care hospital stay and will begin at initiation of post-acute care services with a participating skilled nursing facility, inpatient rehabilitation facility, long-term care hospital or home health agency. The post-acute care services included in the episode must begin within 30 days of discharge from the inpatient stay and will end either a minimum of 30, 60, or 90 days after the initiation of the episode. Participants can select up to 48 different clinical condition episodes.

Model 4: Acute Care Hospital Stay Only

Under Model 4, CMS will make a single, prospectively determined bundled payment to the hospital that would encompass all services furnished during the inpatient stay by the hospital, physicians, and other practitioners. Physicians and other practitioners will submit “no-pay” claims to Medicare and will be paid by the hospital out of the bundled payment. Related readmissions for 30 days after hospital discharge will be included in the bundled payment amount. Participants can select up to 48 different clinical condition episodes.

Results

As of September 6, 2012, there have been very enthusiastic responses from providers across the country. Over the last two months we have reviewed the many proposals, which included thousands of episode definitions, identified points of commonality, and considered numerous key policy and operational issues inherent in designing the Bundled Payment model on a sizable scale. We are now moving to the next stage of this process by convening technical panels to review the applications over the next several weeks. Over the next several weeks we also will conduct a webinar update and resume learning sessions to take advantage of the great work being done in the private sector around episode-based payment and care redesign.

Publications / links

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Overview <http://www.innovations.cms.gov/initiatives/bundled-payments/index.html>

Fact sheet <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2013-Fact-Sheets-Items/2013-01-31.html>

Learning and Resource Center <http://innovation.cms.gov/initiatives/Bundled-Payments/learning-area.html>

Model 1 <http://innovation.cms.gov/initiatives/BPCI-Model-1/index.html>

Model 2 <http://innovation.cms.gov/initiatives/BPCI-Model-2/index.html>

Model 3 <http://innovation.cms.gov/initiatives/BPCI-Model-3/index.html>

Model 4 <http://innovation.cms.gov/initiatives/BPCI-Model-4/index.html>

Participating Health Care Facilities <http://innovation.cms.gov/initiatives/Bundled-Payments/Participating-Health-Care-Facilities/index.html>

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Organization	Centers for Medicare & Medicaid Services
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking /Analytics/ Incentive/Reward Programs
Source	https://www.cms.gov http://innovation.cms.gov/
Measure / Initiative	Comprehensive Primary Care Initiative http://www.innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.html

UPDATED IN 2013

Summary

The Comprehensive Primary Care (CPC) initiative is a multi-payer initiative fostering collaboration between public and private health care payers to strengthen primary care. Medicare will work with commercial and State health insurance plans and offer bonus payments to primary care doctors who better coordinate care for their patients. Primary care practices that choose to participate in this initiative will be given resources to better coordinate primary care for their Medicare patients.

Primary care is critical to promoting health, improving care, and reducing overall system costs, but it has been historically under-funded and under-valued in the United States. Without a significant enough investment across multiple payers, independent health plans-- covering only their own members and offering support only for their segment of the total practice population-- cannot provide enough resources to transform entire primary care practices and make expanded services available to all patients served by those practices.

Methodology

The CPC initiative offers a way to break through this historical impasse by inviting payers to join with Medicare in investing in primary care in 7 selected localities across the country. Eligible practices in each market were invited to apply to participate and start delivering enhanced health care services in the fall of 2012.

The CPC initiative offers a way to break through this historical impasse by inviting payers to join with Medicare in investing in primary care in 7 selected localities across the country. Eligible practices in each market were invited to apply to participate and start delivering enhanced health care services in the fall of 2012.

Practices were selected through a competitive application process based on their use of health information technology, ability to demonstrate recognition of advanced primary care delivery by accreditation bodies, service to patients covered by participating payers, participation in practice transformation and improvement activities, and diversity of geography, practice size and ownership structure.

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The resources will help doctors work with patients to ensure the following:

- Manage Care for Patients with High Health Care Needs:
- Ensure Access to Care:
- Deliver Preventive Care:
- Engage Patients and Caregivers:
- Coordinate Care Across the Medical Neighborhood:

The CPC initiative will test two models simultaneously: a service delivery model and a payment model.

Service Delivery Model

The service delivery model will test comprehensive primary care, characterized as having:

- Risk-stratified Care Management
- Access and Continuity
- Planned Care for Chronic Conditions and Preventative Care
- Patient and Caregiver Engagement
- Coordination of Care Across the Medical Neighborhood.

Payment Model

The payment model includes a monthly care management fee paid to the selected primary care practices on behalf of their fee-for-service Medicare beneficiaries and, in years 2-4 of the initiative, the potential to share in any savings to the Medicare program. Practices will also receive compensation from other payers participating in the initiative, including private insurance companies and other health plans, which will allow them to integrate multi-payer funding streams to strengthen their capacity to implement practice-wide quality improvement.

The Comprehensive Primary Care (CPC) initiative is a multi-payer initiative fostering collaboration between public and private health care payers to strengthen primary care. Medicare will work with commercial and State health insurance plans and offer bonus payments to primary care doctors who better coordinate care for their patients.

Statistics on the number of practices, providers, payors, and estimated beneficiaries are available on the CMS website

- Arkansas: Statewide

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- Colorado: Statewide
- New Jersey: Statewide
- New York: Capital District-Hudson Valley Region
- Ohio & Kentucky: Cincinnati-Dayton Region
- Oklahoma: Greater Tulsa Region
- Oregon: Statewide

Results

There are 497 primary care practices participating in the CPC initiative. This represents 2,347 providers serving an estimated 315,000 Medicare beneficiaries.

Results will be provided as they arise

Publications / links

Overview <http://www.innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.html>

Comprehensive Primary Care Initiative Fact Sheet <http://innovation.cms.gov/Files/fact-sheet/CPCI-Fact-Sheet.pdf>

Comprehensive Primary Care Initiative Logic Diagram <http://innovation.cms.gov/Files/x/cpcidiagram.pdf>

Primary Care Practice Solicitation http://innovation.cms.gov/Files/x/CPC_PracticeSolicitation.pdf

CPC Payer initiative solicitation <http://innovation.cms.gov/Files/x/Comprehensive-Primary-Care-Initiative-Solicitation.pdf>

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Organization	Centers for Medicare & Medicaid Services
Category	Incentive/Reward Programs
Source	https://www.cms.gov
Measure / Initiative	Dual Eligible - State Demonstrations Financial Alignment Initiative http://www.innovations.cms.gov/initiatives/State-Demonstrations/index.html

UPDATED IN 2013

Summary

A longstanding barrier to coordinating care for Medicare-Medicaid enrollees has been the financial misalignment between Medicare and Medicaid. To begin to address this issue, CMS will test two models for States to better align the financing of these two programs and integrate primary, acute, behavioral health and long term services and supports for their Medicare-Medicaid enrollees.

These two models include a capitated model and managed Fee-for-Service model

CMS is interested in testing these models across the country in programs that collectively serve up to 2 million Medicare-Medicaid enrollees. All programs will be rigorously evaluated as to their ability to improve quality and reduce costs. Meaningful engagement with stakeholders and ensuring beneficiary protections will be a crucial part of developing and testing these models.

The 15 States that received design contracts under the State Demonstrations to Integrate Care for Dual Eligible Individuals may chose to pursue these models and use their planning contract and stakeholder processes to support the development of the demonstration proposal, described below.

Methodology

State Financial Alignment Proposals

States received funding to design strategies for implementing person-centered models that fully coordinate primary, acute, behavioral and long-term supports and services for dual eligible individuals. States will work with beneficiaries, their families and other stakeholders to develop their demonstration proposals. The goal of the program is to eliminate duplication of services for these patients, expand access to needed care, and improve the lives of dual eligibles, while lowering costs.

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To participate in the Financial Alignment Demonstration, each State had to submit a proposal outlining its proposed approach for the Financial Alignment Demonstration. A total of 26 States submitted proposals, and those with active proposals are listed below. As indicated in the SMD letter, State demonstration proposals are evaluated against standards and conditions that CMS is requiring of all States seeking to participate in the demonstration. Additional information on the proposal process, including a list of standards and conditions, is available to download below. Please note, submission of a State demonstration proposal is an important step – but not the final step – toward demonstration approval.

Interested parties can still review the State proposals above and read the public comments submitted to CMS.

State Financial Alignment Demonstration Memoranda of Understanding (MOUs)

When a State meets the standards and conditions for the Financial Alignment Demonstration, CMS and a State will develop a Memorandum of Understanding (MOU) to establish the parameters of the initiative. The website includes the Medicare-Medicaid Demonstrations Frequently Asked Questions and memorandum for various states.

CMS is also continuing to work with some states to pursue demonstrations designed to improve care for Medicare-Medicaid enrollees outside the two models of the Financial Alignment Initiative.

The contracts must be three-way. Any plan participating in a capitated demonstration must sign a contract also signed by CMS and the state. A plan's participation in the Demonstration formally begins once a contract is signed by all parties, and the plan has passed the readiness review.

Additional background material is available

- 2014 Application Information for Medicare-Medicaid Plans
- Marketing Guidance and Model Materials for Medicare-Medicaid Plans
- Medicare-Medicaid Plan (MMP) Enrollment and Disenrollment Guidance
- Medicare-Medicaid Plan Encounter Data Reporting
- 2014 Annual Requirements for Medicare-Medicaid Plans
- Capitated Financial Alignment Readiness Review
- Funding to Support Options Counseling for Medicare-Medicaid Enrollees
- Funding to Support Ombudsman Programs

Results

Will be released when available

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Publications / links

Overviews

<http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html>

<http://www.innovations.cms.gov/initiatives/State-Demonstrations/index.html>

Various material for participating states is available from the main site above

Other material

Capitated Financial Alignment Demonstration Medicare-Medicaid Plan Annual Requirements and Timeline for CY 2014

http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/2013_State_MMP_Annual_Requirements_for_CY_2014.pdf

Joint Rate-Setting Process Under the Capitated Financial Alignment Demonstration <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/JointRateSettingProcess.pdf>

Capitated Financial Alignment Model Plan Guidance

<http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/FINALCMSCapitatedFinancialAlignmentModelplanguidance.pdf>

Medicare-Medicaid Capitated Financial Alignment Demonstration MMP Readiness Review Presentation 12-17-12

http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMP_ReadinessReview_Presentation.pdf

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Organization	Centers for Medicare & Medicaid Services
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking /Analytics/ Incentive/Reward Programs
Source	https://www.cms.gov
Measure / Initiative	(FQHC) Advanced Primary Care Practice http://innovations.cms.gov/initiatives/fqhcs/index.html

Summary

The Federally Qualified Health Center (FQHC) Advanced Primary Care Practice demonstration will show how the patient-centered medical home model can improve quality of care, promote better health, and lower costs.

Methodology

The 3-year Demonstration is designed to evaluate the effect of the advanced primary care practice model, commonly referred to as the patient-centered medical home, in improving care, promoting health, and reducing the cost of care provided to Medicare beneficiaries served by FQHCs.

FQHCs

- FQHC provided medical services to at least 200 Medicare beneficiaries (with Part A and Part B coverage, not Medicare Advantage) in a 12-month period, including those with both Medicare and Medicaid (dual eligible) coverage. CMS has reviewed administrative data and determined which FQHCs have met this criterion.
- FQHC is listed in the Provider Enrollment Chain and Ownership System (PECOS) file and is able to receive electronic funds transfer (EFT). FQHCs that have not recently submitted an 855A form are not listed in PECOS and, therefore, will not be eligible to participate in the Demonstration. FQHCs that do not receive claims payment through EFT must submit the necessary form to receive EFT or they will also not be eligible to participate in the Demonstration

Medicare Beneficiaries:

- Beneficiaries, including dually eligible Medicare/Medicaid beneficiaries, must be enrolled in the Medicare Part A and Part B fee-for-service program, during the initial 12 month lookback period, and must not be currently in hospice care or under treatment for end-stage renal disease.
- Beneficiaries enrolled in Medicare Advantage are not eligible to participate in this Demonstration.
- Attribution of beneficiaries to an FQHC will be based on Medicare administrative data for beneficiaries for whom CMS has a claim in the look-back period.
- Beneficiary eligibility is verified each quarter prior to payments being made. Participating FQHCs will receive an updated roster of attributed beneficiaries along with the quarterly fee Payment.

Payment:

- Participating FQHCs will receive a monthly care management fee of \$6.00 for each eligible Medicare beneficiary attributed to their practice to help defray the cost of transformation into a person-centered, coordinated, seamless

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primary care practice. This payment, which will be made quarterly, is in addition to the usual all-inclusive payment FQHCs receive for providing Medicare covered services.

- The fee will be paid automatically without the need to submit a claim

Results

This demonstration project, operated by the Centers for Medicare and Medicaid Services (CMS) in partnership with the Health Resources Services Administration (HRSA), will test the effectiveness of doctors and other health professionals working in teams to coordinate and improve care for up to 195,000 Medicare patients. Participating FQHCs are expected to achieve Level 3 patient-centered medical home recognition, help patients manage chronic conditions, as well as actively coordinate care for patients. To help participating FQHCs make these investments in patient care and infrastructure, they will be paid a monthly care management fee for each eligible Medicare beneficiary receiving primary care services. In return, FQHCs agree to adopt care coordination practices that are recognized by the National Committee for Quality Assurance (NCQA). CMS and HRSA will provide technical assistance to help FQHCs achieve these goals.

Publications / links

Overview	http://innovations.cms.gov/initiatives/fqhcs/index.html
FHQC Fact sheet	http://innovations.cms.gov/initiatives/FQHCs/FQHC-Fact-Sheet.html

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Organization	CMS Medicare & Medicaid
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	www.cms.hhs.gov
Measure	Hospital Compare http://www.medicare.gov/hospitalcompare/search.html?AspxAutoDetectCookieSupport=1

UPDATED IN 2013

Summary

Hospital Compare has information about the quality of care at over 4,000 Medicare-certified hospitals- Opens in a new window across the country. You can use Hospital Compare to find hospitals and compare the quality of their care. Hospital Compare was created through the efforts of the Centers for Medicare & Medicaid Services (CMS)- Opens in a new window, in collaboration with organizations representing consumers, hospitals, doctors, employers, accrediting organizations, and other Federal agencies.

Methodology

You can get a “snapshot” of the quality of hospitals in your area and across the nation by looking at the following aspects of healthcare:

Key information includes:

- Timely and effective care: How often and quickly each hospital gives recommended treatments for certain conditions like heart attack, heart failure, pneumonia, children’s asthma, and for surgical patients.
- Readmissions, complications and deaths:
 - How each hospital’s rates of readmission and death rates compare with the national rate.
 - How likely patients will suffer from complications while in the hospital.
 - How often patients in the hospital get certain serious conditions that could have been prevented if the hospital followed procedures based on best practices and scientific evidence.
- Use of medical imaging: How a hospital uses outpatient medical imaging tests- Opens in a new window (like CT scans and MRIs).
- Survey of patients’ experiences: How recently discharged patients responded to a national survey about their hospital experience. For example, how well did a hospital’s doctors and nurses communicate with patients and manage their pain?

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- Number of Medicare patients: How many people with Medicare have had certain procedures or have been treated for certain conditions at each hospital.
- Medicare payment: Information about how much Medicare pays hospitals.

The data collection approach is primarily retrospective. Data sources for required data elements included administrative claims data and medical record documents.

The measures include process and outcome measures

Results

Searchable data base

Publications / links

Hospital specific results - core search engine <http://www.medicare.gov/hospitalcompare/search.html>

Measures reported <http://www.medicare.gov/hospitalcompare/Data/Measures-Displayed.html>

Data sources <http://www.medicare.gov/hospitalcompare/Data/Data-Sources.html>

Linking value to payment <http://www.medicare.gov/hospitalcompare/linking-quality-to-payment.html>

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Organization	CMS Medicare & Medicaid
Category	Standards Setting, Industry Organizations
Source	www.cms.hhs.gov
Measure	Measures Management System (MMS) http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/MeasuresManagementSystemBlueprint.html

UPDATED IN 2013

Summary

Centers for Medicare & Medicaid Services (CMS) has developed a standardized system for developing and maintaining the quality measures used in its various quality initiatives and programs. Known as the Measures Management System, CMS-funded measure developers (or contractors) should follow this core set of business processes and decision criteria when developing, implementing, and maintaining quality measures. The primary goal of the Measures Management System is to provide information to measure developers to help them produce high-caliber quality measures that are appropriate for accountability. The CMS Measures Management System Blueprint, Version 10.0 (the Blueprint), documents the full Measures Management System core set of business processes.

Though the Blueprint receives a comprehensive annual update by the Measures Manager, continuous improvements are incorporated through quarterly updates as the need arises. The Measures Manager systematically solicits feedback and suggestions from the end users of the Blueprint. One simple way to submit feedback and suggestions is to e-mail the Measures Manager at blueprint@hsag.com.

Methodology

The Centers for Medicare and Medicaid Services (CMS) developed a standardized approach for the development and maintenance of the quality measures it uses in its various quality initiatives and programs. Known as the Measures Management System (MMS), this system is composed of a set of business processes and decision criteria that CMS-funded measure developers (or contractors) follow to develop, implement, and maintain quality measures. Measures developed following the MMS meet the high standards required by the National Quality Forum (NQF) for consensus endorsement. The Measures Management System helps CMS manage the ever-increasing demand for quality measures to use in its various public reporting, quality programs, and value purchasing initiatives.

The Measures Management System is a set of processes and decision criteria used by CMS to oversee the development, implementation, and maintenance of healthcare quality measures. CMS recognizes the need for quality measures of the highest caliber, maintained throughout their life cycle to ensure they retain the highest level of scientific soundness, importance, feasibility, and usability. Through the use of a standardized process with broadly recognized criteria, the Measures Management System ensures that CMS will have a coherent, transparent system for measuring quality of care delivered to its beneficiaries.

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The Measures Management System has been developed in collaboration with the National Quality Forum (NQF), the Agency for Healthcare Research and Quality (AHRQ), The Joint Commission, the National Committee for Quality Assurance (NCQA), the American Medical Association Physician Consortium for Performance Improvement (AMA PCPI) and other measure stakeholders.

A ten step process with a flowchart and outline is included in the MMS Measure Development Overview.

Publications / links

MMS Measure Development Overview

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/MMSMeasureDevelopmentOverview-.pdf>

Blueprint 10.0 (note this PDF is 13 M)

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Blueprint100.zip>

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Organization	CMS Medicare & Medicaid
Category	Standards Setting, Industry Organizations, Incentives, Rewards Programs
Source	www.cms.hhs.gov
Measure	Hospital Value-Based Purchasing (VBP) Plan http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html?redirect=/hospital-value-based-purchasing

UPDATED IN 2013

Summary

Section 3001(a)(1) of the Affordable Care Act requires CMS to implement a Hospital VBP program that rewards hospitals for the quality of care they provide. Under the Hospital VBP program, CMS will evaluate hospitals' performance during a performance period based on both achievement and improvement on selected measures. Hospitals will receive points on each measure based on the higher of their level of achievement relative to an established standard or their improvement in performance from their performance during a prior baseline period. Their combined scores on all the measures will be translated into value-based incentive payments for discharges occurring on or after October 1, 2012.

The **final rule** includes a number of provisions related to the FY 2013 Hospital VBP program, including the measures, the performance standards, the scoring methodology, and, finally, the methodology for translating hospitals' Total Performance Scores into value-based incentive payments.

HOSPITAL VBP MEASURES: For the FY 2013 Hospital VBP program, CMS will measure hospital performance using two domains: the clinical process of care domain, which is comprised of 12 clinical process of care measures, and the patient experience of care domain, which is comprised of Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey measure. Hospitals should be familiar with these measures because they were selected from the measures that have been specified for use in the Hospital IQR program. CMS will utilize the following measures in the Hospital VBP program for the FY 2014 payment determination: three mortality outcome measures, eight Hospital Acquired Condition (HAC) measures, and two Agency for Healthcare Research and Quality (AHRQ) composite measures.

PERFORMANCE SCORING:

Performance Period: CMS has established a performance period that runs from July 1, 2011 through March 31, 2012, for the FY 2013 Hospital VBP payment determination. CMS anticipates that in future program years, if it becomes feasible, it may propose to use a full year as the performance period.

Scoring Methods: CMS will score each hospital based on achievement and improvement ranges for each applicable measure. A hospital's score on each measure will be the higher of an achievement score in the performance period

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or an improvement score, which is determined by comparing the hospital's score in the performance period with its score during a baseline period.

For scoring on achievement, hospitals will be measured based on how much their current performance differs from all other hospitals' baseline period performance. Points will then be awarded based on the hospital's performance compared to the threshold and benchmark scores for all hospitals. Points will only be awarded for achievement if the hospital's performance during the performance period exceeds a minimum rate called the "threshold," which is defined by CMS as the 50th percentile of hospital scores during the baseline period.

For scoring on improvement, hospitals will be assessed based on how much their current performance changes from their own baseline period performance. Points will then be awarded based on how much distance they cover between that baseline and the benchmark score. Points will only be awarded for improvement if the hospital's performance improved from their performance during the baseline period.

Finally, CMS will calculate a Total Performance Score (TPS) for each hospital by combining the greater of its achievement or improvement points on each measure to determine a score for each domain, multiplying each domain score by the proposed domain weight and adding the weighted scores together. In FY 2013, the clinical process of care domain will be weighted at 70 percent and the patient experience of care domain will be weighted at 30 percent.

Incentive Payment Calculations: CMS will utilize a linear exchange function to calculate the percentage of value-based incentive payment earned by each hospital. Those hospitals that receive higher Total Performance Scores will receive higher incentive payments than those that receive lower Total Performance Scores.

Publications / links

Main page

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html?redirect=/hospital-value-based-purchasing>

Fact Sheet

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Hospital_VBPurchasing_Fact_Sheet_ICN907664.pdf

Fact sheet – final rule

<http://www.cms.gov/apps/media/press/factsheet.asp?Counter=3947&intNumPerPage=10&checkDate=&checkKey=2&srchType=2&numDays=0&srchOpt=0&srchData=value-based&keywordType=All&chkNewsType=6&intPage=&showAll=1&pYear=&year=0&desc=&cboOrder=date>

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Organization	CMS Medicare & Medicaid
Category	Incentive/Reward Programs
Source	www.cms.hhs.gov
Measure	Medicare Quality Improvement Organization (QIO) Program. http://www.cms.hhs.gov/QualityImprovementOrgs/01_Overview.asp#TopOfPage

Summary

QIO program was created in 1982. QIO's work to reduce disparities, or variations, in health care provided to minority and underserved Medicare beneficiaries by helping providers increase access to health care services, address cultural and language differences, and overcome social barriers to preventive care. QIOs work under contract to the Centers for Medicare & Medicaid Services (CMS) in three-year cycles.

Methodology

Based on the statutory charge, and CMS' Program experience, CMS identifies the core functions of the QIO Program as:

- Improving quality of care for beneficiaries;
- Protecting the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and goods that are reasonable and necessary and that are provided in the most appropriate setting; and
- Protecting beneficiaries by expeditiously addressing individual complaints, such as beneficiary complaints; provider-based notice appeals; violations of the Emergency Medical Treatment and Labor Act (EMTALA); and other related responsibilities as articulated in QIO-related law.

Results

CMS published a Report to Congress every fiscal year that outlines the administration, cost, and impact of the QIO Program. See the links in the "Downloads" section to read our most recent fiscal year Report to Congress.

Publications / links

Independent Evaluation of the 9th SOW, QIO Program: Final Report (Nov 2011)

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs/Downloads/MPRRReport.pdf>

Annual Report to Congress: QIO Program - Fiscal Year 2009

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<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs/Downloads/2009QIORtC.pdf>

Report to Congress: Response to IOM Study on the QIO Program

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs/Downloads/QIO_improvement_RTC_fnl.pdf

Current work (material from 2011)

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs/Current.html>

FedBizOpps.gov - 10th Statement of Work for QIOs RFP Request

https://www.fbo.gov/?s=opportunity&mode=form&id=c9758e6861085718832064025f15d75f&tab=core&_cview=1

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Organization	CMS Medicare & Medicaid
Category	Standards Setting, Industry Organizations
Source	www.cms.gov
Measure	Patient Protection and Affordable Care Act (2010) – measurement provisions http://www.cms.gov/LegislativeUpdate/downloads/PPACA.pdf http://www.cms.gov/Center/healthreform.asp http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590ENR/pdf/BILLS-111hr3590ENR.pdf

UPDATED IN 2010

Summary

The comprehensive health reform legislation, the Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. The provisions of this law included expansion of health insurance coverage, the expansion of public programs, financing health reform, improving quality and health system performance, prevention and wellness, long-term care, workforce training and development. This summary only covers aspects of the PPACA related to improving quality and health system performance. The reader is referred to the CMS links above or to the references listed at the end of this entry for further information on the provisions of the PPACA.

Improving quality and health system performance

The Affordable Care Act includes a wide range of strategies and provisions that will improve the quality of care, develop and promote new models of care delivery, appropriately price services, modernize the health system, and fight waste, fraud, and abuse.

1. Center for Medicare and Medicaid Innovation

To support the ongoing development of new models of payment and delivery, the Affordable Care Act establishes the Center for Medicare and Medicaid Innovation. The new law invests \$10 billion in this Center over the next 10 years to test payment and delivery innovations that can improve the quality of care and/or increase cost efficiency; identifying successes that could be expanded by the Secretary of Health and Human Services (either regionally or nationally). These funds will produce returns on investment and reduce Medicare spending over the long-term.

Intended to be operational by 2011, the Center is intended to enhance the CMS's role in promoting improvements in payment and service delivery. The objective is "to test innovative payment and service delivery models to reduce program expenditures...while preserving or enhancing quality of care." Areas of focus include primary care and long-term care as well as examining various payment methods. Research protocol constraints that have heretofore restricted CMS in the conduct of demonstrations and pilot programs have been relaxed to foster innovation, give more flexibility in research design and evaluation methods and to foster a faster research process. The CMI has approval to select and run pilot programs rather than demonstration projects, enabling the Secretary of Health and Human Services the authority to expand pilots that promise spending reductions or improvements in the quality of care. The objective is to be able to disseminate research information more rapidly whilst maintaining a credible and valid research process.

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2. Accountable Care Organizations

The Affordable Care Act promotes team-based health care through Accountable Care Organizations (ACOs) under the Medicare shared savings program. ACOs create delivery systems that encourage and support teams of physicians, hospitals, and other health care providers to collaboratively manage and coordinate care for Medicare beneficiaries. If these providers meet certain quality and efficiency benchmarks, they may receive a share of any savings from reducing duplicative services, improving productivity, minimizing paperwork, or otherwise improving cost efficiency. While the CMS Office of the Actuary estimates that this provision will be budget neutral, the CBO has projected that it will reduce Medicare spending by nearly \$5 billion over the next ten years. CMS is working to make the program operational by January 1, 2012. Proposed rules will be issued later in 2010 and CMS and its partner organizations will continue to hold public forums to foster ACO development and coordinate with on-going private sector efforts.

3. Independent Payment Advisory Board

The Affordable Care Act also establishes the Independent Payment Advisory Board, or IPAB, to monitor the fiscal health of the Medicare program and to recommend payment policy revisions to contain Medicare cost growth. The IPAB will begin work in 2012 and will be required to submit its recommendations to Congress annually on how to best improve quality of care for Medicare beneficiaries, while reducing the rate of growth in Medicare costs. The law stipulates that the IPAB will have to report to the public on system-wide health care costs, patient access to care, utilization, and quality of care. The IPAB's proposals on how to improve care and control program expenditures are binding when Medicare cost projections exceed certain targets, unless Congress acts to reduce expenditures in other ways. The CMS Office of the Actuary projects that the IPAB could reduce Medicare costs by almost \$24 billion by 2019.

Other provisions include:¹

Improving Quality/Health System Performance

- Comparative effectiveness research
- Medical malpractice
- National Medicare pilot re bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge.
- Hospital value-based purchasing program in Medicare to pay hospitals based on performance on quality measures
- Medicaid demonstration projects to pay bundled payments for episodes of care

National quality strategy

- National quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health.

Prevention/Wellness National strategy

- Develop a national strategy to improve the nation's health. Establish a grant program to support the delivery of evidence-based and community-based prevention and wellness services

¹ These notes are highly summarized. Refer to the Act for full details. <http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590ENR/pdf/BILLS-111hr3590ENR.pdf>

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Coverage of preventive services

- Cover for proven preventive services and eliminating cost-sharing for preventive services in Medicare and Medicaid.
- Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan.
- Require qualified health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women.
- Provide grants for up to five years to small employers that establish wellness programs.

Publications / links

The Patient Protection and Affordable Care Act - All CMS Provisions -- As of July 23, 2010,
<http://www.cms.gov/LegislativeUpdate/downloads/PPACA.pdf>

Affordable Care Act Update: Implementing Medicare Cost Savings
<http://www.cms.gov/apps/docs/ACA-Update-Implementing-Medicare-Costs-Savings.pdf>

Health Affairs edition June 2010 - Volume 29, Number 6 - *Moving Forward On Health Reform* includes the following articles:

- The Foundation That Health Reform Lays For Improved Payment, Care Coordination, And Prevention
Kenneth E. Thorpe and Lydia L. Ogden
- Innovation In Medicare And Medicaid Will Be Central To Health Reform's Success
Stuart Guterman, Karen Davis, Kristof Stremikis, and Heather Drake
- How Physician Practices Could Share Personnel And Resources To Support Medical Homes
Melinda Abrams, Edward L. Schor, and Stephen Schoenbaum
- Communities' Readiness To Commit To High-Quality Health Care
Risa Lavizzo-Mourey

Health Affairs July 2010 - Volume 29, Number 7 - *Weighing the Impact of Health Reform* includes the following articles:

- The Vast *Terra Incognita* Of U.S. Health Care Reform - *Susan Dentzer*
- Lessons For The New CMS Innovation Center From The Medicare Health Support Program
Michael S. Barr, Sandra M. Foote, Randall Krakauer, and Patrick H. Mattingly
- How The Center For Medicare And Medicaid Innovation Should Test Accountable Care Organizations
Stephen M. Shortell, Lawrence P. Casalino, and Elliott S. Fisher
- Public Reporting On Hospital Process Improvements Is Linked To Better Patient Outcomes
Rachel M. Werner and Eric T. Bradlow

Kaiser Family Foundation Healthcare Reform Gateway <http://healthreform.kff.org/>

Mechanic R, Altman S. Medicare's opportunity to encourage innovation in health care delivery. *N Engl J Med.* 2010;362(9):772-4

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Organization	CMS Medicare & Medicaid
Category	Incentive/Reward Programs
Source	www.cms.hhs.gov
Measure	Physician Group Practice Demonstration project http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Medicare-Demonstrations-Items/CMS1198992.html?DLPage=1&DLFilter=PHYSICIAN&DLSort=2&DLSortDir=descending

UPDATED IN 2013

Summary

Authors note: The demonstration has ended, but the program serves as one of building block for various current initiatives. A modified version of this project is continuing.

The Physician Group Practice (PGP) Demonstration was the first pay-for-performance initiative for physicians under the Medicare program. The demonstration created incentives for physician groups to coordinate the overall care delivered to Medicare patients, rewarded them for improving the quality and cost efficiency of health care services, and created a framework to collaborate with providers to the advantage of Medicare beneficiaries. Mandated by Section 412 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the goals of the demonstration were to:

- Encourage coordination of Part A and Part B services;
- Promote cost efficiency and effectiveness through investment in care management programs, process redesign, and tools for physicians and their clinical care teams; and
- Reward physicians for improving health outcomes.

Under the five year demonstration, the Centers for Medicare & Medicaid Services (CMS) rewarded physician groups for improving patient outcomes by proactively coordinating their patients' total health care needs, especially for beneficiaries with chronic illness, multiple co-morbidities, and transitioning care settings.

Methodology

CMS selected ten physician groups on a competitive basis to participate in the demonstration. The groups were selected based on technical review panel findings, organizational structure, operational feasibility, geographic

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location, and demonstration implementation strategy. Multi-specialty physician groups with well-developed clinical and management information systems were encouraged to apply since they were likely to have the ability to put in place the infrastructure necessary to be successful under the demonstration.

The ten physician groups represent 5,000 physicians and 220,000 Medicare fee-for-service beneficiaries.

Results

By performance year 5, all ten of the physician groups achieved benchmark performance on at least 30 of the 32 measures. Seven groups achieved benchmark performance on all 32 performance measures and all ten of the groups achieved benchmark performance on the nineteen. The PGPs have increased their quality scores from baseline to performance year 5 on the various quality measures. Five of the physician groups achieved benchmark quality performance on all 27 quality measures. These groups achieved outstanding levels of performance by having clinical champions (physicians or nurses who are in charge of quality reporting) at the practice, redesigning clinical care processes, and investing in health information technology.

In addition to the quality performance, four physician groups -- Marshfield Clinic, Park Nicollet Health Services, St. John's Health System, and the University of Michigan -- earned incentive payments based on the estimated savings in Medicare expenditures for the patient population they serve. The groups received performance payments totaling \$29.4 million as their share of the \$36.2 million of savings generated for the Medicare Trust Funds in performance year 5.

The demonstration started April 1, 2005 and the fifth performance year ended March 31, 2010. As included in The Affordable Care Act, CMS has worked collaboratively with the organizations participating in the PGP Demonstration to update the Demonstration design based on lessons learned and statutory requirements for the Medicare Shared Savings Program. All ten PGPs participated in the 2-year PGP Transition Demonstration that began January 1, 2011.

Publications / links

PGP Transition Fact Sheet – August 2012

http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Downloads/PGP_TD_Fact_Sheet.pdf

PGP Transition Design Summary

http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Downloads/PGP_Transition_Design_Summary.pdf

PGP Transition Performance Payment Methodology Specifications

http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Downloads/PGP_Transition_Payment_Specs.pdf

PGP Transition Quality Specs Report

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http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Downloads/PGP_Transition_Quality_Specs_Report.pdf

PGP Demonstration Fact Sheet

http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Downloads/PGP_Fact_Sheet.pdf

PGP Demonstration Summary Results

http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Downloads/PGP_Summary_Results.pdf

Report to Congress - September 2009

http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Downloads/PGP_RTC_Sept.pdf

Performance Payment Methodology Specifications

http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Downloads/PGP_Payment.pdf

Medicare Physician Group Practice Demonstration Design:Quality and Efficiency Pay-for-Performance

John Kautter, Gregory C. Pope, Michael Trisolini, and Sherry Grund, Health Care Financing Review/Fall 2007/Volume 29, Number 1 pp. 15-29

Physician Group Practice Demonstration First Evaluation Report

<http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/Leavitt1.pdf>

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Organization	Centers for Medicare & Medicaid Services (CMS / CMMI)
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking /Analytics/ Incentive/Reward Programs
Source	https://www.cms.gov
Measure / Initiative	Pioneer ACO Models http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/

UPDATED IN 2013

Summary

The Pioneer ACO Model is a CNS Innovation Center designed for health care organizations and providers that are already experienced in coordinating care for patients across care settings. It will allow these provider groups to move more rapidly from a shared savings payment model to a population-based payment model on a track consistent with, but separate from, the Medicare Shared Savings Program. And it is designed to work in coordination with private payers by aligning provider incentives, which will improve quality and health outcomes for patients across the ACO, and achieve cost savings for Medicare, employers and patients. The Pioneer ACO Model was designed specifically for organizations with experience offering coordinated, patient-centered care, and operating in ACO-like arrangements.

The Medicare Shared Savings Program provides incentives for ACOs that meet standards for quality performance and reduce cost while putting patients first. Working in concert with the Shared Savings Program, the Innovation Center is testing an alternative ACO model, the Pioneer ACO Model.

Methodology

Savings calculations

There are extensive formal methodologies supporting beneficiary alignment and financial calculations for the first three performance years of the Pioneer ACO Model.

In the first two performance years, the Pioneer Model tests a shared savings and shared losses payment arrangement with higher levels of reward and risk than in the Shared Savings Program. These shared savings would be determined through comparisons against an ACO's benchmark, which is based on previous CMS expenditures for the group of patients aligned to the Pioneer ACO. In year three of the program, those Pioneer ACOs that have shown savings over the first two years will be eligible to move to a population-based payment model. Population-based payment is a per-beneficiary per month payment amount intended to replace some or all of the ACO's fee-for-service (FFS) payments with a prospective monthly payment.

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The Pioneer ACO model will use a shared savings/losses arrangement in which the expenditure target for a performance year (PY) is based on the historical expenditures during a base period for a prospectively defined cohort of beneficiaries. Savings or losses are defined as the difference between an expenditure benchmark for a performance year and the observed expenditure of that year's aligned beneficiaries.

There are additional adjustments for alignment-eligible beneficiaries who died, eligibility, age, and sex category.

Quality metrics

CMS has established robust quality measures that will be used to monitor the quality of care provided and beneficiary satisfaction. These measures mirror those in the Shared Savings Program (for more information, view the fact sheet entitled "Improving Quality of Care for Medicare Patients: Accountable Care Organizations.")

There are additional requirements on the minimum number of aligned beneficiaries, Beneficiary Protections, and Health Information Technology.

Results

Pioneer ACO Cost

Costs for the more than 669,000 beneficiaries aligned to Pioneer ACOs grew by only 0.3 percent in 2012 where as costs for similar beneficiaries grew by 0.8 percent in the same period. 13 out of 32 pioneer ACOs produced shared savings with CMS, generating a gross savings of \$87.6 million in 2012 and saving nearly \$33 million to the Medicare Trust Funds. Pioneer ACOs earned over \$76 million by providing coordinated, quality care. Only 2 Pioneer ACOs had shared losses totaling approximately \$4.0 million. Program savings were driven, in part, by reductions that Pioneer ACOs generated in hospital admissions and readmissions.

Pioneer ACO Quality

All 32 Pioneer ACOs successfully reported quality measures and achieved the maximum reporting rate for the first performance year, with all earning incentive payments for their reporting accomplishments. Overall, Pioneer ACOs performed better than published rates in fee-for-service Medicare for all 15 clinical quality measures for which comparable data are available. (Seven measures had no comparable data in the published literature.)

In addition, Pioneer ACOs were rated higher by ACO beneficiaries on all four patient experience measures relative to the 2011 Medicare fee-for-service results.

Publications / links

Overview <http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/>

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Press Release - 07/17/13

<http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-07-16.html>

Pioneer ACO Fact Sheet

<http://innovation.cms.gov/Files/fact-sheet/Pioneer-ACO-General-Fact-Sheet.pdf>

Frequently Asked Questions

<http://innovation.cms.gov/Files/x/Pioneer-ACO-Model-Frequently-Asked-Questions-doc.pdf>

Frequently Asked Questions for the Pioneer ACO Applicants

<http://innovation.cms.gov/Files/x/Pioneer-ACO-Model-Frequently-Asked-Questions-ADDENDUM-document.pdf>

Pioneer ACO descriptions document

<http://innovation.cms.gov/Files/x/Pioneer-ACO-Model-Selectee-Descriptions-document.pdf>

Pioneer ACO Benchmark Methodology

<http://innovation.cms.gov/Files/x/PioneerACOBmarkMethodology.pdf>

Pioneer ACO Alternative Payment Arrangements

<http://innovation.cms.gov/Files/x/Pioneer-ACO-Model-Alternative-Payment-Arrangements-document.pdf>

Improving Quality of Care for Medicare Patients: Accountable Care Organizations.

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Quality_Factsheet_ICN907407.pdf

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Organization	CMS Medicare & Medicaid
Category	Incentive/Reward Programs
Source	www.cms.hhs.gov
Measure	Physician Quality Reporting System (PQRS) http://www.cms.hhs.gov/pqrs/

UPDATED IN 2013

Summary

PQRS is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs).

The program provides an incentive payment to practices with EPs (identified on claims by their individual National Provider Identifier [NPI] and Tax Identification Number [TIN]). EPs satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer).

Beginning in 2015, the program also applies a payment adjustment to EPs who do not satisfactorily report data on quality measures for covered professional services. This website serves as the primary and authoritative source for all publicly available information and CMS-supported educational and implementation support materials for PQRS.

Methodology

Analysis and Payment

Each year, the Physician Quality Reporting System (PQRS) incentive payment and the PQRS feedback report are issued through separate processes. PQRS feedback report availability is not based on whether or not an incentive payment was earned. PQRS participants will not receive claim-level details in the feedback reports.

Incentive Payments

Eligible professionals who satisfactorily report quality-measures data for services furnished during a PQRS reporting period are eligible to earn an incentive payment equal to a percentage of the eligible professional's estimated total allowed charges for covered Medicare Part B Physician Fee Schedule (PFS) services provided during the reporting period. The authorized incentive payment amounts for each program year are:

2010 PQRS – 2.0%

2009 PQRS – 2.0%

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2008 PQRS – 1.5%
 2007 PQRS – 1.5% subject to a cap

The Affordable Care Act authorized incentive payment through 2014:

2011 PQRS – 1.0%
 2012 PQRS – 0.5%
 2013 PQRS – 0.5%
 2014 PQRS – 0.5%

Incentive payments for each program year are issued separately as a single consolidated incentive payment in the following year..

Results

Within the system, results will be distributed based on the results for the physician.

Overall reports will be developed as the program moves forward.

Publications / links

Physician Quality Reporting System FAQ

<https://questions.cms.gov/faq.php?id=5005&rtopic=1893&rsubtopic=7163>

How to Get Started

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/How_To_Get_Started.html

Learn more about PQRS

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/PQRS_OverviewFactSheet_2013_08_06.pdf

2013 Physician Quality Reporting System (PQRS) Implementation Guide:

http://www.cms.gov/apps/ama/license.asp?file=/PQRS/downloads/2013_PQRS_MeasuresList_ImplementationGuide_12192012.zip

Measures Codes

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html>

Analysis and Payment

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html>

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Payment Adjustment Information

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Payment-Adjustment-Information.html>

Registry Reporting

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Registry-Reporting.html>

EHR Incentive Program Reporting

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Electronic-Health-Record-Reporting.html>

Group Practice Reporting Option

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Group_Practice_Reporting_Option.html

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Organization	Centers for Medicare & Medicaid Services
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking /Analytics/ Incentive/Reward Programs
Source	https://www.cms.gov http://innovation.cms.gov/
Measure / Initiative	Shared Savings ACO http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram/

UPDATED IN 2013

Summary

The Centers for Medicare & Medicaid Services (CMS) has established a Medicare Shared Savings Program (Shared Savings Program) to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO).

ACOs create incentives for health care providers to work together to treat an individual patient across care settings – including doctor’s offices, hospitals, and long-term care facilities. The Medicare Shared Savings Program (Shared Savings Program) will reward ACOs that lower their growth in health care costs while meeting performance standards on quality of care and putting patients first. CMS worked closely with agencies across the Federal government to ensure a coordinated and aligned inter- and intra-agency effort to facilitate implementation of the Shared Savings Program.

The Shared Savings Program is designed to improve beneficiary outcomes and increase value of care by:

- Promoting accountability for the care of Medicare FFS beneficiaries
- Requiring coordinated care for all services provided under Medicare FFS
- Encouraging investment in infrastructure and redesigned care processes

The Shared Savings Program will reward ACOs that lower their growth in health care costs while meeting performance standards on quality of care and putting patients first. Participation in an ACO is purely voluntary.

Methodology

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Under the Shared Savings Program, the ACO providers and suppliers will continue to be paid for services rendered to Fee-For-Service Medicare beneficiaries. In addition, the participating ACO will be eligible to receive a shared savings payment if the ACO meets the quality performance standards and has generated shareable savings under the performance-based payment methodology.

Track 1 – Shared Savings Only for the Initial Agreement:

Shared savings will be calculated for each performance year during the term of an ACO’s first agreement. ACOs will not be held accountable for losses in this Track

Track 2 – Shared Savings and Shared Losses for All Years of the Agreement:

More experienced ACOs that are ready to share in losses in return for the opportunity for a higher share of savings may elect to enter the two-sided model. Under this model, the ACO will be eligible for a higher sharing rate, with a higher performance payment limit, than will be available under the one-sided model.

Determining Shared Savings and Losses

Step 1 – Establish Benchmark and Update for Each Performance Year Within the Agreement Period:

Establish the “benchmark for each agreement period for each ACO using the most recent available 3 years of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO. In calculating the benchmark, CMS will trend the benchmark years forward to the third benchmark year by employing the national growth rate in Medicare Parts A and B expenditures for Fee-For- Service beneficiaries

Step 2 – Compare Performance to the Benchmark to Determine Shared Savings/Losses:

Establishes that an ACO shall be eligible for payment of shared savings “only if the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified by the Secretary below the applicable benchmark.”

Step 3 – Determining Sharing Rate and Shared Savings:

If an ACO meets quality standards and achieves savings according to Step 2, the ACO will share in savings. CMS will apply a sharing rate, determined for each ACO based upon its quality performance, to the difference between the updated benchmark and the actual expenditures for the performance year.

Quality measures

As required by the Affordable Care Act, before an ACO can share in any savings generated, it must demonstrate that it met the quality performance standard for that year

The CMS will measure quality of care using 33 nationally recognized measures in four key domains.

- Patient/caregiver experience (7 measures)
- Care coordination/patient safety (6 measures)
- Preventive health (8 measures)
- At risk population
 - Diabetes (6 measures)
 - Hypertension (1 measure)
 - Ischemic vascular disease (2 measures)
 - Heart failure (1 measure)
 - Coronary artery disease (CAD) (2 measures)

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Required quality measures that are part of the quality performance standard, including the Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience survey measures, claims-based measures, the Electronic Health Record (EHR) Incentive Program measure, and the required Group Practice Reporting Option (GPRO) web interface quality measures that are required for purposes of ACO participants earning a Physician Quality Reporting System (PQRS) incentive under the Medicare Shared Savings Program.

The Affordable Care Act allows CMS to incorporate the Physician Quality Reporting System reporting requirements and incentive payments into the Shared Savings Program. ACO participants that include providers/suppliers who are also eligible professionals for purposes of the Physician Quality Reporting System will earn the Physician Quality Reporting System incentive as a group practice under the Shared Savings Program, by reporting required clinical quality measures through the ACO Group Practice Reporting Option (GPRO) web interface, in each calendar year reporting period the ACO fully and completely reports the ACO GPRO measures.

Results

Results will be released as the programs move forward.

Publications / links

Fact sheet

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Quality_Factsheet_ICN907407.pdf

Frequently Asked Questions

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/FAQ.html>

Medicare Shared Savings Program ACO Fast Facts

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/ACO-Fast-Facts.html>

Summary of final rule

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Summary_Factsheet_ICN907404.pdf

What providers need to know

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Providers_Factsheet_ICN907406.pdf

Methodology for determining Shared Savings and Losses

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https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Methodology_Factsheet_ICN907405.pdf

Quality measures and performance standards

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html

Improving Quality of Care for Medicare Patients: Accountable Care Organizations.

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Quality_Factsheet_ICN907407.pdf

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Organization	The Commonwealth Fund
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	http://www.whynotthebest.org
Measure	Why Not the Best

UPDATED IN 2013

Summary

WhyNotTheBest.org was created and is maintained by The Commonwealth Fund, a private foundation working toward a high performance health system. It is a free resource for health care professionals interested in tracking performance on various measures of health care quality. It enables organizations to compare their performance against that of peer organizations, against a range of benchmarks, and over time. Case studies and improvement tools spotlight successful improvement strategies of the nation's top performers. A regional map shows performance at the county, HRR, state, and national levels.

WhyNotTheBest.org includes process-of-care measures, patient satisfaction measures (from the Hospital Consumer Assessment of Healthcare Providers and Systems), readmission rates, mortality rates, and average reimbursement rates.

Methodology

All of these performance measures are publicly reported on the Centers for Medicare and Medicaid Services Web site, Hospital Compare, and include data from nearly all U.S. hospitals. WhyNotTheBest.org also includes data on the incidence of central line-associated bloodstream infections, from over 1,500 hospitals across the nation. It also includes measures assessing whether and to what extent hospitals have adopted electronic medical records (from the American Hospital Association survey), as well as measures of population health and utilization and costs, from the Institute of Medicine. Finally, the site includes performance data for a subset of the Agency for Healthcare Research and Quality Inpatient Quality Indicators (IQIs), Patient Safety Indicators (PSIs), and Prevention Quality Indicators (PQIs). Currently, we have such data for the majority of hospitals in 12 states. Although Hospital Compare is used for data, some of the metrics are different.

Various comparisons can be performed

- Hospitals by region, health system, size, ownership, or type.
- Hospital groupings - by size, ownership, or type.
- U.S. counties, hospital referral regions, and states.
- Examples of featured hospital, group, and regional reports.

Performance Data (metrics)

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- Recommended Care (Core Measures)
- Composite Measures of Recommended Care
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
- Emergency Care
- Immunization
- Readmission Rates
- Mortality Rates
- Spending per Medicare Beneficiary
- Health Care Costs
- Health Care–Associated Infections
- Health Information Technology
- Inpatient Quality Indicators
- Patient Safety Indicators
- Prevention Quality Indicators
- Population Health / Utilization and Costs
- County Health Rankings

Results

The Commonwealth Fund creates many papers on these topics. Specific reports and case studies are available in a data base that can be sorted by topic.

Publications / links

Various reports can be produced on the site. These are accessed from the master web link
<http://www.whynotthebest.org/>

Case studies <http://www.whynotthebest.org/contents/index/1>

Tools <http://www.whynotthebest.org/contents/index/2>

Related publications / links (from other organizations)

<http://www.whynotthebest.org/contents/index/5>

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Organization	The Commonwealth Fund Commission on a High Performance Health System
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	http://www.commonwealthfund.org/usr_doc/Why_Not_the_Best_national_scorecard_2008.pdf?section=4039
Measure	Multiple papers National Scorecard on U.S. Health System Performance

UPDATE IN 2013

Summary

Although the Commission concluded its activities in March 2013, the website still contains a series of related papers about the US health system.

In establishing the Commission on a High Performance Health System in 2005, The Commonwealth Fund's Board of Directors recognized the need for national leadership to revamp, revitalize, and retool the U.S. health care system. The Commission's 16 members—distinguished experts and leaders representing every sector of health care, as well as the state and federal policy arenas, the business sector, and academia—are charged with promoting a high-performing health system that provides all Americans with affordable access to excellent care while maximizing efficiency in its delivery and administration. Of particular concern to the Commission are the most vulnerable groups in society, including low-income families, the uninsured, racial and ethnic minorities, the very young and the aged, and people in poor health.

Background on Scorecard from

Methodology

Scorecards

The Scorecards take a broad look at how the health care system is doing and where improvements are needed, as well as models of exemplary care from which others may learn. They look at such issues as: Do people have access to the health care they need? Are they getting the highest-quality care? Are we spending money and using health care resources efficiently?

The Scorecards compares national performance against benchmark levels achieved by top performing groups within the U.S. or other countries. In a few instances, benchmarks reflect targets or policy goal. Each score is a ratio of the current U.S. average performance to the benchmark representing best levels of achievement, with a maximum possible score of 100. Benchmarks were based on rates achieved by the top 10 percent of U.S. states, regions, hospitals, health plans or other providers or top countries. Where patient data were available only at the national

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level, benchmarks were based on the experiences of high-income, insured individuals. Four access benchmarks aim for logical policy goals, such as 100 percent of the population to be adequately insured.

Other commission Projects

The report *Organizing the U.S. Health Care Delivery System for High Performance* highlighted the detrimental effects of the nation's fragmented health care delivery and payment systems and offered recommendations for establishing greater coordination across providers and care settings. Among other changes, the Commission favors moving away from fee-for-service payment and toward bundled-payment methods that reward coordinated, high-value care.

Tracking Health System Performance - the Commission has issued three national and two state-level scorecards for the U.S. health system. In March 2012 released a new scorecard for health system performance at the local level.

Rising to the Challenge: Results from a Scorecard on Local Health System Performance - Scorecard on health system performance within the nation's hospital referral regions, provides U.S. communities with comparative data that they can use to assess the performance of their health systems, establish priorities for improvement, and set achievement targets. The findings show clearly that when it comes to health care access and care experiences, where one lives matters.

In the 2011 report *High Performance Accountable Care: Building on Success and Learning from Experience*, the Commission provides a set of recommendations for ensuring the successful implementation and spread of the ACO model, which holds promise as an effective and efficient way to deliver care, especially to people with chronic or complex medical conditions.

A 2012 report from the Commission called on the federal government to develop a comprehensive, disciplined strategic plan to take full advantage of the new opportunities in recent health care legislation. In *The Performance Improvement Imperative: Utilizing a Coordinated, Community-Based Approach to Enhance Care and Lower Costs for Chronically Ill Patients*, the Commission lays out a strategy for addressing one of the greatest health system challenges: improving the coordination of health services provided to people with multiple chronic health conditions. Five percent of the U.S. population accounts for 50 percent of all health care costs, and most in this group have chronic diseases like congestive heart failure, coronary artery disease, and diabetes.

Providing Access for Vulnerable Populations

The Commission also has released a series of reports focusing on the need to ensure access to a high-performing health system for vulnerable populations, including people without health insurance, families with low incomes, and disadvantaged minorities.

Results

Based on the Scorecard's 42 indicators of health system performance, the U.S. earned an overall score of 64 out of a possible 100 when comparing national averages with benchmarks of best performance achieved internationally and

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within the U.S. Although the Scorecard draws on the latest available data, primarily from the period 2007 to 2009, the results do not fully reflect the effects of the recent economic recession on access to and use of care.

The overall performance on the indicators failed to improve relative to benchmarks since the first National Scorecard was issued in 2006, or since the last update in 2008. Benchmarks, however, improved in many cases, raising the bar on what is attainable.

The 2011 edition of the National Scorecard on U.S. Health System Performance finds that despite pockets of improvement, the United States as a whole failed to improve when compared with the top 10 percent of U.S. states, regions, health plans, or health care providers, or the top-performing countries.

Publications / links

National Scorecard 2011

http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2011/Oct/1500_WNTB_Natl_Scorecard_2011_web.pdf

Rising to the Challenge: Results from a Scorecard on Local Health System Performance

<http://www.commonwealthfund.org/Publications/Fund-Reports/2012/Mar/Local-Scorecard.aspx>

Why Not the Best? *Results from the National Scorecard on U.S. Health System Performance, 2008*. The Commonwealth Fund Commission on a High Performance Health System July 2008 Report.

http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2008/Jul/Why%20Not%20the%20Best%20%20Results%20from%20the%20National%20Scorecard%20on%20U%20S%20%20Health%20System%20Performance%20%202008/Why_Not_the_Best_national_scorecard_2008%20pdf.pdf

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Organization	Dartmouth Atlas Project
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	http://www.dartmouthatlas.org/
Measure	Dartmouth Atlas Project

UPDATED IN 2013

Summary

For more than 20 years, the Dartmouth Atlas Project has documented glaring variations in how medical resources are distributed and used in the United States. The project uses Medicare data to provide information and analysis about national, regional, and local markets, as well as hospitals and their affiliated physicians. This research has helped policymakers, the media, health care analysts and others improve their understanding of our health care system and forms the foundation for many of the ongoing efforts to improve health and health systems across America.

Data from the Dartmouth Atlas Project has been used by other researchers and groups to explore variations in use among local areas, health systems and hospitals.

Methodology

Over the past two decades, the Dartmouth Atlas Project has developed a national strategy of providing population-based information describing resource inputs, utilization and outcomes of care across the United States. Much of the variation among regions in per capita resource inputs, utilization and spending has proven to be unwarranted; it cannot be adequately explained on the basis of differences among regions in prices, illness rates, patient characteristics, patient preferences, or the dictates of evidence-based medicine. Much of the variation relates to differences among providers.

The problem of unwarranted variation has attracted widespread attention from the press, policy makers and clinicians interested in quality improvement and health care reform. It has led to legislation promoting demonstration projects to deal with unwarranted variations among the Medicare population. Of particular importance is the evidence that populations living in regions with greater levels of spending and greater use of physician visits and hospitalizations do not experience better health care outcomes or better quality of care. This finding has several implications for patients and for the cost of Medicare. First and foremost, overtreatment harms patients, and it contributes to the chaotic quality of American health care. Second, overtreatment wastes taxpayer dollars. And because of the way Medicare is financed, overtreatment also entails a systematic transfer of tax dollars from residents of low-cost regions to high-cost regions, where those dollars fund the useless, and potentially harmful, care that is being delivered.

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There is published material on:

- Medicare Spending
- Supply-Sensitive Care
- Preference-Sensitive Care
- Effective Care
- The Physician Workforce
- End-of-Life Care
- Racial Disparities
- Accountable Care
- Reflections on Variations
- International

Benchmarking can be used to compare the experience in areas or hospitals of your choice to the national average, state average, or to the rate in other areas or hospitals. The question being explored in the Benchmarking tool is: what if rates in the comparison areas or hospitals were equal to rates in selected benchmarks? The table gives the populations and rates in the benchmark and comparison areas; the ratios of the rates in the comparison areas to rates in the benchmark areas; and the number of events in the comparison areas above (+) or below (-) the number predicted by the experience in the benchmark area, if the rate of the benchmark area had been attained for the residents of the comparison areas.

{From previous material } Three key areas identified. Much of the variation found to relate to provider quality defects:

1. **Failure to provide needed care** or higher than average levels of undesirable outcomes through medical error or system failures
2. **Systematic underuse of effective care techniques**, misuse of preference-sensitive care (eg. Discretionary surgery)
3. **Overuse of supply-sensitive care** such as physician visits, tests and hospitalization rates among chronically ill patients

Results

This web site provides access to all Atlas reports and publications, as well as interactive tools to allow visitors to view specific regions and perform their own comparisons and analyses. These tools have helped other groups create reports like those listed on our Case Studies page. A selection of videos and presentations can be found on our Multimedia page.

Current case studies are available on the website. At the time of this report, studies from the Florida Health Care Coalition, Health Action Council Ohio, and Iowa Health Buyers Alliance were included.

Publications / links

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Downloads (wide range of material) <http://www.dartmouthatlas.org/tools/downloads.aspx>

Hospital Care Intensity <http://www.dartmouthatlas.org/tools/care.aspx>

Benchmarking <http://www.dartmouthatlas.org/tools/benchmarking.aspx>

Case Studies <http://www.dartmouthatlas.org/tools/casestudies.aspx>

Publications <http://www.dartmouthatlas.org/publications/reports.aspx>

Key issues <http://www.dartmouthatlas.org/keyissues/>

This includes a wide range of material on Medicare Spending, Supply-Sensitive Care, Preference-Sensitive Care Effective Care, Physician Workforce, End-of-Life Care, Racial Disparities, Accountable Care, Reflections on Variations, and International

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Organization	Deloitte Center for Health Solutions, Deloitte LLP
Category	Other
Source	www.deloitte.com
Measure	Episodes and Payment Reform papers; Comparative Effectiveness paper http://www.deloitte.com/view/en_US/us/Industries/health-care-providers/center-for-health-solutions/274ed1800c0fb110VgnVCM100000ba42f00aRCRD.htm

UPDATED IN 2013

Summary

The Deloitte Center for Health Solutions is the health services research arm of Deloitte LLP. Our goal is to inform all stakeholders in the health care system about emerging trends, challenges and opportunities using rigorous research. Through our research, roundtables and other forms of engagement, we seek to be a trusted source for relevant, timely and reliable insights.

The Deloitte Center for Health Solutions produces research and other thought leadership that is objective, data-driven and embraces a diversity of viewpoints on trends and issues affecting U.S. health care. Our research is focused in three major areas:

- Health policy and health reforms in the U.S. health care system
- Disruptive innovations that result in innovative solutions to improve efficiency and effectiveness
- Consumerism, incorporating how end users of health goods and services think and behave

In addition to conducting both primary and secondary research studies (surveys, forecasts, case studies, qualitative research), DCHS also provides briefings and educational training sessions to corporate boards, trade associations and senior management teams. We also produce webcasts and podcasts to further inform the debate on issues of importance.

DCHS's studies are available at no cost on this Web site.

Methodology

Health Care Reform

The U.S. health care system is complex, fragmented and expensive. Some might say it is not a system at all; rather, it is a collection of organizations that provide goods and services for individual patients and groups, under the scrutiny of industry watchdogs.

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The cost of the U.S. health care system is projected to increase at 5.8 percent annually through 2020. Health care is the fastest-growing expense in the average American household, in the overhead of employers who provide health insurance, and in state and federal government budgets. Not surprisingly, new entrants offering “lower-cost, better solutions” are now focused on the health care industry: They regard it as a prime target for disruptive innovation. Reforming the U.S. health care system is a fiscal imperative. Reducing its costs while enhancing the quality of its goods and services is its greatest challenge.

Disruptive Innovations in Health Care Big change creates big value opportunities — if you know where to look

You can feel it happening in the marketplace around us. Retail clinics, medical tourism, technology-enabled self care — disruptive innovations in the U.S. health care system challenge the status quo. These and other new phenomena zero in on unmet needs, leverage new technologies and business models, and deliver enhanced value throughout the health care supply chain. When they work, they change the game. Along with consumerism and health reform, disruptive innovation is one of the three major themes we follow at the Deloitte Center for Health Solutions.

Health Care Consumerism

Companies faced with soaring increases in health care costs are taking the lead in the battle to contain them. Consumer-driven health care (CDHC) is a trend that encourages individuals to get the care they need, and helps make employees more engaged health care consumers. The Deloitte Center for Health Solutions examines consumer health options such as consumer-directed health plans and care management programs, which can help control excessive benefits consumption and curb costs.

Papers related to measurement and payment

ACOs

This paper concludes that successful ACOs are more likely to have specific competencies in governance and leadership, operational and clinical effectiveness, IT and infrastructure, risk management and workforce organization. Finally, to enable ACOs to lower costs and improve care, health plans and providers should consider reasonable targets to reduce spending and improve outcomes. At the same time, physicians and consumers will look for a rationale to participate.

Medical Home 2.0

Conceptually, a medical home model makes sense: Improved consumer access to primary care health services and increased accountability for healthy lifestyles are foundational to a reformed health system. For primary care clinicians, the current system of volume-based incentives limits their ability to appropriately diagnose and adequately manage patient care. For consumers, lack of access to effective and clinically accurate diagnostics and therapeutics via primary care is a formula for delayed treatment, overall poor health and higher costs. The medical home model is designed to address these issues.

The “medical home 2.0” is an advancement in the design, delivery and payment for health care services that leverages emergent characteristics of a transformed health system – shared decision-making with patients, multidisciplinary teams where all participate actively in the continuum of care, incentives for adherence to evidence-based practices and cost efficiency and health

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information technologies that equip members of the care team and consumers to make appropriate decisions and monitor results.

Comparative Effectiveness: Health Care Policy Perspectives for Consideration

A Deloitte study that profiles comparative effectiveness systems in the United Kingdom, Australia, Canada and Germany concludes that, if implemented correctly, comparative effectiveness has the potential to improve care and reduce health care costs for Americans.

Publications / links

Health Care Reform

http://www.deloitte.com/view/en_US/us/Industries/health-care-providers/center-for-health-solutions/health-care-reform/index.htm

Disruptive Innovations in Health Care

http://www.deloitte.com/view/en_US/us/Industries/health-care-providers/center-for-health-solutions/disruptive-innovations/index.htm

Health Care Consumerism

http://www.deloitte.com/view/en_US/us/Industries/health-care-providers/center-for-health-solutions/health-care-consumerism/index.htm

Accountable Care Organizations: A new model for sustainable innovation

http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/US_CHS_AccountableCareOrganizations_070610.pdf

Episode-based payment: Perspectives for consideration

http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/us_chs_EpisodeBasedPayment_PerspectivesforConsideration_091609.pdf

Medical Home 2.0: The Present, the Future

http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/US_CHS_MedicalHome2_092210.pdf

Comparative effectiveness: Perspectives for consideration

[http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/us_chs_ComparisoneffectivenessStudy_may2009\(1\).pdf](http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/us_chs_ComparisoneffectivenessStudy_may2009(1).pdf)

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Organization	Dr Foster Intelligence. United Kingdom
Category	International, Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	http://www.drfoosterintelligence.co.uk/
Measure	Dr Foster Intelligence Good Hospital Guide http://www.drfoosterhealth.co.uk/hospital-guide/

Summary

Dr Foster exists to make healthcare data better and help healthcare organisations improve the quality of care. We are the leading provider of healthcare information and benchmarking solutions in England – and increasingly, worldwide. We enable healthcare organisations to benchmark and monitor performance against key indicators of quality and efficiency. If you need intelligent insight into health data, we can help.

Dr Foster Intelligence is a public-private partnership launched in February 2006 that aims to improve the quality and efficiency of health and social care through better use of information. Aim to make it easier for professionals and the public to access health and social care information through a range of innovative products and services. The partnership is in the form of a 50:50 joint venture involving the new Health and Social Care Information Centre (a special health authority of the NHS) and Dr Foster, a commercial provider of healthcare information.

Good Hospital Guide

Annual, first published in 2001. Guides contain information about hospital-specific mortality rates; the total number of staff; wait times; numbers of complaints; as well as private hospital prices for services. A partnership (50:50 joint venture) between Health and Social Care Information Centre (a special health authority of the NHS) and Dr. Foster, a commercial provider of healthcare information.

Other products include:

- Real Time Monitoring (RTM)
- Clinician Outcomes and Benchmarking Tool
- Practice and Provider Monitor
- Patient Experience Tracker
- High-impact User Manager

Methodology

The Dr Foster Research Hospital Guide lists all NHS acute hospitals with more than 300 beds, some smaller NHS acute hospitals that provide key services to a particular geographical area, selected specialist hospitals that provide services covered by the questionnaire, and private hospitals with more than 30 beds.

Two main sources were used for the guide: central Department of Health data for the four UK nations, most of which is at Trust level, and data collected through Dr Foster Research surveys which are also mainly completed at Trust level.

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Data relating to mortality and procedure waiting times, volumes, readmission rates, length of stay and day case rates is based on Hospital Episode Statistics (HES) which covers the NHS in England only. In future, plan to include Scotland, Wales and Northern Ireland and the private sector in assessments of quality and safety, using comparable routinely collected data.

Trust Level Information (mostly only for England) includes:

- Hospital Standardized mortality Ratio
- Number of operations done
- Waiting times by operation
- Day case rates
- Length of stay
- Re-admission rate
- Doctors per 100 beds
- Nurses per 100 beds
- Long outpatient waits
- Outpatient waits by Specialty
- Inpatient waits by Specialty
- Quality of service overall rating
- Infection Control
- Admissions cancelled within seven days of admission for a non-clinical reason
- Choice of food prepared safely
- Effective barriers to prevent prescribing admin errors relating to allergy
- Food and help with eating is available 24 hours a day
- Patients treated with dignity and respect
- Surroundings are well designed, maintained and cleaned
- Views of patients and others are taken into account

Dr Foster's commissioning solutions

Dr Foster is a specialist supplier of comparative benchmarking data and has offerings to support you at every step of the way:

- Quality monitoring of acute providers (Quality Investigator)
- Efficiency monitoring (Practice and Provider Monitor, Commissioning Insight Briefings)
- Identification and addressing frequent users of secondary care (High Impact User Manager)
- Linking of primary and secondary care data (GP Connect)

Results

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Reports do not seek to rank the indicators of individual trusts but to identify 'outliers', namely those whose performances fall beyond statistical control limits and can therefore be regarded as significantly outside expected levels, whether positive or negative. Report on key areas including choice and competition and dimensions of quality including patient safety, effectiveness of care, and patients' experiences.

Publications / links

User guide <http://www.drfoosterhealth.co.uk/hospital-guide/user-guide/>

Methodology <http://www.drfoosterhealth.co.uk/hospital-guide/methodology/>

Features <http://www.drfoosterhealth.co.uk/features/>

2010 Hospital report cards 28th November 2010 <http://www.drfoosterhealth.co.uk/quality-reports/>

Quality monitoring of acute providers (Quality Investigator)

<http://drfoosterintelligence.co.uk/wp-content/uploads/2013/01/qi-brochure-web-012013.pdf>

Efficiency monitoring (Practice and Provider Monitor, Commissioning Insight Briefings)

<http://drfoosterintelligence.co.uk/wp-content/uploads/2013/03/commissioning-investigating-efficiency.pdf>

Identification and addressing frequent users of secondary care (High Impact User Manager)

<http://drfoosterintelligence.co.uk/wp-content/uploads/2013/03/commissioning-managing-high-cost-pts.pdf>

Linking of primary and secondary care data (GP Connect)

<http://drfoosterintelligence.co.uk/wp-content/uploads/2013/03/commissioning-connecting-data.pdf>

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Organization	The Fraser Institute. Canada.
Category	International, Performance ratings, Reports, Scorecards, Databases, Benchmarking
Source	www.fraserinstitute.org
Measure	Hospital Report Card http://www.fraserinstitute.org/report-cards/hospital-performance/overview.aspx

Summary

Our Hospital Report Cards assess up to 50 measures of patient safety and quality of care for acute care hospitals in British Columbia and Ontario. These comparisons help you make more informed choices about your health care.

These measures are provided only for informational purposes. Those in need of health care should seek the advice of their physician before making any decisions on medical treatment.

The comparisons also help to improve hospital performance through enhanced transparency and accountability.

Our Hospital Report Card looks at three categories for each hospital:

- Hospital procedures
- Medical conditions
- Medical conditions related to child birth

An independent research and educational organization with offices in Calgary, Montréal, Tampa, Toronto, and Vancouver, and international partners in over 70 countries. The Fraser Institute measures and studies the impact of markets and government interventions on the welfare of individuals.

Hospital Report Card = Performance report card enabling individuals are able to look up a given condition or procedure and compare death rates, volumes of procedures, rates of adverse events, and utilization rates. Shown across 39 quality and safety indicators for 95 hospitals and 50 municipalities over five years. Rates, scores, and ranks are published separately for each indicator. Future editions of The Fraser Institute's *Hospital Report Card* will include performance measurement of acute-care hospitals in other provinces.

Methodology

Based on administrative data. Uses US Agency for Healthcare Research and Quality (AHRQ) indicators. Primary source of information is the Canadian Institute for Health Information's (CIHI) Discharge Abstract Database (DAD). Demographic, administrative, and clinical data are extracted from the Discharge Abstract Database for inpatient hospital stays from all acute care hospitals in British Columbia. The international standard for risk adjustment, 3M™ APR™ DRG Classification System, is employed to risk adjust the data. Hospital death rates, adverse events rates and utilization rates are risk-adjusted for patients with the same condition but a different health status.

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Uses 39 of AHRQ's indicators of quality – uses the Inpatient Quality Indicators (IQIs and Patient Safety Indicators (PSIs) of AHRQ modules. The indicators are classified into three groups: those related to medical conditions, hospital procedures, and child birth. The indicators are further classified by type: death rates, volumes of procedures, utilization rates, and adverse events. Constructed a hospital mortality index. The 39 indicators and the Hospital Mortality Index apply only to acute-care conditions and procedures for inpatient care.

Publications / links

Hospital performance in Ontario <http://www.hospitalreportcards.ca/on/>

Hospital performance in British Columbia. <http://www.hospitalreportcards.ca/bc/>

Hospital performance in Alberta <http://www.hospitalreportcards.ca/ab/>

Research studies and other links

<http://www.fraserinstitute.org/research-news/research/topics-display.aspx?topic=123&name=Hospital+Report+Cards>

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Organization	Geisinger Health System
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	http://www.geisinger.org/
Measure	ProvenCare Model http://www.geisinger.org/provencare/media.html

Summary

Geisinger is a physician-led health care system, dedicated to health care, education, research and service spanning 43 counties of 20,000 square miles in Pennsylvania and serving 2.6 million people. Geisinger is an integrated delivery system with over 700 employed physicians, three acute care hospitals; specialty hospitals and ambulatory surgery campuses; and a 229,000-member health plan.

Proven Health Navigation (medical home); the ProvenCare Model

In 2005, Geisinger began developing an approach that focused upon innovation and targeted strategies around care coordination and transitions, chronic care optimization and illness prevention, transformation of acute episodic care and engagement of patients. In its core, this approach represents a system of quality and value initiatives based on 3 major programs— Proven Health Navigation (medical home); the ProvenCare model; and transitions of care. The goal of such an approach is to optimize disease management by using a rational reimbursement paradigm for appropriate interventions, providing innovative incentives, and engaging patients in their own care as part of any intervention.

- **ProvenHealth Navigation** - Advanced medical home; this means wrapping a bundle of services around a patient, or a consumer, and his/her family. The goal of Proven Health Navigation is to address healthy behaviors, disease prevention, and disease management once a patient has past the point where prevention is no longer working.
- **ProvenCare** - ProvenCare is about optimizing an acute care intervention and rationalizing the reimbursement paradigm for that intervention, as well as engaging the consumer more actively in his/her own self-care during the time of intervention.
- **Transitions of care** - Recognizes the many handoffs between outpatient and inpatient, between inpatient and outpatient, between inpatient and nursing home, between home and nursing home— particularly vulnerable points for ensuring care safety, quality, and efficiency.

A key component of Geisinger's approach to healthcare is an innovative model of incentives for the consumer, the provider, and the payer. ProvenCare's unique approach to risk management revolves around a 90-day 'care warranty' (for participating payers). ProvenCare Portfolio includes elective CABG; elective PCI, total hip replacement, cataract, EPO, perinatal, bariatric surgery, low back pain.

ProvenCare Components include:

- Patient-centricity
- Appropriate care

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- Evidence/consensus-based best practices
- Highly reliable care
- Optimized work flows
- Explicit accountabilities
- Packaged pricing
- Performance-based reimbursement "Warranty"

Methodology

Proven Care Process

1. Identify eligible patients
2. Document appropriateness
3. Enroll and activate the patient and family
4. Deliver evidence-based care
5. Geisinger is paid a global fee - One fee for the entire identified period of time; Global fee includes 50% share of historical readmission rate (guaranteed payer savings, Geisinger upside based on complication and readmission reduction and efficient care)

All or None Measures

- Measure percentage of patients who receive all related services (not individual measure alone)
- Most all or none measures will not reach 100%
- Some goals not appropriate for all patients, some goals not achievable for all patients

Health Policy Considerations

- Access to health insurance is key - should include regional plans (provide flexibility and innovation)
- Formation of Integrated Systems should be facilitated
 - Bundled payments
 - Episode of care payments
 - Treatment based – not insurance risk
 - Accountable care organizations
 - “Cost saving” shared with providers
- Healthcare Information Technology
 - Computers and Electronic Health Records are necessary, not sufficient
 - Redesign of care required
 - Ongoing upgrades needed
- Comparative effectiveness research
- Training of next generation

Publications / links

Frequently Asked Questions <http://www.geisinger.org/provencare/faq.html>

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ProvenCare Process	http://www.geisinger.org/provencare/faq.html
ProvenCare PCI	http://www.geisinger.org/provencare/pci.html
ProvenCare Benchmarks	http://www.geisinger.org/provencare/benchmarks.html
ProvenCare by the Numbers	http://www.geisinger.org/provencare/podcast.html

Continuous Innovation In Health Care: Implications Of The Geisinger Experience. Ronald A. Paulus, Karen Davis, and Glenn D. Steele, *Health Affairs* 27, no. 5 (2008): 1235–1245

ProvenCare: quality improvement model for designing highly reliable care in cardiac surgery. S A Berry, M C Doll, K E McKinley, A S Casale, A Bothe, Jr. *Qual Saf Health Care* 2009;**18**:360-368

“ProvenCare: A Provider-Driven Pay-for-Performance Program for Acute Episodic Cardiac Surgical Care,” A.S. Casale et al., *Annals of Surgery* 246, no. 4 (2007): 613–621.

[entry updated 2010]

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Organization	HCI³ (Health Care Incentives Improvement Institute)
Category	Incentive/Reward Programs; Standards Setting, Industry Organizations
Source	www.hci3.org
Measure	Bridges to Excellence http://www.bridgestoexcellence.org/

Updated in 2013

Summary

HCI3 is a non-profit organization, guided by a Board of Directors that includes physicians, employers, health plans, and others. We have created a broad range of programs to:

- Measure health outcomes
- Reduce preventable care defects
- Promote a team-based approach to caring for patients
- Realign provider payment incentives around quality
- Reward excellence wherever we find it

Bridges to Excellence programs recognize and reward clinicians who deliver superior patient care.

Methodology

Our programs measure the quality of care delivered in provider practices. We place a special emphasis on managing patients with chronic conditions, who are most at risk of incurring potentially avoidable complications. Our Recognitions cover all major chronic conditions, plus office systems – and a real Medical Home measurement scheme to promote comprehensive care delivery and strong relationships between patients and their care teams.

Physicians, nurse practitioners and physician assistants who meet our performance benchmarks can earn a range of incentives, sometimes including substantial cash payouts. Insurers and employers fund these payouts from the savings they achieve through lower health care costs and increased employee productivity.

BTE Recognition programs use standardized sets of measures and criteria to analyze quality of care, including AQA/NQF-endorsed and NCQA-developed measures.

Development of each Recognition program involves the following steps. First, a physician panel is selected to help develop the program. The panel includes a balance of specialists and primary care physicians. Then, an inventory of measures from the National Quality Forum (NQF), AQA, American Medical Association (AMA), Physician Quality Reporting Initiative (PQRI), National Committee for Quality Assurance (NCQA), and the Agency for Healthcare Research and Quality (AHRQ) is performed. The relative strength of each of the measures is weighed to determine

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the core measures and thresholds for the program. Next, program rules such as patient eligibility and specifications, measures' weights, and Recognition levels and tiers are decided upon. Scoring rules are then defined, which includes defining measures criteria and weights, setting Recognition levels, and developing Recognition tiers. Each BTE Recognition program has three levels of certification, in order to promote continuous quality improvement.

In order to speed up, simplify and standardize a national clinician performance assessment process, BTE has created a performance assessment system for clinicians using electronic medical record data. The automated EMR/Registry System allows for rapid and independent, medical record-based clinician performance assessments by connecting local and national medical record data sources, or data aggregators (DAs) to BTE PAOs. Through the automated EMR/Registry System, BTE aims to: reduce the reporting burden for clinicians; leverage existing reporting/data aggregation initiatives; reduce data collection and reporting costs; facilitate the connection between quality improvement and incentives; and speed up cycle times between reporting and improvement.

BTE programs are designed around three key lessons gained from our research and experience.

First, it's critical to measure what matters most—the handful of indicators that have truly significant clinical and financial impact.

Second, clinicians who follow those quality measures will consistently provide better care at lower costs. Typically, they outperform their peers on process measures of quality, and have lower average costs per patient and per episode.

Third, incentives only work if they are fair and designed to increase over time, so clinicians who continually improve their practices are rewarded in kind. The better they get, the more incentives they deserve—and the more patients should be encouraged to utilize them. As in any industry, the best performers should earn the most and have the biggest market share.

There are two types of incentives that encourage physicians to participate in the Recognitions: public/peer recognition of the achievement, and higher revenue for the practice. It is the latter that is the focus of our national or regional implementations because our research has clearly shown a link between the size of the financial incentives available to a practice and their participation.

BTE Programs don't have any downside. Clinicians and practices get a complete report on their measures from the clinical data submitted, with benchmarks on performance and peer comparisons. Only those that achieve the passing grade get recognized and can become eligible for incentives. For the others, the report is private.

Results

Typically, BTE-recognized physicians have been found to

- Outperform non-recognized physicians on process measures of quality.

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- Have fewer episodes per patient and lower resource use per episode.
- Have lower average costs per patient and per episode.

Patients with chronic conditions generally had fewer hospital admissions, and were healthier on average. And Recognized practices reported a higher level of shared accountability between patients and providers. As a result, these patients are better managed and incur fewer potentially avoidable hospitalizations and emergency department visits.

Many health Plans and Employers are participating in BTE efforts across the country.

Publications / links

HCI3 - A Vision to Transform U.S. Health Care

<http://www.hci3.org/sites/default/files/files/HCI3VisionBrch-F2.pdf>

BTE Physician Brochure

<http://www.hci3.org/sites/default/files/files/BTE-PhysBrch-F3.pdf>

Tools and Resources

http://www.hci3.org/what_is_bte/tools_and_resources

Recognition programs

http://www.hci3.org/recognition_programs

Rosenthal. Meredith B., Francois S. de Brantes, Anna D. Sinaiko, Matthew Frankel, Russell D. Robbins, and Sara Young. *Am J Manag Care. 2008;14(10):670-677*

de Brantes. Francois, Paula S. Wickland, and John P. Williams The Value of Ambulatory Care Measures: A Review of Clinical and Financial Impact from an Employer/Payer Perspective., *Am J Manag Care. 2008;14(6):360-368*)

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Organization	HCI³ (Health Care Incentives Improvement Institute)
Category	Incentive/Reward Programs; Standards Setting, Industry Organizations
Source	www.hci3.org
Measure	PROMETHEUS Payment System www.PrometheusPayment.org

Updated in 2013

Summary

HCI3 is a non-profit organization, guided by a Board of Directors that includes physicians, employers, health plans, and others. We have created a broad range of programs to:

- Measure health outcomes
- Reduce preventable care defects
- Promote a team-based approach to caring for patients
- Realign provider payment incentives around quality
- Reward excellence wherever we find it

Everyone knows the U.S. must transform the way it pays for health care. The question, of course, is how. We believe PROMETHEUS Payment® is the model that best addresses the full range of issues that can drive profound long-term, system-wide improvements. This model:

Compensates providers fairly—and rewards excellence by allowing top performers to earn more.

Offers direct and powerful incentives for providers to deliver greater value and better outcomes.

Encourages caregivers to work in teams, share information, and take collective responsibility for a patient's health.

Provides a realistic framework to transform today's fragmented and inefficient system into one that is far more integrated and accountable.

By bringing economic incentives in line with the medical profession's strong desire to improve patient health, PROMETHEUS creates an environment where doing the right things for patients helps providers and insurers do well financially. And it does this without introducing new administrative burdens, or changing the way patients access care.

P.R.O.M.E.T.H.E.U.S.: Provider Payment Reform for Outcomes, Margins, Evidence, Transparency Hassle-reduction, Excellence, Understandability and Sustainability

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Methodology

The PROMETHEUS model packages payment around a comprehensive episode of medical care that covers all patient services related to a single illness or condition.

Covered services are based on commonly accepted clinical guidelines or expert opinions that define the best methods for treating a given condition from beginning to end. The prices of all treatments are tallied to generate an Evidence-informed Case Rate™ (ECR). This creates a budget for the entire care episode. ECRs include all covered services bundled across all providers that would typically treat a patient for the given condition (hospital, physicians, laboratory, pharmacy, rehabilitation facility, etc.). The ECR is adjusted for the severity and complexity of each patient's condition.

To determine the relevant costs of a specific episode, the model separates out two types of risk.

Probability Risk: These are risks outside the provider's control, assumed by the insurer.

Technical Risk: These are risks within a provider's control, and therefore assumed by the provider. These include potentially avoidable complications (PACs) and other variations. PACs are deficiencies in care that cause harm to the patient, and might have been prevented with more effective treatment. An example is when a patient with diabetes needs an amputation because of uncontrolled blood sugar. We have found that up to 40 cents of each dollar spent on chronic conditions, and up to 20 cents of each dollar spent on acute hospitalizations and procedures, are because of PACs.

Evidence-Informed Case Rates™ (ECR)

An Evidence-informed Case Rate, or ECR®, is a budget for an entire care episode that includes all covered services bundled across all providers that would typically treat a patient for a single illness or condition (hospital, physicians, laboratory, pharmacy, rehabilitation facility, etc.) ECRs are also patient-specific in that they are adjusted for the severity and complexity of each patient's condition. ECR® methodology was developed by the PROMETHEUS Payment design team.

ECRs are calculated by taking into account the following factors: covered services, practice pattern variation, severity-adjustment, a margin, and potentially avoidable complication (PAC) allowance.

- Covered services are the foundation of an ECR budget. They are commonly accepted clinical guidelines or expert opinions that define the best methods for treating a given condition from beginning to end. The covered services are then adjusted to reflect local practice patterns.
- An ECR is severity-adjusted based on both patient and provider characteristics. The severity-adjustment is arrived at through a stepwise multi-variable regression model. This adjustment takes multiple factors into account including patient demographics and co-morbidities, geographic location, and provider specialty.

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- An ECR also factors in a margin, which reflects the importance for any going concern to have a return on capital assets invested and a reason to reinvest in business operations. Currently a margin of zero percent is factored into the ECR, though this number can be adjusted by the user.

The Prometheus Payment Engine

HCI3 contracted with MedAssets to develop an engine for PROMETHEUS Payment. In order to implement PROMETHEUS Payment, a pilot site must plug into or hook up to the PROMETHEUS engine. The engine is hosted by a service bureau to allow for easy "plug and play". The engine is a combination of a claims tracking and financial accounting system, along with a scorecard that uses both claims and other data, including medical records data, to measure the quality of care that is being delivered to patients.

The engine is a clinically based, financial "credit/debit" system that reconciles the actual cost of care against the predicted cost of care for any given ECR using existing claims data. The engine automatically calculates patient-specific ECRs, while also including a PAC allowance, the margin and the underuse adjustment. Upon the conclusion of an ECR, the engine will automatically and retrospectively tally actual accumulated costs versus predicted costs for Scorecard analysis.

Results

HCI3 is currently working with several implementation partners throughout the country to pilot the PROMETHEUS Payment model.

A summary of many pilots is available on their website (see below)

Publications / links

Tools & Resources

http://www.hci3.org/what_is_prometheus/tools_and_resources

Implementation Toolkit

http://www.hci3.org/implementations/prometheus_implementation_toolkit

What is an Episode of Care Engine?

<http://www.hci3.org/content/what-is-an-episode-of-care-engine>

Results

http://www.hci3.org/what_is_prometheus/results

PMPMEstimator-11-4-11 FINAL.xlsx

<http://www.hci3.org/sites/default/files/files/PMPMEstimator-11-4-11-FINAL.xlsx>

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Issues Brief June 2008

http://www.commonwealthfund.org/usr_doc/de_Brantes_issue_brief_SBA_final.pdf?section=4039

de Brantes F, D'Andrea G, Rosenthal MB. [Should health care come with a warranty?](#) Health Aff (Millwood) 2009; 28:w678-w687
de Brantes, François., Meredith B. Rosenthal, , and Michael Painter, [Building a Bridge from Fragmentation to Accountability — The Prometheus Payment Model.](#) NEJM 2009; 361:1033 (Perspective)

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Organization	HealthGrades
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	http://www.healthgrades.com/hospital-solutions/connecting-point/
Measure	Hospital Quality in America http://www.healthgrades.com/media/DMS/pdf/HealthGradesEleventhAnnualHospitalQualityStudy2008.pdf

Summary

Founded in 1998 and headquartered in Denver, Healthgrades is the leading online resource for comprehensive information about physicians and hospitals. Today, more than 225 million visitors use the Healthgrades websites to find, evaluate, compare, select, connect and communicate with physicians and hospitals that best meet their treatment needs.

HealthGrades has studied and measured the quality of care at the nation's hospitals since 1998. Reviewed and measured quality of approx. 5,000 US hospitals. Results published annually on the web. Focus is on measuring global quality which incorporates performance/ process measures, outcomes, systems, and people. Believed that the combination of quality metrics which focus both on process and outcomes will provide the ideal motivation for improved healthcare.

America's 50 Best Hospitals Award - Identifies hospitals that have received HealthGrades' Distinguished Hospital Award for Clinical Excellence designation for the most consecutive years.

Distinguished Hospital Award – Patient Safety - Analyzes patient outcome data for virtually every US hospital.

Distinguished Hospital Award – Clinical Excellence- Evaluates and compares hospital performance in two groups: teaching and non-teaching hospitals.

Ten clinical areas and thirty procedures and treatment areas at hospitals are rated. In each category, hospitals receive a five-, three- or one-star rating, indicating that their risk-adjusted mortality or complications rates are above, at or below average.

- Five star = performance was better than predicted and the difference was statistically significant.
- Three star = Actual performance was not statistically significant from what was predicted,
- One star = Actual performance was worse than predicted and the difference was statistically significant.

Methodology

2008 study (11th in series) analyzed over 41 million Medicare discharges from every U.S. hospital from 2005 through 2007. Risk adjusted mortality and complication rates were calculated and hospitals were assigned a 1-star (poor), 3-star (as expected), or 5-star (best) quality rating for 27 diagnoses and procedures. Part two of the study, assessed quality differences between 1-, 3-, and

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5-star rated hospitals by analyzing the in-hospital mortality rates for over 11 million Medicare discharges associated with 17 diagnoses and procedures.

Performance of individual states and regions was evaluated across eight service areas: cardiac surgery, coronary interventional procedures, critical care, gastrointestinal services, heart attack treatment, heart failure, pulmonary care, and stroke care. State and regional performance was benchmarked against the national average and against the best-performing hospitals

Data Source and Analysis - Initial data purchased from the Centers for Medicare and Medicaid Services (CMS) (MedPAR file) containing inpatient records for Medicare patients. Data analyzed via multivariate Logistic Regression-Based Ratings –to account for patient characteristics/risk factors such as age, gender, source of admission, specific procedure performed, and co-morbid conditions such as hypertension, chronic renal failure, heart failure, diabetes and other underlying medical diagnoses that could increase the patient’s risk of mortality or complication.

Publications / links

American Hospital Quality Outcomes 2014 Executive Summary

<https://d2dcgio3q2u5fb.cloudfront.net/56/90/e07df9f64a5fb741ab59924a9e0d/2013-american-hospital-quality-outcomes-2014-healthgrades-report-to-the-nation.pdf>

2013: American Hospital Quality Outcomes 2014: Healthgrades Report to the Nation

<https://d2dcgio3q2u5fb.cloudfront.net/56/90/e07df9f64a5fb741ab59924a9e0d/2013-american-hospital-quality-outcomes-2014-healthgrades-report-to-the-nation.pdf>

2013: Healthgrades America's Best Hospitals Report

<https://d2dcgio3q2u5fb.cloudfront.net/01/1c/7c5acc36487298a32a7c5f7dac4f/2013-healthgrades-americas-best-hospitals-report.pdf>

America’s Best Hospitals Methodology

<http://hg-article-center.s3-website-us-east-1.amazonaws.com/cf/e1/1f48a92d440eafb877e765ec1107/americas-best-hospitals-methodology-2013.pdf>

Mortality and Complications Outcomes Methodology

<https://d2dcgio3q2u5fb.cloudfront.net/6a/4e/1db7e19b4f418e8d488987e4ef12/2014-mortality-and-complications-outcomes-methodology.pdf>

Specialty Excellence Award 2014 Methodology

<https://d2dcgio3q2u5fb.cloudfront.net/0e/0e/6d38e64942ac99690e39f91a00de/specialty-excellence-award-2014-methodology.pdf>

Bariatric Surgery Methodology

<https://d2dcgio3q2u5fb.cloudfront.net/d7/42/f938f22441828f96cbe0f1dbda56/2013-bariatric-surgery-methodology.pdf>

Emergency Medicine Excellence Award Methodology

All weblinks were updated in 2013. Written material is extracted from publicly-available material on the websites of organizations - much of the content was extracted in 2013. But, some of the continuing programs come from earlier editions (2008 or 2010). It has not been independently validated and the authors and the Society of Actuaries make no warranty as to its accuracy.

<http://hg-article-center.s3-website-us-east-1.amazonaws.com/dd/8d/bd044db04e28acfdedf448285a22/EmergencyMedicineExcellenceAwardMethodology2012.pdf>

Recognized Doctor Methodology

<https://d2dcgio3q2u5fb.cloudfront.net/3d/07/2738761f44efbf8e40c62a821e97/recognized-doctor-methodology.pdf>

Archived reports

<http://www.healthgrades.com/quality/archived-reports>

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Organization	HealthInsight
Category	State focus; Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	http://healthinsight.org/
Measure	Rankings for Hospitals, Home Health, and Nursing Homes

UPDATED IN 2013

Summary

HealthInsight is a private, non-profit, community-based organization dedicated to improving health and health care, that is composed of locally governed organizations in three western states: Nevada, New Mexico and Utah. As such, it is able to draw upon the unique social and cultural elements of each state, as well as the quality improvement expertise in those states that has been developed over three decades.

Methodology

The hospital reports come in part from the Hospital Compare national site from CMS. Some measures are supplemented from a data warehouse.

Some hospital quality measures come from data collected and submitted by hospitals to the QIO Clinical Warehouse. Below is a list of the 19 measures used to calculate the hospital rankings. All are process measures with higher percentages indicating better performance.

Home health care rankings using computed using publicly reported data downloaded from the Centers for Medicare & Medicaid Services (CMS) Medicare website. The Home Health Compare data set contains agency-specific, risk-adjusted, performance on 22 quality measures for over 12,000 agencies nationwide.

he nursing home rankings are computed using publicly reported data downloaded from the Centers for Medicare & Medicaid Services (CMS) website (last accessed 7/23/2013). On this web-site CMS displays facility-specific, risk adjusted, performance on 18 quality measures for over 15,000 nursing homes nationwide.

Health Status and Performance of the Healthcare Systems

The systems measures provide a broad and general picture of the performance of the state's healthcare system. The measures were chosen to reflect the different dimensions of care, including type of care (e.g. preventive, acute and chronic) and setting of care (e.g. hospitals, nursing homes and ambulatory care).

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Publications / links

Systems Measures-Healthcare

Nevada Report	http://healthinsight.org/Internal/assets/Systems_Measures/nv.pdf
New Mexico Report	http://healthinsight.org/Internal/assets/Systems_Measures/nm.pdf
Utah Report	http://healthinsight.org/Internal/assets/Systems_Measures/ut.pdf
Report References	http://healthinsight.org/Internal/assets/Systems_Measures/ref.pdf

All weblinks were updated in 2013. Written material is extracted from publicly-available material on the websites of organizations - much of the content was extracted in 2013. But, some of the continuing programs come from earlier editions (2008 or 2010). It has not been independently validated and the authors and the Society of Actuaries make no warranty as to its accuracy.

Organization	Healthnet
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	www.healthnet.com
Measure	Silver Network https://www.healthnet.com/portal/broker/content.do?mainResourceFile=/content/general/unprotected/html/ca/plans/all_other/mid_hmo_silver_network.html Decision Power

UPDATED TO 2013

Summary

Health Net, Inc. is a publicly traded managed care organization that delivers managed health care services through health plans and government-sponsored managed care plans. Its mission is to help people be healthy, secure and comfortable. Health Net provides and administers health benefits to approximately 5.4 million individuals across the country through group, individual, Medicare (including the Medicare prescription drug benefit commonly referred to as “Part D”), Medicaid, Department of Defense, including TRICARE, and Veterans Affairs programs.

Methodology

HMO Silver Network

Health Net’s HMO Silver Network was designed to help confront the challenge of ever rising health care costs, without sacrificing quality. For groups of 51 or more, it achieves this by combining the comprehensive benefits of any of our existing HMO plans with a select network of cost-efficient providers. The HMO Silver Network is available in all or parts of Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Francisco Stanislaus, Santa Clara and Ventura Counties. Group must be favorable to the network service area.

HMO Silver Network advantages:

- **Affordability** – The HMO Silver Network is simply a select subset of our regular HMO network to include the most cost-efficient providers.
- **Choice** – For groups of 51 or more, the HMO Silver Network is available with any of our existing HMO plans. You get the same benefits at lower price points.
- **Accessibility** – The HMO Silver Network maintains excellent access and service standards, with a large network of PCPs, specialists and hospitals over a ten-county service area.

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- Simplicity – Nothing is new except the network and the price, and we've made sure that network selection will go smoothly.
- Decision PowerSM – Health Net addresses the needs of the whole person and fosters long-term benefit sustainability with Decision Power. Integral to all our health plans, Decision Power helps reduce high-cost service utilization and supports workplace productivity by helping people make the decisions that are right for their health and their life — from wellness to health coaching, chronic condition management to end-stage disease support.

Decision Power

Decision Power Health & Wellness is a complimentary benefit available to Health Net members:

- Talk to a Registered Nurse
- Health Risk Questionnaire
- Healthy Living Programs
- Personal Health Record
- Decision Power Healthy Discounts
- Decision Power Maternity and Healthy Baby
- Decision Power Nurse
- Decision Power Tools

Results

Premiums and rates for the Silver plan have seen sustained at rates below for other comparable programs in many parts of the state.

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Organization	HealthPartners
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	http://www.healthpartners.com/public/
Measure	<p>Partners in Excellence Program (PIE) https://www.healthpartners.com/provider-public/quality-and-measurement/partners-in-quality/</p> <p>Total Cost of Care and Resource Use (TCOC) http://www.healthpartners.com/public/tcoc/</p>

Updated in 2013

Summary

HealthPartners is an award-winning integrated health care system based in Bloomington, Minn., with a team of 21,000 people dedicated to a mission to improve the health of members, patients and the community. It also serves more than 1.4 million medical and dental health plan members. The largest consumer-governed, nonprofit health care organization in the nation, HealthPartners provides care, coverage, research and education to improve the health of our members, patients and the community.

Methodology

Partners in Excellence Program (PIE)

The Partners in Excellence Program forms the basis for HealthPartners' financial and public recognition for medical, specialty or pharmacy groups achieving high levels of performance on Triple Aim Performance.

Financial rewards are based on medical, specialty or pharmacy group performance as measured by Minnesota Community Measurement. For those measures that do not have a corresponding MNCM measures, we utilize HealthPartners Clinical Indicator measurement set, and HealthPartners Consumer Choice Satisfaction survey.

HealthPartners pay for performance program, Partners in Quality, is built considering the principles endorsed by various national and local groups with the goal of driving improvements in healthcare quality within care delivery systems and to maximize participation of all providers over time

Total Cost of Care and Resource Use (TCOC)

HealthPartners' method of measuring health care costs:

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- Measures all care: professional, inpatient, outpatient, pharmacy, ancillary
- Is indicative of price and resource use drivers at every level
- Yields comparable measures of cost and resource use across the marketplace
- Supports development of reformed payment approaches

The NQF 2012 has announced the organization's endorsement of the Total Cost of Care measurement.

Other programs

Medical Group and Hospital Ratings - high cost doesn't necessarily mean best quality; lower-cost providers often deliver high-quality care. HealthPartners cost and quality ratings for primary care, specialists and hospitals help consumers have a better understanding of health care value.

HealthPartners quality assessment ratings are based on clinical quality as well as patient experience surveys, in which members rate quality of care and service. HealthPartners collects clinical quality measures across our regional network and also draws upon reputable third-party sources, such as Minnesota Community Measurement, that collect, analyze, and publicly report measures of clinical quality. These measures are based on standards established by organizations such as the National Quality Forum and the Institute for Clinical Systems Improvement.

Provider cost comparisons - compare provider costs for common conditions, treatments and services.

Cost calculator - estimate medical costs for specific treatments or for the year. Knowing the actual cost of your medical care can make it easier to budget for health care expenses. One element is an annual planner to plan your annual health care expenses for you and your family. Another estimates treatment costs model that show the total cost of care for treating a variety of health conditions.

Publications / links

Total Cost of Care and Resource Use (TCOC)

<http://www.healthpartners.com/public/tcoc/>

Partners in Quality Programs

<https://www.healthpartners.com/provider-public/quality-and-measurement/partners-in-quality/>

Partners in Excellence Executive Summary for Primary Care, Pediatric and Specialty Care

http://www.healthpartners.com/ucm/groups/public/@hp/@public/documents/documents/dev_057898.pdf

Consumer Reports article

<http://www.consumerreports.org/cro/magazine/2012/10/when-costlier-medical-care-isn-t-better/index.htm>

All weblinks were updated in 2013. Written material is extracted from publicly-available material on the websites of organizations - much of the content was extracted in 2013. But, some of the continuing programs come from earlier editions (2008 or 2010). It has not been independently validated and the authors and the Society of Actuaries make no warranty as to its accuracy.

Organization	The Health System Performance Research Network (HSPRN) Canada
Category	International; Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	www.hsprn.ca
Measure	The Hospital Report Series (through 2008)

Weblinks updated in 2013 – report series ended in 2008

Summary

Initially sponsored by Ontario Hospital Association and the Ministry of Health and Long Term Care. In January 2008, the research activities of the Hospital Report Research Collaborative (HRRC) were assumed by the Health System Performance Research Network (HSPRN). Aims to produce a series of report cards for hospitals of Ontario to help people better understand and assess the performance of their local hospitals and of the provinces hospitals as a whole. Also supports efforts by hospitals to improve the quality of their services. Reports on Acute Care, Complex Continuing Care, Emergency Department Care, Rehabilitation, Mental Health.

The new organization has not continued this analysis and reports, but the structure and content is still available.

b

Methodology

Uses a balanced scorecard. Broad areas (quadrants) of activities and outcomes are accessed in the areas of Financial Performance, Clinical Utilization and Outcomes, System Integration and Change and Patient Satisfaction. Performance measures for each of the four quadrants are provided at the hospital-specific level, along with average scores by local health integration network (LHIN), hospital type and the province as a whole. a summary of performance scores for 40 indicators across four areas of performance.

Indicators - Clinical Utilization and Outcomes (7), Financial Performance and Condition (9), Patient Satisfaction (4 general, 8 pediatric), System Integration and Change (12)

Results

From 2008, hospital specific results are available for participating hospitals on an e-scorecard developed using the Metrics3d platform (ABS Systems). Comparative information is available to regions and the province as a whole.

Publication

Guidelines on Person-Level Costing Using Administrative Databases in Ontario

http://www.hsprn.ca/activities/papers/hsprn_case_costing_vol1_2013.pdf

Reports by sector and year

<http://www.hsprn.ca/reports/bysector.html>

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Organization	The Hearst Corporation
Category	International, Standards Setting, Industry Organizations; Summary for Public, Consumer
Source	http://www.hearst.com/business-media/map-of-medicine.php
Measure	Map of Medicine http://www.mapofmedicine.com/ Healthguides http://healthguides.mapofmedicine.com/choices/map-open/index.html

UPDATED IN 2013

Summary

The Map of Medicine is a web-based visual representation of evidence-based patient care journeys covering 28 medical specialties and 390 pathways. As healthcare provision becomes much more specialized, the need to plan and then benchmark clinical practice against national standards —while incorporating local intricacies —is key.

Map of Medicine pathways deliver clarity on the evidence base. Map of Medicine care maps are based on over 170 sources of guidance, one of which is NICE, to describe a complete clinical pathway. All sources are quality-assured by the Map. The Map also goes beyond the evidence to include practice-based knowledge from those with front-line clinical experience. No other care maps aggregate knowledge in such a comprehensive manner.

The Map supports GPs in decisions about local services planning through the provision of best practice information. It enables customisation by local groups wanting to define and communicate services. When used as part of a service review or redesign, the patient-focused output sets clinical standards across all care settings in a local health economy.

Map of Medicine is the combined inspiration of medical entrepreneur Dr Mike Stein and Prof. Owen Epstein. Map of Medicine was born as a tool to improve dialogue between primary and secondary care.

Hearst Corporation, acquired the business in April 2008. It now includes sister organizations:

- Zynx Health, which provides evidence-based solutions for improving the quality, safety, and efficiency of patient care;
- First Databank provides medication decision-making solutions;
- MCG (formerly Milliman Care Guidelines) helps providers drive effective care, and provides fast access to globally sourced, clinically validated best practices that support clinical decision making.

Full access to the Map of Medicine is licensed to healthcare communities. In addition to the clinicians version, the Map of Medicine has developed a patient-oriented version – Healthguides.

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Methodology

Map of Medicine

The ideal starting point for defining and communicating services, Map of Medicine is a collection of evidence-based, practice-informed care maps which connect all the knowledge and services around a clinical condition. The care maps can be customised to reflect local needs and practices by commissioners looking to devise new care pathways.

Map of Medicine develops pathways from recognized international sources of evidence-based knowledge. These are supported where necessary with expert opinion. Continuous evidence searching means that pathways can be updated rapidly in response to any change in the information landscape. Indexed and grey literature is constantly monitored for new evidence, and feedback is collected from users year-round.

The methodology delivers high-quality, authoritative and up-to-date care maps in over 250 clinical topics.

HealthGuides

The Map of Medicine has developed a patient-oriented version – Healthguides – and has made them available on the NHS Choices website. NHS Choices is the new digital 'front door' to the NHS. A one-stop-shop for all NHS accredited health information and services.

Healthguides is a limited functionality version of the Map that allows patients to see what the doctor sees. They present the different steps of a patient journey, from symptoms to diagnosis and treatment, using the same easy to follow charts as the Map of Medicine.

Results

More than 50 local communities are using the Map to improve clinical outcomes and the patient experience. See our case studies to learn how they are benefiting from lower healthcare delivery costs, improved clinical effectiveness and patient safety and an improved patient experience, such as reduced hospital admissions and lowered waiting times.

According to a study by the Cochrane Library, clinical pathways are associated with reduced in-hospital complications and improved documentation without negatively impacting on length of stay and hospital costs.

Publications / links

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Current pathways	http://www.mapofmedicine.com/solution/editorialmethodology/currentpathways
Methodology	http://www.mapofmedicine.com/solution/editorialmethodology/
Case studies	http://www.mapofmedicine.com/mapinnhs/casestudies/
Map Referrals	http://www.mapofmedicine.com/global/pdf/factsheets/MapReferrals_V7.pdf

Clinical pathways: effects on professional practice, patient outcomes, length of stay and hospital costs – Cochrane Library
<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006632.pub2/abstract;jsessionid=3877A1490204A08ED94884883C293B30.f02t03>

All weblinks were updated in 2013. Written material is extracted from publicly-available material on the websites of organizations - much of the content was extracted in 2013. But, some of the continuing programs come from earlier editions (2008 or 2010). It has not been independently validated and the authors and the Society of Actuaries make no warranty as to its accuracy.

Organization	The Hearst Corporation
Category	International, Standards Setting, Industry Organizations; Summary for Public, Consumer
Source	http://www.hearst.com/business-media/mcg.php
Measure	MCG (formerly Milliman Care Guidelines) http://www.careguidelines.com/

UPDATED IN 2013

Summary

MCG (formerly Milliman Care Guidelines) independently develops and produces evidence-based clinical guidelines and software used by more than 2,200 clients, including more than 1,200 provider organizations and seven of the eight largest US health plans.

Annually updated MCG products—available through a variety of interactive and non-interactive software options—are: Ambulatory Care, Inpatient & Surgical Care, General Recovery Care, Recovery Facility Care, Home Care, Chronic Care, and Behavioral Health Care. Covering the continuum of care, our evidence-based clinical guidelines support the healthcare management of a majority of Americans.

Authors note: given the new owner changes, the website was new - more material may be available later. For reference, this entry includes extracts from previous Milliman web material.

Methodology

The guidelines address various types of treatment

- Ambulatory Care
- Inpatient & Surgical Care
- General Recovery Care
- Home Care
- Recovery Facility Care
- Behavioral Health Care
- Chronic Care
- Patient Information

Inpatient & Surgical Care

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As one example, Inpatient & Surgical Care offers evidence-based criteria, goals, care pathways, and other decision-support tools, making it a valuable resource for care management, case review, and patient assessments. It includes:

- Optimal recovery guidelines – Recovery and treatment plans with day-by-day steps that yield the most favorable outcomes.
- Actionable criteria – Admission criteria, alternatives to admission, procedures, and discharge details to support your clinical care efforts.
- Observation care guidelines – Comprehensive criteria covering observation care admission and discharge decisions.
- Integrated quality measures – Hospital Quality Alliance (HQA) measures to support quality care.
- Easy evidence access – Annotated bibliographies and footnotes integrated into the guidelines for easy reference.
- Readmission risk – Measures to help reduce readmission for heart failure, myocardial infarction, and community-acquired pneumonia.

Disclaimer: Qualified healthcare professionals may use our guidelines as a tool to support medical necessity decisions, but they should not use them as the sole basis for denying treatment or payment. Our guidelines must be applied to individual patients on a case-by-case basis and always in the context of a qualified healthcare professional's clinical judgment.

PREVIOUS MATERIAL – FROM THE MILLIMAN WEBPAGES IN PRIOR YEARS

Milliman Care Guidelines are evidence-based clinical guidelines that span the continuum of care, including chronic care and behavioral health management. Providing much more than authorization criteria, they drive high-quality care through such tools as care pathway tables, flagged quality measures, and integrated medical evidence.

Care Guidelines Products:

1. Ambulatory Care

Tool for authorizing established and emerging technologies, outpatient procedures, diagnostic tests, imaging, rehabilitation services, DME, injectables and more.

2. Inpatient and Surgical Care

Evidence-based resource for proactive inpatient care management, including criteria, goals, care pathways and other decision-support tools.

3. General Recovery Guidelines

Ideal when there isn't a guideline for the diagnosis, or when the clinical situation is so complex that a guideline is not easily applied.

4. Recovery Facility Care

A detailed and comprehensive means to develop effective plans for recovery facility admission, care and discharge.

5. Home Care

A comprehensive planning resource to smoothly move patients through home healthcare.

All weblinks were updated in 2013. Written material is extracted from publicly-available material on the websites of organizations - much of the content was extracted in 2013. But, some of the continuing programs come from earlier editions (2008 or 2010). It has not been independently validated and the authors and the Society of Actuaries make no warranty as to its accuracy.

6. Chronic Care Guidelines

A tool to facilitate outpatient care for chronic or complex diagnoses.

7. Behavioral Health Guidelines

Reliable, evidence-based tools and criteria that address appropriateness of specific psychological, behavioral and pharmacologic therapies.

Care Guidelines are incorporated into either client-hosted or Web-based software that readily interfaces with many medical management and clinical information systems. Interactive version CareWebQI® enables quality improvement and cost efficiency through targeting and reducing inappropriate care. This progressive workflow tool not only identifies potential gaps in care, but also provides information about why variances are occurring—and thus, how they can be reduced.

CareWebQI® Interactive Software Interactive workflow tool captures and reports on user interactions and on variances from best practice. Able to be customized eg user-defined fields; configurable time zones; and date and time formats.

- Clinical Variance Tracking
- Real-time Reporting
- Customizable
- Quality Measure Tracking
- Guideline Modification
- Integration with Other Systems

Clinical team of doctors, nurses, and other clinicians reviewed more than 100,000 abstracts, articles, and other sources of evidence and chose more than 14,000 unique citations. Findings are used to build evidence-based authorization criteria, care pathways, and other care management tools. These decision-support resources enable payors, care providers, and facilities to efficiently and consistently make care decisions grounded in rigorous, up-to-date research. They also assist clients in evaluating current practices and finding opportunities to improve both quality of care and care management.

END OF PREVIOUS MATERIAL – FROM THE MILLIMAN WEBPAGES IN PRIOR YEARS

Other Product for providers: Indicia for Utilization Review, Indicia for Case Management, CareWebQI, and Interrater Reliability Module

Other Products for payors: CareWebQI, Cite AutoAuth Module, and Interrater Reliability Module

Results

Author's note: The owner and website was relatively new. More material may be available at a later date. However, the MCG guidelines have been widely used through the industry.

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Organization	Highmark Blue Cross Blue Shield
Category	Value based payment / Payment reform
Source	https://www.highmark.com/hmk2/index.shtml
Measure	QualityBLUE Provider Quality BLUE hospital https://prc.highmarkblueshield.com/rscprc/faces/prcMainPage.jsp

UPDATED IN 2013

Summary

Highmark was created in 1996 by the consolidation of two Pennsylvania licensees of the Blue Cross and Blue Shield Association — Pennsylvania Blue Shield (now Highmark Blue Shield) and Blue Cross of Western Pennsylvania (now Highmark Blue Cross Blue Shield).

They have developed pay for performance programs for hospitals and physicians. They also provide a broad Provider Resource Center which includes a variety of incentive programs and resources. Highmark was awarded a Best of Blue Clinical Distinction Award for QualityBLUE, its hospital pay-for-performance program.

Methodology

Quality Blue Hospital Program

The Highmark Quality BlueSM Hospital Pay-for-Performance Program affords Highmark an opportunity to partner with network hospitals toward the common goal of improving patient care and safety. The program aligns with nationally recognized guidelines and incorporates industry standards and evidence-based care. The Quality Blue program focuses on key public health issues and quality indicators that have been identified nationally as areas for improvement.

One of the most important and challenging aspects of the quality improvement process is sustaining quality gains. With the introduction of voluntary sustainability in 2011, hospitals were able to earn points for achieving targets associated with several infection prevention indicators and processes involving stroke care, surgical safety and capacity management within their emergency departments. Highmark has continued this recognition by including sustainability achievements for 41 hospitals, 92 percent of which demonstrated success in maintaining their previous year's gains. Sustainability is a demonstration of true process change and transformation.

Quality Blue Physician Program

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The Highmark Quality Blue Program recognizes and financially rewards Primary Care Physicians (PCPs) who work collaboratively with Highmark to improve quality and effectiveness of health care for Highmark members. PCP practices (Family Practice, Internal Medicine, and Pediatrics) that participate are measured on several quality and efficiency indicators, which drive the overall member quality improvement. The main focus is clinical quality where patients receive evidence-based-care in accordance with nationally recognized guidelines.

The program incorporated a requirement in our pay-for-value programs to encourage our providers' adoption of national Meaningful Use standards for electronic health records. Clinical data availability, data sharing and meaningful data use among and between providers at the point of patient care continue to be critical drivers for superior care quality and efficiency of care delivery necessary to optimally manage and coordinate care for patient populations.

PCMH Pilot Program

Highmark implemented the PCMH Pilot Program in 2011. A physician advisory board was formed for the pilot program that consisted of physician representatives from the pilot practices and Highmark representatives. The board met quarterly, providing feedback regarding the pilot program, which noted that the volume of quality measures required for the program was vast, the technological infrastructure to support the provider-reported metrics was lacking by some practices, the NCQA Accreditation requirement was difficult to achieve, and the attribution reconciliation process was cumbersome and resource-intensive. Highmark incorporated the physician advisory board's feedback and the lessons learned from the pilot program enhancements to deliver a more scalable network PCMH program

PCMH programs have been expanded to other locations and states.

Results

Hospitals have experienced 1853 fewer CLABSI than what would be expected at the national rate. With mortality rates between 12-25 percent for these adverse events, this represents a potential 222-463 fewer deaths compared to the national rate.

Hospitals that participated in the Quality Blue readmissions portion of the program for four consecutive years showed a decrease of nearly three percent for 7-day inpatient readmissions. Those same hospitals also showed a nearly five percent decrease in 30-day readmissions.

Comparing rates of "defect free care" for heart failure patients, Quality Blue hospitals provided defect free care at a rate of 76.2 percent defect free care compared to the national rate of 60.4 percent. This means that 193 more Quality Blue hospital's patients received heart failure defect free care improving chances for reduced morbidity and mortality.

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In a PCMH pilot in West Virginia, there was nearly a 2 percent reduction in cost, while the rest of the membership actually saw an increase.

Publications / links

Quality BlueSM Hospital Program (main link)

<https://prc.highmarkblueshield.com/rscprc/hbs/fac?document=https%3A//www.highmarkblueshield.com/health/documents/facility/qualityblue-hosp.html&docId=248>

Compendium (summary of results)

<https://www.highmarkblueshield.com/health/pdfs/facility/qb-hos-compendium.pdf>

Critical analysis tools

<https://prc.highmarkblueshield.com/rscprc/hbs/fac?document=/documents/facility/qb-hosp-critical-analysis-tools.html>

Meaningful Use FAQ

<https://www.highmarkblueshield.com/health/pdfs/qb-fags-mu.pdf>

Best Practice Guidebook

<https://www.highmarkblueshield.com/health/pdfs/bs-best-practice-guidebook.pdf>

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Organization	Hospital in Pursuit Of Excellence (HPOE)
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	http://www.hpoe.org/
Measure	Guides and reports http://www.hpoe.org/resources/hpoehretaha-guides/1360

UPDATED IN 2013

Summary

Hospitals in Pursuit of Excellence is the American Hospital Association's strategic platform to accelerate performance improvement and support delivery system transformation in the nation's hospitals and health systems.

HPOE provides:

- Education on best practices through multiple channels,
- Develops evidence-based tools and guides,
- Provides leadership development through fellowships and networks, and
- Engages hospitals in national improvement projects.
- Working in collaboration with allied hospital associations and national partners, HPOE synthesizes and disseminates knowledge, shares proven practices and spreads innovation to support care improvement at the local level.

Methodology

The website contains a variety of material including case studies, chair Files, guides/Reports, webinars, and other resources. Many are available without registration. This includes a research library. Contents cover topics such as care delivery transformation, operational Excellence, patient safety, and quality. Many provide detailed implementation support (such as stop hospital acquired infections or infection control); some of the recent material is more strategic. Some material is focused on types of hospitals (community to teaching hospitals, rural, or large health care systems).

Several recent reports are directly connected to measurement, systems transformation, and alternative payment systems.

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HPOE also supports specific initiatives such as Stop BSI, Stop CAUTI, and an NICU collaborative on central line-associated bloodstream infections.

Metrics for the Second Curve of Health Care - expands on four strategies originally identified in the report, "Hospitals and Care Systems of the Future." These strategies were identified as major priorities for hospitals and health care organizations moving from the volume-based first curve to the value-based second curve.

1. Aligning hospitals, physicians and other clinical providers across the continuum of care
2. Utilizing evidence-based practices to improve quality and patient safety
3. Improving efficiency through productivity and financial management
4. Developing integrated information systems

To further assist leaders trying to implement these major strategies, HPOE created a road map for leaders to assess their organization's progress

Hospitals and Care Systems of the Future - Must-Do Strategies to Succeed in the Future

1. Aligning hospitals, physicians and other providers across the care continuum
2. Utilizing evidence-based practices to improve quality and patient safety
3. Improving efficiency through productivity and financial management
4. Developing integrated information systems
5. Joining and growing integrated provider networks and care systems
6. Educating and engaging employees and physicians to create leaders
7. Strengthening finances to facilitate reinvestment and innovation
8. Partnering with payers
9. Advancing through scenario-based strategic, financial and operational planning
10. Seeking population health improvement through pursuit of the "triple aim"

Value-based Care

The nation's health care system is undergoing dramatic change as the country shifts to a value-based business model. The pace of the transition varies by market, but hospitals, care systems and other providers must be proactive. The Hospitals in Pursuit of Excellence guide "Value-based Contracting" provides specific guidance related to assessment and to financial, operational and implementation issues that health care organizations should examine as they prepare for value-based contracting arrangements. The guide is published by the AHA's Health Research & Educational Trust and Kaufman, Hall & Associates.

Results

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HPOE provides support through partners like AHA to various hospitals in core areas, including a hospital engagement network, Catheter-Associated Urinary Tract Infections (CAUTI), Central Line Associated Blood Stream Infections (CLABSI), Adverse Drugs Events (ADE), Obstetrical Adverse Events, Preventable Readmissions, and others.

For example, the NICU Collaborative successfully reduced central line-associated bloodstream infections (CLABSI) in newborns by 58 percent in less than one year. Participating NICUs had an overall infection rate of 2.043 per 1,000 central line days when the project began. At the end of the project, that rate was reduced to 0.855 per 1,000 central line days, a relative reduction of 58 percent.

Publications / links

Value-Based Contracting <http://www.hpoe.org/resources/hpoehretaha-guides/1406>

HPOE Guides and Reports--The Complete List <http://www.hpoe.org/resources/hpoehretaha-guides/887>

Hospitals and Care Systems of the Future <http://www.aha.org/about/org/hospitals-care-systems-future.shtml>

Metrics for the Second Curve of Health Care <http://www.hpoe.org/resources/hpoehretaha-guides/1357>

Creating the Hospital of the Future: The Implications for Hospital-Focused Physician Practice
<http://www.hpoe.org/resources/hpoehretaha-guides/1169> (REGISTRATION IS REQUIRED)h

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Organization	IMS Health
Category	Proprietary/Analytics/Decision Support/Healthcare Data Technology
Source	http://www.imshealth.com/portal/site/imshealth
Measure	MDsource 360° http://www.imshealth.com/portal/site/imshealth/menuitem.3e17c48750a3d98f53c753c71ad8c22a/?vgnnextoid=cc0853eba15dc310VgnVCM100000a48d2ca2RCRD

UPDATED IN 2013

Summary

IMS Health is an information, services and technology company dedicated to making healthcare perform better.

IMS Health provides an actionable view of performance to identify cost drivers and opportunities for improvement. We offer the largest independent source of health plan claims and prescription data, deep expertise in healthcare informatics, data management and warehousing to support:

- Provider Performance Management—interactive tools to engage providers and measure their improvement on cost and quality metrics
- Pharmacy Benefit Performance Management—comprehensive solutions to measure pharmacy spend, utilization and outcomes
- Plan Performance Management—a platform for monitoring your performance over time and compared to industry benchmarks
- Care Pathway Analytics—insights into variation in service delivery across providers
- Payment Innovation—services to design, manage and run innovative payment programs

Methodology

New reimbursement models require health plans to better engage physicians and accurately measure performance to drive improved outcomes. Cost-effectively implementing these models and scaling programs across large numbers of physicians requires proven solutions for integrating and automating provider engagement.

Key solutions include

- IMS MDsource 360°»
- IMS RxSource 360°»

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- IMS Physician
- Insights 360^o™»
- Enhanced Provider Directory»
- IMS Readmission Targeter™»

IMS MDsource 360^o»

Automate physician engagement to drive healthcare value initiatives.

- Establish goals against plan & physician benchmarks to show why, where and how providers can improve
- Change physician behavior & align performance with key plan payment incentives and programs
- Build collaboration with vetted measures & two-way communication, based on trust, credibility and timely information
- Steer to high-quality, low-cost options to reduce population cost-of-care for all healthcare players

IMS RxSource 360^o

Includes RxBenchmark™, RxQuality™, RxIntegrated™, RxFormulary™, and IMS RxSpecialty™.

IMS Readmission Targeter™

Prevent readmissions and reduce financial penalties with in-depth insights into patient behavior post-discharge. Determine if medication non-compliance driving up your readmissions penalties

Publications / links

IMS MDsource 360^o - Overview

<http://www.imshealth.com/portal/site/imshealth/menuitem.3e17c48750a3d98f53c753c71ad8c22a/?vgnnextoid=76365ecec5c3e310VgnVCM10000076192ca2RCRD>

IMS RxSource 360^o - Overview

<http://www.imshealth.com/portal/site/imshealth/menuitem.3e17c48750a3d98f53c753c71ad8c22a/?vgnnextoid=88b763cd2da7e310VgnVCM10000076192ca2RCRD>

IMS Readmission Targeter™

<http://www.imshealth.com/portal/site/imshealth/menuitem.3e17c48750a3d98f53c753c71ad8c22a/?vgnnextoid=28f6489f895bd310VgnVCM1000001b9e2ca2RCRD>

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Organization	Institute for Healthcare Improvement (IHI)
Category	Accreditation/Certification
Source	http://www.ihl.org/ihl
Measure	The Improvement Map http://www.ihl.org/offerings/Initiatives/Improvemaphospitals/Pages/default.aspx

UPDATED IN 2013

Summary

The Institute for Healthcare Improvement (IHI), an independent not-for-profit organization based in Cambridge, Massachusetts, is a leading innovator in health and health care improvement worldwide. For more than 25 years, we have partnered with visionaries, leaders, and front-line practitioners around the globe to spark bold, inventive ways to improve the health of individuals and populations. To advance our mission, IHI's work is focused in five key areas: Improvement Capability; Person- and Family-Centered Care; Patient Safety; Quality, Cost, and Value; and Triple Aim for Populations.

Methodology

The IHI Improvement Map

The Improvement Map is a free, interactive, web-based tool designed to bring together the best knowledge available on the key process improvements that lead to exceptional patient care.

The Improvement Map aims to help you:

- Make care safer
- Make patient care transitions smoother
- Lead improvement efforts effectively
- Reduce costs and increase quality

It offers clear guidance through an often confusing health care landscape, helping hospitals set change agendas, establish priorities, organize work, and optimize resources.

Don Berwick introduced the concept of the Improvement Map at IHI's National Forum in December 2008 and IHI worked intensively with expert advisors, national stakeholders and hospital quality leaders to create and deploy this resource. The Improvement Map emerged from the knowledge gained in the 100,000 Lives Campaign, the 5 Million Lives Campaign, and the IMPACT Network and was publicly launched on September 15, 2009. IHI continues to and refine the key processes on the Improvement Map, clustering them by care setting and content area, and will help hospitals identify where they should focus to maximize impact.

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For each of the 73 processes, the Improvement Map has details on individual elements of implementation, expected outcomes, and metrics for measurement of the process. When planning your project, the Map will tell you the anticipated time, cost, difficulty, and level of evidence associated with each process. A list of relevant evidenced-based research and correlations to quality standards as set by such organizations at The Joint Commission and The Center for Medicare and Medicaid Services will allow you to correlate your projects to accrediting and payer requirements. The Improvement Map also has many resources to support project implementation, including How-to Guides and access to the Mentor Hospital Registry.

From front-line staff to the hospital executive team, anyone can use the Improvement Map! Whether you are planning specific details for executing a project or setting your organizations quality agenda, the Improvement Map can guide your quality improvement journey.

In keeping with the spirit of the Campaigns, IHI will continue to provide How-to Guides and introductory calls for all Improvement Map key processes at no cost.

Helping Hospitals Improve in Nine Core Focus Areas Identified by Partnership for Patients

The federal government's new Partnership for Patients has identified nine areas of focus and IHI has an Improvement Map key process for each:

- Adverse Drug Events (including medication reconciliation and high-alert medication safety)
- Catheter-Associated Urinary Tract Infections
- Central Line-Associated Bloodstream Infections
- Injuries from Falls and Immobility (including delirium)
- Obstetrical Adverse Events (Perinatal Elective Induction Safety and Perinatal Labor Augmentation Safety)
- Pressure Ulcers
- Surgical Site Infections
- Venous Thromboembolism
- Ventilator-Associated Pneumonia

IHI has also identified Mentor Hospitals that can offer tips and support to accelerate improvement in these areas:

- Adverse Drug Events (medication reconciliation)
- Catheter-Associated Urinary Tract Infections
- Central Line-Associated Bloodstream Infections
- Injuries from Falls and Immobility
- Pressure Ulcers
- Surgical Site Infections and Surgical Complications
- Venous Thromboembolism
- Ventilator-Associated Pneumonia

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Care that Costs Less

Quality Improvement projects require an investment of time and money, but can result in a net savings once implemented. The 13 processes in this section are projects that can be implemented with minimal upfront cost, that will reduce expenses and are related to guidelines set by CMS. They were found sorting by Cost: Minimal, Finance: Expense Reduction, and Requirements: CMS See **Care that Costs Less** link below.

Selected Publications / links

Improvement map (link)

<http://app.ihi.org/imap/tool/>

Gap analysis

<http://www.ih.org/offerings/Initiatives/Improvemaphospitals/Documents/IHIGapAnalysis.pdf>

Reducing Costs and Increasing Quality

<http://www.ih.org/offerings/Initiatives/Improvemaphospitals/Documents/CostLessPreSort.pdf>

CMS Partnership for Patients

<http://www.ih.org/explore/CMSPartnershipForPatients/Pages/default.aspx>

Publications

<http://www.ih.org/knowledge/Pages/Publications/default.aspx>

White papers (registration often required)

<http://www.ih.org/knowledge/Pages/IHIWhitePapers/default.aspx>

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Organization	Integrated Healthcare Association (IHA)
Category	Value based payment / Payment reform
Source	http://www.iha.org/
Measure	Bundled Payment Project http://www.iha.org/bundled-payment.html

UPDATED IN 2013

Summary

The Integrated Healthcare Association is a statewide multi-stakeholder leadership group that promotes quality improvement, accountability and affordability of health care in California. IHA is a nonprofit association working to actively convene all healthcare parties for cross sector collaboration on health care topics. IHA administers regional and statewide programs and serves as an incubator for pilot programs and projects.

Bundled payment emerged from the Value-Based Purchasing project as a promising opportunity to align incentives and improve coordination across care settings. In 2009, the California HealthCare Foundation (CHCF) funded an IHA pilot project to test implementation of bundled payments in California. A year later, the Agency for Healthcare Research and Quality awarded IHA a three-year grant to expand the bundled payment pilot. In 2012-2013, IHA also served as a Facilitator Convener for the Center for Medicare and Medicaid Innovation's Bundled Payments for Care Improvement (BCPI) initiative, supporting several California hospitals as they explored the BPCI opportunity.

Methodology

Interest continues to grow in alternatives to fee-for-service reimbursement with the potential to simultaneously reduce costs while maintaining or improving quality. Among the candidates is bundled payment -- paying for services on the basis of an episode of care rather than an individual test, procedure, or visit.

IHA's interest in bundled payment originated with a 2006 statewide initiative aimed at improving efficiency and performance in the medical device arena. The Value-Based Purchasing of Medical Devices Project gathered and analyzed data on device use and costs for major orthopedic, spine, and cardiac procedures. Findings revealed significant variation in procedure costs, complication rates, and lengths of stay across hospitals for these procedures.

The demonstration project set out to define ten episode definitions, recruit physician-hospital teams, develop contract templates to support bundled payment negotiations, and facilitate contract discussions between health plans and providers. The initiative focused primarily on orthopedic procedures; project partners overcame a variety of implementation challenges and the project concluded with multiple contracts in place -- though with a small number of cases reimbursed through the bundled payment approach.

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Developing a standardized definition for an episode of care is an important first step in implementing a bundled payment model. For the AHRQ-funded demonstration project, IHA developed ten episode definitions in three clinical areas: Orthopedics, Cardiovascular, and Maternity and Women's Health. Specific procedures were selected based on patient volume, insurer expenditures, potential for quality improvement and cost reduction, and opportunity for physician-hospital alignment.

Publications / links

AHRQ Demonstration Overview

http://www.iha.org/pdfs_documents/bundled_payment/IHA_AHRQ_Demonstration_Overview.pdf

AHRQ Dissemination Products

http://www.iha.org/pdfs_documents/bundled_payment/IHA_AHRQ_Dissemination_Products.pdf

Episode Definitions

<http://www.iha.org/episode-definitions.html>

Commercial PPO Episode Selection and Definition in IHA's Bundled Episode Payment and Gainsharing Demonstration (2012)

http://www.iha.org/pdfs_documents/resource_library/BEPPIssueBrief_FINAL.doc.pdf

Publications

<http://www.iha.org/bundled-payment-publications.html>

Value-Based Purchasing (VBP) of Medical Devices

http://www.iha.org/pdfs_documents/bundled_payment/Value-Based-Purchasing-of-Medical-Devices-Overview.pdf

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Organization	Integrated Healthcare Association (IHA)
Category	State focus; Incentive/Reward Programs
Source	http://www.iha.org/
Measure	Division of Financial Responsibility (DOFR) http://www.iha.org/dofr.html

UPDATED IN 2013

Summary

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The Integrated Healthcare Association (IHA) assembled a group of stakeholders to develop a coded Division of Financial Responsibility (DOFR) template for use in contracts between hospitals, physician organizations, and health plans. The IHA DOFR™ provides a framework for plans and providers to use when allocating financial responsibilities for service.

Methodology

The coded IHA DOFR™ has benefits for all healthcare stakeholders. Although it does not assign risk, it gives plans and providers a uniform starting point for capitated payment negotiations. The implementation of a coded DOFR providing a standard set of service categories with associated codes should help manage any redefinition of the DOFR, commonly called “DOFR creep.” This should help to reduce payment ambiguities between parties and claims re-direction from organization to organization that drive up administrative costs and can lead to consumer frustration with health plans and providers. Providers – both hospitals and physician organizations – will benefit from reductions in both administrative burdens associated with managing multiple risk relationships and in the costs associated with misdirected claims that can result from ill-defined lines of responsibility. Consumers will also ultimately benefit from fewer misdirected claims, which can negatively impact their experience of care. Under the Affordable Care Act, health plans are required to keep administrative expenses at or below 20% of premiums in the individual and small group markets, and 15% of premiums in the large group market. Having a standardized template for determining the assignment of risk should help California health plans to meet these requirements.

The coded IHA DOFR™ provides a framework for plans and providers to use when allocating financial responsibilities for services and is available free of charge to California physician organizations, hospitals, and health plans; and can be purchased by other organizations. The IHA DOFR™ Release 3.0 was launched in December 2012

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followed by a 60-day public comment period. As the DOFR 3.0 (Draft) public comments did not indicate the need for revisions, there were no changes for DOFR 3.1.

The IHA DOFR TM Release 3.1 incorporates updates based on comments received during the 2011 public comment period but not yet incorporated, and includes the following reports:

- Duplicate Codes Report (all instances of duplicate codes in the DOFR)
- Flat File View (a flat file version of the DOFR except for guidelines)
- Recommended Guidelines (to accompany Flat File View)

Results

IHA will maintain an annual release schedule that incorporates annual coding updates and other updates resulting from stakeholder comments and other feedback into one annual release targeted for the second quarter of each year.

Publications / links

DOFR Overview

http://www.iha.org/pdfs_documents/dofr/DOFROverview_April2013.pdf

DOFR Frequently Asked Questions

http://www.iha.org/pdfs_documents/dofr/DOFR_FAQ_April2013.pdf

DOFR Release 3.1 Recommended User Guidelines

http://www.iha.org/pdfs_documents/dofr/DOFRRecommendedGuidelinesRelease3.1.pdf

DOFR Registration Site

<https://www.regonline.com/builder/site/?eventid=1153010>

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Organization	Integrated Healthcare Association (IHA)
Category	State focus; Incentive/Reward Programs+
Source	http://www.iha.org/
Measure	California P4P (Pay for Performance) Collaboration http://www.ncqa.org/tabid/666/Default.aspx

UPDATED IN 2013

Summary

The Integrated Healthcare Association is a statewide multi-stakeholder leadership group that promotes quality improvement, accountability and affordability of health care in California. IHA is a nonprofit association working to actively convene all healthcare parties for cross sector collaboration on health care topics. IHA administers regional and statewide programs and serves as an incubator for pilot programs and projects.

The California P4P program is the largest non-governmental physician incentive program in the United States. Founded in 2001, it is managed by the Integrated Healthcare Association (IHA) on behalf of eight health plans representing 10 million insured persons. IHA is responsible for collecting data, deploying a common measure set, and reporting results for approximately 35,000 physicians in nearly 200 physician groups. This program represents the longest running U.S. example of data aggregation and standardized results reporting across diverse regions and multiple health plans. California consumers benefit from the availability of standardized performance results from a common measure set, which are available to the public through the State of California, Office of the Patient Advocate.

The P4P Program adopted improved value, which encompasses both cost and quality, as the ultimate goal of P4P between 2011 and 2015. The primary initiative for reaching this goal is Value Based Pay for Performance (Value Based P4P), which will hold physician organizations (PO) accountable for the costs of all care provided to their HMO members, as well as the quality of this care, and will help to align POs and health plans toward a more price-competitive HMO product.

Methodology

Nearly 200 physician organizations – representing approximately 35,000 physicians who provide care for about 9 million Commercial HMO/POS members – participate in P4P. Seven California health plans contribute data and provide incentive payments based on the aggregated P4P results.

The IHA P4P common measure set is designed to include measures that are evidence-based and relevant to

California consumers. The measure set is dynamic, with new measures added each year and an increasing focus

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on outcome measures. The original measure set implemented in 2003 included 25 measures; by 2013, the P4P common measure set had grown to a total of 73 measures recommended for payment and 21 additional measures for collection and internal reporting. The complete set of measures is available on the IHA website. For Measurement Year (MY) 2012, there are four measurement domains.

Clinical Quality - Includes process and outcome measures, using standardized national measures wherever possible.

Patient Experience - patient ratings of care received from their doctor and other providers in the physician organization. The ratings are based on the national CAHPS Clinician & Group survey tool.

Meaningful Use of Health IT - physician organizations complete an online tool to collect information for the 15 measures in this domain.

Resource Use - IHA added Appropriate Resource Use measures to its P4P program in MY 2009. In MY 2011, a measure of Total Cost of Care was added to the P4P measure set.

Public Reporting

IHA partners with the California Office of the Patient Advocate (OPA) to publicly report the P4P program results each year. The online quality report card compares physician organization performance within a county, showing overall performance, as well as scores on individual measures. The P4P Governance Committee approved expansion of public reporting to include readmissions for MY 2013 and overall value for MY 2014.

Results

The MY 2012 results are used by health plans to calculate the incentive payments distributed during the third and fourth quarters of 2013. Each plan determines its own budget and methodology for calculating incentive payments to the physician organizations, which are reported in the Financial Transparency Report on the IHA website. Total quality incentive payouts from health plans to California physician organizations started at \$38M in 2004, peaked at \$65M in 2007, and have leveled off since, with 2012 payouts totaling \$40M. In all, about \$450M has been paid, not including MY 2012.

Publications / links

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IHA P4P Program Fact Sheet (2013)

http://www.iha.org/pdfs_documents/p4p_california/P4P-Fact-Sheet-September-2013.pdf

Program Governance

http://www.iha.org/program_governance.html

Manuals & Operations

http://www.iha.org/manuals_operations.html

Program Results

http://www.iha.org/program_results.html

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Organization	The Johns Hopkins University
Category	Proprietary/Analytics/Decision Support/Healthcare Data Technology
Source	http://acg.jhsph.org/
Measure	Adjusted Clinical Groups Case-Mix System (ACG) Aggregated Diagnosis Groups™(ADGs®) And other related products

UPDATED IN 2013

Summary

The ACG® System—characterized by excellence in both research and practice—is based at the Johns Hopkins Bloomberg School of Public Health and has been performing risk measurement and case-mix categorization for more than 25 years. The ACG® System Team has virtually “written the book” on risk adjustment through numerous contributions in the published literature.

Methodology

Case-Mix Classification is a central feature of the ACG System, permitting comparisons between service populations that may differ significantly in terms of their overall health (morbidity burden). Comparative analyses have been used in a number of ways, including to fairly allocate health care resources, to assess provider performance, and to set insurance and reimbursement rates.

Aggregated Diagnosis Groups™(ADGs®)

ACG actuarial cells are based on building blocks called Aggregated Diagnosis Groups (ADGs). Each ADG is a grouping of diagnosis codes that are similar in terms of severity and likelihood of persistence of the health condition over time. All diagnostic codes are assigned to one of the 32 ADG clusters. Since individuals can have more than one diagnosis, they may have more than one ADG. Individual diseases or conditions are placed into a single ADG based on five clinical dimensions:

- Duration of the condition (acute, recurrent, or chronic): How long will healthcare resources be required for the management of this condition?
- Severity of the condition (e.g., minor and stable versus major and unstable): How intensely must healthcare resources be applied to manage the condition?
- Diagnostic certainty (symptoms versus documented disease): Will a diagnostic evaluation be needed or will services for treatment be the primary focus?
- Etiology of the condition (infectious, injury, or other): What types of healthcare services will likely be used?
- Specialty care involvement (e.g., medical, surgical, obstetric, hematology): To what degree will specialty care services be required?

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How do ACGs Work?

Adjusted Clinical Groups are a person-focused method of categorizing patients' illnesses. Over time, each person develops numerous conditions. Based on the pattern of these morbidities, the ACG approach assigns each individual to a single ACG category. Thus, an ACG captures the specific clustering of morbidities experienced by a person over a given period of time, such as a year. Because most management applications for population-based case-mix adjustment systems require that patients be grouped into single, mutually exclusive categories, the ACG methodology uses a branching algorithm to place people into one of 102 discrete categories based on their assigned ADGs, their age and their sex. Individuals within a given ACG experience a similar pattern of morbidity and resource consumption over the course of a given year. A patient/enrollee is assigned to a single ACG based on the diagnoses assigned by all clinicians seeing them during all contacts, regardless of setting. Thus ACGs are truly person-oriented and are not based on visits or episodes. ACGs dramatically outperform age and sex adjustment, the traditional risk-adjustment mechanism used within the health insurance industry.

ACG® Predictive Models (ACG-PMs™)

The Johns Hopkins University ACG® System includes a suite of predictive models, referred to collectively as ACG PMs. ACG PMs present an innovative and accurate way to identify individual high-risk patients and estimate resource use for an entire population based on clinically relevant classifications. ACG PM models are built to use: diagnosis information (Dx-PM™), pharmacy information (Rx-PM™), or both (DxRx-PM™).

The Version 9.0 release added models for future hospitalization and for predicting patients who will experience unexpectedly high pharmacy use.

The models have been calibrated to identify patients at high risk for using large amounts of health care resources in the future, and to estimate potential expenses. Before their health care situation worsens and service use increases, the ACG Predictive Models can help to identify persons who could benefit from intensive disease management, case management, and other types of outreach. The ACG Predictive Models can also be used to estimate future resource use for sub-groups within a population and the method has many applications within the quality improvement domain. There is also a unique model to assist in the management of pharmacy benefits and a separate model for predicting hospitalization.

Future Hospitalizations - hospitalization prediction is a refinement to the ACG predictive models specifically calibrated to identifying patients with risk of future hospitalization. The hospital prediction models focus on unanticipated hospitalizations and are complementary to the ACG cost prediction models.

Unexpected High Pharmacy Use – a specific model was developed for capturing unexpected high pharmacy users to address an important group of patients who offered opportunities for care management.

The program also includes

Johns Hopkins Expanded Diagnosis Clusters™ (EDCs™) - groupings of diagnostic codes

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Pharmacy Defined Morbidity Groups™ (Rx-MGs™) - the Pharmacy Defined Morbidity Groups (Rx-MGs) provide further methods to describe the unique morbidity profile of a population and form the basis of the pharmacy based predictive model.

Applications of the ACG System

The Johns Hopkins ACG® System is more than just a risk-adjustment model. It is a comprehensive family of measurement tools designed to help explain and predict how healthcare resources are delivered and consumed. The ACG System provides a varied toolkit for developing the most appropriate solution for each application. Common applications of ACGs include: care Management (including case management, disease management and high risk case identification.), provider Profiling (Performance Assessment), financial Analysis, population Profiling

Publications / links

About the system

http://acg.jhsph.org/index.php?option=com_content&view=article&id=55&Itemid=149

Resource center (registration required)

http://acg.jhsph.org/index.php?option=com_content&view=article&id=144&Itemid=370

Bibliography

<http://acg.jhsph.org/public-docs/AcgBibliography.pdf>

Adjusting For Risk Selection In State Health Insurance Exchanges Will Be Critically Important And Feasible, But Not Easy
Health Aff February 2012 31:2306-315;

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Organization	The Joint Commission (JCAHO)
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	www.jointcommission.org
Measure	Improving America’s Hospitals: Annual Report on Quality and Safety Top Performer http://www.jointcommission.org/annualreport.aspx

UPDATED IN 2103

Summary

An independent, not-for-profit organization, The Joint Commission accredits and certifies more than 20,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization’s commitment to meeting certain performance standards.

Methodology

The annual report summarizes the performance of 3,300 Joint Commission-accredited hospitals on 47 accountability measures of evidence-based care processes closely linked to positive patient outcomes. Hospital performance on accountability measures has improved significantly over time, greatly enhancing the quality of care provided in Joint Commission-accredited hospitals. In 2012, Joint Commission-accredited hospitals achieved 97.6 percent composite accountability measure performance on 18.3 million opportunities to perform care processes closely linked to positive patient outcomes – an improvement of 15.8 percentage points since 2002, when hospitals achieved 81.8 percent composite performance on 957,000 opportunities.

The Joint Commission’s Top Performer on Key Quality Measures® program recognizes accredited hospitals that attain excellence on accountability measure performance. The program is based on data reported in the previous year about evidence-based clinical processes that are shown to be the best treatments for certain conditions, including heart attack, heart failure, pneumonia, surgical care, children’s asthma, inpatient psychiatric services, stroke, venous thromboembolism, and immunization.

The current eligibility criteria for the Top Performer program include a three step process: 1) achieving cumulative performance of 95 percent or above across all reported accountability measures; 2) achieving performance of 95 percent or above on each and every reported accountability measure where there are at least 30 denominator cases; and 3) having at least one core measure set that has a composite rate of 95 percent or above, and within that measure set all applicable accountability measures have a performance rate of 95 percent or above.

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Results

Thirty-three percent of all Joint Commission-accredited hospitals that reported accountability measure data to The Joint Commission in 2012 are recognized as Top Performer hospitals. These 1,099 hospitals represent a 77 percent increase in Top Performer organizations from last year.

In 2013, 1,099 hospitals are being honored for their performance on 2012 calendar year discharge data as part of the Top Performer on Key Quality Measures program. Of that number, 22 percent were rural hospitals, 51 percent were non-profit hospitals, and 46 percent had between 100 and 300 beds. Major teaching hospitals accounted for 7 percent of the recipients, and 5 percent were critical access hospitals.

Publications / links

Improving America's Hospitals. The Joint Commission's Annual Report on Quality and Safety
http://www.jointcommission.org/assets/1/6/TJC_Annual_Report_2013.pdf

Top Performers
http://www.jointcommission.org/accreditation/top_performers.aspx

Eligibility Criteria
http://www.jointcommission.org/assets/1/6/Eligibility_Criteria_2012.pdf

Accountability_Measures
http://www.jointcommission.org/accountability_measures.aspx
http://www.jointcommission.org/assets/1/18/2013_Accountability_Measures.pdf

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Organization	The Joint Commission (JCAHO)
Category	Accreditation/Certification
Source	http://www.jointcommission.org/
Measure	ORYX Initiative http://www.jointcommission.org/facts_about_oryx_for_hospitals/

UPDATED IN 2103

Summary

An independent, not-for-profit organization, The Joint Commission accredits and certifies more than 20,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.

ORYX Initiative

ORYX® is The Joint Commission's performance measurement and improvement initiative, which integrates outcomes and other performance measure data into the accreditation process. ORYX measurement requirements are intended to support Joint Commission accredited organizations in their quality improvement efforts. Performance measures are essential to the credibility of any modern evaluation activity for health care organizations. ORYX data are publicly reported on The Joint Commission website at Quality Check®, www.qualitycheck.org. The public availability of performance measure data permits user comparisons of hospital performance at the state and national levels.

Mandatory measures sets - four of the six measure sets are mandatory for all general medical/surgical hospitals that serve specific patient populations addressed by the measure sets and related measures. The mandatory measure sets include:

- Acute Myocardial Infarction (AMI)
- Pneumonia (PN)
- Heart Failure (HF)
- Surgical Care Improvement Project (SCIP)
- Perinatal Care (PC) (mandatory for hospitals with 1,100 or more births per year)

Discretionary measure sets

The sixth measure set (or fifth and sixth measure sets for hospitals with fewer than 1,100 births per year) can be chosen from among the remaining complement of core measure sets. These sets include:

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- Children's Asthma Care
- Stroke
- Emergency Department
- Substance Use
- Hospital-Based Inpatient Psychiatric Services
- Tobacco Treatment
- Hospital Outpatient
- Venous Thromboembolism
- Immunization

Publications / links

Facts about Oryx for hospitals

http://www.jointcommission.org/facts_about_oryx_for_hospitals/

All weblinks were updated in 2013. Written material is extracted from publicly-available material on the websites of organizations - much of the content was extracted in 2013. But, some of the continuing programs come from earlier editions (2008 or 2010). It has not been independently validated and the authors and the Society of Actuaries make no warranty as to its accuracy.

Organization	Leapfrog Group
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	http://www.leapfroggroup.org
Measure	Top Hospitals Survey Top Hospitals

Updated in 2013

Summary

Mission Statement: To trigger giant leaps forward in the safety, quality and affordability of health care,

The Leapfrog Group is a voluntary program aimed at mobilizing employer purchasing power to alert America's health industry that big leaps in health care safety, quality and customer value will be recognized and rewarded. Among other initiatives, Leapfrog works with its employer members to encourage transparency and easy access to health care information as well as rewards for hospitals that have a proven record of high quality care.

The Leapfrog Hospital Survey compares hospitals' performance on the national standards of safety, quality, and efficiency that are most relevant to consumers and purchasers of care. Hospitals that participate in The Leapfrog Hospital Survey achieve hospital-wide improvements that translate into millions of lives and dollars saved. Leapfrog's purchaser members use Survey results to inform their employees and purchasing strategies. In 2009, 1206 hospitals across the country completed The Leapfrog Hospital Survey.

Methodology

Our initiatives have been built upon the fact that hospital performance transparency is critical to the optimal functioning of the healthcare marketplace. Leapfrog's public reporting initiatives offer valuable benchmarking capabilities to hospitals, as well as providing consumers and purchasers of healthcare with the information they need on the quality and safety of their hospitals.

The Leapfrog Group has three initiatives to help hospitals meet the demand for transparency in health care:

- The Leapfrog Hospital Survey Introduced in 2001, The Leapfrog Hospital Survey is Leapfrog's hallmark public reporting initiative.
- Leapfrog Hospital Recognition Program (LHRP) These competitive benchmarking reports for Leapfrog-reporting hospitals will help hospitals prepare for value-based purchasing initiatives
- The Leapfrog Group CPOE Comparative Performance Assessment Detailed assessment of your CPOE system's decision support, compared to other hospitals nationally

This tracks key programs such as:

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- Computerized Physician Order Entry (define)
- ICU Physician Staffing (define)
- Coronary Artery Bypass Graft Surgery (define)
- Percutaneous Coronary Intervention (define)
- Abdominal Aortic Aneurysm Repair (define)
- Pancreatic Cancer Resection (define)
- Esophageal Cancer surgery (define)
- High Risk Delivery (define)
- Leapfrog Quality Index based on National Quality Forum Safe Practices

Top Hospitals Survey

The Leapfrog Hospital Survey assesses hospital performance based on national performance measures. These measures and practices are of specific interest to healthcare purchasers and consumers, and cover a broad spectrum of hospital services, processes, and structures. The measures also provide hospitals with the opportunity to benchmark the progress they are making in improving the safety, quality, and efficiency of the care they delivery. The Leapfrog Hospital Survey is free to all hospitals. Leapfrog Hospital Survey results are publicly reported, by hospital, at www.LeanfrogGroup.org/cp. The Leapfrog Group thanks you for your willingness to be transparent, and to seek opportunities such as this to improve care delivery.

Top Hospitals

The Leapfrog Top Hospital award is given annually to the highest performing hospitals on the Leapfrog Hospital Survey. The award is not given to a set number of hospitals, but rather, to all urban, rural, and children's hospitals that meet the high standards defined in each year's Top Hospitals Methodology, which is updated annually.

Author's note: Initial focus (from previous entries)

Voluntary survey provides the most complete picture of hospital quality and safety available in the U.S., and asks hospitals about their performance in four crucial areas, or "leaps":

- Use of CPOE by physicians and regular testing alert capabilities of medication error prevention software.
- Performance of hospitals on seven complex high-risk procedures and care for high-risk deliveries. Including Coronary artery bypass graft, percutaneous coronary intervention, abdominal aortic aneurysm repair, aortic valve replacement, pancreatic resection, esophagectomy, bariatric surgery.
- Staffing of hospital intensive care units (ICUs) staffed by qualified specialists.
- Adoption of safety practices and policies advocated by the National Quality Forum to reduce harm and errors.

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Results

Using Leapfrog's new calculator, employers and purchasers can calculate the surcharge they pay as a result of hospital errors. This estimate can be derived using an employer's claims data as well as the Hospital Safety Scores of utilized hospitals. The calculator enables purchasers to discover their annual hidden hospital error surcharge and average surcharge per admission. By shifting employees to "A" hospitals through improved benefits plan design, employers can decrease these hidden surcharges and protect their employees and dependents from harm.

Consider, as an example, a medium-sized, self-insured company that provides health coverage for 10,000 people. Each year, this company pays for 1,000 hospital admissions, of which 450 are surgical admissions. If all of these admissions occurred in hospitals with a grade of "C" or lower, that company could expect to pay almost \$8.8 million in hidden surcharges. On the other hand, if all of the admissions were in "A" hospitals, the hidden surcharge would "only" be around \$6.9 million. The company would save more than \$1.9 million by steering employees to safer hospitals.

Publications / links

Compare Hospitals Now (searchable database)

<http://www.leapfroggroup.org/cp>

Top Hospitals <http://www.leapfroggroup.org/56440/TopHospitals>

Survey <https://leapfroghospitalsurvey.org/>

Town Hall slides http://www.leapfroggroup.org/media/file/2013_LeapfrogHospitalSurvey_TownHallCalls.pdf

CompetitiveBenchmarking <http://www.leapfroggroup.org/56440/CompetitiveBenchmarking>

2013 Leapfrog Hospital Survey (overview)

<https://leapfroghospitalsurvey.org/web/wp-content/uploads/2013LeapfrogHospitalSurveyContentOverview.pdf>

Calculator http://www.leapfroggroup.org/media/file/Fall2013_HiddenSurchargeCalculator.xlsx

Does The Leapfrog Program Help Identify High-Quality Hospitals? Ashish K. Jha, E. John Orav, Abigail B. Ridgway Jie Zheng, Arnold M. Epstein. *Joint Commission Journal on Quality and Patient Safety*. June 2008 34(6):318–25 http://www.commonwealthfund.org/usr_doc/Jha_doesleapfroghelpidentify_1143_itl.pdf

All weblinks were updated in 2013. Written material is extracted from publicly-available material on the websites of organizations - much of the content was extracted in 2013. But, some of the continuing programs come from earlier editions (2008 or 2010). It has not been independently validated and the authors and the Society of Actuaries make no warranty as to its accuracy.

Composite Measures for Predicting Hospital Mortality with Surgery. White Paper 2008.

<http://www.leapfroggroup.org/media/file/SurvivalPredictorWhitepaper.pdf>

Development of Severity-Adjustment Models for Hospital Resource Utilization Data. White Paper. 2008.

http://www.leapfroggroup.org/media/file/Severity-Adjustment_Model_Whitepaper_Final_080421.pdf

All weblinks were updated in 2013. Written material is extracted from publicly-available material on the websites of organizations - much of the content was extracted in 2013. But, some of the continuing programs come from earlier editions (2008 or 2010). It has not been independently validated and the authors and the Society of Actuaries make no warranty as to its accuracy.

Organization	Maine Health Management Coalition
Category	State focus; Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	http://www.mehmc.org/
Measure	Pathways to Excellence / Get Better Maine http://www.getbettermaine.org/

UPDATED IN 2013

Summary

Pathways to Excellence is the name of each of the public reporting initiatives of the Maine Health Management Coalition (MHMC). MHMC currently measures and publicly reports quality data on primary care practices and hospitals at www.getbettermaine.org. Efforts to measure and publicly report quality data on specialists are currently underway.

The Maine Health Management Coalition Foundation (MHMC-F) is a charitable organization whose mission is to bring the people who get care, pay for care, and provide care together in order to measure and improve the quality of health care services in Maine. By publicly reporting quality information on Maine doctors and hospitals, the MHMC-F hopes to empower the public to make informed decisions about the care they receive.

MCMC also has a variety of other programs.

Methodology

Doctor Ratings

Doctors who treat adults, voluntarily submit clinical information to Bridges to Excellence and/or the National Committee on Quality Assurance. These organizations in turn conduct assessments and generate rankings regarding the quality of the care being provided. The participating adult doctors and cardiologists or heart doctors may also submit information about the tools they use in maintaining and transferring medical information, and assisting their patients. Bridges to Excellence and the National Committee on Quality Assurance are independent, non-profit organizations that publish information about how well doctors and their staffs across the U.S. are doing at taking care of their patients. Once a ranking is given it remains valid for two to three years.

Doctors who treat children (pediatricians) also voluntarily submit clinical information to us. Because there is no national organization that performs assessments or rankings of pediatricians, we developed our own quality assessment program. In developing our assessment program we held forums of local doctors, patients, employers and health plan representatives and thereby determined what questions to ask and how to assign our ratings. Furthermore; we periodically conduct random telephonic and on-site audits of practices to help assure that our participants are honestly and accurately submitting their information.

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Doctors who treat heart problems (cardiologists) submit clinical information voluntarily to us. Because there is no national organization that performs assessments or rankings of cardiologists, we developed our own quality assessment program. In developing our assessment program we held forums of local doctors, patients, employers and health plan representatives and thereby determined what questions to ask and how to assign our ratings. Furthermore; we periodically conduct random telephonic and on-site audits of practices to help assure that our participants are honestly and accurately submitting their information. You can review the questions we ask at www.mehmc.org. As noted above, cardiologists may submit information about the tools they use in maintaining and transferring medical information, and assisting their patients. Bridges to Excellence and the National Committee on Quality Assurance are independent, non-profit organizations that publish information about how well doctors and their staffs across the U.S. are doing at taking care of their patients. Once a ranking is given it remains valid for two to three years.

From time to time we may raise the bar regarding what constitutes a “good”, “better” or in the case of office systems a “best” rating. When we do that, we give the doctors ample notice that their ranking could change if they do not make improvements.

Hospital Ratings

Almost all U.S. hospitals give data to the federal government about how well they provide that care which the experts recommend. Patients also fill out surveys about their hospital experiences and those survey results are submitted to the federal government. You can see this data at www.hospitalcompare.hhs.gov. Our ratings use this data to compare Maine’s hospitals to those in the remainder of the United States. We receive updates from the federal government every three months and update our information accordingly.

In Maine, every hospital also reports information voluntarily to the Leapfrog Group. The Leapfrog Group is an independent not-for-profit organization that collects, analyzes, and publicly reports information on the progress of hospitals to meet evidence-based quality and safety standards. Leapfrog fields an annual hospital survey that is based on the quality and safety recommendations of the National Quality Forum, The Joint Commission, and the Centers for Medicare and Medicaid Services. All of these organizations work to improve the quality of health care by developing standardized methods for assessing health system performance. To learn more about the Leapfrog Hospital Survey click [here](#).

Because of the importance of protecting patients from serious medication errors, we developed our own Medication Safety Survey. A team of hospital pharmacists and nurses developed the questions to ask and how to assign ratings. The tool they came up with is called the Medication Spotlight Survey. The idea is to assess the systems hospitals have in place to prevent medication errors and insure the effectiveness of medication therapy. If you have any questions about the information, please contact the hospital.

When national programs become available to measure the use of medication tools and procedures in hospitals, we will work to use them instead of our own survey.

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Other programs – incentives for employees

MHMC’s members, such as the State of Maine, the University of Maine, and The Jackson Laboratory, are using the Coalition’s GetBetterMaine quality reports to design health benefits and provide incentives for employees who go to top-rated providers.

The State Employee Health Commission (SEHC) uses the MHMC’s data to tier hospitals and providers based on the quality of care provided. SEHC waives the \$10 co-pay when employees get care from “preferred” physician practices and the \$200 deductible when visiting a “preferred” hospital. The tiering program has generated competition among providers and spurred quality improvement and patient safety efforts across the state, leading to significant improvements in the quality and safety of care provided.

Results

For 7 years the Maine Health Management Coalition Foundation has been publishing quality data. During that time, the quality of health care delivered in Maine has improved. In fact, according to the latest information published by the Agency for Healthcare Research and Quality (a part of the U.S. Dept. of Health and Human Services) Maine had the greatest improvement in measured health care quality of any state in the nation. Maine currently ranks 3rd best overall in the U.S. in health care quality (up from 10th the year before).¹ We believe publishing quality ratings over these years has contributed to the improvements in Maine.

Publications / links

Compare doctors and hospitals (searchable database)

<http://www.getbettermaine.org/>

Physician practice rating methodology

http://www.getbettermaine.org/sites/default/files/physician_practice_rating_methodology_updated_july_2013_final.pdf

Pediatric practice rating methodology

http://www.getbettermaine.org/sites/default/files/pediatric_practice_rating_methodology_updated_july_2013.pdf

Hospital rating methodology

http://www.getbettermaine.org/sites/default/files/hospital_ratings_methodology_sept_2013_v1.pdf

AHRQ snapshot methodology

<http://statesnapshots.ahrq.gov/snaps10/Methods.jsp?menuId=67&state=ME#scoring>

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Organization	Massachusetts Group Insurance Commission (GIC)
Category	State focus; Incentive/Reward Programs
Source	http://www.commonwealthfund.org/usr_doc/1053_Alteras_value-driven_Massachusetts_case_study.pdf?section=4039
Measure	Clinical Performance Improvement (CPI) Initiative

Light update in 2013

Summary

The Group Insurance Commission provides high value health insurance and other benefits to state, housing and certain other authorities' employees, retirees, and their survivors/ dependents. The GIC also provides health-only benefits to participating municipalities' employees, retirees, and their survivors/ dependents.

Eighth year update

The GIC's important Clinical Performance Improvement (CPI) initiative continued to evolve during its eighth year. Under this program, tens of millions of physician claims are analyzed for differences in quality and efficiency; members pay lower copays for providers with better quality and/or cost-efficiency scores. During FY12, the GIC added another year of quality data to its analysis, thereby improving the program's ability to measure physician quality.

The provider community had not previously embraced this project, but the GIC and the Massachusetts Medical Society (MMS) have re-established closer communications on this project.

As a sample, the benefit design below was used in 2012 by one of the larger programs.

Services You May Need	In-network Provider
Primary care visit to treat an injury or illness	\$20 copay/visit
Specialist visit	Tier 1 (Excellent) - \$25 copay/visit Tier 2 (Good) - \$35 copay/visit Tier 3 (Standard) - \$45 copay/visit All other specialists - \$35 copay/visit

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{Author's note: Previous material (program continues but limited material on web)}

CPI initiative - a tool to measure the performance of doctors and hospitals and to recognize doctor and hospital excellence via performance-based payments and/or plan redesigns that encourage selection of better performing providers. Quality-based system of care that integrates data, performance measures, plan design, technology and consumer information.

The GIC's CPI Initiative seeks to improve health care quality and promote cost-effectiveness through increased transparency. Participating health plans were required to provide their entire book of business claims (de-identified) to be aggregated and analyzed for relative provider efficiency and quality. Health plans used this information to develop benefit designs in which members are given modest co-pay incentives to use better performing doctors and, in some plans, hospitals.

Physician tiering was introduced in July, 2006. As of 2008, all of the GIC's Non-Medicare plans, including the Indemnity Basic plan have introduced physician tiering. All Massachusetts doctors in the Indemnity Basic plan were tiered. Additional specialists were tiered in two of the GIC's major PPO plans. Specialist tiering was added to one of the GIC's HMOs, and another HMO merged its two plans and introduced physician tiering.

Methodology

Tiered products by combining efficiency data with quality data. Data are run through Episode Treatment Group (ETG) software, which identifies and classifies an entire episode of care for each patient, including inpatient, ambulatory, outpatient, and pharmacy claims. Mercer provides efficiency scores to the plans. Resolution Health, Inc. provides quality indicator information to the plans. Efficiency and quality data were developed in 2005 using data from 3years of statewide BOB claims data, provider files, and member files from each of the six contracted health plans. RHI selected quality measures in concert with the specific provider types analyzed in the efficiency analysis. Currently, 79 quality measures, all based on nationally accepted guidelines, are involved in the analysis.

In FY08, 150 million de-identified health claims representing 2.3 million lives and seven million complete episodes of care were analyzed, making this one of the largest multi-payer analytic databases of its kind being used in this manner.

Publications / links

Annual report 2012

<http://www.mass.gov/anf/docs/gic/annual-report/arfy2012.pdf>

PHYSICIAN TIERING – FAQ (Unicare)

<https://www.unicarestateplan.com/pdf/physicianTieringFAQ.pdf>

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Organization	Massachusetts Health Care Quality and Cost Council (HCQCC)
Category	State focus; Summary for Public; Consumer; Infomedary
Source	http://hcqcc.hcf.state.ma.us/
Measure	Myhealthcareoptions www.mass.gov/myhealthcareoptions

Summary

Established in 2006 to develop and coordinate the implementation of health care quality improvement goals that are intended to lower or contain the growth in health care costs while improving the quality of care, including reductions in racial and ethnic health disparities.

Myhealthcareoptions

Interactive website designed to promote transparency in the health care industry launched in December 2008. Part of the ongoing, multipronged efforts to control rising health care costs and ensure that residents of Massachusetts can get the best care available. The first of its kind in the nation to offer consumers, providers, employers, and policymakers comparative cost and quality information about medical procedures performed at Massachusetts hospitals and outpatient facilities.

Methodology

Website created by taking ratings from other recognized organizations and by calculating some new ratings from our own Massachusetts health care database

The HCQCC gets some of its data from established health care organizations that perform data collection and analysis, including:

- US Centers for Medicare and Medicaid Services (CMS) for hospital quality ratings on heart attack, heart failure, pneumonia, and surgical care.
- The Leapfrog Group for ratings of patient safety and quality for certain services (aortic valve replacement, weight loss surgery, and neonatal ICU care). Hospitals complete Leapfrog's patient safety survey based on their assessment of their own practices. Leapfrog uses this survey information to assess the hospital's patient safety practices.
- The Massachusetts Division of Healthcare Finance and Policy for a complete database of all hospital admissions in MA.
- Massachusetts Department of Public Health's Data Acquisition Center (Mass-DAC) for angioplasty and bypass surgery death rate and volume.

The HCQCC uses **measures of quality** that have been created by established organizations and are widely used. They include:

- US Agency for Healthcare Research and Quality for standardized measures of mortality
- US Centers for Medicare and Medicaid Services (CMS) for "process of care" measures, such as whether patients are receiving all needed care for their condition.
- The National Quality Forum which endorses measures of quality, safety and efficiency of care.

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Cost calculations:

The Health Care Quality and Cost Council calculated costs per case from their database of commercial health plan claims. Cost is based on the actual price that health plans pay hospitals. These are median dollar amounts meaning that half of the cases at this hospital cost more and half cost less. Costs are adjusted for severity of illness (how sick patients are).

To make fair comparisons among hospitals treating a variety of different patients, adjust inpatient costs for severity of illness. This is done by every patient claim in our database being rated for severity of illness on a scale of 1 (minor) to 4 (extreme). The claims are rated using APR-DRG (All Patient Refined-Diagnosis Related Groups) software by 3M Health Information Systems.

Each inpatient claim in the database is assigned a severity level. The average cost of caring for patients at each of the four severity levels across all hospitals in Massachusetts is then calculated. Then, for each hospital, a predicted average cost for each severity level, based on the state-wide averages is calculated. The hospital's actual cost are compared to the predicted average cost, and adjusted for the difference.

Diagnostically Related Groups (DRGs). Inpatient claims are grouped using 3M's All Patient Refined (APR-DRG) grouper software, version 24.

Minimum Sample Size. Display cost data for hospitals that had 30 inpatient discharges or 30 outpatient visits for the condition or procedure. Display summary ratings using dollar signs (\$\$\$) for conditions and procedures where at least 10 Massachusetts hospitals provided at least 30 discharges or 30 visits.

Hospital Systems. Some hospital systems provide hospital care at more than one campus. Shows measures for each campus when available.

Statistical Significance is tested the 0.05 significance level.

Publications / links

About the ratings

<http://hcqcc.hcf.state.ma.us/Content/AboutTheRatings.aspx>

Hospital quality data was updated in June 2012. Medical Group and Community Health Center quality data was updated in October 2011. Hospital cost data was updated in January 2011. The periods covered by the data are specified on the Detailed Report tab.

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Organization	Massachusetts Health Quality Partners (MHQP)
Category	State focus; Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	http://www.mhqp.org/
Measure	Quality Insights http://www.mhqp.org/quality/clinical/cqMASumm.asp?nav=032400 Others including Consumer Reports and Choosing Wisely

UPDATED IN 2013

Summary

HQP measures and reports on the quality of healthcare services provided to residents of Massachusetts. Our work includes measuring performance and developing reports to share performance results. We collaborate with other organizations locally and nationally on improving the quality of care. We also perform research to learn how to improve the measures and reports, evaluate their impact, and assess steps needed to improve care.

MHQP and Consumer Reports have teamed up to provide Massachusetts consumers with reliable and useful information about primary care physicians in the Commonwealth.

Methodology

Clinical Quality of Care

Continuing MHQP's annual reporting of clinical quality performance to physicians and the public, MHQP publicly reported on 2010 performance for over 150 medical groups in April 2012. The Quality Insights: Clinical Quality in Primary Care report measures the performance of Massachusetts primary care physicians on a variety of preventive and chronic care services. These measures have been developed by the National Committee for Quality Assurance (NCQA), and are known as HEDIS measures. This nationally recognized effort is funded by MHQP member health plans.

This report shows results for how primary care doctors provide their patients preventive care services such as colon cancer screening, and chronic disease care, such as diabetes control. These measures are evidence-based (researched) and recognized nationwide. MHQP reports this information for over 150 medical groups across the state. This is available on-line.

Primary Care Performance Measurement and Reporting for MassHealth (Medicaid)

In collaboration with MassHealth and the Center for Health Policy and Research (CHPR) and the University of Massachusetts Medical School, MHQP conducted a pilot project to aggregate and report clinical quality HEDIS

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metrics for the MassHealth managed care patient population. Results were calculated at the practice site level and reports were distributed to practice sites with enough reportable MassHealth patient volume in December 2011.

Choosing Wisely

Massachusetts Health Quality Partners (MHQP) has been awarded a two-year grant from the ABIM Foundation to advance the organization's Choosing Wisely® campaign. The goal of this effort is to encourage physicians and patients to discuss medical tests and procedures that may be unnecessary, and in some instances cause harm. Reducing unnecessary medical care can improve quality for Massachusetts patients .

Results

Statewide, Massachusetts physicians excel, performing above the national average on 29 of 31 measures. On 14 out of 31 measures they score above the NCQA national 90th percentile

Publications / links

Quality Insights: Primary Care in Massachusetts - Analysis of 2011 Clinical Quality Performance Results and Trends

<http://c354275.r75.cf1.rackcdn.com/MHQP%20Clinical%20Quality%20Report%202011.pdf>

Technical Appendix

<http://www.mhqp.org/quality/clinical/cqTechApp.asp?nav=032444>

Consumers Reports for Massachusetts residents

<http://c354183.r83.cf1.rackcdn.com/MHQP%20Consumer%20Reports%20Insert%202012.pdf>

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Organization	MEDai, Inc.
Category	Incentive/Reward Programs
Source	http://www.medai.com/
Measure / Initiative	Pinpoint Compliance® Risk Navigator Solutions http://www.innovations.cms.gov/initiatives/State-Demonstrations/index.html

UPDATED IN 2013

Summary

Med Ai is now with Lexus/Nexis rather than Elsevier. Given recent change, material on web was very limited. The content below comes from material in mid 2012.

Whether you are a health care provider, commercial payer or government health care agency or are blazing new ground as an Accountable Care Organization, Patient-Centered Medical Home or other delivery organization, we'll empower you to make sound clinical and financial decisions. Decisions that reduce risk, lower costs and — most important — improve the quality of care.

Author's note:: MED AI HAS CHANGED OWNERS – MATERIAL APPEARS TO BE LIMITED

Methodology

Risk Navigator Solutions

Risk Navigator Clinical analyzes administrative and clinical data to identify high-risk populations and individuals who are motivated to follow preventive care initiatives. Risk Navigator Clinical cleans, verifies and transforms raw data from claims, PBMs, laboratories and HRAs, into award-winning predictive analytics that are presented in a way that clinicians understand, enabling decisions and actions to prevent chronic illness, enhance population management and drive down excessive health care costs. Quality care will require enrolling members in the right programs where the right interventions will produce optimal results. Risk Navigator Clinical can help manage the risk and find opportunities to cut costs and improve patient quality.

Instead of a simple “risk score”, Risk Navigator Clinical uses multiple risk assessments and predictions to enable the movement of certain members from disease and care management to the healthy, preventive care spectrum. Featuring six unique clinical risk predictions, used alone or together, appropriate targeted selection of individuals to manage is enabled.

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For example, the forecasted risk index identifies whether a person with diabetes is at greatest risk from diabetes or comorbid cardiovascular or renal disease, and what level of risk is attributed to each. Knowing the answer enables healthcare stakeholders to develop interventions and care management protocols that target the individual's greatest risk factors and promote better health. In addition to the forecasted risk and forecasted cost indices, four additional risk impact insights round out the unique Clinical solution: Acute, Chronic, Motivation and Movers, all aggregated by a client's need for reporting – by Providers, Patients, Populations, Groups, Risk Factors or your own defined custom filters.

Key Benefits:

- Maximize intervention efforts with actionable analytics
- Accurately identify those members with current low utilization levels that will become high-risk in the next twelve months
- Reduce PMPY costs, incidences of catastrophic cases, inpatient admissions, readmissions and emergency room visits
- Enable modification of existing guidelines to align with internal state, or other quality organization requirements
- Easier reporting for all users, without IT intervention:

Med AI provides analytics for health care for population health management, physician profiling and measurement, clinical surveillance, outcome analysis, medical risk analysis, predictive Analytics

Results

Gilsbar Gains More Than \$600,000 in Benefits, Achieves 166% Return on Investment Using MEDai Population Health Management Tool

For Geisinger Health Plan (GHP) as part of the system's model "Medical Home" program –case managers has dropped hospital admissions for entire practice populations by approximately 15 percent, positively influencing medical expense for Medicare populations.

Publications / links

Author's note: limited web material including registration and secured PDFs

Risk Navigator Solutions <http://www.medai.com/products/risk-navigator-solutions/>

Product overview (secured)

go.pardot.com/l/7222/2011-08-03/HMMF/7222/17351/MEDai_RiskNavigatorOverviewBrochure_2011.pdf

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Organization	Milliman
Category	Proprietary/Analytics/Decision Support/Healthcare Data Technology Benchmarking
Source	http://www.milliman.com/home/
Measure	Health Cost Guidelines Suite http://www.milliman.com/Solutions/Products/Health-Cost-Guidelines-Suite/ MedInsight http://www.milliman.com/Solutions/Products/MedInsight/# MedInsight Waste Calculator http://www.medinsight.milliman.com/solutions/individual-tools/health-waste-calculator/

UPDATED IN 2013

Summary

Milliman is one of the leading experts in healthcare financing and delivery. We advise clients on a wide range of issues—from assessing the impact of healthcare reform on organizations or populations to streamlining operations while advancing the quality of patient care. Our consulting work is supported by a powerful toolkit of data analytics solutions and informed by the most trusted, comprehensive set of cost guidelines in the industry.

Estimate expected claims costs and model healthcare utilization with Milliman’s Health Cost Guidelines™, an industry standard used by health care organizations worldwide.

MedInsight® is a data warehousing and decision-support tool for medical insurers, employers, and state Medicaid agencies that enables performance reporting across claims, enrollment, and pharmaceutical records. MedInsight combines vital patient information into a single, comprehensive reporting system that can accurately generate performance metrics on demand. By making high-quality data easily accessible, MedInsight empowers evidence-based decision making and strengthens care management.

Methodology

Estimate expected claims costs and model healthcare utilization with Milliman’s Health Cost Guidelines™, an industry standard used by health care organizations worldwide. Incorporating more than 50 years of research and consulting practice, the Health Cost Guidelines are compiled from published, unpublished, private, and public data sources. Today, more than 100 risk-bearing entities rely on our proprietary methodologies and comprehensive data to:

- Model healthcare utilization.
- Estimate claim costs.
- Adjust national average healthcare costs for specific geographic areas, benefits, reimbursement structures, and plan characteristics.

The Health Cost Guidelines are updated annually to address the latest trends and regulatory compliance issues. Milliman uses multiple sources of data to produce the most comprehensive Health Cost Guidelines available.

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The information you need to evaluate pricing

The Health Cost Guidelines Suite includes the following products:

- Ages 65 and Over
- Commercial
- Dental
- Grouper
- Prescription Drug Rating Manual
- Reinsurance

For example, The Health Cost Guidelines – Commercial include three volumes and two rating models: Commercial Rating Structures, Commercial Area Factors, Commercial Claim Probability Distributions, the Managed Care Rating Model (MCRM), and the Prescription Drug Rating Model (RXRM).

The Health Cost Guidelines Suite is comprehensive and flexible enough to accommodate your specific situation. Whether the focus is on a single benefit area or on redesigning an entire benefit plan, the Health Cost Guidelines will keep you up-to-date on the issues that affect your bottom line.

MedInsight

MedInsight is an open architecture system that is customized to work seamlessly with existing management systems so that real-time information can be accessed anytime and anywhere. Its data, analysis, and benchmarks are designed by experts with industry experience—information is clearly presented in formats that make sense. Milliman's healthcare consultants provide post-implementation training and support so that clients can get the full benefit from their data.

Using data to make better healthcare decisions and reduce costs is one of the key challenges facing the healthcare industry and a primary driver of healthcare reform. Often, the data is available, but the technology and expertise to instantaneously analyze the data is missing. Milliman MedInsight® is helping more than 180 clients from various segments of the healthcare industry effectively leverage data to uncover actionable insight. Each client has unique needs, different time frames, and varying budgets. They may need an enterprise-wide analytic reporting platform, a benchmarking tool, an All-payer Claims Database, or a custom analytic project—but data is always at the heart of the solution.

MedInsight 8.0 is a comprehensive, flexible, and adaptable decision-support solution. There are multiple tools underlying the program.

Health Waste Calculator

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The MedInsight Health Waste Calculator is a stand-alone, analytical tool that provides actionable data to support health care quality, efficiency, and effectiveness reporting. The calculator brings together clinical expertise and powerful data analytics—allowing health care managers to target and reduce wasteful spending.

The MedInsight Health Waste Calculator:

- Adds value to existing publicly available cost and quality reporting efforts.
- Denotes whether services were appropriate or potentially wasteful.
- Indicates which services should be reviewed and flags potentially wasteful spending.
- Operates within a data warehouse or runs on a desktop PC for a flexible, scalable solution.
- Improves reporting for efficiency and effectiveness measurement.
- Includes Milliman benchmarks.

Other analysis within MedInsight

- ACO Care Management Impact Model
- Healthcare Reform Dashboard
- Chronic Conditions Hierarchical Groups (CCHGs)
- GlobalRVUs
- Hospital Operating Costs and Performance Benchmarks Report

Publications / links

Health Cost Guidelines Suite brochure

[http://www.milliman.com/uploadedFiles/Solutions/Products/hcg_suite\(4\).pdf](http://www.milliman.com/uploadedFiles/Solutions/Products/hcg_suite(4).pdf)

MedInsight Portfolio of Solutions and Services

<http://medinsight.milliman.com/home/pdfs/MedInsight-v8.pdf>

MedInsight Fact Sheet

<http://www.medinsight.milliman.com/about-us/pdfs/MedInsight-Fact-Sheet.pdf>

Inpatient costs – a sudden increase

<http://www.medinsight.milliman.com/casestudies/medinsight-identifies-cause-sudden>

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Organization	Milliman
Category	Proprietary/Analytics/Decision Support/Healthcare Data Technology Benchmarking
Source	http://www.milliman.com/home/
Measure	Hospital Performance Index http://www.hospitalefficiencybenchmarks.com/

UPDATED IN 2013

Summary

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The Milliman Hospital Performance Index (HPI) has been in use by national payors, regional payors, health systems, and government health care agencies since 1993, and was re-launched in 2013 with a newly designed, user-friendly interface. The HPI helps payors and providers analyze performance against national or regional best practice benchmarks.

The HPI identifies potentially avoidable admissions and inpatient days, all the way down to the DRG level. This allows better strategic deployment of care management resources. The HPI is also an extremely powerful tool when evaluating risk contracts or considering expansion into a new market.

Methodology

Our benchmarks are statistically robust—the HPI benchmarks every facility to a common benchmark (the most efficient national or regional practice), allowing any payor or provider to compare (by specific DRG a specific hospital) against either national best practice or any other provider in the U.S. The HPI also accounts for complicated patients and accounts for complicated cases so that comorbidities or unavoidable complications don't prevent clear, specific, detailed insight.

The HPI addresses critical business needs, including:

- Risk or capitation evaluation
- Long-term strategic planning
- Profitability of Medicare DRGs—which are efficient,
- identifying areas for improvement
- Identification of most efficient practice facilities

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- Selection/evaluation/integration of networks
- Determination of hospital efficiency adjusted charge or reimbursement levels
- Development of new reimbursement structures
- Contract negotiation
- Care management opportunities
- Insight into why days and admissions are potentially avoidable—users clearly see percentages of avoidable days and admissions
- Identification of national, regional, and user defined benchmarks at the DRG level

The HPI takes nationally available data sets, performs severity adjustments, and then analyzes and creates best practice benchmarks. This process replicates the process that individual networks have tracked for years, but on a much larger scale than individual networks. The HPI also lets clients to incorporate their data, allowing our clients to view and manipulate their data against our benchmarks.

Publications / links

Electronic Brochure

<http://www.milliman.com/uploadedFiles/Solutions/Products/hospital-performance-index.pdf>

Comparing episode of cancer care costs in different settings / chemotherapy

<http://www.milliman.com/insight/2013/Comparing-episode-of-cancer-care-costs-in-different-settings-An-actuarial-analysis-of-patients-receiving-chemotherapy/>

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Organization	Milliman
Category	Proprietary/Analytics/Decision Support/ Risk Adjustment
Source	http://www.milliman.com/home/
Measure	Milliman Advanced Risk Adjusters (MARA) http://www.milliman.com/expertise/healthcare/products-tools/milliman-advanced-risk-adjusters/

UPDATED IN 2013

Summary

Milliman is one of the leading experts in healthcare financing and delivery. We advise clients on a wide range of issues—from assessing the impact of healthcare reform on organizations or populations to streamlining operations while advancing the quality of patient care. Our consulting work is supported by a powerful toolkit of data analytics solutions and informed by the most trusted, comprehensive set of cost guidelines in the industry.

Milliman Advanced Risk Adjusters

(MARA) is a suite of risk adjustment tools for population analysis for a broad range of risk action applications. MARA creates a comprehensive risk profile to quantify the influence of illness burden in cost variation making it suited for:

- healthcare budgeting and payment
- reform initiatives
- pricing and underwriting
- stratifying risks
- assessing provider and, or plan risk and efficiency
- assessing risk selection
- high cost patient identification
- clinical risk driver analysis
- outcomes measurements

Methodology

MARA's methodology considers disease progression by taking advantage of longitudinal data sets. Using longitudinal data assets that are geographically well-represented and a detailed clinical grouping system that recognizes risk for more than 1,100 conditions results in more precise observations of chronic and costly conditions over time. Once risk is defined by individual's diagnosis, pharmacy and demographic data, advanced statistical algorithms refine risk profiles to more accurately reflect severity and progression when the presence of chronic, co-morbid, and persistent conditions are presented. The result is improved statistical performance from every model.

Components

MARA includes a library of model sets

- RxAdjusters – for organizations that do not have access to medical data, RxAdjusters offer a more timely risk assessment requiring only data from pharmacy claims and demographic records. RxAdjusters offer concurrent and prospective models with three lag options, as well as individual risk scores by service categories: inpatient, outpatient, physician drug, and total risk score.

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- DxAdjusters – include concurrent and prospective models with three lag options. DxAdjusters use medical and demographic data to predict total resource use plus risk scores by service categories: Inpatient, Outpatient, Physician and Pharmacy. Clinical risk drivers are an additional, optional output.
- CxAdjusters – superior predictive performance using a comprehensive set of data – medical, pharmacy and demographic data. CxAdjusters also include concurrent and prospective models with three lag options, and risk scores by service categories: Inpatient, Outpatient, Physician and Pharmacy. Clinical risk drivers as an additional, optional output.

Other Outcomes

Inpatient Risk Score: Among the category risk scores, the Inpatient (IP) Risk Score is highly correlated with the probability of admissions. Scores are highly functional for risk actions focused on reductions in hospitalizations.

Clinical Risk Drivers: Revealing the percent contribution for each condition identified in the risk assessment period provides risk ranking by medical problem, offering greater transparency for medical management risk actions.

Strategic Alliances – MARA is integrated within decision support, business intelligence, care management products and used by Milliman Healthcare Actuaries and Consultants plus integrations are underway with a variety of business intelligence, decision support systems, EMRs, EHRs, HIEs, reporting and workflow tools.

Publications / links

Risk Adjustment and the Power of 4. Ksenia Draaghtel, ASA, MAAA, Diane Laurent. March, 2012

<http://insight.milliman.com/article.php?cntid=8048>

What kind of risk adjustment is needed for health exchanges. Rong Yi, Ph.D., Diane Laurent October 2010

<http://insight.milliman.com/article.php?cntid=7410>

Risk Adjustment and its Applications for Global Payments to Providers, Rong Yi, Ph.D., Jon Shreve, FSA, MAAA, Bill Bluhm, FSA, MAAA, FCA, J Milliman Advanced Risk Adjusters July 2011

<http://insight.milliman.com/article.php?cntid=7679>

Predictive Value of Inpatient Risk Score: MARA, Ksenia Draaghtel, ASA, MAAA, November, 2011

<http://publications.milliman.com/periodicals/rsa/pdfs/milliman-advanced-risk-adjuster.pdf>

Refining the credibility factors, MARA and credibility, Ksenia Draaghtel, ASA, MAAA, October 2010

<http://publications.milliman.com/periodicals/rsa/pdfs/mara-and-credibility.pdf>

Milliman Advanced Risk Adjusters Brochure

<http://www.milliman.com/expertise/healthcare/products-tools/milliman-advanced-risk-adjusters/>

Milliman Advanced Risk Adjusters Performance Measures for Prospective and Concurrent Models

<http://www.milliman.com/expertise/healthcare/products-tools/milliman-advanced-risk-adjusters/>

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Organization	Minnesota Health Action Group (previously Buyers Health Care Action Group)
Category	State; Standards Setting, Industry Organizations
Source	http://mnhealthactiongroup.org/
Measure	Multiple programs

UPDATED IN 2013

Summary

The Minnesota Health Action Group is the only Minnesota organization whose sole purpose is to represent the collective voice of those who pay the bill for health care — employers, public purchasers, and individuals. We drive innovation, collaboration and engagement in ways that improve health care and ensure the economic vitality of all Minnesota communities.

This was previously the Buyers Health Care Action Group (BHCAG). It was founded in 1988 when several Minnesota business leaders met informally to discuss how they could control escalating health care prices that were rising nationally at double-digit levels.

Methodology

Key programs include:

MN Adverse Events Report - Adverse events, defined as serious, clearly identifiable and preventable medical errors, are a serious problem in our nation. The Minnesota Health Action Group has worked to hold Minnesota hospitals accountable for medical errors.

Leapfrog Group - The Leapfrog Group is an employer-driven initiative that aims to “trigger giant leaps in the safety, quality and affordability of health care.” The Action Group served as the Regional Roll-out Leader in Minnesota when the Leapfrog Group was launched.

MN Hospital Quality Reporting - The Minnesota Hospital Quality Report, a website with information by hospitals on quality of care and patients’ experiences, enables consumers to make informed decisions about future hospital care.

Minnesota Bridges to Excellence – this recognizes and rewards clinicians who deliver superior patient care. It advances both care delivery and outcomes by rewarding clinics for meeting or exceeding a strict set of care standards for patients with diabetes, depression, and vascular disease. These conditions are known to be primary drivers of health care costs.

Other programs include Health Plan Quality and Performance, Choosing Wisely®, and Private/Public Alignment

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Publications / links

Adverse health events in Minnesota <http://www.health.state.mn.us/patientsafety/ae/2013ahereport.pdf>

Minnesota Hospital Quality Report <http://www.mnhospitalquality.org/>

Minnesota Bridges to Excellence
<http://mnhealthactiongroup.org/wp-content/uploads/2013/10/MNBTE.pdf>

Adverse Health Care Events Reporting System: What have we learned? 5-year Review. January 2009. Minnesota Department of Health.

<http://www.health.state.mn.us/patientsafety/publications/09aheeval.pdf>

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Organization	Minnesota Hospital Quality Partnership
Category	State focus; Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	http://www.mnhospitalquality.org/
Measure	Minnesota Hospital Quality Report http://www.mnhospitalquality.org/

Summary

The Minnesota Hospital Quality Report is a web resource for health care consumers about hospital quality of care and patient's experiences, launched in April 2006. Intended to support and assist consumers, and providers, by making information available about the quality and safety of care in Minnesota hospitals.

Developed by the Minnesota Hospital Quality Partnership (a partnership with the Minnesota Hospital Association and Stratis Health, Minnesota's Quality Improvement Organization), and a steering committee comprised of Minnesota hospital representatives.

The site includes two different types of information:

1. Hospital Quality

Quality of care measures in five key areas:

1. heart attack
2. heart failure
3. pneumonia
4. infection reporting
5. surgical care

Two types of quality measures are used:

- Quality of care measures such as frequency are used to broadly describe the care provided by a hospital.
- Appropriate Care Measure (ACM) showing whether a patient received all of the "appropriate or right care" (recommended treatments) that they should have received, based on their clinical condition are also used.

2. Patients Care Ratings

Comparable ratings on patients' hospital experiences are publicly available. HCHAPS national survey, used to measure the frequency of important aspects of care, such as communication with nurses and doctors as well as pain management.

Methodology

The best practice quality measures reported are tied to three conditions: heart attack, heart failure, pneumonia and to surgical care. Based upon Hospital Compare data. Data is sourced from Centers for Medicare & Medicaid Services, the Joint Commission on Accreditation of Healthcare Organizations, and state databases.

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Patients' data rating of their hospital care is drawn from the Hospital Consumer Assessment of Healthcare Providers and Systems, or HCAHPS. The HCAHPS survey is administered 48 hours to six weeks after discharge to a random sample of adult patients across medical conditions. Participating hospitals may either use an approved survey vendor, or collect their own HCAHPS data (if approved by CMS to do so). Patients identify the frequency by which important elements of care occurred. These include

- Communication with doctors
- Communication with nurses
- Responsiveness of hospital staff
- Pain control
- Communication about medicines
- Cleanliness of hospital environment
- Quietness of hospital environment
- Discharge Instructions

The data will also include patients overall rating of the hospital and their willingness to recommend the hospital to others.

Results

Statistical data is available in spreadsheet form for research or other purposes.

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Organization	National Academy for State Health Policy (NASHP)
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking Incentive/Reward Programs
Source	http://www.nashp.org/
Measure	Multiple papers Medicaid Incentive/Reward Programs by State http://www.hpoe.org/resources/hpoehretaha-guides/1360

UPDATED IN 2013

Summary

The National Academy for State Health Policy (NASHP) is an independent academy of state health policymakers. We are dedicated to helping states achieve excellence in health policy and practice. A non-profit and non-partisan organization, NASHP provides a forum for constructive work across branches and agencies of state government on critical health issues.

The responsibility for health care and health care policy does not reside in a single state agency or department. At NASHP, we provide a unique forum for productive interchange across all lines of authority, including executive offices and the legislative branch.

Our strengths and capabilities include:

- Active participation by a large number of volunteer state officials
- Consensus reports among people with disparate political views
- Executing conferences and meetings with substantial user input in defining the agenda
- Distilling the literature in language useable and useful for practitioners
- Identifying and describing emerging and promising practices
- Developing leadership capacity within states by enabling communication within and across states

Methodology

This is a reference site with a variety of material. Three types of material are highlighted below

Quality, Cost, and Health System Performance – topics

ACOs

Adverse Event Reporting

Care Transitions

Comparative Effectiveness

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Cost Sharing
 Delivery System Reform
 Fraud and Abuse
 Health Care Workforce
 Health Information Technology
 Managed Care
 Medical Homes & Health Homes
 Medical Malpractice
 Patient Safety
 Payment Reform
 Performance Measurement
 Provider Payment Policy
 Quality Oversight

Map of state initiatives

An inventory of state initiatives has been created. Since state efforts to advance accountable care models vary considerably. Programs with three core characteristics and capabilities, consistent across designs, are recorded:

1. Organizations or structures should assume responsibility for a defined population of patients across a continuum of care, including across different institutional settings.
2. Participants should be held accountable through payments linked to value, emphasizing dual goals of improving quality and containing costs.
3. Accountability should be facilitated by reliable performance measurements that demonstrate savings are achieved in conjunction with improvements in care.

State accountable care activity is characterized on this map along seven domains: Project scope, authority, governance, criteria for participation, payment, support for infrastructure, measurement and evaluation

ABCD Resource Center – for children’s care

The ABCD Electronic Resource Center is designed to provide state policymakers, primary care providers and other child and family service providers with easy access to research and resources that they can use to promote early childhood health and development. The resources in this ERC confirm findings from the ABCD Consortia that there are three factors critical to success:

- A simultaneous focus on policy improvement at the state level and quality improvement at the primary care provider practice level.

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- The creation of a public/private quality improvement partnership that explicitly includes children’s primary care provider leadership.
- The development of policies with stakeholder input and based on practical experience.

Four types of resources are available in the Resource Center: NASHP-CMWF Resources, state-specific Resources, peer Reviewed resources, and other Resources:

Results

Within the site, a variety of analysis and reports are referenced – including state specific analysis as part of the map

Medical Homes

As of April 2013, 43 states have adopted policies and programs to advance medical homes. Medical home activity must meet the following criteria for inclusion on this map: (1) program implementation (or major expansion or improvement) in 2006 or later; (2) Medicaid or CHIP agency participation (not necessarily leadership); (3) explicitly intended to advance medical homes for Medicaid or CHIP participants; and (4) evidence of commitment, such as workgroups, legislation, executive orders, or dedicated staff.

Over the past few years, there has been a notable increase in the number of states that are implementing medical home programs. NASHP has fostered a great deal of this work, directly providing technical assistance to 25 states since 2007. A few of our current medical home projects include:

- Four states seeking to implement multi-payer medical home programs through the Multi-Payer Medical Home Learning Collaborative:
- Tracking and analyzing policy context and implementation activities in eight states participating CMS Evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) Five-Year Demonstration.
- Summary analyses of each approved state plan amendment outlined in the 2014 Interim Report to Congress of Affordable Care Act Section 2703 Health Homes for Enrollees with Chronic Conditions.

Accountable Care Models

With the support of The Commonwealth Fund, NASHP is tracking state efforts to lead or participate in accountable care models that include Medicaid and Children’s Health Insurance Program populations. Accountable care models aim to address lack of care coordination and wide disparities in cost and quality of care in the U.S. health care system, perpetuated by the prevailing fee-for-service payment method, through shared incentives to manage utilization, improve quality, and curb cost growth.

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Publications / links

ABCD Resource Center <http://www.nashp.org/abcd-welcome>

Quality, Cost, and Health System Performance – links to various educational material
<http://www.nashp.org/quality-cost-and-health-system-performance>

Medical Home & Patient-Centered Care - interactive map (click to details of each state – does not work on all web browsers) <http://www.nashp.org/med-home-map>

Payment reform <http://www.nashp.org/quality-cost-and-health-system-performance/payment-reform>

Aligning Reimbursement & Purchasing: State-by-state summaries –practices which meet performance expectations.
<http://www.nashp.org/med-home-strategies/reimbursement-purchasing>

Measuring Results: State-by-state summaries - evaluation to assess whether states' efforts are succeeding
<http://www.nashp.org/med-home-strategies/measuring-results>

Performance Measurement

<http://www.nashp.org/quality-cost-and-health-system-performance/performance-measurement>

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Organization	National Cardiovascular Data Registry (NCDR)
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	https://www.ncdr.com/webncdr/
Measure	CathPCI™ Registry ACTION Regist^{ry}®-GWTG™ CARE Registry™ IMPACT Registry™ IC3

UPDATED IN 2013

Summary

The NCDR® is the American College of Cardiology’s worldwide suite of data registries helping hospitals and private practices measure and improve the quality of cardiovascular care they provide. The NCDR encompasses six hospital-based registries and one outpatient registry, making it the most comprehensive outcomes-based quality improvement program in the United States. With growing domestic and international participation, there are currently more than 2,400 hospitals and nearly 1,000 outpatient providers participating in NCDR registries.

A trusted resource, the NCDR has developed clinical modules that support the areas of cardiovascular care where quality can be measured, benchmarked, and improved to make a difference in patients’ lives. With 18 million patient records, the NCDR has the deep clinical data needed to provide an evidence-based rationale that informs treatment choices and lowers treatment costs.

NCDR registries use standardized data elements and definitions for patient demographics, clinical variables, and outcomes to facilitate communication and allow for “apples to apples” comparisons across disciplines and studies. And, as part of the NCDR’s data quality program, all submissions are reviewed for completeness, consistency, and accuracy.

NCDR participants benefit from timely confidential benchmark reports that compare practice patterns, demographics, and outcomes of diagnostic procedures and therapies with those from the national aggregate.

Methodology

Major registries

ACTION Registry®-GWTG™ - Acute coronary syndrome

CARE Registry® - Carotid artery revascularization and endarterectomy procedures

CathPCI Registry® - Diagnostic cardiac catheterization and percutaneous coronary intervention

ICD Registry™ - Implantable cardioverter defibrillator and leads procedures

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IMPACT Registry® - Pediatric and adult congenital treatment procedures

PINNACLE Registry® - Coronary artery disease, hypertension, heart failure and atrial fibrillation in the outpatient setting

STS/ACC TVT Registry™ - Transcatheter valve therapy procedure

Sample overview of one registry

ACTION Registry®-GWTG™ is risk-adjusted, outcomes-based, quality improvement program that focuses exclusively on high-risk STEMI/NSTEMI patients. It helps hospitals apply ACC/AHA Clinical Guidelines recommendations in their facilities, and provides invaluable tools to assist them in achieving their goal of quality improvement. Participating in this program helps hospitals improve their adherence to ACC/AHA Clinical Guidelines recommendations as they satisfy the data collection and reporting requirement of regulatory and contracting organizations. The registry's real-time quarterly reports will support efforts to reduce procedural complications, identify areas of excellence and opportunities for improvement, and document the results of QI efforts.

When you enroll in the ACTION Registry®-GWTG™ you will receive quarterly online access to comprehensive, timely information available for measuring quality of care for patients with a diagnosis of and/or treatment for STEMI and NSTEMI patients.

Metrics and Measures

Metrics and measures in NCDR reports provide information on hospital performance compared with aggregate benchmarks of all registry participants to guide internal quality improvement efforts. NCDR follows the American College of Cardiology Foundation (ACC)/American Heart Association (AHA) classifications:

Performance Measures are those process, structure, efficiency, or outcome measures that have been developed using American College of Cardiology (ACC)/American Heart Association (AHA) methodology, including the process of public comment and peer review and have been specifically designated as performance measures by the ACC/AHA Task Force on Performance Measures.

Quality Metrics are those measures that have been developed to support self-assessment and quality improvement at the provider, hospital, and/or healthcare system level.

Data Quality

The NCDR Data Quality Program (DQP) is comprised of a series of checks and balances to validate and ensure the quality of the collected data. These activities occur at different stages of the data collection process beginning with the registry database development. These activities are embedded into registry development and data collection.

Training

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The NCDR's training and education program provides materials and resources to healthcare professionals to facilitate building their knowledge and skills to:

- Document, measure, collect and submit data
- Assess and use outcomes reports
- Implement quality improvement programs related to cardiovascular care

Results

In addition to the systematic reporting back to registry participants, the NCDR is able to leverage its seven registries to conduct observational studies to provide information regarding a multitude of cardiovascular treatments and patient care issues through custom analytics.

NCDR custom analytics offers the opportunity to analyze clinical data from real world populations to gain a broad understanding of a myriad of issues including safety, effectiveness and quality to satisfy a variety of stakeholders.

There is a published paper "The National Cardiovascular Data Registry (NCDR) Data Quality Brief: The NCDR® Data Quality Program in 2012" from the September 20, 2012 issue of the Journal of the American College of Cardiology (JACC). It highlights the critical need for data accuracy in light of increasing interest on the part of payers, consumer coalitions, and federal and state agencies in using registry data for efforts like pay-for-performance, direct-to-consumer reporting and post-market surveillance. Recognizing that these efforts often have implicit or explicit consequences for patients, providers and manufacturers, the paper focuses on the need for enhanced data validation as the use of registry data expands, and specifically looks at the Data Quality Program developed by the NCDR as a model for success.

Extensive lists of research projects, manuscripts and abstracts. And training material.

Publications / links

Starting page

<https://www.ncdr.com/webncdr/home/getstarted>

V2.1 ACTION Registry - GWTG sample Premier Outcomes Report

<https://www.ncdr.com/WebNCDR/docs/default-source/ncdr-private-general-documents/actionsamplerreport.pdf?sfvrsn=2>

V2.2 ACTION Registry - GWTG sample Limited Outcomes Report

https://www.ncdr.com/WebNCDR/docs/default-source/ncdr-private-general-documents/2012q2_sample_144_actionv2_or_rev5.pdf?sfvrsn=2

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Metrics and measures

<http://content.onlinejacc.org/article.aspx?articleid=1188061>

"The National Cardiovascular Data Registry (NCDR) Data Quality Brief: The NCDR® Data Quality Program in 2012"

<http://content.onlinejacc.org/article.aspx?articleid=1360569>

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Organization	National Committee for Quality Assurance (NCQA)
Category	Accreditation/Certification
Source	http://www.ncqa.org/
Measure	HEDIS - Healthcare Effectiveness Data and Information Set http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx

Summary

The National Committee for Quality Assurance is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality. Since its founding in 1990, NCQA has been a central figure in driving improvement throughout the health care system, helping to elevate the issue of health care quality to the top of the national agenda.

Healthcare Effectiveness Data and Information Set

HEDIS is a tool used by health insurance plans to measure performance on important dimensions of care and service. It is offered by the National Committee for Quality Assurance (NCQA) which adapted and refined the first set of measures initially developed by a coalition of health plans and employer groups. The Healthcare Effectiveness Data and Information Set (HEDIS) was first released in 1993. It is a tool used by more than 90% of America's managed health care plans--and a growing number of PPO plans--to measure performance on important dimensions of care and service. Employers, consultants and consumers use HEDIS data, along with accreditation information, to help select the best health plan for their needs. Health plans seeking accreditation by NCQA are required to report on HEDIS measures, and their performance scores on these measures are factored into the accreditation process. CMS requires health plans participating in the Medicare program to submit data on HEDIS-developed measures of health care quality. These are contained in the comparative quality reports available on the CMS website. Many state governments also require plans participating in Medicaid to report HEDIS data. Additionally, HEDIS measures are frequently used in pay for performance programs sponsored by private purchasers.

Measures are added, deleted, and revised annually.

Methodology

Provides objective clinical performance data measured against a detailed set of measure criteria. Address a broad range of important health issues, including:

- Use of Appropriate Medications for People with Asthma
- Cholesterol Management for Patients with Cardiovascular Conditions
- Controlling High Blood Pressure
- Antidepressant Medication Management
- Breast, Cervical and Colorectal Cancers
- Comprehensive Diabetes Care

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To ensure the validity of HEDIS results, all data are rigorously audited by certified auditors, using a process designed by NCQA. HEDIS data are collected through surveys, medical charts and insurance claims for hospitalizations, medical office visits and procedures. Surveys must be conducted by an NCQA-approved external survey organization. Clinical measures use the administrative or hybrid data collection methodology, as specified by NCQA. Administrative data are electronic records of services, including insurance claims and registration systems from hospitals, clinics, medical offices, pharmacies and labs.

Results

Physician-specific measurement is currently conducted using a wide array of different methods and measures. A single, nationally standardized set of performance measures and detailed implementation rules would provide physicians with actionable feedback and allow benchmarking across health plans or geographic regions. Joint efforts to develop standardized measures have recently matured; notable among them is NCQA's work with the AQA and the National Quality Forum (NQF) on standardized measures, and its work with several physician specialty societies to encourage quality measurement. NCQA has collaborated with leading software vendors to develop standards for cost-of-care physician measurement. With the increasing use of episode grouping and population risk adjustment software for applications such as physician cost-of-care evaluation and network tiering, software vendors and users of these technology solutions agree that method standardization represents an important step toward reducing confusion in the marketplace about multiple measurement approaches.

NCQA believes that cost of care measurement must be linked to quality of care measurement in order to estimate a physician's efficiency at providing care.

Publications / links

HEDIS 2014 (clicks to various details)

<http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2014.aspx>

HEDIS 2014 measures

<http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2014/List%20of%20HEDIS%202014%20Measures.pdf>

PCR/RRU Risk Adjustment and RRU Standard Pricing Tables (Posted November 1, 2013)

<http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2014/2014SPTUsageAgreement.aspx>

HEDIS Archives

<http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDISArchives.aspx>

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Organization	National Committee for Quality Assurance (NCQA)
Category	Value based payment / Payment reform
Source	http://www.ncqa.org/
Measure	Patient-Centered Medical Home http://www.ncqa.org/tabid/631/Default.aspx

UPDATED IN 2013

Summary

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The patient-centered medical home—one of modern health care’s most important innovations—is a model of care that emphasizes care coordination and communication to transform primary care into “what patients want it to be.” NCQA Patient-Centered Medical Home (PCMH) Recognition is the most widely-adopted model for transforming primary care practices into medical homes.

Methology

The Patient Centered Medical Home is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

NCQA’s PCMH 2011 (6 Standards, 28 Elements, 152 Factors)

Points	Standard and Element	No. Factors
20	Enhance Access and Continuity	34
16	Identify and Manage Patient Populations	34
17	Plan and Manage Care	24
9	Provide Self-Care Support and Community Resources	10
18	Track and Coordinate Care	25
20	Measure and Improve Performance	22

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NCQA's New Distinction in Patient Experience Reporting

NCQA recently developed the Distinction in Patient Experience Reporting to help practices capture feedback through the new CAHPS PCMH Survey. Because consumer experience is a critical component of quality of care, giving more prominence to patient engagement is a crucial change to the PCMH program.

Patient-Centered Medical Home Prevalidation Program

NCQA's Patient-Centered Medical Home Prevalidation program evaluates electronic health record (EHR) systems, advanced registries, population health management tools and other related technology solutions to identify alignment with PCMH standards requirements.

Publications / links

Patient Experience Reporting Brochure

<http://www.ncqa.org/LinkClick.aspx?fileticket=x9jnmEoT2tw%3d&tabid=1429>

PCMH Content Expert Certification Handbook

https://inetshop01.pub.ncqa.org/publications/product.asp?dept_id=2&pf_id=30018-200-12

HIMSS/NCQA PCMH Fact Sheet

http://www.ncqa.org/Portals/0/Public%20Policy/HIMSS_NCQA_PCMH_Factsheet.pdf

NCQA Patient-Centered Medical Home 2011

<http://www.ncqa.org/Portals/0/PCMH2011%20withCAHPSInsert.pdf>

PCMH 2011 Overview 5.2

http://www.ncqa.org/Portals/0/Programs/Recognition/PCMH_2011_Overview_5.2.pdf

Solberg LI, Asche SE, Shortell SM, Gillies RR, Taylor N, Pawlson LG, Scholle SH, Young MR. Is Integration in Large Medical Groups Associated with Quality? *Am J Managed Care*, 2009 June; 15(6):e34-e41.

Solberg LI, Asche SE, Pawlson LG, Scholle SH, Shih SC. Practice Systems are Associated with High Quality Care for Diabetes *Am J Managed Care*, 2008 Feb;14(2):85-92.

Scholle SH, Pawlson LG, Solberg LI, Shih SC, Asche SE, Chou A, Thoele MJ. Measurement of Practice Systems for Chronic Illness Care: Accuracy of Self-Reports from Clinical Personnel. *Joint Commission Journal on Quality Improvement*, 2008; 37 (7) 407-416.

Solberg LI, Scholle SH, Asche SE, Shih SC, Pawlson LG, Thoele MJ, Murphy AL. Practice systems for chronic care: frequency and dependence on an electronic medical record. *American Journal of Managed Care* 2005; 11(12):789-96.

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Organization	National Committee for Quality Assurance (NCQA)
Category	Accreditation/Certification
Source	http://www.ncqa.org/
Measure	Physician and Hospital Quality Certification (PHQ) http://reportcard.ncqa.org/phq/external/PHQAbout.aspx

Updated in 2013

Summary

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Physician and Hospital Quality (PHQ) certification program

PHQ standards evaluate how organizations measure physicians to ensure that measurement methods are fair and rely not only on cost, but also on accepted measures of quality. For hospitals, the standards evaluate if organizations provide members with performance information on hospitals from reliable government and other sources to inform decision-making. NCQA's PHQ Certification is awarded to organizations that meet or exceed NCQA's standards, which are widely acknowledged to be the most rigorous in the field.

PHQ standards were developed with input from physicians and physician groups; consumer advocates; employers; representatives from state and local agencies; and health plans. NCQA consulted with physician measurement experts and considered feedback from a formal public comment period. The PHQ standards were approved by NCQA's multi-stakeholder Standards Committee and by its Board of Directors.

PHQ evaluation is divided into two standards: Measuring Physician Performance, which assesses how organizations measure and report on physician performance; and Hospital Performance, which reviews whether third-party information on hospital performance is available in a manner that is useful to members. An organization can be reviewed on either standard or on both standards.

The PHQ standards are built on the following principles:

- Standardization and sound methodology, allowing results to be compared across organizations.
- Transparency, giving physicians and hospitals the opportunity to provide input on measurement programs and how measurement results will be used.
- Collaboration, pooling data on standardized measures to produce results with greater statistical reliability.

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- Action on quality and cost, avoiding the use of cost measurement results alone.

Publications / links

The Report Card lists the status of organizations that have been evaluated against NCQA's PHQ Program. To view detailed information about an organization's performance against the PHQ standards, click the organization's name below.

Publications / links

Organization search (data base)

<http://reportcard.ncqa.org/phq/external/PHQSearch.aspx>

PHQ Fact Sheet

<http://www.ncqa.org/LinkClick.aspx?fileticket=KDNUdul94GQ%3d&tabid=753&mid=2911&forcedownload=true>

PHQ 2013 Program Details

<http://reportcard.ncqa.org/phq/external/PHQAbout.aspx?Tab=PHQ2013ElementDetails>

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Organization	National Committee for Quality Assurance (NCQA)
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	http://www.ncqa.org/Programs/Recognition/PatientCenteredSpecialtyPracticeP CSP.aspx http://www.ncqa.org/
Measure	Other Recognition Programs (for Physicians) Diabetes Recognition Program (DRP) Heart/Stroke Recognition Program (HSRP) Physician Practice Connections Patient-Centered Specialty Practice http://www.ncqa.org/PublicationsProducts/RecognitionProducts.aspx http://www.ncqa.org/Programs/Recognition/PhysicianPracticeConnectionsPPC.aspx x

Updated in 2013

Summary

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They offer a variety of programs to recognize physicians.

Summary

Recognition Programs (for physicians)

Diabetes Recognition Program (DRP)

NCQA developed the Diabetes Recognition Program (DRP) to provide clinicians with tools to support the delivery and recognition of consistent high quality care. This voluntary program is designed to recognize clinicians who use evidence-based measures and provide excellent care to their patients with diabetes.

Heart/Stroke Recognition Program (HSRP)

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The Heart/Stroke Recognition Program was launched in 2003. This voluntary program is designed to recognize clinicians who use evidence-based measures and provide excellent care to persons with cardiovascular disease (CVD) or who have had a stroke.

Back Pain Recognition Program (BPRP) – RETIRED 2012

Physician Practice Connections Recognition Program (PPC)

Physician Practice Connections® (PPC®) recognizes practices that use systematic processes and information technology to enhance the quality of patient care. Meeting PPC® standards shows practices have established connections to information, patients and other providers that allow them to:

- Know and use patient histories
- Follow up with patients and other providers
- Manage patient populations and use evidence –based care
- Employ electronic tools to prevent medical errors.

There are nine PPC® standards and three levels of recognition. Practices seeking PPC® Recognition will complete a Web-based data collection tool and provide documentation that validates responses.

Patient-Centered Specialty Practice Recognition

NCQA—architect of America’s most popular patient-centered medical home model—has extended medical home concepts to specialists: NCQA Patient-Centered Specialty Practice Recognition. Now, specialty practices committed to access, communication and care coordination can earn accolades as the “neighbors” that surround and inform the medical home and colleagues in primary care.

Practices that become recognized will demonstrate patient-centered care and clinical quality through: streamlined referral processes and care coordination with referring clinicians, timely patient and caregiver-focused care management and continuous clinical quality improvement.

Results

Clinician Recognition Directory

This Recognized Clinician Directory helps individuals find doctors who have demonstrated that they meet important standards of care.

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Publications / links

Clinician Recognition Directory

<http://www.ncqa.org/Directories/Clinicians.aspx>

Diabetes Recognition Program

<http://www.ncqa.org/Programs/Recognition/DiabetesRecognitionProgramDRP.aspx>

Heart/Stroke Recognition Program

<http://www.ncqa.org/Programs/Recognition/HeartStrokeRecognitionProgramHSRP.aspx>

Physician Practice Connections

<http://www.ncqa.org/Programs/Recognition/PhysicianPracticeConnectionsPPC.aspx>

Patient Practice Connections Brochure

http://www.ncqa.org/Portals/0/Programs/Recognition/PPC_web.pdf

Patient-Centered Specialty Practice

<http://www.ncqa.org/LinkClick.aspx?link=1970&tabid=1779&mid=8122>

Patient Centered Specialty Practice

<http://www.ncqa.org/Programs/Recognition/PatientCenteredSpecialtyPracticePCSP.aspx>

<http://www.ncqa.org/Portals/0/Programs/Recognition/PCSP/PCSP%20brochure%20web.pdf>

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Organization	National Committee for Quality Assurance (NCQA)
Category	Accreditation/Certification
Source	http://www.ncqa.org/
Measure	Relative Resource Use (RRU) http://www.ncqa.org/HEDISQualityMeasurement/HEDISandQualityMeasureImprovement/HEDISandRelativeResourceUseRRU.aspx

Updated in 2013

Summary

The National Committee for Quality Assurance is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality. Since its founding in 1990, NCQA has been a central figure in driving improvement throughout the health care system, helping to elevate the issue of health care quality to the top of the national agenda.

The NCQA RRU tool shows that some health plans delivering high-quality care also do better at avoiding the waste that plagues our health care system. NCQA's —Relative Resource Use (RRU) measures help illustrate how services like doctor visits and medical procedures relate to quality. They reveal that overall, the number of services used to treat people often has little to do with the quality of care. RRUs can help identify plans that provide high quality using fewer costly resources like hospital stays and surgeries. RRUs begin to identify ways that we can get better value for our scarce health care dollars.

Methodology

What is Relative Resource Use?

Relative Resource Use (RRU) measures indicate how intensively plans use physician visits, hospital stays and other resources to care for members identified as having one of five chronic diseases; cardiovascular disease, COPD, diabetes, hypertension and asthma. When evaluated alongside quality measures, RRU measures make it possible to consider quality and spending simultaneously.

For purchasers, a key insight of Quality Compass® 2013 RRU + Quality Index is that, unlike some goods and services, the level of resources that plans expend to care for members and the quality achieved are weakly related. In some instances, quality and resource use appear to be inversely related (i.e., higher quality is associated with lower resource use). Therefore, quality and resource use should both be considered when comparing health plans.

Understanding the value of these measures requires both cost and quality information. NCQA's HEDIS performance measures reflect quality; however, when it comes to cost, little information is publically available.

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When linked with HEDIS quality data, RRU measures help members, plans, employers, benefit managers and other interested groups, make informed choices about health care services. Members get a more detailed look at the value of services they pay for, while plans can see how effectively they use resources, compared to other plans, when delivering health care.

What Are RRUs? RRUs measure use of services like doctor visits, hospital stays, surgeries, drugs and other care for people with five common, chronic diseases: asthma, cardiac disease, COPD, diabetes and hypertension. These conditions account for over 50 percent of all health spending, and people with them do substantially better if they get effective treatments and avoid ineffective care. Combined with other NCQA HEDIS® measures—the gold standard for assessing health care quality—RRUs begin to reveal value, or the benefit that people get for the services provided to them.

How Does NCQA Calculate RRUs?

NCQA RRUs represent actual service use, based on audited data from health plans. We —risk adjustll to account for factors like age, gender and serious health conditions so we can directly compare plans serving different members. RRUs do not reflect payment rates that plans negotiate with providers, another important factor in the value plans provide that they usually keep private. Because we do not have that information, NCQA calculates RRUs with standardized prices. We calculate averages for all plans and compare them with individual plan results. Results are broken out for each disease into five categories: inpatient hospital care; —evaluation and managementll (generally, physicians figuring out what patients need); surgery and procedures; outpatient prescription drugs; and laboratory and imaging services.

Publications / links

RRU Fact sheet

http://www.ncqa.org/Portals/0/HEDISQM/RRU/NCQA%20RRU%20Fact%20Sheet%20for%20HEDIS%202014_Final.pdf

RRU Standard Pricing Tables

<https://www.ncqa.org/tabid/1437/Default.aspx>

Insights for Improvement Measuring Health Care Value: Relative Resource Use

http://www.ncqa.org/portals/0/hedisqm/RRU/BI%20NCQA_RRU_Publication_FINAL.pdf

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Organization	National Institute of Health and Clinical Excellence – NICE. United Kingdom
Category	International; Standards Setting, Industry Organizations
Source	http://www.nice.org.uk/
Measure	Evidence-Based Clinical Guidelines, Technical Guidelines

Updated in 2013

Summary

The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. Recently, in April 2013 we were established in primary legislation, becoming a Non Departmental Public Body (NDPB) and placing us on a solid statutory footing as set out in the Health and Social Care Act 2012. At this time we took on responsibility for developing guidance and quality standards in social care, and our name changed once more to reflect these new responsibilities.

As an NDPB, we are accountable to our sponsor department, the Department of Health, but operationally we are independent of government. Our guidance and other recommendations are made by independent committees. The NICE Board sets our strategic priorities and policies, but the day to day decision-making is the responsibility of our Senior Management Team (SMT).

Summary

NICE guidance supports healthcare professionals and others to make sure that the care they provide is of the best possible quality and offers the best value for money.

We provide independent, authoritative and evidence-based guidance on the most effective ways to prevent, diagnose and treat disease and ill health, reducing inequalities and variation

We develop our guidance and other products by working with experts from the NHS, social care, local authorities, and others in the public, private and voluntary sectors - including patients and the public. Our recommendations are based on the best available evidence of the most effective care. Our guidance is produced openly and transparently, and we make sure that those that use our guidance, as well as those it affects, are involved every step of the way.

NICE Evidence Services

NICE Evidence Services are a suite of services that provide internet access to high quality authoritative evidence and best practice. The services cover health, social care and public health evidence.

Quality standards

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Our quality standards define what high quality care should look like for a specific disease, condition or clinical area. Our quality standards are an important part of a wider suite support available from NICE, to help organisations improve quality, achieve excellence and identify priorities for improvement.

Quality and Outcomes Framework (QOF)

The QOF is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients. We oversee the development of indicators used in the QOF to show that GPs should be rewarded for providing good quality clinical care and for helping to improve people's health.

NICE Support for commissioning

NICE Support for commissioning are web-based resources supporting quality improvement and service redesign. Support for commissioning also signposts to other implementation support tools to assist with quality improvement and provides information on key clinical, cost and service-related issues to consider during the commissioning process.

These resources will help to inform discussions with providers about the development of services and may include measurement and action planning tools. As part of this, NICE provides five types of costing tool:

- national cost reports summarise the national estimate cost and discuss the assumptions made when estimating the financial impact of implementing the guidance. For technology appraisals, the report is incorporated into the costing template.
- costing templates support estimating the local cost of implementing guidance. and public health guidelines. These templates allow individual NHS organisations and local health economies to quickly assess the impact guidance will have on local budgets. A video tutorial explaining how to use the costing templates is available in Windows Media Player and Quick Time format.
- business case. It presents the financial costs and benefits of implementing guidance.
- cost impact and commissioning assessment for NICE quality standards
- costing statements are used when cost impact is considered to be minimal to explain why the cost impact is not considered to be significant.

Summary

Much of the content discussed below is in a searchable data bases.

NICE Pathways

NICE Pathways is an online tool for health and social care professionals that brings together all related NICE guidance and associated products in a set of interactive topic-based diagrams. Visually representing everything NICE has said on a particular topic, the pathways enable you to see at a glance all of NICE's recommendations on a specific clinical or health topic.

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There are other searchable data bases within the “In practice / Using guidance” material (which includes cost analysis).

Publications / links

Pathways (visual process charts)

<http://pathways.nice.org.uk/>

Quality Standards

<http://www.nice.org.uk/guidance/qualitystandards/qualitystandards.jsp>

In practice / using guidance

<http://www.nice.org.uk/usingguidance/>

Full list of quality standards (searchable)

<http://www.nice.org.uk/guidance/qualitystandards/QualityStandardsLibrary.jsp>

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Organization	National Quality Forum (NQF)
Category	Standards Setting, Industry Organizations
Source	http://www.qualityforum.org/
Measure	NQF Endorsed Standards Measure Applications Partnership Quality Positioning System (QPS)

UPDATED IN 2013

Summary

Transforming our healthcare system to be safe, equitable, and of the highest value will take time and the work of many, but the potential rewards are great. The National Quality Forum (NQF) is a nonprofit, nonpartisan, public service organization committed to this transformation.

NQF reviews, endorses, and recommends use of standardized healthcare performance measures. Performance measures, also called quality measures, are essential tools used to evaluate how well healthcare services are being delivered. NQF's endorsed measures are often invisible at the clinical bedside but quietly influence the care delivered to millions of patients every day. Measures:

- Make our healthcare system more information rich
- Point to actions physicians, other clinicians, and organizations can take to make healthcare safe and equitable
- Enhance transparency in healthcare
- Ensure accountability of healthcare providers
- Generate data that helps consumers make informed choices about their care

Methodology

NQF uses its formal Consensus Development Process (CDP) to evaluate and endorse consensus standards, including performance measures, best practices, frameworks, and reporting guidelines. The Consensus Development Process is designed to call for input and carefully consider the interests of stakeholder groups from across the healthcare industry.

Because NQF uses this formal Consensus Development Process, it is recognized as a voluntary consensus standards-setting organization as defined by the National Technology Transfer and Advancement Act of 1995 and Office of Management and Budget Circular A-119.

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Two key roles are:

Sets standards. NQF endorsed measures are considered the gold standard for healthcare measurement in the United States. Expert committees made up of varied stakeholders, including patients, evaluate measures for NQF endorsement. The federal government and many private sector entities use NQF-endorsed measures above all others, given the rigor and consensus process behind them. Nearly all NQF-endorsed measures are in use.

Recommends measures for use in payment and public reporting programs. By 2017, nine percent of all Medicare payments will be performance-based. Under legislated authority, the NQF-convened Measure Applications Partnership advises the federal government and private sector payers on the optimal measures for use in specific payment and accountability programs. MAP also bridges public and private sector use of measures to help the nation use measures efficiently and reduce burden.

MAP is a public-private partnership that reviews performance measures for potential use in federal public reporting and performance-based payment programs, while working to align measures being used in public- and private-sector programs. MAP is the first group of its kind to provide upstream, pre-rulemaking input to the federal government on the selection of measures.

NQF was selected by HHS to fulfill a statutory requirement to convene multi-stakeholder groups to:

- Identify the best available performance measures for use in specific applications.
- Provide input to HHS on measures for use in public reporting, performance-based payment, and other programs.
- Encourage alignment of public- and private-sector performance measurement efforts.

In convening MAP, NQF brings together stakeholder groups in a unique collaboration that balances the interests of consumers, businesses and purchasers, labor, health plans, clinicians and providers, communities and states, and suppliers. MAP operates in a thoroughly transparent manner, broadcasting meetings, posting content on the Web, and soliciting and responding to public comments.

QPS, NQF's measure search tool helps you find the endorsed measures you need quickly and easily. Search by measure title or number, as well as by condition, care setting, or measure steward.

Results

The QPS data base contains various NQF endorsed measures. Searches can be done on various criteria:

- NQF Endorsed No longer NQF-Endorsed All
- Measure Steward
- National Quality Strategy Priorities
- Use in Federal Program
- Actual/Planned Use

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- Care Setting
- Clinical Condition/ Topic Area
- Cross-Cutting Area
- Data Source
- Level of Analysis
- Measure Status
- Measure Type
- Target Population
- eMeasure Available

Publications / links

Quality Positioning System <http://www.qualityforum.org/qps/>

Measuring performance
http://www.qualityforum.org/Measuring_Performance/Measuring_Performance.aspx

Field Guide http://www.qualityforum.org/Field_Guide/

NQF Measure Endorsement Projects <http://www.qualityforum.org/Projects.aspx>

NQF Measure Endorsement Project Summaries
<http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=69815#in%20minim>

Measures identified by the Measure Application Partnership (MAP)
<http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=71178>

NQF Measure Gaps Analysis Report (2012)
<http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=72982>

NQF Testimony on the Role of Quality Measurement (PDF)
<http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=73099>

Safe Practices for Better Healthcare– 2010 Update.
<http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=25690>

Patient Focused Episodes Of Care . Measurement Framework: Evaluating Efficiency Across Patient-Focused Episodes of Care.
<http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=25912>

Identifying Gaps in Specialty Physician Performance Measurement .
<http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=22017>

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Organization	New York State Department of Health
Category	State; Performance Ratings, Reports, Scorecards, Benchmarking (report actual performance)
Source	http://www.health.state.ny.us/statistics/diseases/cardiovascular/
Measure	Cardiac Surgery Reporting System (CSRS)

Summary – author’s note: key historical program

This program is included since the CSRS was the base data used to report on hospital-specific performance within a clinical framework. These reports were released to the public during the last decade and the public-disclosure was highly discussed in the industry. It also provides an illustration of the types of clinical observations made.

A recent report states “The New York “experiment,” on the heels of a maligned effort by HCFA to release provider data to the public, has proven to be robust over the course of 20 years, has helped spawn several similar statewide efforts (33-36), and has served as a model for current federal and professional association initiatives. Much has been learned from this experience, but many more challenges exist to make public reporting of healthcare outcomes as accurate, informative, and beneficial as possible to patients, providers, regulators and policy makers.

From History, Contributions, Limitations, and Lessons for Future Efforts to Assess and Publicly Report Healthcare Outcomes by Hannan, et al (longer citation listed below)

Summary

New York State has a Cardiac Surgery Reporting System (CSRS), which contains information about cardiac preoperative risk factors, postoperative complications, and hospital discharge. Reports information on coronary artery bypass graft surgery, valve surgery, and the two procedures done in combination at hospitals in New York State where these procedures are performed. Provides data on risk factors associated with death following coronary artery bypass and heart valve surgery and lists hospital and physician-specific mortality rates which have been risk-adjusted to account for differences in patient severity of illness.

The CSRS results have been used to create a cardiac profile system that assesses the performance of hospitals and surgeons over time, independent of the severity of individuals' pre-operative conditions. The program is aimed at:

1. understanding the health risks of patients that adversely affect how they will fare in coronary artery bypass surgery and valve surgery,
2. improving the results of different heart disease treatments,
3. improving cardiac care, and
4. providing information to help patients make better decisions about their own care.

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Data on cardiac surgery and care is published annually.

Methodology

The primary source of data is the New York State Cardiac Surgery Reporting System, which gathers information on each patient's demographic and clinical characteristics, the procedure performed, and the outcomes.

All analyses (cardiac bypass surgery, valve surgery, combined bypass/valve surgery, and physician-specific data) use the outcome of combined in-hospital/30-day mortality. These mortalities include any death occurring in the same hospital stay in which a patient underwent cardiac surgery and any death that occurs after hospital discharge but within 30 days of the surgery.

Data is adjusted to account for

- patient risk
- hospital/30-day deaths risk adjusted mortality analysis
- patient mortality rates for providers - predict mortality rate for each hospital and surgeon

CAC reviews the data collected and analyzed. Committee members assist with interpretation and advise DOH regarding hospitals and surgeons that may need special attention. The CAC has also visited particular hospitals and has recommended that some facilities use outside consultants to design improvements for their programs.

Recent reports

State Department of Health Issues Report on Adult Cardiac Surgery and Angioplasty Procedures In-Hospital and Thirty-Day Valve and Combined Valve Bypass Mortality Rate at All-Time Low

ALBANY, N.Y. (October 15, 2012) - Cardiac care in New York hospitals continues to be of the highest quality with low risk of death or complications, according to two reports issued by the state Department of Health (DOH). The reports include information on adult cardiac surgery and angioplasty procedures performed at hospitals in the state from 2008-2010.

The Adult Cardiac Surgery Report includes analyses of cardiac bypass surgery, valve surgery, combined bypass/valve surgery and physician-specific data from 40 hospitals in New York State. The Percutaneous Coronary Interventions (PCI) Report provides data on procedures used to clear blocked coronary arteries. These procedures are commonly referred to as "coronary stenting" or "angioplasty." The outcomes outlined in the report, show 164,547 patients underwent PCI at 59 hospitals that perform this procedure in New York.

Highlights of the reports include:

Adult Cardiac Surgery

The 2010 in-hospital/30-day mortality rate for cardiac bypass surgery was 1.58 percent – a decrease from the 2009 rate of 1.79 percent.

The 2008-2010 combined in-hospital/30-day mortality rate for valve and combined valve bypass surgeries was 4.59 percent, down from 5.45 percent for 2005-2007.

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In 2010, 9,421 cardiac bypass surgeries were performed in New York State, compared to 11,445 performed in 2007 (10,148 in 2009) and a high of 20,220 in 1997. Cardiac bypass surgeries have decreased due to the increase in the use of PCI, particularly among patients with 2-3 vessel disease.

Percutaneous Coronary Interventions

The 2010 combined in-hospital/30-day mortality rate of PCI procedures was 0.84 percent, down slightly from 0.91 percent in 2009. In 2010 the number of angioplasties in New York State increased to 54,035 from 53,893 in 2009.

2010 non-emergency PCI procedures (procedures performed on patients who are not in shock, do not have very low blood pressure and have not had a heart attack within 24 hours before the procedure) increased to 46,749 from 46,642 in 2009.

Mortalities include any death occurring during the same hospital stay in which a patient underwent cardiac surgery or angioplasty, as well as any death that occurs after hospital discharge and within 30 days of the procedure. Results are reported for hospitals and individual physicians performing the procedures.

"It is of particular note that the mortality rate for cardiac valve procedures has dropped substantially during the many years in which these reports have been issued," said Dr. Edward Hannan, Ph.D., distinguished professor and associate dean for research emeritus at the University at Albany School of Public Health and consultant to New York's Cardiac Advisory Committee. "The overall surgery and PCI results are a tribute to the unrelenting and successful efforts of the New York State Department of Health and its Cardiac Advisory Committee to provide hospitals, physicians and patients in the state with risk-adjusted cardiac outcomes that serve as the impetus for monitoring and improving the quality of cardiac care in the State."

In response to the program's results for surgery, facilities have refined patient criteria, evaluated patients more closely for pre-operative risks and directed them to the appropriate surgeon. Many hospitals have identified medical care process problems that have led to less than optimal outcomes.

Publications / links

History, Contributions, Limitations, and Lessons for Future Efforts to Assess and Publicly Report Healthcare Outcomes
Edward L. Hannan, PhD; Kimberly Cozzens, MA; Spencer B. King, MD; Gary Walford, MD; Nirav R. Shah, MD
J Am Coll Cardiol. 2012;59(25):2309-2316. doi:10.1016/j.jacc.2011.12.051
<http://content.onlinejacc.org/article.aspx?articleid=1208661>

Press release

http://www.health.ny.gov/press/releases/2012/2012-10-15_cardiac_reports_released.htm

Statistics

<http://www.health.ny.gov/statistics/diseases/cardiovascular/>

Risk Analysis for Readmission after Coronary Artery Bypass Surgery: Developing a Strategy to Reduce Readmissions
<http://www.journalacs.org/article/S1072-7515%2812%2901366-X/abstract>

The Burden of Cardiovascular Disease in New York

http://www.health.ny.gov/diseases/cardiovascular/heart_disease/docs/burden_of_cvd_in_nys.pdf

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Cardiovascular Disease Mortality in New York State

http://www.health.ny.gov/diseases/cardiovascular/heart_disease/docs/cvd_mortality.pdf

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Organization	New York State Department of Health
Category	State focus; Performance Ratings/Reports/Scorecards/b Databases/Benchmarking
Source	http://hospitals.nyhealth.gov/
Measure	New York State Hospital Quality Ratings

Updated in 2013

Summary

The New York State Hospital Profile Web site allows you to:

1. search for hospitals;
2. view hospital details, including quality of care measurements and other information; and
3. compare hospitals' quality of care with each other and with the state average.

This Web site offers you many ways to find hospitals. The Hospital Profile home page lets you find hospitals by region or county, by name, or by alphabetical browsing. There is also an advanced search page that allows you in addition to search by zip code, available care, or state designation, or simply to list all hospitals in New York State. These options are described in detail below.

Hospitals can be added individually or in groups to your own personal list of My Hospitals. Adding hospitals to My Hospitals allows you to:

1. view comparisons of their scores on various quality measures; and
2. switch among each of their detailed profiles easily.

Methodology

Hospital quality measures indicate how well a hospital provides care for its patients. Measurements on this Web site currently relate to:

- heart conditions
- pneumonia care
- surgical infection prevention
- performance of coronary artery bypass graft, angioplasty or pediatric heart surgery

While these measures have been proven the most useful indicators of quality care, a hospital's overall quality cannot be expressed by its scores on these measures alone.

You are encouraged to use the information available here to begin conversations with your doctor, hospital representatives, or other health care professionals, as well as with family members, friends, and associates who may

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have direct experience with a hospital. The site provides a checklist of other information that can be of value when choosing a hospital.

Recommended Care

The information shown on this Web site comes from hospitals that voluntarily submit data to the Quality Improvement Organization (QIO) Clinical Warehouse, the national data repository for private healthcare data. The QIO Clinical Warehouse validates the information, provides feedback to the hospitals, and makes data available to the public through the Centers for Medicare & Medicaid Services (CMS).

Composite Scores

Each set of Recommended Care measures pertains to a specific condition, namely Heart Attack, Heart Failure, Pneumonia or Surgical Infection. In each set, all measures are required for hospitals participating in the Hospital Quality Alliance. For Heart Attack, Heart Failure, Pneumonia and Surgical Infection, the composite or overall score is calculated using the following methodology:

For all hospitals reporting, sum the number of patients who received care under a required measure (numerator) and sum the number of patients who were eligible for care under a required measure (denominator). This takes into consideration any contraindications. Divide the numerator by the denominator. Report the composite score to one decimal place.

Note: For Surgical Infection we used the two voluntary measures. All hospitals reporting surgical infection report both measures.

Outcome Measures

Outcome measures refer to what happens to a patient as a result of the treatment received. The New York State Department of Health has been studying the effects of patient and treatment characteristics (risk factors) on outcomes for patients with heart disease since 1994. In the case of cardiac surgery and angioplasty, a risk-adjusted mortality rate is the measurement used.

Mortality rate means the percentage of patients who die in the hospital after heart surgery. For many reasons, some heart surgery patients face a greater risk of dying during heart surgery than others. For example, they may be older, or sicker, or have other complications. Since the risk level of patients treated at each hospital varies, the Department of Health identifies risk factors and uses a statistical model to estimate what a hospital's mortality rate would have been if each hospital had identical patients. The result is a risk-adjusted mortality rate that accounts for differences in severity of illness.

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Organization	New Zealand Ministry of Health
Category	International; Performance ratings, Reports, Scorecards, Databases, Benchmarking
Source	www.moh.govt.nz
Measure	Various district reports

Updated in 2013

Summary

Balanced scorecard for public hospitals introduced in 2001 to look at financial performance, customer satisfaction, internal processes, and organizational learning. From 2004, data have been published as quarterly District Health Board (DHB) reports which provide a tool for DHBs to use as a basis for benchmarking and other performance improvement exercises, as well as a form of public accountability. System was reviewed in 2005 to further enhance transparency and utility of hospital performance data. Hospital Benchmark Information reports, report on data supplied by the hospital services in District Health Boards.

4 categories of information organizational health, quality and patient satisfaction, process and efficiency, and financial. 15 high-level comparative measures of New Zealand hospital performance include triage times, patient satisfaction, average length of stay, acute readmissions, hospital acquired infections and a number of measures relating to organizational issues (turnover, workplace injuries).

The original scorecard has changes over the years. Various district reports are now available.

Methodology (for original balanced scorecard)

Performance measures included in the report are provided for use by DHBs as a basis for benchmarking.

1. The **Quality and Patient Outcome quadrant** contains four measures: emergency triage rates acute readmissions patient satisfaction and HABS (Healthcare Associated *S. aureus* Bloodstream Infections)
2. **The Process and Efficiency Quadrant** contains four measures: average length of stay (ALOS), day case procedures; day of surgery admission; and did not attends.
3. The **Organizational Health quadrant** contains three measures: staff turnover, sick leave, workplace illness and injuries.
4. **Financial Quadrant**

Publications / links

How is my DHB performing?

<http://www.health.govt.nz/new-zealand-health-system/health-targets/how-my-dhb-performing/how-my-dhb-performing-2012-13?icn=health-targets&ici=text>

DHB Hospital Benchmark Information: Report for the Quarter - January - March 2010

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[http://www.moh.govt.nz/notebook/nbbooks.nsf/0/fc0590e749aa6f93cc25734e006d039c/\\$FILE/dhb-hospital-benchmark-information-mar2010.pdf](http://www.moh.govt.nz/notebook/nbbooks.nsf/0/fc0590e749aa6f93cc25734e006d039c/$FILE/dhb-hospital-benchmark-information-mar2010.pdf)

NZ health statistics

<http://www.health.govt.nz/nz-health-statistics>

PHO performance programme

<http://www.health.govt.nz/our-work/primary-health-care/primary-health-care-services-and-projects/pho-performance-programme>

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Organization	OptumInsight
Category	Proprietary/Analytics/Decision Support/Healthcare Data Technology
Source	http://www.optuminsight.com/
Measure	<p>Hospital Benchmarks https://www.hospitalbenchmarks.com/index.aspx</p> <p>Hospital Insights http://www.optuminsight.com/reduce-costs/hospitals/performance-improvement-and-data-analysis/hospital-insight/overview</p>

Updated in 2013

Summary

Ingenix is now OptumInsight, part of Optum— a leading health services business. We specialize in technology services, information, analytics, business services and consulting to help solve the most important problems clients face across the health system. We provide resources that combine connectivity with intelligence to major participants in the health industry — enabling them to make better business and care decisions

Methodology

Hospital Benchmarks

Various hospital financial tools are available.

- Commercial Rate Builder (CRB) is an outpatient pricing tool used to audit and maintain competitive and accurate chargemaster pricing.
- Coding-Reimbursement Benchmarks is a tool for creating comparative performance profiles for any Medicare hospital in the nation.
- Financial Benchmarks, (HospitalBenchmarks.com) provides access to financial, utilization and cost/price information for every hospital in the country.
- Medicare Cost Reports
- Custom Benchmarks provides access to a client's own proprietary data and/or client specific data views of our public databases.
- ProviderMetrics is a robust analytic tool. It provides the complete Medicare databases

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- Almanac of Hospital Financial & Operating Indicators - provides a comprehensive analysis of the financial and operating performance of U.S. hospitals and five-year trend information on more than 70 important financial measures.
- Web-based MS-DRG Grouper - is now available online for users with a low-volume or only occasional need to calculate an expected MS-DRG assignment.

Hospital Insights

Hospital INSIGHT™ is a Web-based benchmarking tool for creating comparative performance profiles for any Medicare hospital in the nation. The robust database enables you to produce graphical, comparative performance profiles for any Medicare hospital in the nation. These profiles provide an accurate snapshot of how a hospital is performing in comparison to peer facilities in the areas of coding, compliance, reimbursement and outcomes.

- Focuses billing and revenue optimization efforts
- Enhances performance monitoring programs
- Improves compliance

Hospital INSIGHT draws data from multiple public data sources, including:

- Medicare Provider Analysis and Review File (MedPAR)
- Hospital Cost Report Information System (HCRIS)
- Medicare Outpatient Prospective Payment System (OPPS) claims file
- Medicare Cost reports

Publications / links

White papers (most require registration)

<http://www.optuminsight.com/resources/accountable-care-organizations/whitepapers/>

Hospital INSIGHT™ Improve the Efficiency and Cost Effectiveness of Care. Product Brochure

<http://www.optuminsight.com/content/attachments/06-10202%20Hospital%20Insight.pdf>

Revenue Cycle Management. Using data to benchmark coding and compliance performance helps improve revenue management. Product Brochure

http://www.optuminsight.com/content/attachments/06_10384FacilityEditingRevCycleWP.pdf

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Organization	OptumInsight
Category	Proprietary/Analytics/Decision Support/Healthcare Data Technology
Source	http://www.optuminsight.com/improve-quality/health-plans/
Measure	Symmetry EBM Connect http://www.ingenix.com/Products/Payers/ConsumerTools/EvidenceBasedHealthPAYCT/EBMConnect/

UPDATED IN 2013

Methodology

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This product is part of the Symmetry Suite of products supporting provider measurement, population and individual health care measurement, and clinical and financial trend analysis.

Methodology

Optum Symmetry® EBM Connect® is decision support software that compares medical and pharmacy claim, lab result and enrollment data with evidence-based best practices for clinical conditions and preventive measures. EBM Connect helps customers assess provider and patient compliance with proven evidence-based treatment standards.

EBM Connect helps you:

- Identify areas of non-compliance for providers and patients
- Perform targeted interventions based on evidence-based standards
- Improve care quality
- Reduce health care costs

EBM Connect compares the medical claim, pharmacy claim, lab result, and enrollment data from your plan with evidence-based best practices for over 90 clinical conditions and almost 600 measures of care. These measures provide a quantifiable basis for actionable interventions by health plans, employers, disease managers, and others.

EBM Connect provides:

- Flexibility to choose a set of measures and eligibility requirements to meet the unique needs of your population
- Easy-to-use output files readily integrated with existing disease management systems, care management systems, and many other analytical and reporting applications

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- Seamless integration with other Symmetry component engines such as Episode Treatment Groups®, Episode Risk Groups®, Procedure Episode Groups®, and Pharmacy Risk Groups®, without requiring multiple setups
- Complete transparency of measure specifications for confidence in citing results to physicians
- Customization of measure content by allowing modification of EBM Connect measures and creation of new measures

Several of the metrics are endorsed by the NQF for Diabetes Mellitus, Hypertension, Hypertension, Migraine Headache, Cerebral Vascular Accident & Transient Cerebral Ischemia, and Pregnancy Management

Publications / links

Optum Impact Benchmark Solutions

<http://www.optuminsight.com/~media/Ingenix/Resources/Downloads/Product%20Sheets/OptumImpactBenchmarkSolutions.pdf>

EBM Connect: Congestive Heart Failure.

http://www.optuminsight.com/~media/Ingenix/Resources/White%20Papers/EBM_Connect_Congestive_HeartFailure_wp_06_2012.pdf

EBM Connect: Coronary Artery Disease

http://www.optuminsight.com/~media/Ingenix/Resources/White%20Papers/EBM_Connect_Coronary_Artery_Disease_wp_06_2012.pdf

EBM Connect: Diabetes Mellitus

http://www.optuminsight.com/~media/Ingenix/Resources/White%20Papers/EBM_Connect_Diabetes_Mellitus_wp_06_2012.pdf

EBM Connect: Low Back Pain

http://www.optuminsight.com/~media/Ingenix/Resources/White%20Papers/EBM_Connect_Low_Back_Pain_wp_06_2012.pdf

Symmetry EBM Connect Product Sheet –

<http://www.optuminsight.com/content/attachments/SymmetryEBMConnectproductsheet.pdf>

Creating Quality Composite Scores: Challenges and Issues in Physician Quality Measurement

http://www.optuminsight.com/content/attachments/29504_Decision_Support_EBM_WhitePaper_LO4.pdf

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Organization	OptumInsight
Category	Proprietary/Analytics/Decision Support/Healthcare Data Technology
Source	http://www.optuminsight.com/improve-quality/health-plans/
Measure	Symmetry Episode Risk Groups Symmetry Pharmacy Risk Groups

UPDATED IN 2013

Summary

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Methodology

Optum Symmetry® Episode Risk Groups ® (ERG®)

Optum Symmetry® Episode Risk Group ® (ERG®) is a risk assessment solution that predicts current and future health care usage for individuals and groups. Episode Risk Groups creates individual risk measures that incorporate episodes-of-care methodology, medical pharmacy claims information, and demographic variables.

Through accurate assessment of current health care risk for individuals and groups, ERG helps managed care and underwriting organizations enhance the efficiency of underwriting and boost the effectiveness of network and care management programs. The Society of Actuaries recognizes ERG as one of the best risk assessment tools for predicting future health care costs.

Episode Risk Groups gives your organization:

- Predictive risk assessment based on sound methodology
- Clinical relevance offering clinicians a basis for understanding different patient conditions and overall level of risk
- Retrospective, prospective, and actuarial & underwriting risk models
- Administrative practicality: diagnostic and procedural information health plans collect as part of claims transaction process will support ERG methodology

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- Systematic and logical clinical approach to creating episodes of care enhances understandability
- Better understanding of variations in medical costs and practice and how they relate to differences in health risk
- Single, comprehensive solution for health risk assessment and episode-of-care methodologies
- More clinical detail, and reflects ETG 7.0 Severity

Summary - Pharmacy Risk Groups

In addition to being able to provide risk measures for every member in a plan, PRG enables users to make timely predictions regarding those members highest in risk. Compared to medical claims, pharmacy claims data is available to users faster—typically within two weeks of the prescription fill date.

- Calculate relative health risk scores for members
- Develop markers for pharmaceutical treatments
- Determine the key factors driving relative risk
- Better predict future health care costs
- Better predict future pharmaceutical use

Pharmacy-based health risk assessment system - using prescription data and proprietary classification systems to create markers of health risk that may indicate a patient's disease prevalence, severity, and comorbidities, PRG allows health care analysts and actuaries to more accurately predict future health care costs and pharmaceutical use.

Predictive accuracy - Pharmacy Risk Groups create markers of risk in the areas of disease prevalence, severity, and comorbidities, combine these markers with others that describe a member's age and gender, and weight them appropriately to provide a measure of each patient's potential need for future health care services.

Flexible Implementation - PRG provides a 'Partial Enrollment' feature utilizing one of four sets of weights corresponding to the member's length of enrollment, creating relevant risk scores for members who are enrolled 12 months, 9 months, 6 months, and even 3 months during the term of claims data.

Publications / links

Symmetry Episode Risk Groups® (ERGs®)

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<http://www.optuminsight.com/~media/Ingenix/Resources/Downloads/Product%20Sheets/SymmetryEpisodeRiskGroupsproductsheet.pdf>

Symmetry Pharmacy Risk Groups (PRG)

http://www.optuminsight.com/~media/Ingenix/Resources/Downloads/Product%20Sheets/PRG_ProductSheet_FINAL_110907.pdf

Symmetry Episode Risk Groups: A Successful Approach to Health Risk Assessment. White Paper

http://www.optuminsight.com/content/attachments/Symmetry_ERG_7-0_WhitePaper.pdf

Symmetry™ Pharmacy Risk Group. A Pharmacy-Based Approach to Health Risk Assessment.

http://www.optuminsight.com/content/attachments/SymmetryPRG_WhitePaper.pdf

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Organization	OptumInsight
Category	Proprietary/Analytics/Decision Support/Healthcare Data Technology
Source	http://www.optuminsight.com/improve-quality/health-plans/
Measure	Symmetry Episode Treatment Groups Symmetry Procedure Episode Groups

UPDATED IN 2013

Summary

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OptumInsight decided to make many underlying details about their episode and procedure methodology more broadly available. Any interested stakeholder can now access, understand, and potentially improve our leading methodology for grouping episodes of care. Summaries are available on the web. Details are available through an registration process. **See Transparency Link at the end of this entry.**

Methodology

Episode treatment groups - Symmetry® Episode Treatment Groups ®

Intuitive - because ETG is intuitive and adjusts for clinical severity, it can be utilized in diverse applications integral to the success of clinicians, health care researchers, and administrators.

ETG can help you:

- Identify clinically homogenous episodes of care
- Organize claims/encounter data into intuitive units
- Identify effective medical interventions
- Base your information needs on methodology
- Quantify your organization's performance

Financial and clinical metrics for analyzing evidence-based medicine - using routinely collected claims or encounter data as input, the ETG software captures the relevant services provided during a patient's treatment, and organizes

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the claims/encounter data into meaningful episodes of care resulting in accurate identification of clinically homogenous episodes of care, regardless of treatment location or duration.

A foundation for superior health care management reporting - the ETG methodology is similar to that of Diagnosis Related Groups (DRGs) but with several important differences. Perhaps the most obvious is that ETG identifies and classifies an entire episode of care irrespective of whether the patient has received medical treatment as an outpatient, inpatient, or both.

Procedure Episode Groups

Symmetry® Procedure Episode Groups® (PEG®) is decision support analytic software that categorizes surgical procedures into procedural episodes to form consistent episodes of care as building blocks for analysis of clinical specialists.

PEG, the only procedure episode grouper software that is commercially available in the market, provides organizations that need to evaluate the value of health care provided by specialty surgeons with a simple method for comparing clinical specialists and performing sequence-of-care analysis.

Unified Unit of Measurement for Surgical Procedures - the PEG methodology uses carefully designed algorithms, based on clinical guidelines and a complete understanding of the complexity of medical claims data, to facilitate accurate identification and thorough development of complete procedure episodes.

One of the most important considerations in comparing procedures is accurate assignment of procedure episodes to the clinical specialists who perform them. PEG uses a sophisticated system for ranking and identifying for effective assignment of the appropriate provider.

PEG uses a new approach to measuring the value in surgical procedures, delivering:

- More than 180 Procedure Episodes, categorized into six (6) Procedure Practice Categories
- A complete unit of analysis for surgical procedures
- Easy identification of repeated procedures Consistent methodology with the Symmetry Suite of products
- Flexible output files that offer seamless integration with existing data-marts and other applications
- Information for analyzing the sequence of care related to surgical procedures
- Combined Episode Flag to alert the presence of a competing Anchor Procedure
- Transparent and available data for drill-down detail to the original claims
- Included content update service to keep pharmacy and medical code libraries up to date
- Grouping of responsible surgical providers into pre-defined clinical specialties creating ideal conditions for value-based measurement

PEG is the only commercially available procedure episode grouper software available in the market. It supports a comprehensive suite of products, leveraging a single methodological platform to address a wide array of business needs, when combined with other Symmetry products – ETGs, ERGs, PRGs, and EBM Connect.

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Transparency

Measuring and improving the quality & efficiency of health care.

Performance measurement is critical to achieving durable health care reform that truly improves cost and quality of care by enabling value-based purchasing and performance-based incentives. Yet performance measurement poses one of the biggest challenges in the U.S. health care industry: What elements make up a fair, accepted system for assessing the quality and efficiency of care provided to patients?

To that end, OptumInsight has opened an online forum for public review of the methodologies behind our patented Episode Treatment Groups® (ETG®) and Procedure Episode Groups® (PEG®). We believe this is an important contribution to advancing the national performance measurement conversation. Now, any interested stakeholder can access, understand, and potentially improve our leading methodologies for grouping episodes of care.

See Transparency Link below.

Publications / links (summaries from web; additional details available with registration)

Transparency Link

<http://www.optuminsight.com/transparency/etg-links/>

Background on ETGs

Symmetry Episode Treatment Groups: Measuring health care with meaningful episodes of care

http://www.optuminsight.com/~media/Ingenix/Resources/White%20Papers/symmetry_episode_treatment_groups_wp_06_2012.pdf

Symmetry Episode Treatment Groups. Measuring Health Care with Meaningful Episodes of Care. White Paper

http://www.optuminsight.com/content/File/IX_PYR_CL_19960_ETG_WP.pdf

Symmetry Episode Treatment Groups. Issues and Best Practices in Physician Episode Attribution. White Paper

http://www.optuminsight.com/content/attachments/Symmetry_EpisodeAttribution_WP_FINAL_112007.pdf

Leveraging the Power of ETG 7.0: New opportunities for health care information analysis. White Paper.

http://www.optuminsight.com/content/attachments/IX_PYR_CL_23746_LeveragingSymmetry_WP.pdf

Background on PEGs

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Symmetry PEG: cost and quality of surgical procedures

http://www.optuminsight.com/~media/Ingenix/Resources/White%20Papers/Symmetry_Procedure_Episode_Groups_wp_06_2012.pdf

Symmetry Procedure Episode Groups Product Sheet

<http://www.ingenix.com/content/attachments/Procedure%20Episode%20Groups%20Product%20Sheet.pdf>

What are PEGs?

<http://www.ingenix.com/content/file/What%20Are%20Procedure%20Episode%20Groups.pdf>

PEG Approach and Methodology

<http://www.optuminsight.com/content/file/PEG%20Approach%20and%20Methodology.pdf>

Assessing Surgical Specialists with Value-Based Measurement

http://www.optuminsight.com/content/file/100-1778_PEG%20White%20Paper%202009-01-08_L03.pdf

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Organization	OptumInsight
Category	Proprietary/Analytics/Decision Support/Healthcare Data Technology
Source	http://www.optuminsight.com/improve-quality/health-plans/
Measure	Symmetry® Provider Cost & Quality Connect (PCQ Connect) Benchmark Solutions

UPDATED IN 2013

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Methodology

Symmetry® Provider Cost and Quality Connect (PCQ Connect)

Symmetry® Provider Cost and Quality Connect (PCQ Connect) is software that delivers a methodology for defining peer groups of physicians so as to perform like-to-like comparisons, attributing physician responsibility for specific patients and risk adjusting for differences in patient morbidity and case mix across providers in a peer group.

Measure Provider and Provider Network Performance - PCQ Connect helps measure network value by providing comparisons among similar specialties and geographies, adjusting for differences in severity, and attributing results to individual providers. With PCQ Connect, you can:

- Improve the quality of care that providers offer members
- Increase revenue and reduce costs by providing high-quality networks
- Increase provider acceptance and reduce risk by using industry-accepted and transparent measures of provider cost and quality

Adjust for severity - PCQ Connect provides multiple methods to reflect underlying differences in the types of cases addressed and the severity of a patient’s condition, so you can create valid comparisons across providers.

Manage outliers - Outlier cost episodes can skew an analysis and lead to incorrect conclusions. PCQ Connect provides different user-adjustable methods to identify outliers. In addition, PCQ Connect provides the ability to include, exclude, or set the cost to the threshold value to account for and treat outlier episodes appropriately in analysis.

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Define peer groups - PCQ Connect provides standard methodology for creating peer groups within the same region and specialty while offering a wide range of flexibility to meet your unique requirements. You can also define each peer group by a unique collection of quality rules and episodes of care, leading to more relevant, reliable evaluations.

Attribute properly - PCQ Connect correctly attributes the right cost and quality measures to the right provider by integrating data from two other Optum Symmetry products: Episode Treatment Groups® and EBM Connect®. You can address unique needs and requirements based on your populations and networks while achieving defensible results and better transparency with PCQ Connect's multiple configuration parameters.

Service Options - provider satisfaction and communication are important aspects of a successful program. OptumInsight experts can help you build and implement a complete, easy-to-understand, and transparent provider measurement program that accurately and fairly defines providers' quality and value of care.

Publications / links

Symmetry™ PCQ Connect™

http://www.optuminsight.com/content/attachments/PCQ_Connect_PS.pdf

Optum Impact Benchmark Solutions

<http://www.optuminsight.com/~media/Ingenix/Resources/Downloads/Product%20Sheets/OptumImpactBenchmarkSolutions.pdf>

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Organization	Oregon Health Authority
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking /Analytics/ Incentive/Reward Programs
Source	https://cco.health.oregon.gov/
Measure / Initiative	Oregon Health Plan (Medicaid) Coordinated Care Organization http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram/

UPDATED IN 2013

Summary

The Centers for Medicare and Medicaid Innovation awarded a State Innovation Model (SIM) grant to Oregon for up to \$45 million for three and a half years. Oregon was one of six states to receive the grant for testing innovative approaches to improving health and lowering costs across the health care system, including Medicaid, Medicare, and the private sector.

The grant will support the state's ongoing health system transformation and provide opportunities for Oregon to share what it learns with other states. Oregon's health reform to its Medicaid program started with the creation of coordinated care organizations (CCOs) last year. This is an opportunity for Oregon to strengthen the coordinated care model and make some of its key elements, such as patient-centered primary care homes, available to others such as PEBB, OEBC, and Medicare beneficiaries.

A Coordinated Care Organization, or CCO, is a network of all types of health care providers (physical health care, addictions and mental health care and sometimes dental care providers) who have agreed to work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid). CCOs are focused on prevention and helping people manage chronic conditions, like diabetes. This helps reduce unnecessary emergency room visits and gives people support to be healthy. Today, there are 15 CCOs operating in communities around Oregon.

Methodology

How Coordinated Care Organizations work

CCOs are local. They have one budget that grows at a fixed rate for mental, physical and ultimately dental care. CCOs are accountable for health outcomes of the population they serve. They are governed by a partnership among health care providers, community members, and stakeholders in the health systems that have financial responsibility and risk.

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What will stay the same and what will be different with Coordinated Care Organizations

Under CCOs, the Oregon Health Plan's medical benefits will not change. Before CCOs, the system separated physical, behavioral and other types of care. That made things more difficult for patients and providers and more expensive for the state.

CCOs have the flexibility to support new models of care that are patient-centered and team-focused, and reduce health disparities. CCOs are able to better coordinate services and also focus on prevention, chronic illness management and person-centered care. They have flexibility within their budgets to provide services alongside today's OHP medical benefits with the goal of meeting the Triple Aim of better health, better care and lower costs for the population they serve.

Reporting

Every quarter, the Oregon Health Authority is publishing performance data and financial data for each of our state's 15 coordinated care organizations. Over time, these reports will also show progress the state and the CCOs are making towards meeting the benchmarks set for key measurements.

The measures reported – 12 CCO incentive measures and 16 state performance measures – were chosen in an open and public process to represent the health care needs and challenges of Oregon's Medicaid population. This includes

Financial data – bending the cost curve - to reduce the trend of Medicaid spending by two percentage points by the end of 2014.

Financial cost and utilization data for services like hospital stays, prescription drugs, and primary care services

Health goals – the program will measure health goals such as improving the timeliness of prenatal care to cutting down on unnecessary emergency department use.

Seven key areas are:

- Improving behavioral and physical health coordination
- Improving perinatal and maternity care
- Reducing preventable re-hospitalizations
- Ensuring appropriate care is delivered in appropriate settings
- Reducing preventable and unnecessarily costly utilization by super-users
- Addressing discrete health issues (such as asthma, diabetes, high blood pressure)
- Improving primary care for all populations

Seventeen initial outcome and quality measures have been developed by the Metrics and Scoring Committee. Funds from a quality pool will be awarded to CCOs based on their performance on these 17 CCO Incentive Measures.

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Additional support

The program also offers guidance, technical assistance, best practice resources, and webinars.

Results

Oregon's first coordinated care organizations (CCOs) were launched one year ago in August of 2012. Key to the success of CCOs is measuring, tracking and publishing information about how the state and CCOs are doing on our most important goal: improving the health of the people we serve.

To that end, every quarter, the Oregon Health Authority is publishing performance data and financial data for each of our state's 15 coordinated care organizations. Over time, these reports will also show progress the state and the CCOs are making towards meeting the benchmarks set for key measurements.

It is still early, results will be available each quarter.

Publications / links

Coordinated Care Organizations <http://www.oregon.gov/oha/OHPB/pages/health-reform/ccos.aspx>

FACT SHEET: Coordinated Care Organizations <http://www.oregon.gov/oha/OHPB/docs/cco-factsheet.pdf>

Baseline data and technical specifications for measures <http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx>

Frequently Asked Questions <http://www.oregon.gov/oha/CCODData/CCO%20Incentive%20Measures%20FAQs%20--%20Revised%20June%202013.pdf>

Early financial analysis <http://www.oregon.gov/oha/OHPB/healthreform/docs/cco-fin-analysis-full.pdf>

Oregon's Health System Transformation" Quarterly Progress Report
<http://www.oregon.gov/oha/Metrics/Documents/report-august-2013.pdf>

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Organization	Organization for Economic Cooperation and Development (OECD)
Category	International; Performance ratings, Reports, Scorecards, Databases, Benchmarking
Source	http://www.oecd.org/health/hcqi
Measure	Health Care Quality Indicator (HCQI) Project http://www.oecd.org/dataoecd/1/36/36262363.pdf

Summary

The mission of the Organisation for Economic Co-operation and Development (OECD) is to promote policies that will improve the economic and social well-being of people around the world.

The OECD Health Care Quality Indicators project, initiated in 2002, aims to measure and compare the quality of health service provision in the different countries. An Expert Group has developed a set of quality indicators at the health systems level, which allows to assess the impact of particular factors on the quality of health services.

Methodology

Our approach is to complement and coordinate efforts of national and other international bodies. These efforts will offer policy makers and other stakeholders a toolkit to stimulate cross-national learning.

Quality of care is one of the key dimensions of value. Through ongoing national and international efforts, such as the System of Health Accounts, information on health care spending is expanding, yet information on the value that health services create is still limited.

Health at a Glance 2011

Health at a Glance 2011 presents the existing set of quality of care indicators considered suitable for international comparison. Data, charts and related information are provided for OECD and non-OECD countries which provided the data for each of the following indicators:

Care for Chronic Conditions

- Avoidable admissions: respiratory diseases
- Asthma hospital admission rates
- COPD hospital admission rates
- Avoidable admissions: uncontrolled diabetes
- Uncontrolled diabetes hospital admission rates

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Care for Acute Exacerbation of Chronic Conditions

- In-hospital mortality following acute myocardial infarction
- In-hospital case-fatality rates within 30 days after admission for AMI
- In-hospital mortality following stroke
- In-hospital case-fatality rates within 30 days after admission for ischemic stroke
- In-hospital case-fatality rates within 30 days after admission for hemorrhagic stroke

Patient Safety

- Obstetric trauma
- Obstetric trauma, vaginal delivery with instrument
- Obstetric trauma, vaginal delivery without instrument
- Procedural or postoperative complications
- Foreign body left in during procedure
- Accidental puncture or laceration
- Postoperative pulmonary embolism or deep vein thrombosis
- Postoperative sepsis

Care for Mental Disorders

- Unplanned hospital re-admissions for mental disorders
- Schizophrenia re-admissions to the same hospital
- Bipolar disorder re-admissions to the same hospital

Cancer Care

- Screening survival and mortality for cervical cancer
- Cervical cancer screening, percentage of women aged 20-69 screened
- Cervical cancer five-year relative survival rate
- Cervical cancer mortality, females
- Screening, survival and mortality for breast cancer
- Mammography screening, percentage of women aged 50-69 screened
- Breast cancer five-year relative survival rate
- Breast cancer mortality, females
- Survival and mortality for colorectal cancer
- Colorectal cancer, five-year relative survival rate
- Colorectal cancer mortality

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Data and information on quality indicators for communicable diseases (screening and immunisation), cancer (screening and mortality) along with various other quality indicators related to lifestyle and prevention can be found through OECD Health Data and Health at a Glance.

Other program - Health Care Quality Reviews

OECD Health Care Quality Reviews seek to examine what works and what does not work in different countries – both to benchmark the efforts of countries and to provide advice on reforms to improve their health system. The reviews will cover around 10 to 12 country reports. Each report highlights best practices and offers recommendations for improvement. A final report on policies to drive improvements in health care quality across countries will be produced in 2015.

Publications / links

The OECD Health Care Quality Framework

<http://www.oecd.org/els/health-systems/36262363.pdf>

Health Promotion, Prevention and Primary Care

<http://www.oecd.org/els/health-systems/hcqihealthpromotionpreventionandprimarycare.htm>

Mental Health Care

<http://www.oecd.org/health/health-systems/hcqiicareformentaldisorders.htm>

Cancer Care

<http://www.oecd.org/els/health-systems/cancer-care.htm>

Health Care Quality Reviews

<http://www.oecd.org/els/health-systems/newoecdseriesonhealthcarequalityreviews.htm>

Strengthening Health Information Infrastructure

<http://www.oecd.org/els/health-systems/strengtheninghealthinformationinfrastructure.htm>

Health Care Quality Indicators Project Initial Indicators Report. Soeren Mattke, Edward Kelley, Peter Scherer, Jeremy Hurst, Maria Luisa Gil Lapetra 09-Mar-2006 OECD Health Working Papers No. 22

<http://www.oecd.org/health/health-systems/36262514.pdf>

Health Care Quality Indicators Project Conceptual Framework Paper Edward Kelley and Jeremy Hurst. OECD Health Working Papers No. 23. 09-Mar-2006.

<http://www.oecd.org/health/health-systems/36262363.pdf>

Facilitating Cross National Comparisons of Indicators for Patient Safety at the Health System Level in the OECD Countries. Saskia Drösler. OECD Health Technical Papers No. 19. 07-Apr-2008

<http://www.oecd.org/health/health-systems/40401929.pdf>

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Organization	California Healthcare Performance Information System (previously part of Pacific Business Group Health)
Category	State focus; Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	http://www.chpis.org/
Measure	Health California Healthcare Performance Information System Formerly California Physician Performance Initiative (CPPI) http://www.cchri.org/ http://www.cchri.org/programs/programs_CPPI.html

Lightly updated in 2013

Summary

The California Healthcare Performance Information System (CHPI) is a non-profit, public benefit corporation whose mission is to serve as a trusted source of healthcare data to measure the quality and affordability of care, report performance ratings to and educate the public about healthcare value, and drive improvements in healthcare in California. CHPI's key objectives are to:

- Produce performance ratings of physicians, medical groups, hospitals and other providers;
- Educate the public about performance information and support policies to reduce barriers to such information;
- Achieve measurement system efficiencies by serving as a central claims data resource in California;
- Create and administer a multipayer claims database – aggregate, score and report data supplied by multiple California health plans, Medicare, and other data suppliers; and
- Integrate Medicare claims into the CHPI data set as a designated Medicare Qualified Entity.

Methodology

California Healthcare Performance Information System

CHPI's mission is to serve as a trusted source of healthcare data to measure the quality and affordability of care. CHPI is assembling a massive database and, once the rigorous statistical analyses and audits are complete, will release performance information to an on-line publisher.

CHPI is one of the first organizations in the U.S. to be certified as a Medicare Qualified Entity. This designation allows us to include the experiences of millions of California Medicare beneficiaries in producing healthcare ratings for consumers and purchasers.

Since this website is relatively new, information on the predecessor program is below.

California Physician Performance Initiative (CPPI) - previous program

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Collaborative project of the California Cooperative Healthcare Reporting Initiative (CCHRI), managed by the Pacific Business Group on Health. Commenced in 2006. Generates standard performance measures and reports at the health plan, physician group, and physician levels. A standardized system for analyzing administrative claims data to measure and report on the quality and cost of physician-provided health care in California. Goals are to work collaboratively with physicians, health plans, consumers, and employers as part of a national effort to improve the quality of patient care while moderating costs.

In 2006, the Centers for Medicare and Medicaid Services (CMS) provided funding to aggregate Medicare fee-for-service and commercial claims data to calculate and report quality measures as part of a national effort to establish physician performance standards. (The six-site pilot project is known as the **Better Quality Initiative**). The voluntary addition of data from California's three largest commercial PPOs (Anthem Blue Cross, Blue Shield of California, and United Healthcare) provided a large enough pool to test the reliability of an initial set of 15 quality measures (cancer, care for older adults, diabetes, heart disease, heart failure, pulmonary disease, rheumatology & orthopedics) as well as methods for attributing patients based on claims data of patient care provided in 2007.

Methodology

During the pilot phase, CPPI combined Medicare fee-for-service data with commercial claims data to establish an infrastructure to aggregate claims data across multiple data suppliers, score and report results to physicians and other stakeholders. 15 clinical quality measures. Uses aggregated data to test a broader set of quality measures. Uses composites indicators that aggregate related, individual quality measures. Tests episode-based cost of care measures.

Physician Performance Reports - advise physicians of the quality measurement work that is underway in California, to share results with physicians, and to begin an information exchange about ways to improve the measurement data and performance. California physicians who participate in the Medicare program and/or contract with one or more of three participating commercial PPOs during 2007 are eligible to receive a report. Approximately 20,000 physicians have a reliable score for at least one of the fifteen measures and will receive a Physician Performance Report. CPPI assessed physician performance using clinical quality measures that are evidence-based, nationally standardized. CPPI used measure specifications from the NCQA, HEDIS, and the Physician Consortium for Performance Improvement. The measures address both preventive care and chronic condition management.

Publications / links

Overview

<http://www.chpis.org/>

Program summary

http://www.pbgh.org/storage/documents/PBGH_CHPI_102613.pdf

Case Study Pacific Business Group on Health Quality Initiatives

<http://www.ahrq.gov/legacy/qual/value/suscqcollappa1.htm>

Blue Shield – measure physician performance

<https://www.blueshieldca.com/bsca/about-blue-shield/newsroom/physician-performance.sp>

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Medical group ratings published by the California Office of the Patient Advocate
<http://reportcard.opa.ca.gov/rc2013/medicalgroupcounty.aspx>

Hospital ratings published by the California HealthCare Foundation
<http://reportcard.opa.ca.gov/rc2013/medicalgroupcounty.aspx>

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Organization	Patient Centered Medical Home (major supporting organizations)
Category	Standards Setting, Industry Organizations
Source	http://www.aafp.org/practice-management/pcmh/overview.html http://www.pediatricmedhome.org/ http://www.acponline.org/running_practice/delivery_and_payment_models/pcmh/ http://www.medicalhomeimprovement.org/ http://www.pcdc.org/ http://www.pcpc.org/ http://www.transformed.com/
Measure	Websites for various organizations

Updated in 2013

Summary - Author's note

This is different type of entry. It only lists organizations and their websites)

Many organizations are helping physicians prepare for Patient Centered Medical Homes. Although, provider support is not the direct focus of this paper; a successful system is directly tied to performance. Given the high activity, this unique entry lists organizations working on these topics outside of measurement or rewards.

Organizations

American Academy of Family Physicians (AAFP)

The American Academy of Family Physicians and its chapters proudly represent more than 110,600 family physician, resident, and medical student members. Family physicians play a critical role in improving the health of patients, families, and communities across the United States. The AAFP is committed to helping family physicians improve the health of Americans by advancing the specialty of family medicine, saving members time, and maximizing the value of membership. Our focus every day is to help family physicians spend more time doing what they do best: providing quality and cost-effective patient care.

<http://www.aafp.org/practice-management/pcmh/overview.html>

American Academy of Pediatrics (AAP)

This site is sponsored by the National Center for Medical Home Implementation at the American Academy of Pediatrics (AAP).

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<http://www.pediatricmedhome.org/>

American College of Physicians (ACP)

The American College of Physicians (ACP) is a national organization of internists — physician specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

http://www.acponline.org/running_practice/delivery_and_payment_models/pcmh/

<https://www.practiceadvisor.org/home>

Center for Medical Home Improvement

CMHI (Center for Medical Home Improvement) is a organization affiliated with Crooked Mountain Foundation and Rehabilitation Center (www.cmf.org) founded in 1993 by Dr. W. Carl Cooley, Medical Director and Ms. Jeanne W. McAllister, B.S.N., M.S., M.H.A., Director. The mission of the Center for Medical Home Improvement (CMHI) is to promote high quality primary care in the medical home and secure health policy changes critical to the future of primary care.

<http://www.medicalhomeimprovement.org/>

Primary Care Development Corporation

Founded in 1993, PCDC is a nonprofit organization dedicated to expanding and transforming primary care in underserved communities to improve health outcomes, lower health costs and reduce disparities.

- Capital Investment: We provide the capital and know-how to build, renovate and expand community based health facilities, so that providers can deliver the best care to their patients.
- Performance Improvement: We provide consulting, training and coaching services to help practices deliver a patient-centered model of care that maximizes patient access, meaningful use of health IT, care coordination and patient experience.
- Policy & Advocacy: We lead and support successful policy initiatives that increase access to quality primary care, improve the health of communities, and lower health system costs.

<http://www.pcdc.org/>

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Patient-Centered Primary Care Collaborative

A separate stand-alone entry is already listed.

<http://www.pcpcc.org/>

TransforMED

TransforMED is the trusted leader in Patient-Centered Medical Home transformation. Our mission is nothing less than the transformation of health care delivery to achieve optimal patient care, professional satisfaction and the success of primary care practices. Since 2005, TransforMED has...

- Guided transformation efforts in 677 primary care practices
- Impacted more than 12,445 providers and clinicians
- Supported organizational change in 34 residency programs
- Incorporated PCMH elements in 46 FQHCs
- Touched the lives of over 25 million patients

<http://www.transformed.com/>

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Organization	Patient Centered Primary Care Collaborative (PCPCC)
Category	Standards Setting, Industry Organizations Value based payment / Payment reform
Source	http://www.pcpcc.org/
Measure	Multiple papers Medical Home material and pilots http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home

Updated in 2013

Summary

Founded in 2006, the Patient-Centered Primary Care Collaborative (PCPCC) is dedicated to advancing an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home (PCMH). The PCPCC achieves its mission through the work of our five Stakeholder Centers, led by experts and thought leaders who are dedicated to transforming the U.S. health care system through delivery reform, payment reform, patient engagement, and employee benefit redesign. Today, PCPCC's membership represents more than 1,000 medical home stakeholders and supporters throughout the U.S.

Methodology

The website contains a wide variety of material and papers around Patient Centered Medical Homes. Key material related to this study includes:

Resources

- Care Delivery Reform
- Payment Reform
- Patient Engagement
- Research and Evidence
- Maps (various nationwide inventories)Benefit Design

Task Forces & Special Interests

- Behavioral Health
- Education & Training
- eHealth
- Medication Management

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There are also various presentations, webcasts, videos, and other material on the site, including links to many external publications related to these programs.

Publications / links

Resources

<http://www.pcpcc.org/resources/list/170>

Outcomes - evaluation

<http://www.pcpcc.org/outcomes-evaluation>

Why the Medical Home Works: A Framework

<http://www.pcpcc.org/sites/default/files/resources/Why%20Medical%20Home%20Works%20-%20FINAL.pdf>

Payment Reform

<http://www.pcpcc.org/sites/default/files/media/paymentreformpub.pdf>

<http://www.pcpcc.org/resources/list/170>

<http://www.pcpcc.org/publications>

Summary of Patient Centered Medical Home Cost and Quality Results,

<http://www.pcpcc.net/sites/default/files/PCPCC%20Medical%20Home%20Cost%20and%20Quality%202013.pdf>

Proof in Practice (compilation of Medical Home Initiatives)

<http://www.pcpcc.org/sites/default/files/media/PilotGuidePip.pdf>

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Organization	Premier Healthcare / CMS
Category	Standards Setting, Industry Organizations
Source	http://www.cms.gov/ https://www.premierinc.com/wps/portal/premierinc/public/home
Measure	Premier Hospital Quality Incentive Demonstration (HQID) http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalPremier.html

Updated in 2013 – program has ended

Summary – author’s note: key historical program

From CMS fact sheet in October 2013 - “CMS is implementing value based purchasing for all hospitals, as required by the Affordable Care Act. The Premier demonstration was extremely valuable in providing design and testing of the concept.

Summary

The Premier Hospital Quality Incentive Demonstration (HQID) recognized and provided financial rewards to hospitals that demonstrated high quality performance in a number of areas of acute care by increasing their payment for Medicare patients. The initial HQID was operational for three fiscal years, beginning on October 1, 2003, and ending on September 30, 2006. It was then extended for an additional three years, beginning October 1, 2006 and ended September 30, 2009. The demonstration was a CMS partnership with Premier, Inc., a nationwide organization of not-for-profit hospitals.

Methodology

QUALITY OF CARE MEASURES

Under the initial demonstration, top performing hospitals received bonuses based on their performance on evidence-based quality measures for inpatients with: heart attack, heart failure, pneumonia, coronary artery bypass graft, and hip and knee replacements. Starting in year five, we provided incentives for Surgical Care Improvement Project (SCIP) measures. The quality measures in the demonstration have an extensive record of validation through research, and are based on work by the Quality Improvement Organizations (QIOs), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Agency for Healthcare Research and Quality, the National Quality Forum (NQF), the Premier system and other CMS collaborators.

HOSPITAL SCORING AND FINANCIAL AWARDS

Hospitals were scored on the quality measures related to each condition measured in the demonstration. Composite quality scores were calculated annually for each demonstration hospital by “rolling-up” individual measures into an overall quality score for each clinical condition. CMS determined the distribution of hospital quality scores into deciles to identify top performers for each condition. Under the extension’s new reimbursement model, CMS awarded incentive payments of \$12 million in year six to 211 hospitals for top performance, as well as top

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improvement 2 and overall attainment, in the project's six clinical areas. Overall, 1,343 awards were given in the sixth year of the project. Through the project's six years, CMS awarded more than \$60 million to participating hospitals.

PUBLIC REPORTING

Hospitals participating in Premier Hospital Quality Incentive Demonstration reported previously collected quality data currently available in the Premier Perspective database to provide a historical reference on these quality indicators. The data was published at www.cms.hhs.gov/HospitalQualityInits

Results for all six years are reported on the CMS website, recognizing those hospitals with the highest quality and noting those hospitals that received bonus awards.

HOSPITAL PARTICIPATION

Participation in the demonstration was voluntary. A total of 216 hospitals completed the demonstration. HQID hospitals included small/large, urban/rural and teaching/non-teaching facilities that volunteered to report their quality data for six high-volume inpatient conditions using national measures of quality care.

CMS is implementing value based purchasing for all hospitals, as required by the Affordable Care Act. The Premier demonstration was extremely valuable in providing design and testing of the concept.

Results

The average composite quality score (CQS), an aggregate of all process and outcomes measures within each clinical area, improved project-wide by 18.6 percent age points over the project's six years (October 2003 through September 2009):

- From 87.5 percent to 98.1 percent for patients with AMI (heart attack);
- From 84.8 percent to 97.6 percent for patients with coronary artery bypass graft (CABG);
- From 64.5 percent to 95.5 percent for patients with heart failure (HF);
- From 69.3 percent to 94.8 percent for patients with pneumonia (PN); and
- From 84.6 percent to 98.0 percent for patients with hip and knee (HK) replacement.

In the Surgical Care Improvement Project (SCIP) clinical area, CQS improved from 85.8 percent to 96.2 percent, year four to year six only (October 2006 to September 2009).

Publications / links

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White paper on the Centers for Medicare & Medicaid Services (CMS)/Premier Hospital Quality Incentive Demonstration Project

https://www.premierinc.com/wps/wcm/connect/d7ea1df4-bed3-4f96-bfbf-a2c664e64993/Premier_HQID_Final_White_Paper_28Nov2012.pdf?MOD=AJPERES

Evaluation of the Premier Hospital Quality Incentive Demonstration

http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/Premier_ExecSum_2010.pdf

Press Releases and Fact Sheet

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Downloads/HospitalPremierPressRelease-FactSheet.pdf>

All performers for Year 6

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Downloads/HospitalTop50PercentYear6.zip>

Clinical Conditions and Measures and List of Revised or Suppressed

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Downloads/HospitalPremierClinicalConditionsMeasuresAndListOfRevised.zip>

Composite Quality Score Methodology Overview And Sample

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Downloads/HospitalPremierCompositeQualityScoreAndSample.zip>

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Organization	Premier Healthcare
Category	Standards Setting, Industry Organizations
Source	https://www.premierinc.com/wps/portal/premierinc/public/home
Measure	QUEST® and other programs http://www.premierinc.com/quest/

Updated in 2013

Summary

Premier, Inc. (Nasdaq: PINC) is a healthcare performance improvement alliance of approximately 2,900 U.S. community hospitals and 100,000 alternate sites. Our mission is simple: To improve the health of communities.

As an industry leader, the Premier alliance has created one of the most comprehensive databases of actionable data, best practices and cost reduction strategies.

QUEST® is one of the most comprehensive hospital collaboratives in the nation. QUEST evolved from Premier's groundbreaking pay-for-performance demonstration. Including 330 members, QUEST has become the only initiative to help members deliver the best possible care to each patient, every time.

Methodology

QUEST targets the needs of all patients and has made great strides in driving improvements across six domains:

- Evidence-based care
- Cost of care
- Patient experience
- Harm
- Mortality
- Readmissions

QUEST drives performance improvement by allowing members to:

- Identify opportunities and best practices
- Participate in rapid performance improvement challenges
- Collaborate to define performance goals
- Use healthy competition to drive performance improvement
- Participate in face-to-face meetings, conference calls and webinars

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Ultimately, QUEST members are better prepared to deal with reform provisions and, by improving in QUEST's six domains, can earn Medicare incentives, avoid Medicare penalties and better manage reimbursement cuts.

Other collaborative programs (related to these topics)

PACT Population Health collaborative is the model for developing integrated care delivery.

Bundled Payment collaborative to reduce the cost of an episode of care, improve patient outcomes and redesign care delivery

Data Alliance Collaborative to work with leading healthcare organizations to shape the future of healthcare data and care delivery models.

Emergency Department Safety Initiative work to improve patient care and satisfaction in the ED through consistent, accurate and timely diagnosis and treatment of high-risk ED patients.

Our Perinatal Safety Initiative develops, implements and measures best practices that improve the reliability of clinical quality and lead to better patient outcomes in labor and delivery.

Performance Improvement Research Collaboratives – by merging secondary outcomes research with disease state level performance improvement programs, manufacturers and providers go beyond traditional research studies by working together.

SOAR to access discounted prices, customized to your ambulatory surgery center's needs

Other products

Improving the quality of healthcare delivery is at the heart of what we do. We use industry-leading technology and a robust database to reveal customized savings opportunities. Our data-driven approach to quality improvement empowers you to:

- Reduce average length of stay
- Reduce readmissions
- Reduce hospital-acquired conditions (HACs)
- Improve resource utilization
- Improve physician alignment
- Reduce the overall cost of care

Premier's quality improvement apps are part of an integrated system that helps you improve quality while safely reducing costs. Last year, our members saved \$5 billion.* (*Member-validated savings for fiscal year 2012)

Multiple products are offered: QualityAdvisor™, PhysicianFocus™ Hospital, PhysicianFocus™ Ambulatory, Quality Measures Reporter® as well as Implementation services.

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Results

Over four years, QUEST members have avoided 92,000 hospital deaths and saved over \$9.1 billion since its inception in 2008.

Publications / links

Collaborating for results

<https://www.premierinc.com/wps/portal/premierinc/public/transforminghealthcare/collaboratingforresults>

QUEST's fourth year results

<https://www.premierinc.com/wps/wcm/connect/678eac81-2a4d-482f-a55e-126f4d567a6e/QUEST+Year+4+White+Paper.pdf?MOD=AJPERES>

IOM's white paper From pilots to practice: Speeding the movement of successful pilots to effective practice

<https://www.premierinc.com/wps/wcm/connect/ffb57c9d-93c5-4e65-87fd-d054b09b8b52/IOM+white+paper+pilots+to+practice.pdf?MOD=AJPERES>

QUEST case studies on pertinent healthcare issues: Cost of care

<https://www.premierinc.com/wps/wcm/connect/42ceafbd-acfb-47da-853c-ce88401b0343/QUEST+Cost+of+Care+Issue+Brief+081412.pdf?MOD=AJPERES>

QUEST case studies on pertinent healthcare issues: Affordable Care Act

<https://www.premierinc.com/wps/wcm/connect/ceeacb19-6fcc-4acb-962e-78ea2f756345/aca+issue+brief+finalized.pdf?MOD=AJPERES>

Premier's white paper on the Centers for Medicare & Medicaid Services (CMS)/Premier Hospital Quality Incentive Demonstration Project

https://www.premierinc.com/wps/wcm/connect/d7ea1df4-bed3-4f96-bfbf-a2c664e64993/Premier_HQID_Final_White_Paper_28Nov2012.pdf?MOD=AJPERES

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Organization	Puget Sound Health Alliance
Category	State focus; Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	http://www.pugetsoundhealthalliance.org/
Measure	Community CheckUp http://www.wacommunitycheckup.org/

Summary

Puget Sound Health Alliance is a regional partnership involving employers, physicians, hospitals, patients, health plans, and others working together to improve quality and efficiency while reducing the rate of health care cost.

Community Checkup is a publicly-available report comparing health care across the Puget Sound region. Objective is to help improve health care decision-making. This measure includes 21 measures of medical group care and 41 measures of hospital care for as many as 200 health care facilities. Results are available on the website and are searchable by areas of interest, health conditions or geographic location.

Methodology

Contains 21 measures of medical group care and 41 measures of hospital care.

- **The medical group measures** address important topics in health care including preventive care, such as screening for certain cancers; appropriate use of commonly overused services, such as prescriptions for antibiotics; generic drug prescribing; and care for certain chronic conditions—asthma, depression, diabetes, and heart disease. All of the medical group measures are based on extensive work by Clinical Improvement Teams convened by the Alliance. These teams are comprised of local physicians and other community and medical leaders. Each team recommended measures, most of which are based on generally accepted national guidelines for quality care endorsed by the National Quality Forum, the Institute of Medicine and/or HEDIS.
- **The hospital measures** include care for heart failure, heart attack, and pneumonia; surgical care, the occurrence of “never events” (errors that should never happen); and patients’ experience of care. The hospital measures are combined from several public sources including the Washington State Department of Health, the Leapfrog Group, and the US Department of Health and Human Services Hospital Compare Program.

Results are benchmarked or compared to those for the top 10 percent of medical groups in the nation for which measurements are available. Objective is to establish a baseline for the region. The focus areas of the Community Checkup—address care for people with diabetes, heart disease and other chronic conditions—reflect the categories of care that make up a significant portion of health care services provided in the community.

Based on data that reflect care provided to approximately 1.6 million people in the region. Uses insurance claims data to measure aspects of care. The data are “de-identified”, public report includes only results for clinics or physicians with at least 160 patients with the condition being measured. Community Checkup measures “processes of care” that do not require risk adjustment in the results to account for differences in patient populations

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Publications / links

September 2012 Community Checkup Report

http://www.wacommunitycheckup.org/Media/Default/Documents/puget_sound_health_alliance_community_checkup_report_9_2012.pdf

Compare scores – medical groups

<http://www.wacommunitycheckup.org/compare-scores/medical-groups>

Compare scores – hospitals

<http://www.wacommunitycheckup.org/compare-scores/hospitals>

Provider resource library

<http://www.wacommunitycheckup.org/resources/resource-library/provider-resource-library?resid=592>

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Organization	RAND Corporation
Category	Standards Setting, Industry Organizations
Source	http://www.rand.org/
Measure	Multiple papers Rand Health http://www.rand.org/health/ http://www.rand.org/topics/health-and-health-care.html

Updated in 2013

Summary

RAND advances understanding of health and health behaviors and examines how the organization and financing of care affect costs, quality, and access. RAND's body of research—conducted primarily through the RAND Health division—includes innovative studies of health insurance, health care reform, health information technology, and women's health, as well as topical concerns such as obesity, complementary and alternative medicine, and PTSD in veterans and survivors of catastrophe.

Methodology

RAND topics related to this study

- Health Care Costs
- Health Care Facilities
- Health Care Financing
- Health Care Organization and Administration
- Health Care Program Evaluation
- Health Care Quality
- Health Care Reform
- Primary Care

Solving the Health Care Cost Challenge

In a series of research briefs dedicated to flattening the trajectory of health care spending, RAND Health outlines four broad strategies for constraining spending growth in our market-oriented health care system:

- Foster efficient and accountable providers.

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- Engage and empower consumers.
- Promote population health.
- Facilitate high-value innovation.

For example, under the first topic, Fostering Efficient and Accountable Providers

Health care providers drive the bulk of spending through their purchasing decisions (e.g., tests, treatments, hospital admissions, etc.) and the fees they charge patients. Thus, the U.S. cannot hope to control cost growth without active provider participation. Unfortunately, fee-for-service payment, the prevailing approach to reimbursement, gives providers a powerful economic incentive to boost costs. Nonetheless, there are many ways that motivated providers can deliver better care at lower cost:

- Focus on value rather than volume. Payment policies must change to motivate providers to deliver value (broadly defined as health benefits per dollar spent) rather than volume (the number of exams, tests, procedure, and treatments).
- Apply the best available evidence to eliminate wasteful and inappropriate care.
- Enhance patient safety. Measures to enhance patient safety and improve quality must be tailored to specific patients and settings.
- Strengthen primary care.

Selected Publications / links -

Research area (health and health care)

<http://www.rand.org/topics/health-and-health-care.html>

Health care costs

<http://www.rand.org/topics/health-care-costs.html>

Health economics and financing

<http://www.rand.org/health/research/current-studies/health-economics-and-financing.html>

Quality of Care

<http://www.rand.org/health/research/current-studies/quality-of-care.html>

Health Reform

<http://www.rand.org/health/research/current-studies/health-care-reform.html>

Solving the Health Care Cost Challenge: Leveraging RAND Expertise

<http://www.rand.org/health/feature/health-care-cost.html>

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Foster Efficient and Accountable Providers

http://www.rand.org/pubs/research_briefs/RB9690z2/index1.html

Policy Options for Addressing Medicare Payment Differentials Across Ambulatory Settings

http://www.rand.org/content/dam/rand/pubs/technical_reports/2011/RAND_TR979.pdf

The First National Report Card on Quality of Health Care in America (core early paper)

http://www.rand.org/content/dam/rand/pubs/research_briefs/2006/RAND_RB9053-2.pdf

The Quality of Health Care Delivered to Adults in the United States. Appendix

http://www.rand.org/content/dam/rand/pubs/working_papers/2006/RAND_WR174-1.pdf

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Organization	Resolution Health (subsidiary of WellPoint)
Category	Proprietary/Analytics/Decision Support/Healthcare Data Technology
Source	http://www.resolutionhealth.com/
Measure	Physician Quality Profiler http://www.resolutionhealth.com/536.html Personal Health Scan™ http://www.resolutionhealth.com/534.html

Updated in 2013

Summary

Resolution Health is a personal health care guidance company. We give individuals the knowledge and confidence they need to interact more effectively with their health care providers. We help each individual get more value from their health plan, their doctors and the health dollars they spend.

Resolution Health is a member of the WellPoint family of companies.

Methodology

In 2010 Resolution Health, Inc.,(RHI) received endorsement for 25 measures developed by the company from NQF (National Quality Forum).

Physician Quality Profiler

Physician Quality Profiler can improve quality of care

- Improve transparency of physician quality
- Increase physician compliance with evidence-based guidelines
- Support pay-for-performance programs
- Support design of tiered, performance-based provider networks

Provider-specific Quality Reports - Quality score and profile, by quality measure, are created for individual physicians and physician groups. Physician performance is evaluated within single health plan or across multiple plans. Composite scores by clinical condition (e.g., diabetes) or type of care (e.g., prevention) can be created for physicians or physician groups

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Health plan members whose care was not consistent with best practice guidelines are identified, allowing providers to validate findings and improve performance

Physician Quality Profiler employs 110 clinical performance measures. Quality measures are based on widely accepted, evidence-based clinical practice guidelines and include measures endorsed by the Ambulatory Care Quality Alliance and National Quality Forum that can be applied to claims data. The profiler addresses care related to 20 clinical specialties.

Evidence-Based Care

Our Personal Health Scan™ identifies specific opportunities for an individual to improve their health, stay healthy or better manage chronic illness by comparing their Personal Health Picture™ to evidence-based care and best clinical practices. When we identify an evidence-based care gap, we translate this knowledge into action by sending a personalized, easy-to-understand message to the individual, their doctor and their care manager.

After our Personal Health Scan™ has identified ways for an individual to improve their health or reduce their costs, we translate this knowledge into action by sending personalized, easy-to-understand messages to the individual, their physician and their care manager.

This Scan identifies evidence-based care gaps related to two dozen diseases and conditions.

Results

Physician Quality Profiler compares performance of different physicians in a statistically meaningful way

- Uses claims data to evaluate quality of care delivered by individual physicians and physician groups
- Carefully attributes responsibility for the management of each covered health plan member's clinical issues to the appropriate physicians
- Provides state-of-the-art statistical analyses to support quality profiles

Publications / links

Physician Quality Profiler®

<http://www.resolutionhealth.com/536.html>

Improving the Quality of Care. Can We Practice What We Preach? *The New England Journal of Medicine*, Volume 348, No. 26

http://www.resolutionhealth.com/downloads/Steinberg_NE_Journal_of_Medicine.pdf

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Organization	Robert Wood Johnson Foundation (papers)
Category	Standards Setting, Industry Organizations
Source	www.rwjf.org
Measure	Multiple papers Cost and Value, Payment Reform, Quality Reporting http://www.rwjf.org/en/topics/rwjf-topic-areas/cost-and-value.html

Updated in 2013

Summary

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to health and health care, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, measurable, and timely change. For more than 40 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime

The foundation funds multiple papers within specific topics. Three topics related to this report are highlighted below.

Methodology

Cost and Value

America Is Not Getting Good Value for Its Health Dollar. The United States spends more money per person on health than any other country, but our lives are shorter—by nearly four years—than expected based on health expenditures.

Americans Say Cost of Care is a Serious Problem - a majority of the general public (87%) thinks the cost of care is a serious problem for the U.S., according to a poll by RWJF, NPR, and the Harvard School of Public Health.

Current information is available on the website, but recent material includes: (links below)

- Bending the Curve: Person-Centered Health Care Reform
- A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment

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Payment reform

The current method of paying for health care is broken. RWJF is testing and learning from new payment innovation models with the goal of managing costs and increasing quality.

Various RWJF programs and grants find new ways to advance payment reform.

- AcademyHealth
- Aligning Forces for Quality
- Consumer-Purchaser Disclosure Project
- PROMETHEUS Payment
- Urban Institute

Publications / links (overall)

Overall index

<http://www.rwjf.org/content/rwjf/en/topics.html>

Publications / links (related to Cost and Value)

Cost and Value (overall link to most current updates)

www.rwjf.org/en/topics/rwjf-topic-areas/cost-and-value.html

Poll by RWJF, NPR, and the Harvard School of Public Health

<http://www.rwjf.org/en/research-publications/find-rwjf-research/2012/05/sick-in-america.html>

Bending the Curve

<http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/04/bending-the-curve-iii.html>

A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment

<http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/04/a-bipartisan-rx-for-patient-centered-care-and-system-wide-cost-c.html>

Payment reform (overall link to most current updates)

<http://www.rwjf.org/en/topics/rwjf-topic-areas/payment-reform.html>

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AcademyHealth

<http://www.rwjf.org/en/grants/grantees/academyhealth.html>

Consumer-Purchaser Disclosure Project

<http://www.rwjf.org/en/grants/grantees/academyhealth.html>

PROMETHEUS Payment

<http://www.rwjf.org/en/grants/grantees/academyhealth.html>

Urban Institute

<http://www.rwjf.org/en/grants/grantees/academyhealth.html>

Quality reporting (overall link to most current updates)

Comparing Health Care Quality: A National Directory

This lists Health Care Quality Public Reports across the rest of the country / 208 Total / 26 National Reports

<http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/09/national-directory.html>

Achieving the Potential of Health Care Performance Measures

<http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/05/achieving-the-potential-of-health-care-performance-measures.html>

Using Present-On-Admission Coding to Improve Exclusion Rules for Quality Metrics

<http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/08/using-present-on-admission-coding-to-improve-exclusion-rules-for.html>

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Organization	Robert Wood Johnson Foundation
Category	Standards Setting, Industry Organizations
Source	www.rwjf.org
Measure	<p>Aligning Forces for Quality http://forces4quality.org/</p> <p>Learning from Effective Ambulatory Practices (LEAP) Learning from Effective Ambulatory Practices (LEAP) http://www.rwjf.org/content/rwjf/en/grants/grantees/the-primary-care-team-leap.html</p>

Updated in 2013

Summary

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to health and health care, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, measurable, and timely change. For more than 40 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime

The foundation funds multiple papers and also provides grants. Two sample programs are outlined below: Aligning Forces for Quality, and Leap

Methodology

Aligning Forces for Quality (AF4Q)

Aligning Forces for Quality is the Robert Wood Johnson Foundation's signature effort to improve the overall quality of health care in targeted communities.

The 16 communities and people who make up AF4Q are not only open to new ideas, they are enthusiastically finding and testing them. They are igniting improvement in the way health care is delivered, paid for, and received. Each community is taking on the complicated issue of improving quality of care by tapping into their influence to spark reform and get things done.

The website summaries initiatives in various communities – some samples are below

The Greater Kansas City's area Aligning Forces for Quality community, led by the Kansas City Quality Improvement Consortium (KCQIC), was named as the first Missouri/Kansas organization to receive recognition as a Community-based Care Transitions Program (CCTP) by the Centers for Medicare and Medicaid. KCQIC will work with local

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hospitals, health care providers, and social service providers to improve care transitions for high-risk Medicare beneficiaries when transitioning from hospital stays to their home, nursing home, or other care settings.

The Puget Sound Health Alliance, leader of Aligning Forces for Quality in Washington State, will partner with the state on a \$3.4 million, two-year federal grant to make health care pricing more transparent through the establishment of a statewide data center. The Alliance will use a portion of the federal funding from the grant to establish the framework for implementing an all-payer claims database that builds upon the Alliance's existing capabilities. The grant, which was awarded to the state, will also help provide data to the Washington Office of the Insurance Commissioner for rate reviews.

Learning from Effective Ambulatory Practices (LEAP)

Thirty Primary Care Practices Selected as Exemplary Models of Workforce Efficiency and Innovation

Following a rigorous nationwide review process, 30 primary care practices have been selected as exemplary models of workforce innovation and will form the basis for a new project: The Primary Care Team: Learning from Effective Ambulatory Practices (LEAP). The LEAP project, a joint initiative of the Robert Wood Johnson Foundation (RWJF) and the MacColl Center for Health Care Innovation at Group Health Research Institute, will study the 30 practices in depth to document practice innovations that make primary care more efficient, effective, and satisfying to patients and providers.

“The nation will not be able to train new primary care providers quickly enough to meet the needs of our country’s health system, so part of the solution must be to use the workforce we have more effectively,” said John Lumpkin, MD, MPH, RWJF senior vice president and director of RWJF’s Health Care Group.

“With millions more Americans about to enter the health care system, primary care must become more efficient and effective. Building high-performing care teams is a key step,” said Ed Wagner, MD, MPH, co-director of the LEAP project and director emeritus of the MacColl Center for Health Care Innovation.

The 30 practices selected represent a variety of settings, practice configurations, sizes, and locations and include private practices, large health systems, and community health centers across the country. They represent 20 states, and settings as varied as rural Colorado, inner-city New York, and Washington, D.C. A LEAP team is currently conducting three-day site visits to each of the 30 practices to better understand how each delivers high-quality, patient-centered primary health care. Site visits will continue through autumn 2013. The exemplar practices will then join together in a learning community to share best practices and distill their innovations into training and technical assistance materials that can be used by others across the United States.

Publications / links (overall)

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Overall index

<http://www.rwjf.org/content/rwjf/en/topics.html>

Publications / links (related to specific topics)

Aligning Forces for Quality

Impact (topics)

<http://forces4quality.org/impact-overview>

Alliances

<http://forces4quality.org/af4q-alliances-overview>

Tools and resources

<http://forces4quality.org/tools-and-resources>

LEAP

Overview

<http://www.rwjf.org/content/rwjf/en/grants/grantees/the-primary-care-team-leap.html>

News release

<http://www.rwjf.org/content/rwjf/en/about-rwjf/newsroom/newsroom-content/2013/04/thirty-primary-care-practices-selected-as-exemplary-models-of-wo.html>

Acad Med. 2013 Oct 14.

The Emerging Primary Care Workforce: Preliminary Observations From the Primary Care Team: Learning From Effective Ambulatory Practices Project.

Ladden MD, Bodenheimer T, Fishman NW, Flinter M, Hsu C, Parchman M, Wagner EH.

<http://www.ncbi.nlm.nih.gov/pubmed/24128622>

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Organization	Truven Health Analytics (previously Thomson Reuters Healthcare)
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	www.100tophospitals.com/
Measure	100 Top Hospitals www.100tophospitals.com/

Updated in 2013

Summary

Truven Health Analytics delivers unbiased information, analytic tools, benchmarks, and services to the healthcare industry. Hospitals, government agencies, employers, health plans, clinicians, and pharmaceutical and medical device companies have relied on us for more than 30 years. We combine our deep clinical, financial, and healthcare management expertise with innovative technology platforms and information assets to make healthcare better by collaborating with our customers to uncover and realize opportunities for improving quality, efficiency, and outcomes.

They produce the three different studies of Top Hospitals.

Summary

Each of our annual independent studies are founded on trusted, validated methodologies. Criteria for qualifying hospitals and key performance measures are listed below. For more detailed information, please review the methodology highlights posted for each of the three studies.

Public data sources include:

- Medicare Provider Analysis and Review (MedPAR)
- Medicare Hospital Cost Report Information System (HCRIS)
- Centers for Medicare & Medicaid Services (CMS) Hospital Compare

100 Top Hospitals

The Truven Health Analytics annual 100 Top Hospitals® study uses objective research and independent public data to recognize the best hospitals in the nation. Hospitals do not apply, and winners do not pay to market this honor. Study results and winner lists are highly anticipated each year and have been for two decades.

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Our study is unique in that it evaluates hospitals on measures of overall organizational performance, including patient care, operational efficiency, and financial stability. It compares hospitals only against similar facilities in terms of size and teaching status.

Identified from nearly 3,000 U.S. hospitals, our award winners demonstrate that high-quality patient outcomes can be achieved — while improving efficiency.

Qualifying Hospitals - short-term, acute care, non-federal U.S. hospitals treating a broad spectrum of patients.

Key Performance Measures

- Risk-adjusted mortality index (in-hospital)
- Risk-adjusted complications index
- Risk-adjusted patient safety index
- Core measures score
- 30-day mortality rate
- 30-day readmission rate
- Severity-adjusted average length of stay
- Case mix- and wage-adjusted inpatient expense per adjusted discharge
- Operating profit margin
- HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) score indicating patient ratings of overall hospital performance

50 Top Cardiovascular Hospitals

The Truven Health 50 Top Cardiovascular Hospitals is an annual quantitative study that identifies the nation's best providers of cardiovascular service. Selected from more than 1,000 U.S. hospitals, these celebrated winners provide outstanding care and set new standards in excellence for the healthcare industry. Hospitals do not apply, and winners do not pay to market this honor.

This study is conducted separately from our 100 Top Hospitals study, but is based on many of the same principles of performance.

Qualifying Hospitals - short-term, acute care, non-federal U.S. hospitals with an open heart program. Specialty heart hospitals are included.

Key Performance Measures

- Risk-adjusted mortality index (in-hospital)
- Risk-adjusted complications index
- Core measures
- Percentage of CABG patients with internal mammary artery use
- 30-day mortality rate

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- 30-day readmissions rate
- Severity-adjusted average length of stay
- Wage- and severity-adjusted average cost per case

15 Top Health Systems

The Truven Health 15 Top Health Systems study identifies the 15 best health systems in the nation. This annual, quantitative study uses objective, independent research and public data sources. Health systems do not apply, and winners do not pay to market their award.

Our 15 Top Health Systems award study is the only study that aggregates individual hospital performance into system-level data. Building on the 100 Top Hospitals® National Balanced Scorecard concept, this research allows health system leaders to understand how they measure up in terms of clinical quality and efficiency.

Qualifying Health Systems - a health system must have at least two short-term, acute care, non-federal U.S. hospitals that report a parent or related organization in their cost report. Specialty hospitals, such as Womens', Orthopedics, Cardiac, and Critical Access, are included in the study if they belong to a system.

Key Performance Measures

- Risk-adjusted mortality index (in-hospital)
- Risk-adjusted complications index
- Risk-adjusted patient safety index
- Core measures mean percent
- 30-day mortality rate
- 30-day readmission rate
- Severity-adjusted average length of stay
- HCAHPS score (patient rating of overall hospital performance)

Results

Health 100 Top Hospitals® - based on the results of this year's study, if all Medicare inpatients received the same level of care as those treated in the award-winning facilities:

- More than 164,000 additional lives could be saved.
- Nearly 82,000 additional patients could be complication free.
- \$6 billion could be saved.
- The average patient stay would decrease by half a day.

If the same standards were applied to all inpatients, the impact would be even greater.

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The **50 Top Cardiovascular Hospitals** spent roughly \$2,000 less per bypass surgery and about \$1,000 less per heart attack patient admitted. The winners were also quicker to release their patients: a half day better than their peers for heart attack, heart failure, and angioplasty cases, and a full day sooner for bypass patients.

The **15 Top Health Systems** saw

- Better Survival Rates - 3.4 percent fewer deaths
- Lower 30-Day Mortality Rates: lower than peer systems', and small winning systems outperformed their peers by the widest margin.
- Fewer Complications: 3 percent fewer complications
- Shorter Hospital Stays: median average length of stay of 4.49 days, over half a day shorter than their peers' median of 5.06 days.
- Better Patient Safety and Core Measure Adherence: 7 percent fewer adverse patient safety events than expected , given the case mix of the particular hospital, and had better adherence to core measures of care than their peers.

Publications / links

News and events (link to the most current studies

http://www.100tophospitals.com/news_and_events/

Research findings

http://www.100tophospitals.com/research_findings/

Understanding Our Methodologies

<http://www.100tophospitals.com/methodologies/>

Hospital System Membership and Performance

http://www.100tophospitals.com/assets/Health_System_Hospitals_Perform_Better.pdf

Sample report: A NATIONAL BENCHMARKS REPORT

http://www.100tophospitals.com/assets/15Top_Health_Systems_2013_Sample_Report.pdf

2012 HIMSS Analytics Report: Quality and Safety Linked to Advanced Information Technology Enabled Processes

<http://www.himssanalytics.org/research/AssetDetail.aspx?pubid=79927&tid=121>

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Organization	Truven Health Analytics (previously Thomson Reuters Healthcare)
Category	Proprietary/Analytics/Decision Support/Healthcare Data Technology
Source	http://www.truvenhealth.com/
Measure	CareDiscovery™ CareDiscovery® Quality Measures Micromedex® 360 Care Insights Suite http://www.truvenhealth.com/products/carediscovery.aspx http://www.truvenhealth.com/your_healthcare_focus/hospital_patient_care_decisions/micromedex_360_care_quality_suite.aspx

Updated in 2013

Summary

Truven Health Analytics delivers unbiased information, analytic tools, benchmarks, and services to the healthcare industry. Hospitals, government agencies, employers, health plans, clinicians, and pharmaceutical and medical device companies have relied on us for more than 30 years. We combine our deep clinical, financial, and healthcare management expertise with innovative technology platforms and information assets to make healthcare better by collaborating with our customers to uncover and realize opportunities for improving quality, efficiency, and outcomes.

This outlines their CareDiscovery and Micromedex® 360 Care Insights Suite.

Methodology

CareDiscovery - Single-Source Insights to Improve Clinical Quality, Optimize Care Outcomes, and Influence Population Health

To thrive in a pay-for-performance world tomorrow, hospitals need to improve clinical quality, optimize care outcomes, reduce physician performance variation, and address process efficiencies today.

These methodologies are created using the most comprehensive database in the U.S. that contains 21 million all-payer discharges representing more than 2,700 hospitals; it uses the same methodologies as the nationally recognized Truven Health 100 Top Hospitals® study.

CareDiscovery starts by applying proven, proprietary methodologies to your data. These methodologies are created through the most comprehensive database in the U.S. that contains 21 million all-payer discharges representing over 2,700 hospitals and that uses the same methodologies as the nationally recognized 100 Top Hospitals® Study.

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We then further enhance your data by benchmarking it at any level of data aggregation (MS-DRG, physician, or any clinical condition). This enables you to view your data simultaneously compared both to the national average and a targeted, top 10-percent benchmark, thereby giving you the best opportunity to assess which outcome metrics have the highest potential for improvement — clinically and financially.

CareDiscovery is positioned to help you identify opportunities and close the gap on improving performance by identifying action-driving benchmarks. We can help you set clinical quality improvement goals based on reliable, objective information that allows you to:

- Gain insights from a patient-centric, provider-driven, process- and outcomes-focused view of performance
- Engage physicians to reduce variation in clinical practice patterns
- Enhance care delivery to thrive in the new value-based healthcare system
- Estimate and proactively address readmissions risk
- Understand how new payment models will affect your organization, and how to improve quality, reduce cost, and maximize reimbursement
- Identify the drivers of variation in cost and quality to optimally deliver care across your specific patient populations

Isn't It Time to Reduce Physician Clinical Variation?

Make physician quality conversations more meaningful.

CareDiscovery Provider Profiles - Reduce Variability in Physician Performance With an Objective, On-the-Go Quality Solution

Create more meaningful physician quality conversations.

Truven Health Provider Profiles is a physician leader clinical performance tool that delivers a powerhouse of highly focused, meaningful physician performance data from the industry-leading CareDiscovery solution.

Provider Profiles allows your physician leaders to access critical variation in care patterns, when and where they need it most — providing easy access to the right detailed data to identify and act on the key drivers of physician performance. Our solution helps you:

- Connect patient outcomes to the doctors who cared for them
- Compare performance against industry and team peers
- Access reports via either iPad® or computer, while having those all-important performance conversations
- Target specific patient populations, specific sets of physicians, and specific physician roles
- Filter out performance differences that are statistically or clinically meaningful for the utmost in credibility
- Prioritize opportunities for clinical performance improvement
- Set improvement goals based on relevant, dependable, and agreed-upon information

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Provider Profiles makes it simple to reduce clinical performance variability — with benchmarks, flexible analytics, evolved reporting capabilities, and the enhanced ability to identify physician-level disparity on critical quality measures such as length of stay, complications, mortality, readmissions, and case distribution.

Micromedex® 360 Care Insights Suite - real-Time Intelligence to Make the Right Call, Faster

At your patient's side, developments are constantly changing. The risk of infection, adverse drug affects and unexpected turns mean immediate access to integrated data is critical. Harness the power of real-time patient-specific monitoring fortified with evidence-based resources from Micromedex

Real-Time Patient Intervention and Preventive Care - 360 Care Insights is a single solution that works with your hospital information system to act as a clinical intelligence dashboard to aid hospital pharmacists, nurses, and infection preventionists in eliminating HAIs and ADEs, monitoring anticoagulant therapy, and improving antimicrobial stewardship. From this one easy-to-install platform, clinicians can leverage real-time patient monitoring to stay on top of potential adverse events and intervene early for better outcomes.

With a proactive approach of stopping an adverse event before it begins, 360 Care Insights includes prebuilt profiles developed by the editorial team from Micromedex to monitor medication therapeutic levels across the patient population. Your team can also customize profiles based on your specific areas of need. 360 Care Insights will push daily rounding or work lists with alerts and recommendations for intervention and prevention, based on what matters most to your teams and in your organization.

This includes both Pharmacy Intervention and Infection Prevention.

Publications / links

News and events (link to the most current studies)

Care Discovery

<http://www.truvenhealth.com/products/carediscovery.aspx>

CareDiscovery Solution Spotlight

http://www.truvenhealth.com/assets/HOSP_12087_1112_CareDiscoverySS_WEB.pdf

CareDiscovery™ Quality Measures

http://www.truvenhealth.com/products/carediscovery_quality_measures.aspx

CareDiscovery Quality Measures Solution Spotlight

http://www.truvenhealth.com/assets/HOSP_11190_0612_CDQM_SS_Web.pdf

Concurrent Abstraction Product Spotlight

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http://www.truvenhealth.com/assets/HOSP_12430_0313_ConcurrentAbstractionPS_WEB.pdf

Micromedex® 360 Care Insights Suite

http://www.truvenhealth.com/your_healthcare_focus/hospital_patient_care_decisions/micromedex_360_care_quality_suite.aspx

An Analytical Approach to Improving Physician Performance

http://www.truvenhealth.com/assets/PEJ_artical_on_PhysicianPerformance_052013.pdf

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Organization	Truven Health Analytics (previously Thomson Reuters Healthcare)
Category	Proprietary/Analytics/Decision Support/Healthcare Data Technology
Source	http://www.truvenhealth.com/
Measure	Medical Episode Grouper http://www.truvenhealth.com/products/medical_episode_grouper.aspx http://www.truvenhealth.com/products/medical_episode_grouper_health_plan.aspx

Updated in 2013

Summary

Truven Health Analytics delivers unbiased information, analytic tools, benchmarks, and services to the healthcare industry. Hospitals, government agencies, employers, health plans, clinicians, and pharmaceutical and medical device companies have relied on us for more than 30 years. We combine our deep clinical, financial, and healthcare management expertise with innovative technology platforms and information assets to make healthcare better by collaborating with our customers to uncover and realize opportunities for improving quality, efficiency, and outcomes.

The Medical Episode Grouper® (MEG), from Truven Health Analytics, enables health plans and government agencies to analyze patient treatments, evaluate quality of care, and manage associated costs. It does so by grouping inpatient, outpatient, and pharmaceutical claims into clinically homogeneous units of analysis called episodes that describe a patient's complete course of care for a single illness or condition. The result is a sophisticated methodology that is used for a wide range of applications such as provider profiling, disease management, quality improvement, and cost and use analysis. Agencies can incorporate MEG into their existing information system, or it can serve as an integrated component of Advantage Suite®.

Methodology

MEG is an established episode methodology analyzing more than 43 million covered lives. Since its inception in 1998, MEG has been continually improved and is a trusted resource for measuring physician performance, improving quality, and reducing costs.

Physicians identify with a methodology that is based on clinical models and find MEG's risk-adjustments credible.

Only MEG has a patent-pending, patient severity based risk-adjustment methodology which results in greater explanatory power. It incorporates the fifth edition Disease Staging® patient classification system with 555 disease categories - enabling a sophisticated understanding of conditions, disease progression, and care choices. To keep up with the latest advances in medicine, Truven Health assembled a distinguished panel of experts including over 50 physician specialists, and every disease category was reviewed by at least three physicians. With this level of

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discipline and continuous improvement you can be confident that MEG delivers better information and better results. It offers:

- Clinically-defined measures that physicians find credible - enabling physician engagement and collaboration
- Ability to review severity stratified data and assess the appropriateness of procedures with a clinically-sound basis to improve quality
- Builds episodes based on the clinical diagnosis of the patient's illness to avoid unnecessary medical interventions and reduce costs
- Identifies high risk patients for disease / care management programs to improve the clinical basis for patient selection, and target the right patients for the right programs
- Allows for evaluation of disease/care management programs on a risk-adjusted basis to gain a more accurate reflection of ROI for your programs

Publications / links

Medical Episode Grouper: Government

http://www.truvenhealth.com/products/medical_episode_grouper.aspx

Medical Episode Grouper: Health Plan

http://www.truvenhealth.com/products/medical_episode_grouper_health_plan.aspx

Medical Episode Grouper: Product Brochure

http://www.truvenhealth.com/assets/HP_11518_0812_MedicalEpisodeGrouper_SS_Web.pdf

Applications and Methodology

http://www.truvenhealth.com/assets/HP_12980_0913_MEG_Apps_Methods.pdf

MEG Case Study

http://www.truvenhealth.com/assets/HP_13009_0913_MEG_Case_Study.pdf

Hospital metrics - overview

http://www.truvenhealth.com/your_healthcare_focus/hospital_management_decisions/

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Organization	Truven Health Analytics (previously Thomson Reuters Healthcare)
Category	Proprietary/Analytics/Decision Support/Healthcare Data Technology
Source	http://www.truvenhealth.com/
Measure	Physician Performance Assessment http://truvenhealth.com/products/physician_performance_assessment.aspx

Updated in 2013

Summary

Truven Health Analytics delivers unbiased information, analytic tools, benchmarks, and services to the healthcare industry. Hospitals, government agencies, employers, health plans, clinicians, and pharmaceutical and medical device companies have relied on us for more than 30 years. We combine our deep clinical, financial, and healthcare management expertise with innovative technology platforms and information assets to make healthcare better by collaborating with our customers to uncover and realize opportunities for improving quality, efficiency, and outcomes.

Truven Health Physician Performance Assessment delivers information for improving the cost efficiency and clinical effectiveness of physicians in easy-to-read report formats. This solution draws on the capabilities and power of Advantage Suite and the clinically robust Medical Episode Grouper (MEG).

Key features:

- Applies the most current nationally adopted quality measures to claims and eligibility data to evaluate effectiveness and manage population care – resulting in higher-quality healthcare and lower costs.
- Reports member compliance rates for specific care, identifying "gaps in care" and facilitating targeted member interventions
- Episode-based analysis of physician performance captures all costs associated with a course of treatment resulting in an accurate evaluation of the total cost associated with physician performance
- Case mix risk adjustment of physician results provides a fairer comparison of physicians against their peers by accounting for both the severity of their patients' illnesses and comorbidities

Measuring and Reporting Physician Performance

We calculate quality and efficiency measures, reporting results at the physician and practice levels. Truven Health maintains an extensive quality measures library, including all of the major nationally endorsed quality measures. We created the Physician Performance Assessment™ (PPA), which delivers easy-to-read, customizable performance

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information that can be used by health information collaboratives to provide physicians direct access to their performance results. Features include:

- Graphical presentation for readily understandable feedback to physicians
- Separate displays of physician effectiveness and efficiency metrics
- Combined physician performance results
- Individual physician performance changes over time
- Peer group performance
- Drill-down capabilities to allow physicians to view the individual patient-level detail underlying the reported measures

Publications / links

Physician Performance Assessment Product Spotlight

http://truvenhealth.com/assets/HP_11520_0812_PhysicianPerformanceAssessment_SS_WEB.pdf

Analytical Approach to Improving Physician Performance

http://truvenhealth.com/assets/PEJ_article_PhysicianPerformance.pdf

Risk-Adjusted Episode Grouping Enables Better Analysis of Physician Quality and Costs

http://truvenhealth.com/assets/HP_11507_0812_BCBSTexas_CS_WEB.pdf

Advantage Suite

http://truvenhealth.com/products/advantage_suite_health_plan.aspx

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Organization	United Healthcare
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	www.UnitedHealthcareOnline.com
Measure	<p>Premium Physician Designation Program https://www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=6956eb70a73a7310VgnVCM100000294ab10a</p> <p>Primary Care Physician (PCP) Incentive Program https://www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=4171fceeafb8310VgnVCM100000294ab10a</p>

Weblinks in Publication section from 2013

Summary

At UnitedHealthcare, we are committed to improving the health care system. UnitedHealthcare is an operating division of UnitedHealth Group, the largest single health carrier in the United States.

Our family of companies delivers innovative products and services to approximately 70 million Americans. UnitedHealthcare's nationwide network includes 595,000 physicians and other health care professionals, 80,000 dentists and 4,965 hospitals. Our pharmaceutical management programs provide more affordable access to drugs for 13 million people.

Federal and state reform mandates as well as other health care industry initiatives are putting a focus on improving the quality of health care for patients and decreasing costs. The UnitedHealth Premium[®] physician designation program will help you to meet these goals and receive the recognition you deserve for adhering to evidence-based, medical society and national industry standards.

Methodology

UnitedHealth Premium[®] Designation Program Description

Although it may seem obvious that attention to quality is intrinsic to providing care for your patients, a study in The New England Journal of Medicine stated that "adults receive the recommended medical treatment only 55 percent of the time."¹ UnitedHealthcare[®] developed the Premium program in part to close the gaps in quality and to guide UnitedHealthcare members with information to make informed health care choices.

Under the Premium program, members can use a physician's Premium designation - available in physician online directories such as myuhc.com - as a valuable tool to select physicians who have met national benchmarks for quality and local benchmarks for cost efficiency.

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The UnitedHealth Premium® physician designation program uses evidence-based, medical society, and national industry standards to recognize physicians for providing quality and cost efficient care. UnitedHealth Premium designations are available to members, employers and physicians through online directories on websites such as our consumer portal, myuhc.com.

Physicians benefit by having access to a broad range of reports that provide comprehensive information about their specific practice - conditions they treat, measures included in their evaluation and specific information on their patients. These reports support physicians with actionable performance information to improve care delivery and maximize value across the entire delivery system.

The Premium program uses clinical information from health care claims both to assist you in your continuous practice improvement and to help consumers make more informed and personally appropriate choices for their medical care. We use evidence-based and nationally accepted standards with a transparent methodology and robust data sources to evaluate physicians across 26 specialty areas to advance safe, timely, effective, efficient, equitable and patient-centered care.

The Premium program uses different software programs to collect or "group" claims data into quality measures and episodes of care, including Symmetry Episode Treatment Groups® (ETG®), Symmetry Procedure Episode Groups® (PEG®), Symmetry Episode Risk Groups® (ERGs®), Symmetry EBM Connect® and 3MTM All Patient Refined Diagnosis Related Groups (APR DRG).

You can also use the assessment results to see how your practice compares to peer groups or national benchmarks. The Premium program supports practice improvement and provides you with access to information on how your clinical practice compares with national and specialty-specific measures for quality, and with local cost-efficiency benchmarks in the same geography. The data used for the assessment process are UnitedHealthcare paid claims data for UnitedHealthcare members generated from January 1, 2010 through February 28, 2013.

What if You Do Not Have Sufficient Data for Quality Measurement?

UnitedHealthcare relies primarily on paid claims data to assess the quality and cost efficiency of care. However, physicians who have insufficient data for quality assessment can still receive the UnitedHealth Premium quality designation. The Premium program counts several non-claims-based programs toward quality designation for the specialties appropriate to each program. These programs include:

- Bridges to Excellence (BTE) individual clinician certification programs:
- National Commission for Quality Assurance (NCQA) recognition programs:
- American Board of Internal Medicine (ABIM) practice improvement modules:

Designation information is as follows:

- Quality & Cost Efficiency
- Cost Efficiency & Not Enough Data to Assess Quality
- Quality & Not Enough Data to Assess Cost Efficiency

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- Quality & Did Not Meet Cost Efficiency
- Not Enough Data to Assess Quality & Did Not Meet Cost Efficiency
- Not Enough Data to Assess
- Not Evaluated
- Did Not Meet Quality & Cost Efficiency

In addition, employers may offer health benefit programs (e.g., reduced cost-sharing or tiered benefit programs) that provide benefit incentives for members to use UnitedHealth Premium Tier 1 physicians.

Publications / links

UnitedHealth Premium® Designation Program Description

<https://www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=a7b0465138a17210VgnVCM1000002f10b10a>

Find answers to frequently asked questions

[https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Premium Methodology/2013-2014 FAQ Premium M52780 ET21 FINAL 101113.pdf](https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Premium%20Methodology/2013-2014%20FAQ%20Premium%20M52780%20ET21%20FINAL%20101113.pdf)

View your assessment results online

<https://www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=d0cff1ab39f24210VgnVCM100000b640dd0a>

Pull up evidence-based medicine synopses

<https://www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=8f60f1ab39f24210VgnVCM100000b640dd0a>

Access multiple helpful resources

<https://www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=3edff1ab39f24210VgnVCM100000b640dd0a>

UnitedHealth Premium Summary Methodology (2013-2014 Version)

[https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Unitedhealth Premium/UnitedHealth Premium Summary Methodology 2013-2014.pdf](https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Unitedhealth%20Premium/UnitedHealth%20Premium%20Summary%20Methodology%202013-2014.pdf)

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Organization	United Healthcare (UHCWest)
Category	State focus; Performance Ratings/Reports/Scorecards/Databases/Benchmarking; Incentive/Reward Programs
Source	https://www.uhcwest.com/
Measure	Quality Index Profile (Medical Groups) https://www.uhcwest.com/commonPortal/link?navnode=Library.BLOT&product=Commercial&audience=Provider-Before-Logon&region=CA&cid=600227954

Updated in 2013

Summary

UnitedHealthcare is dedicated to helping people nationwide live healthier lives by simplifying the health care experience, meeting consumer health and wellness needs, and sustaining trusted relationships with care providers. The company offers the full spectrum of health benefit programs for individuals, employers and Medicare and Medicaid beneficiaries, and contracts directly with 780,000 physicians and other health care professionals and 5,900 hospitals and other care facilities nationwide. UnitedHealthcare serves more than 40 million people in health benefits and is one of the businesses of UnitedHealth Group (NYSE: UNH), a diversified Fortune 50 health and well-being company.

The UHS program discussed below operates in California.

Methodology

QUALITY INDEX® Profile

A unique report on provider group performance in selected areas of clinical and service quality. The QUALITY INDEX® Profile provides consumers with an effective tool to help them make more informed health care decisions.

It also fosters a healthy competition among medical groups – competition that has helped improve health care quality throughout UnitedHealthcare of California’s provider network. Since its first release in September 1998, this award-winning* report has been expanded and enhanced based on suggestions from members, providers, and purchasers.

Because the quality of your health care provider directly affects your quality of care, referencing this report can help you make more informed decisions about choosing or changing health care providers.

The profile measures specific areas of clinical, service and administrative quality. The scores of all participating medical groups are converted to percentiles, which show how one physician group compares to another.

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The Profile takes 32 credible and relevant measures from the Provider Profile and reports the relative performance achieved by the largest medical groups in our contracted network, based on the best information available to us. Those groups that perform in the top 90th percentile on any of the measures exemplifying clinical and service quality earn public recognition for their “Best Practice” status. In addition to highlighting the “Best Practices” in each category, we have summarized performance in an Overall Score on All Measures and in Overall Clinical and Overall Service scores

The Overall Score is the average of the combined total of the physician group's scores. The physician group's Overall Score is a percentile relative to other reported groups statewide, not an actual score. The QUALITY INDEX® profile is helping to increase accountability throughout UnitedHealthcare's physician network by providing consumers with useful information to make more informed health care decisions.

Why is a medical group important to a member?

A medical group helps your doctor deliver quality healthcare to you and other patients. UnitedHealthcare of California provides additional services and programs to help doctors enhance their quality of care.

Explain how a provider’s reputation may not match the number of Best Practices or Overall Score. Different providers excel at different aspects of care. We’ve taken extraordinary steps to assure the QUALITY INDEX® Profile represents a fair, comprehensive, and relevant set of measures by which consumers and providers can better assess performance. However, we recognize that these measures are limited and may not address individual patient preferences or other measures or procedures that may be important to you. While the QUALITY INDEX® Profile contains an extensive range of clinical and service indicators, it is only one way for consumers to measure provider performance

Publications / links

Quality Index Profile

<https://www.uhcwest.com/commonPortal/link?navnode=Library.BLOT&product=Commercial&audience=Provider-Before-Logon®ion=CA&cid=600227954>

Quality Index. Profile of Medical Groups. 2012

https://www.uhcwest.com/vgn/images/portal/cit_60701/600762581_PCA080402_009.pdf

Older related articles

Early Experience With Pay-for-Performance From Concept to Practice. Meredith B. Rosenthal, Richard G. Frank, Zhonghe Li, Arnold M. Epstein. JAMA, October 12, 2005—Vol 294, No. 14

<http://jama.ama-assn.org/cgi/reprint/294/14/1788>

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"Can You Get What You Pay For? Pay-For-Performance and the Quality of Healthcare Providers." Mullen, Kathleen, Richard Frank and Meredith Rosenthal (2008). Unpublished manuscript.

<http://healthcare-economist.com/2008/11/18/does-p4p-improve-quality/>

Do Integrated Medical Groups Provide Higher-Quality Medical Care than Individual Practice Associations?

Ateev Mehrotra, Arnold M. Epstein, and Meredith B. Rosenthal. Ann Intern Med. 2006;145:826-833.

<http://www.annals.org/cgi/reprint/145/11/826.pdf>

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Organization	U.S. News & World Report
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	www.usnews.com
Measure	America's Best Hospitals http://health.usnews.com/sections/health/best-hospitals/index.html .

Weblinks in Publication section from 2013

Summary

U.S. News & World Report is a multi-platform, publisher of news and information, which includes www.usnews.com and www.rankingsandreviews.com, as well as the digital-only U.S. News Weekly magazine. U.S. News publishes annual print and e-book versions of its authoritative rankings of Best Colleges, Best Graduate Schools and Best Hospitals. In 2012 U.S. News launched a conference division focusing on important national conversations and solutions in STEM Education and Hospitals of Tomorrow.

For 2013-14, U.S. News has identified the best hospitals in 16 specialties and the best pediatric centers in 10 specialties.

Methodology

Of the 16 specialties, 12 are ranked on data and four on reputation.

The 12 data-dependent specialties are cancer; cardiology & heart surgery; diabetes & endocrinology; ear, nose & throat; gastroenterology & GI (gastrointestinal) surgery; geriatrics; gynecology; nephrology; neurology & neurosurgery; orthopedics; pulmonology, and urology.

The four reputation-only specialties are ophthalmology, psychiatry, rehabilitation and rheumatology.

Each specialty ranking evaluates hospitals according to their performance across a wide range of conditions and procedures. In pulmonology, for example, one hospital might rank lower than another overall but outperform it in treating patients with a particular condition, such as chronic obstructive pulmonary disease (COPD).

So the rankings are just a starting point. Patients have to do their own research. We also appreciate that families also have to consider the stress and expense of traveling to another city, as well as the willingness of an insurer to pay for care at a hospital outside its network.

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Each candidate in the 12 data-driven rankings received an overall score from 0 to 100 that was based on four elements: reputation, patient survival, patient safety, and care-related factors such as the amount of nurse staffing and the breadth of patient services. The hospitals with the top 50 scores in each specialty were ranked. Scores and data for all eligible hospitals in each specialty are also posted. The four elements and their weightings, in brief:

Reputation with specialists (32.5 percent). Each year, 200 physicians per specialty are randomly selected and asked to list the hospitals they consider to be the best in their specialty for complex or difficult cases. The figure displayed is the average percentage of responding specialists in 2011, 2012 and 2013 who named the hospitals.

Survival (32.5 percent). A hospital's success at keeping patients alive was judged by comparing the number of Medicare inpatients with certain conditions who died within 30 days of admission in 2009, 2010 and 2011 with the number expected to die given the severity of illness. Software used by many researchers (3M Health Information Systems Medicare Severity Grouper) took each patient's condition into account.

Patient safety (5 percent). Harmful blunders occur at every hospital; this score reflects how hard a hospital works to prevent six of the most egregious types. Injuries during surgery and major bleeding afterwards are two examples of the six categories of medical mishaps that were factored in.

Other care-related indicators (30 percent). These include nurse staffing, patient volume, certain clinically proven technologies and other measures related to quality of care. The American Hospital Association's 2011 survey of all hospitals in the nation was the main source.

In the four specialties where rank relies only on reputation, ranked hospitals had to be cited by a total of at least 5 percent of the physicians in a specialty who responded to the most recent three years of U.S. News surveys. That resulted in lists 16 hospitals long in ophthalmology and psychiatry and 17 long in rehabilitation and rheumatology.

Were there changes in the 2013-14 Best Hospital methodology?

Two that are worth noting (and were first noted in this Second Opinion column). A revised version of a programming tool created by the federal Agency for Healthcare Research and Quality to assess safety-related hospital data enabled us to exclude patients from the patient-safety calculation who were admitted to the hospital with conditions that predisposed them to harm. That kept a hospital from being penalized if someone still recovering from pneumonia, for example, was admitted for surgery and had respiratory problems afterwards. (Postsurgical respiratory failure is one of the six categories of events we tabulate.)

Extracting these present-on-admission cases, or POAs, from the case mix boosted patient safety scores for hospitals where such cases had previously exacted a penalty. Some hospitals achieved higher overall scores as a result and rose in the rankings, or displaced ranked hospitals that had been less affected by POAs and therefore gained less from the methodology change. Taking advantage of the POA exclusion requires hospitals to be diligent about identifying such patients and coding them appropriately. Hospitals that do not diagnose all POAs or that code them inaccurately not only derive no benefit from the change, but are penalized relative to hospitals that do better.

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The other significant Best Hospitals change only affected hospitals in neurology & neurosurgery. Spinal fusion procedures ceased to be counted in this specialty. Hospitals and health care experts told us that, because of recent clinical trends neurologists and neurosurgeons now play a minimal role in recommending and performing the procedures. Spinal fusion cases this year counted only in orthopedics, where they were also included in past years.

U.S. News Best Children's Hospitals 2013-14

For the 2013-14 rankings, U.S. News surveyed 179 pediatric centers to obtain clinical data in 10 specialties and asked 150 pediatric specialists in each specialty where they would send the sickest children. Eighty-seven hospitals ranked in at least one specialty. Ten hospitals that had high scores in at least three specialties were named to the Honor Roll.

Details are available on the website.

Publications / links

Overview and search engine - hospitals

<http://health.usnews.com/best-hospitals>

Overview and search engine – children’s hospitals

<http://health.usnews.com/best-hospitals/pediatric-rankings>

How We Ranked the Best Hospitals 2013-14: An FAQ

<http://health.usnews.com/health-news/best-hospitals/articles/2013/07/16/how-we-ranked-the-best-hospitals-2013-14-an-faq>

Methodology: U.S. News & World Report Best Hospitals 2013-14

http://www.usnews.com/pubfiles/BH_2013_Methodology_Report_Final_28August2013.pdf

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Organization	Verisk HealthCare
Category	Proprietary/Analytics/Decision Support/Healthcare Data Technology
Source	http://www.veriskhealth.com/
Measure	DxCG Intelligence http://www.veriskhealth.com/solutions/enterprise-analytics/dxCG-intelligence

Light update in 2012 (deep material requires registration)

Summary

Verisk Health, a subsidiary of Verisk Analytics (Nasdaq:VRSK), helps organizations identify, manage, and mitigate healthcare risk to improve quality, reduce costs, and maximize profitability. Our data-driven risk assessment technologies and business decision analytics enable clients to proactively seize opportunities for improving clinical, financial, and performance results. Our solutions optimize the efficiency of key business objectives, including care management; risk identification and stratification; HEDIS compliance; benefit program measurement; fraud, waste and abuse prevention; payment accuracy; and revenue cycle management.

DxCG Intelligence provides governments, health plans, employers and providers worldwide the insight to identify and plan for population and individual-level risk, control costs and assess quality and efficiency across networks, markets, groups or segments. The solution suite supports medical management, budgeting, underwriting and performance measurement initiatives adjusting for key underlying differences in populations.

Methodology

Features

- Forecast population and member-level costs with validated, best-in-class risk adjustment models
- Use event-based modeling to predict the likelihood of high cost utilization
- Measure performance and variation in efficient use of resources adjusting for underlying differences in populations
- Utilize custom models to assess the unique needs of Commercial, Medicaid and Medicare populations

Benefits

Medical Management Solutions

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- Assess the disease burden of individuals, subgroups or populations
- Inform care management and evaluate the impact of clinical intervention and quality programs
- Identify individuals likely to be hospitalized, end up in the emergency room, or incur high cost in the near future

Budgeting and Underwriting Solutions

- Predict future costs of care for a population and allocate resources appropriately
- Set underwriting rates and inform stop loss and reinsurance rates
- Develop fair and accurate risk-based provider payment systems

Performance Assessment Solutions

- Measure efficiency in health care resource usage compared with expected utilization based on population risk
- Assess performance relative to peer group or a national benchmark
- Evaluate the impact of clinical risk and demographics on performance outcomes

Publications / links

Deep material requires a registration process. The link is below

<http://www.veriskhealth.com/resources/library>

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Organization	Vermont's Health Care Reform
Category	Standards Setting, Industry Organizations; Incentive/Reward Programs
Source	http://hcr.vermont.gov/home
Measure	Blueprint for Health http://hcr.vermont.gov/blueprint

Updated in 2013

Summary

In January of 2012 the Administration released its Strategic Plan for Vermont Health Reform for 2012-2014.

The strategic plan is intended to guide state government in implementing Governor Shumlin's health care agenda and follow the guidance provided by the legislature in Act 48 over the next three years. That state's current health reform plan builds on progress already made over more than two decades to expand and improve health insurance coverage in Vermont, improve fairness in our insurance market, and fundamentally redesign and improve our primary care system.

In the next phase of health reform, our goals are to:

1. Reduce health care costs and cost growth
2. Assure that all Vermonters have access to and coverage for high-quality health care (health care includes mental and physical health and substance abuse treatment)
3. Support improvements in the health of Vermont's population
4. Assure greater fairness and equity in how we pay for health care

Methodology

Strategies to Reduce Health Care Costs and Cost Growth:

- Develop and operationalize (through hospital budgets, certificate of need and insurer rate review processes) a health care budget for Vermont that reflects the principles embodied in Act 48 and is economically sustainable over time. Implement simplifications that reduce administrative costs.
- Implement innovations in payment and benefit design that will encourage individuals and health care providers to reduce costs of care
- Implement specific efforts to better manage care for Vermonters with one or more chronic conditions
- Maximize federal funding to support coverage and health care services in Vermont

Strategies to Increase Access to Affordable Health Care for all Vermonters:

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- Cover uninsured Vermonters
- Increase enrollment and retention in coverage for insured Vermonters
- Assess the adequacy of Vermont’s health care workforce and service availability and recommend specific steps to enhance and improve it as needed
- Define a minimum standard of benefits for all Vermonters that includes coverage of services with proven cost effectiveness in preventing illness and enhancing health status, provides incentives for individuals and their health care practitioners to attain and maintain good health and manage disease appropriately, and coordinates with public health services

Strategies to Improve the Health of Vermont’s Population:

- Assure that all Vermonters have access to high quality, well-coordinated preventive health services by building on and continuously improving the Blueprint integrated health services model and expanding the scope of services coordinated through the Blueprint
- Evaluate and continuously improve health care delivery by expanding the “learning health system” encompassed by the Blueprint
- Assure access for all working Vermonters to healthy worksites, Employee Assistance Programs, and other community supports that can serve as a gateway to health management
- Improve the health of school aged children by promoting and implementing the Coordinated School Health Model recommended by the Centers for Disease Control
- Support Vermont communities to respond to specific public health challenges

Strategies to Assure Greater Fairness in How We Pay for Health Care:

- Pass legislation and win approval of a federal waiver for public financing that is divorced from employment and sensitive to the ability of individuals and businesses to pay for coverage and is more sustainable
- Reduce cost shifting between public and private sectors and between segments of the private sector

Publications / links

Strategic plan 2012

<http://hcr.vermont.gov/sites/hcr/files/2013/Strategic%20Plan%20Revised%20July%202012.pdf>

Main link to BluePrint

<http://hcr.vermont.gov/blueprint>

Vermont Blueprint for Health 2012 Annual Report. February 2013.

http://hcr.vermont.gov/sites/hcr/files/Blueprint/Blueprint%20for%20Health%202012%20Annual%20Report%20%2002_14_13_FINAL.pdf

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Library

<http://hcr.vermont.gov/hit/library>

Link to Payment Implementation Work Group (link says *payor*)

<http://dvha.vermont.gov/advisory-boards/payer-implementation-work-group>

PPPM payment methodology by payer

<http://dvha.vermont.gov/advisory-boards/pppm-payment-methodology-by-payer-1-31-13.pdf>

Vermont attribution algorithm

<http://dvha.vermont.gov/advisory-boards/vermont-attribution-algorithm-2-8-13.pdf>

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Organization	Virginia Mason Hospital & Medical Center
Category	Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	https://www.virginiamason.org
Measure	Virginia Mason Production System (VMPS) https://www.virginiamason.org/VMPS

Updated in 2013

Summary

Virginia Mason Medical Center (VM) is a nonprofit organization offering a system of integrated health services. Gary S. Kaplan, MD, serves as Chairman and CEO. Our system includes physicians, hospitals, research, AIDS Care, philanthropy, transforming Health Care, as well as other affiliations.

The Virginia Mason Production System is the leading methodology for innovations in healthcare. For over a decade, we have been applying lean principles to increase patient safety and quality of care, while reducing costs.

Methodology

In 2002, Virginia Mason embarked on an ambitious, system-wide program to change the way it delivers health care and in the process improve patient safety and quality. It did so by adopting the basic tenets of the Toyota Production System (TPS), calling it the Virginia Mason Production System, or VMPS. While some medical centers have initiated projects using TPS, Virginia Mason is the first to integrate the Toyota management philosophy throughout its entire system.

How does the term "production" apply to health care? Patients of course are not cars. Yet both manufacturing and health care are filled with complex production processes. In health care these processes include admitting a patient, having a clinic visit or having surgery. These processes should embrace the concepts of quality, safety, customer satisfaction, staff satisfaction and cost effectiveness. The Virginia Mason Production System is all about optimizing each of these on behalf of our patients.

Virginia Mason's vision is to be the Quality Leader in health care. This vision requires adopting a paradigm shift from expecting errors and defects, to believing that the perfect patient experience is possible. Key to accomplishing this is understanding that staff who do the work know what the problems are and have the best solutions. VMPS strategies range from small-scale ideas tested and implemented immediately to long-range planning that redesigns new spaces and processes.

Virginia Mason uses several continuous improvement activities, such as Rapid Process Improvement Workshops (RPIWs) and kaizen events focused on incremental changes, as well as 3P workshops intended to completely

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redesign a process. Virginia Mason has held 850 continuous improvement activities involving staff, patients and guests.

The reduction of waste in administrative processes that support patient care but take valuable resources ultimately benefits customers. As a nonprofit organization, savings are reinvested to support Virginia Mason's mission to improve patient health and well-being.

Virginia Mason Institute

Virginia Mason Institute (VMI) is a non-profit corporation that provides education and training in the VMPS management method to other health-care providers and organizations. VMI was established in 2008 in response to growing industry demand to learn how Virginia Mason has applied lean manufacturing principles in health care.

Results

We have had many successes with VMPS. Below are a few examples of how VMPS has improved the quality of patient care.

- PSA System Improves Patient Safety
- One-Stop Care for Patients with Cancer
- Getting Back to Nursing
- Hyperbaric Center Increases Patient Capacity
- Express Treatment in the Emergency Department
- Faster Revenue Cycle
- Primary Care Achieves Positive Net Margins

Publications / links

Overview <https://www.virginiamason.org/VMPS#How>

VMPS Success Stories

One-Stop Care for Patients with Cancer

<https://www.virginiamason.org/dept.cfm?id=378>

Hyperbaric Center Increases Patient Capacity

<https://www.virginiamason.org/dept.cfm?id=376>

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Virginia Mason Institute

<http://www.virginiamasoninstitute.org/>

The Virginia Mason Production System

https://www.virginiamason.org/home/workfiles/clinicians/Winter_Contact_2008.pdf

2010 VMPS Facts

https://www.virginiamason.org/home/workfiles/pdfdocs/press/vmps_fastfacts.pdf

'Reducing Waste in US Health Care Systems.' Roger W. Bush, JAMA, February 28, 2007—Vol 297, No. 8 871-874

Virginia Mason Medical Center. Harvard Business Review Case Study, 2006. (link no longer available)

https://www.virginiamason.org/home/workfiles/VMI/HarvardBusinessSchool_VMPS.pdf

2010 Integrated Healthcare Association Pay for Performance Conference

http://www.ehcca.com/presentations/pfpsummit5/kaplan_2.pdf

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Organization	Wakely Consulting Group
Category	Risk assessment / predictive modeling
Source	http://www.wramodel.com/
Measure	Wakely Risk Assessment Model http://www.wramodel.com/

UPDATED IN 2013

Summary

The Wakely Risk Assessment Model (W.R.A Model) is a tool to measure relative morbidity risk using healthcare claim data. This model is developed by Wakely Consulting Group. The W.R.A Model has been designed keeping in view the changes required under the Patient Protection and Affordable Care Act (ACA), and to provide a transparent, high performing, risk assessment model. It is also free and open-source

Methodology

Design Principles

An overriding objective was to develop, from a user perspective, a predictive model and not *software*. Software entails a fairly static functionality and a prescriptive application. A predictive model needs to be adjusted, calibrated, and modified for every specific application and also be *completely* understood by the user. In order to accomplish this, the model needed to be transparent, simple, and open-source. The idea here was to develop something that offers encouragement for actuaries and other professionals to interact with the model from start to finish, and be able to execute the many modifications necessary for an appropriate risk adjustment process - not to mention having a full understanding of the risk assessment part.

Key Features of the WRA Model

Transparent: payment adjustment is a contentious issue, and transparency of the model helps stakeholder buy-in. Perhaps more importantly, transparency helps parties understand *why* payment is being adjusted - so that they know where the implied potential is for improvement.

Simple: it turns out that a model need not be complex for it to perform adequately. For example, you may get 90% of the way to peak possible performance with a rather simple model, and it is the last stretch that requires all sorts of algorithmic acrobatics. One may well question whether that extra performance is worth complicating the process, making it more intractable and adding burden to already strained IT resources. For most applications, the right answer

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is to keep it simple. The WRA Model uses basic and ubiquitous data elements, such as age, gender, diagnosis code, and national drug code (NDC's).

Open-Source: transparency and simplicity alone are not enough. We ought not to think about a risk adjuster as *software*, and think of it more in terms of a *predictive model* - a model that needs to be calibrated to a specific population and application, and to predict the right variable (recognizing services not part of the contract, recognizing reinsurance arrangements, etc.). The WRA model was designed to be open-source, and is heavily documented in to allow actuaries and other qualified professionals to be able to customize this model.

Free: The model is provided free of cost. Further the model is written in SQL code, which can be run using a commercial SQL server or the [free](#) SQL Server Express software).

Robustness: The WRA model's diagnosis mapping is developed utilizing, as a foundation, the Centers for Medicare & Medicaid Services' Hierarchical Condition Category Model (CMS-HCC). The CMS-HCC model is intended for a Medicare population and is widely used in the Medicare program in the United States. The mapping in this model was heavily adjusted to account for the incidence and cost of treatment of a younger population. The WRA model's pharmacy mapping was developed utilizing, as a foundation, the MedicaidRx model. The MedicaidRx model was developed for a Medicaid population and is also widely used. This mapping was modified after studying pharmacy utilization for a commercial population.

Statistical & Clinical Review: The mapping was based primarily on a statistical analysis of prevalence and cost of treatment of various conditions. As a secondary step a limited clinical review was solicited to make adjustments where needed.

Fairness: besides performance, another desired element for fairness is susceptibility to gaming. Certain diagnosis and pharmacy codes are excluded that are discretionary or susceptible to significant coding variation, abuse, or fraud.

A Foundation: The WRA model provides an open-source extensible foundation for professionals and researchers looking for a risk assessment model. For example, non-traditional predictor variables can be added, the mapping can be changed etc.

Reporting: A basic reporting tool (a Microsoft Excel exhibit) is included with the program code. This tool presents a fairly standard view of the model results, along with a few diagnostics.

Diagnostics: Diagnostics are just as important as performance metrics in a risk adjustment application. They include checking whether the population that the model is applied to is similar to the one that the reference weights are based on, checking the relative prevalence of conditions, identifying anomalies, etc. The WRA Model comes with built-in routines that provide an initial check of the data. These include key metrics such as (1) # of individuals not grouped under diagnosis and/or pharmacy mappings, (2) average eligibility in the experience period, (3) % of members with

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diagnosis and/or pharmacy codes, (4) member months not mapped to an eligibility category (i.e. invalid values for age or gender), and (5) average number of unique diagnosis and/or NDC codes per claimant.

Preparing for ICD10: The model includes a mapping of ICD9 to ICD10 codes (i.e. includes a preliminary mapping of ICD9 to ICD10 using the General Equivalency Mappings [GEMs] from CMS). ICD10 is scheduled to go into effect in the United States in October, 2014.

Publications / links

Detailed white paper on the WRA Model:

http://predictivemodeler.com/sitecontent/book/Ch06_Applications/Actuarial/WRA_Model/Versions/v1.02/Wakely%20Risk%20Assessment%20Model%20-%20White%20Paper.pdf

WRA Quick Start Guide:

http://predictivemodeler.com/sitecontent/book/Ch06_Applications/Actuarial/WRA_Model/Versions/v1.02/WRA%20Quick%20Start%20Guide.pdf

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Organization	WebMD
Category	Proprietary/Analytics/Decision Support/Healthcare Data Technology Summary for Public; Consumer; Infomediary http://www.webmdhealthservices.com/
Source	
Measure	Select Quality Care - Consumer https://admin.webmdhealth.com/SQC/consumer/ Select Quality Care - Professional http://www.selectqualitycare.com/SQC/professional/

Weblinks in Publication section from 2013

Summary

WebMD Health, the Company's portal segment, provides healthcare information, decision support and interactive communication products to more than 20 million consumers and healthcare professionals each month through its public web sites. WebMD also provides online health and benefit management services for employer and payer sponsors through private web sites. These services assist members to make informed benefit, provider and treatment choices that optimize healthcare cost and quality.

Separate Select Quality Care programs to evaluate hospitals are offered for Consumers and Professionals.

Methodology

Select Quality Care Consumer.

Select Quality Care Consumer is a web-based tool that provides health plan members and employees with severity-adjusted, condition-specific, side-by-side comparisons of hospital treatment outcomes. Users can compare up to 10 hospitals at a time according to factors they select as important to them, including:

- Number of patients treated
- Mortality rates by procedure
- Major complications
- Number of days spent in the hospital
- Average hospital charges
- Leapfrog patient safety results
- CMS measures

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Select Quality Care Consumer can be private labeled in a health plan or employer's look-and-feel and customized to support member initiatives:

- Identify your hospital network
- Highlight hospital tiers or centers of excellence
- Integrate with your provider directory
- Incorporate your member out-of-pocket costs
- Provide procedure-specific links related to content, tools and services
- Provide JCAHO accreditation data
- Implement a user feedback survey

Select Quality Care Consumer makes available a rich database of publicly available data from the federal and state governments.

Select Quality Care Professional.

Select Quality Care Professional supports a wide variety of decision-making activities in the contracting, network development, finance, marketing and quality improvement areas of managed care organizations. Specifically, Select Quality Care Professional can be used for:

- Understanding a hospital's performance compared to peer hospitals and best practices
- Comparing severity-adjusted charges, cost and LOS across hospitals by service line
- Understanding physician performance for inpatient care in comparison and benchmarks
- Aligning pay-for-performance incentives with quality
- Evaluating hospitals for network inclusion on the basis of quality and cost
- Identifying centers of excellence for specific product lines and high cost procedures
- Modeling the effect of different reimbursement approaches (e.g., per diem, per case type) on hospital profitability

Improve Network Management and Design - be used to define a market area and identify the appropriate hospitals for analysis, rank the hospitals by severity-adjusted cost and quality, separate hospitals into performance tiers and quantify the savings if volume were to be shifted to high-quality, low-cost hospitals.

Identify Centers of Excellence for Specific Product Lines - identify Centers of Excellence for specific inpatient treatments — such as bariatric surgery, transplants, cancer care and tertiary pediatric services — using volume, cost and quality information.

Model Contract Terms and Determine Hospital Profitability - model the effect of current and contemplated contract terms on specific hospital profitability in total or by hospital service. Incorporate per diems, case rates, capitation, stop-loss provisions and other methodologies into the analysis. Compare your rates with rates under Medicare reimbursement by hospital.

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Better Prepare for Contract Negotiations - have a comprehensive understanding of how each hospital in your network performs. With Select Quality Care Professional, you can go beyond your own claims data to obtain an in-depth, severity-adjusted hospital cost and quality performance profile that incorporates both outcomes and process measures. Select Quality Care Professional also allows you to drill down into the details of a hospital's performance by service line, procedure and more.

Make Meaningful, Severity-Adjusted Benchmark Comparisons - measure and compare the performance of hospital-based services to state, national or customized benchmarks based on resource use and quality measures. Provider performance is compared to benchmarks calculated at each level of risk and severity, taking into account the difference in case mix from one provider to another.

The systems includes a patented Decision Consultant Report is a key feature of Select Quality Care Professional. The Decision Consultant Report is a 10- to 15-page management report that is produced by the system in a matter of minutes.

Publications / links

Overview - consumer

<https://admin.webmdhealth.com/SQC/consumer/>

Overview - professional

<https://admin.webmdhealth.com/SQC/professional/>

Data sources

https://admin.webmdhealth.com/SQC/consumer/data_sources.aspx

Sample Decision Consultant Report

<https://admin.webmdhealth.com/SQC/HealthShareDCR.pdf>

Hospital Quality Comparisons Are Beginning to Influence Consumer Choice and Behavior

http://www.selectqualitycare.com/SQC/HealthShare_Annual_Consumer_Study.pdf

Kane, N. M and R. B. Siegrist. 2002. Understanding Rising Hospital Inpatient Costs: Key Components of Cost and the Impact of Poor Quality

<http://www.selectqualitycare.com/SQC/Understanding%20Rising%20Hospital%20Inpatient%20Costs.pdf>

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Organization	Wisconsin Collaborative for Healthcare Quality (WCHQ)
Category	State focus; Performance Ratings/Reports/Scorecards/Databases/Benchmarking
Source	http://www.wchq.org
Measure	Performance and Progress Report http://www.wchq.org/reporting/

Summary

WCHQ is a multi-stakeholder, voluntary consortium of Wisconsin organizations. WCHQ draws its membership from health systems, medical groups, hospitals and health plans. This diverse and dynamic group includes the state's largest health systems, Aurora Health Care and the University of Wisconsin Hospital and Clinics / University of Wisconsin Medical Foundation.

WCHQ members and stakeholders join together to measure the quality and affordability of healthcare services in Wisconsin. We publicly report these measurement results through our online Performance & Progress Report. We see performance measurement and public reporting as vital, dual mechanisms for promoting greater transparency, improvement, efficiency and equity within healthcare.

Methodology

WCHQ's Unique Approach: All Patients, All Payers

Many other healthcare reporting organizations rely exclusively on administrative claims from commercial insurers to create their performance measures. Such claims-based reports exclude Medicare, Medicaid and self-pay patients, which account for nearly 50% of clinical practice.

Physicians, data analysts and quality specialists from the WCHQ membership have developed ambulatory care specifications that capture all patients and all payers. By uniting claims, clinical and patient data, WCHQ tracks each provider's entire practice. This comprehensive approach enables WCHQ to create a sophisticated measure set that evaluates both clinical processes and intermediate outcomes, like A1c, blood pressure and LDL control.

Report is interactive and criterion include

- Type of Provider – Medical Group, Clinic, Hospital
- Geographic location
- Ambulatory Care Measures – chronic care and preventive care
- Clinical Topics – Diabetes, heart Care, patient Experience, pneumonia, cardiac Surgery, surgery, women's health, cardiovascular specialty care
- Service delivery

Publications / links

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Report data base

<http://www.wchq.org/reporting/>

Measures and Initiatives

<http://www.wchq.org/measures/>

Embracing Accountability

http://www.wchq.org/about/documents/Embracing_Accountability.pdf

WCHQ_brochure

http://www.wchq.org/about/loadfile.php?pdf=/about/documents/WCHQ_brochure.pdf

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Organization	Zynx Health
Category	Proprietary/Analytics/Decision Support/Healthcare Data Technology
Source	http://www.zynxhealth.com/
Measure	ZynxEvidence and ZynxOrder

Weblinks in Publication section from 2013

Summary

Zynx Health, a subsidiary of Hearst Corporation, is the market leader in providing evidence-based clinical decision support solutions that help healthcare organizations measurably improve patient outcomes, enhance safety, and lower costs.

Thousands of hospital organizations and providers “dare to be better” with Zynx Health’s rigorously developed and maintained evidence-based clinical content, patented technology, and tailored services to drive clinical improvements at the point of care. With Zynx Health, healthcare organizations exceed industry demands for delivering high-quality care at lower costs under value-based reimbursement models.

Methodology

ZynxEvidence

ZynxEvidence is an online resource that provides evidence-based clinical content and best practice guidance for physicians, nurses, and allied health professionals in the hospital setting. Content is divided into more than 155 modules that address clinical conditions, procedures, and patient problems.

Evidence-Based Recommendations for Meaningful Results

Organizations using ZynxEvidence have achieved statistically significant improvements in financial and clinical outcomes, such as lower costs per case, decreased hospital length of stay, and reduced mortality.

Improved Compliance with Quality Measures

ZynxEvidence clinical modules highlight the specific interventions that enable compliance with quality measures, major regulatory initiatives, and accreditation programs, including, Centers for Medicare & Medicaid Services, the Joint Commission, and American Nurses Association National Database of Nursing Quality Indicators.

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Using the forecasting functionality in ZynxEvidence, hospital quality improvement teams quantify how effectively evidence-based clinical interventions will improve clinical outcomes and cost. The easy-to-use custom input and calculation tools allow clinical and managerial executives to identify and prioritize quality improvement interventions and to measure the progress of ongoing initiatives.

ZynxOrder

ZynxOrder includes evidence-based order sets, clinical decision support rules, and quality measures. The more than 790 order set templates cover the major disease-related groups and symptoms for adults and pediatric patients in hospital settings, and are customizable in an online content management system that enables version control and maintenance.

Zynx Health's customizable order set templates save time and total resource costs to develop and maintain standardized order sets that guide care based on the most current medical literature. Clinician teams using ZynxOrder's online collaboration tools have demonstrated how this solution can expedite the process of customizing order set templates, soliciting and incorporating feedback, and releasing and maintaining organization-wide order sets.

- Options to add, delete, or modify specific order items and to include links to additional articles or institutional policies and procedures
- Collaborative online workspace facilitates clinician participation without requiring time-consuming meetings
- Project management and version control features help with tracking and managing order set versions
- Integrated quality measures and major regulatory initiatives simplify medication safety compliance and adherence to performance standards from the Centers for Medicare & Medicaid Services and other regulatory and accreditation agencies

Services for ZynxOrder also include mapping of Zynx Health's more than 33,000 healthcare terms to local client catalogs, national electronic medical records catalogs, or other standardized terminology sources. Mapping of standardized terminology allows ZynxOrder clients to upload customized order sets into an electronic medical records system without losing any semantic meaning in the clinical content and to begin using these order sets immediately following go-live.

ZynxCare

ZynxCare delivers evidence-based plan of care templates to the point of care, providing the means to create an evidence-based culture and demonstrate improvements in the quality of care.

Organizations using ZynxCare have demonstrated measurable improvements in key quality indicators such as the rates of surgical site and ventilator-associated pneumonia (VAP) infections, the frequency of pain reassessment, and the rates of serious falls.

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Each of the more than 240 plan of care templates have been developed by a team of nurses and allied health professionals based on rigorous review of emerging literature. These customizable templates include content to reduce care disparities, minimize errors, and save staff time.

Demonstrating Meaningful Use of EHRs

Meaningful use criteria were established by the Centers for Medicare & Medicaid Services (CMS) as a standard for the effective use of electronic health record systems (EHRs) to standardize care and improve clinical outcomes. In July 2010, the CMS outlined stage 1 meaningful use criteria including the use of evidence-based clinical decision support rules and alerts, adherence to specific quality measures, and implementation through electronic order sets. Proposed stage 2 criteria followed in February 2012 tying clinical decision support to CMS quality measures, specifying enhanced care coordination including plans of care, and calling for clinical evidence at the point of care. By adopting these criteria, healthcare organizations aim to achieve improved outcomes, greater efficiency, and reduced clinical variation.

In addition to reducing costs and improving care quality, Zynx Health evidence-based solutions support healthcare organizations in meeting meaningful use criteria by providing the clinical decision support rules, alerts, order sets, plans of care, and evidence-based content specified by meaningful use stage 1 and proposed stage 2 criteria. Key clinical processes included within evidence-based hospital order sets correspond to CMS clinical quality measures, as well as additional measures impacting the quality and efficiency of care. Actionable clinical evidence is available to clinicians at the point of care, additionally satisfying point-of-care requirements for meaningful use.

Methodology

Zynx order sets and plans of care include direct links to clinical summaries of the supporting evidence.

A summary is always presented in the same three-section format:

1. Reminder (ie, a concise recommendation);
2. Rationale (ie, a summary of the supporting evidence); and
3. References (ie, a comprehensive list of citations with links to relevant abstracts or full-text articles).

Updated content released every six months based on new evidence and performance measures or in response to critical issues. Each quarter, Zynx sends an updated list of measures from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Centers for Medicare & Medicaid Services (CMS), Leapfrog Group, Institute for Healthcare Improvement (IHI), and many other organizations.

Performance Measures

Zynx Health solutions incorporate performance measures from a substantial number of national organizations. These include

Hospital Performance Measures

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- American Association of Cardiovascular and Pulmonary Rehabilitation/American College of Cardiology/American Heart Association Clinical Performance Measure
- American College of Cardiology/American Heart Association Clinical Performance Measure
- American Heart Association/American Stroke Association (AHA/ASA) Get With The Guidelines Core Measure
- American Medical Association Consortium for Performance Improvement Performance Measure
- AQA Alliance–Endorsed Performance Measure
- Centers for Medicare & Medicaid Services (CMS) Hospital Quality Alliance Quality Measure
- CMS National Hospital Quality Measure
- CMS Physician Quality Reporting Initiative Physician Quality Measure
- CMS Premier Hospital Quality Incentive Demonstration Measure
- CMS Surgical Care Improvement Project Performance Measure
- Institute for Healthcare Improvement 5 Million Lives Campaign Performance Measure
- Leapfrog Nationally Endorsed Process Measure
- National Quality Forum–Endorsed Performance Measure
- Surviving Sepsis Campaign Performance Measure
- The Joint Commission (formerly known as the Joint Commission on Accreditation of Healthcare Organizations) National Hospital Quality Measure
- The Joint Commission National Patient Safety Goal

Nursing Performance Measures

- American Nurses Association Nursing Quality Indicator
- National Quality Forum–Endorsed Performance Measure

Physician Performance Measures

- American College of Cardiology/American Heart Association Clinical Performance Measure
- American Medical Association Physician Consortium for Performance Improvement Performance Measure
- AQA Alliance–Endorsed Performance Measure
- CMS Doctors’ Office Quality Information Technology Performance Measure
- CMS Medicare Physician Group Practice Demonstration Measure
- CMS Physician Quality Reporting Initiative Physician Quality Measure
- National Committee for Quality Assurance (NCQA) Back Pain Recognition Program Clinical Measure
- National Diabetes Quality Improvement Alliance Performance Measure
- National Initiative for Children’s Healthcare Quality Performance Measure
- National Quality Forum–Endorsed Performance Measure
- NCQA Diabetes Physician Recognition Program Clinical Measure
- NCQA/AHA/ASA Heart/Stroke Recognition Program Clinical Measure

Chronic Disease Management Performance Measures

- The Joint Commission Disease-Specific Care Performance Measure

Health Plan Performance Measures

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- NCQA Healthcare Effectiveness Data and Information Set (HEDIS) Performance Measure

[ZynxCare](#)® named [KLAS Category Leader](#) and #1 offering for Clinical Decision Support - Order Sets and Care Plans

Publications / links

Case studies

ZynxCare – Transition of Care Overview

<http://www.zynxhealth.com/ZynxHealth/media/pdfs/ZynxCare-Transition-of-Care-Overview.pdf>

<http://www.zynxhealth.com/Success-Stories/Case-Studies.aspx#UHS>

<http://www.zynxhealth.com/Success-Stories/Case-Studies.aspx#Norman-Regional>

Clinical Decision Support Solutions

<http://www.zynxhealth.com/Solutions.aspx>

Case Studies

<http://www.zynxhealth.com/Success-Stories/Case-Studies.aspx>

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APPENDIX

Definitions of secondary level categories used to organize data from web-based research are:

1. **Accreditation, Certification** - Products such as published standards based upon defined and agreed best-practice of an accrediting/certifying organization; or, an organization undertaking the action of accreditation - an evaluative process in which a healthcare organizations policies, procedures and performance are self-reviewed and externally examined. Primary purpose is quality oversight with a view to establishing whether the healthcare organization exceeds, meets, or has not met published standards, resulting in some sort of formal acknowledgment or designation of status achieved.
2. **Analytics, Decision Support, Healthcare Data Technology**– Data technology vendor or data product that gathers, organizes/analyzes large amounts of information/data; either provides authoritative analytical information, assists clinical decision-making or the means by which an organization can generate/analyze information (such as episode-grouping tools); intended to assist an organization analyze its results/performance to improve healthcare quality and/or efficiency or to inform and align clinical decision-making with best-practice.
3. **Incentives, Rewards Programs** –Seek to align providers’ financial **incentives** with quality goals; motivate and reward improved performance or reward exemplary performance on targeted dimensions of health care quality through various means such as pay for performance, pay for quality improvement, financial incentive, bonus, reward.
4. **Performance Ratings, Reports, Scorecards, Benchmarking (report actual performance)** - Organization or product that examines/analyzes/categorizes/reports on the way in which a group or organization performs and/or accomplishes its important functions or processes. Involves analysis/interpretation of performance measurement data into contextually useful information to drive quality and efficiency improvement. Use of qualitative and/or quantitative measures of care and services developed to gauge/interpret processes and outcomes. Performance measures may include measures of clinical quality and process, patient outcomes (health attained, mortality, morbidity), patient perceptions of care, organizational structure and systems. Results provided in form of a rating, report card/scorecard or measured against an industry benchmark.
5. **Standards Setting, Industry Organizations** - Organizations formed around specific purpose or subject matter; established for the purposes of developing standards and processes; or, to act on behalf of members promoting the interests of members. Focus is on common issues of interest such as in this context, developing widely applicable standards/criteria of healthcare quality and/or efficiency; or, health sector analysis identifying areas of future research/action.
6. **Summary for Public, Consumer, Infomediaries** - Organization or product that seeks to promote transparency in the health care industry by a comparative analysis and reporting capability. Assists patients make decisions about their health and guide patients regarding quality of care and of providers. Includes gathering and providing information on the performance of healthcare organizations enabling the user to compare performance against that of peer organizations, against a range of user selected benchmarks. This may include providing users (consumers, providers, employers, and policymaker) with comparative cost, volume and quality information about medical procedures performed at various hospitals and outpatient facilities or by various providers – based upon well-tested, standardized measures that are widely accepted and used by a broad base of public and private entities.

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7. **Value based payment / Payment reform** – there are a variety of programs and applications that move beyond basic incentives for particular illnesses to broader changes in the reimbursement structure. The goal is to create a financial structure that encourages results and rewards for the provider community for initiatives to improve quality and manage resources effectively. Payment reform initiatives are part of the health reform legislation.

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