



The Care We Need

DRIVING BETTER HEALTH OUTCOMES FOR PEOPLE AND COMMUNITIES



NATIONAL QUALITY FORUM

Driving measurable health
improvements together

OUR MISSION

To be the trusted
voice driving measurable
health improvements

OUR VISION

Every person experiences
high value care and
optimal health outcomes

OUR VALUES

Collaboration •
Leadership • Passion •
Excellence • Integrity

ABOUT THE NATIONAL QUALITY FORUM (NQF)

The National Quality Forum (NQF) sets standards to improve healthcare quality with measures and guidance based on evidence and innovation to make care better for all people. NQF-endorsed measures are used in federal public reporting and pay-for-performance programs as well as in private-sector and state programs. Hundreds of individuals from NQF's member organizations and beyond devote their time and expertise to address issues of national importance.

Together, we develop and advance quality improvement strategies. Through collaboration, NQF defines field-tested, evidence-based quality standards on a variety of key topics.

NQF identifies and works to close gaps essential to high value care. Strategic measure frameworks and quality improvement priorities identify critical gaps and practice innovations to drive measurable health improvements and deliver better person-centered outcomes and value.

Driven by science, collaboration, measurement, and innovation to make care better for all people, NQF helps drive multiple perspectives into actions that create measurable impact. NQF is the place where everyone has an equal voice in creating healthcare improvements that provide the greatest value to all. We do what nobody can do alone—but what everyone can accomplish together through healthy collaboration on improving outcomes.

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AT THE BEGINNING OF THE MODERN QUALITY

MOVEMENT, the National Quality Forum was founded as a national response to systemic healthcare quality issues. Since the late 1990s, much has been achieved, but many challenges persist. As this report is released, our nation is currently responding to one of the greatest health crises in the last century. During this time, we are reminded that we are one interconnected system of care that performs best when priorities and practices are aligned and coordinated at all levels and across all stakeholders.

The COVID-19 pandemic highlights both the strengths and weaknesses in America's healthcare delivery system. Prior to the outbreak, many healthcare delivery systems across the country were already embracing a culture of safety, implementing Lean and high-reliability practices, and using robust data-driven quality measurement to drive improvement strategies and better outcomes. However, this is not the norm across all, or even the majority, of the healthcare delivery system. For the health of our communities and the public at large, we need to normalize the processes and practices that reliably deliver safe, appropriate, person-centered care. Now, as the healthcare delivery system faces so many challenges, is the opportunity to do just that.

As a nation, we invest heavily in our delivery system. We lead the world in healthcare spending that exceeds \$3.5 trillion per year and approaches one-fifth of our Gross Domestic Product (GDP). Yet, we continue to lag other countries in health outcomes. If we mobilize our resources to support an aligned set of priorities, we should and can expect better health outcomes with the levels of investment in our federal, state, and employer budgets, and consumer spend.¹ The United

States can achieve lower rates of medical errors, preventable hospital admissions, and disease burden than comparable countries.²

Together, we must align public and private leadership to propel the quality movement closer to the goals set 20 years ago by the Institute of Medicine in *To Err is Human* and *Crossing the Quality Chasm*. Even before the COVID-19 outbreak, the quality community, patients, consumers, and many other stakeholders were frustrated that the nation had not achieved more over the past two decades. Now, especially in the face of the pandemic, we see the importance of coming together to systematically address new and persistent challenges. We are able to align our efforts and mobilize support for solutions to great outcomes in the face of a visible crisis. We need to do this as a norm across our system of care.

True to the mission of the National Quality Forum, we pave the path forward by tapping into our collective expertise and shared commitment to improving the quality of care and outcomes for every person—an objective deeply personal to each and every person, and one of the greatest issues facing our nation. We convened the National Quality Task Force, a highly diverse group of experts, to reflect on promising opportunities to address continuing challenges, as well as emerging issues. Longstanding challenges stem from the flawed fee-for-service payment system, inconsistent cultures of quality and safety, and lack of person-centered care. New issues include obstinate data silos, measure proliferation, and insufficient data and performance transparency. Collectively, these challenges stymie efforts to reduce unacceptably high rates of medical errors. Moreover, they undermine the nation's

1 Hartman M, Martin AB, Benson J, et al. National Health care spending in 2018: growth driven by accelerations in Medicare and private insurance spending. *Health Aff (Millwood)*. 2019; 39(1):8-17

2 Peterson-Kaiser Health System Tracker. How does the quality of the U.S. healthcare system compare to other countries? <https://www.healthsystemtracker.org/chart-collection/quality-u-s-healthcare-system-compare-countries/>. Last accessed January 30, 2020.

agenda to move to value-driven care and improve the health and vitality of our communities.

Together, recognizing that we are all part of one interconnected system of care, we need to focus our energies on these critical problems and advance the next steps of the quality movement. A clear, prioritized roadmap to address these challenges is fundamental to gaining trust across all stakeholders that the nation's healthcare delivery system can reliably serve our needs.

The National Quality Task Force knows that the recommendations and timelines stated in this report are ambitious. They require the combined efforts of all stakeholders, from public and private leaders to consumers and patients. We are already seeing many of these opportunities being implemented in response to COVID-19. These efforts do not need to be the exception in a time of crisis; they can be the norm to achieving better health outcomes.

Together, we can achieve these goals. It is of the utmost priority that all stakeholders in the quality community align behind a common roadmap to boost the trajectory of progress dramatically and to build faith that consistent, high quality care is achievable. Meeting this challenge is the necessary next phase in our journey to improve quality and drive value for all in our healthcare system.

We look forward to working with you.

SHANTANU AGRAWAL AND KENNETH W. KIZER

Co-Chairs, National Quality Task Force

Together we can build on 20 years of concerted effort and progress to make care safe, appropriate, and high value for all people—especially the most vulnerable.

8 | Acknowledgments

THE NATIONAL QUALITY FORUM would first like to sincerely thank the generous sponsors that contributed to this vital endeavor.

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“Ultimately, the one thing that matters is the patient at the center of everything. The rest of us have the privilege of being participants in the process.”

DAVID PRYOR, MD, ASCENSION CONSULTING

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The nation has seen significant advances to save lives and avoid harm.

Community by community, person by person, we all want to see our healthcare system consistently work better for every person. We can and need to build on the many great, notable successes to address the challenges that remain. Many of us know what it is like to fight for the comprehensive and connected care people need. For all the people whose stories we do know, there are so many more whose stories go untold.

This report isn't academic. For every person for whom the system worked well, we need to acknowledge the unseen scores of people for whom it did not. Motivated to make safe, high value care the norm for every person, the Task Force maintained as its North Star the experiences and stories of real people to serve as a call to arms to change the status quo.

These are their stories that, together, we can change.

“Chronic kidney disease affects my whole life, but I’m being treated in different pieces.”

When the doctor told me I had Stage 3 chronic kidney disease, I was also told that I was lucky to learn about it as early as I did. It was a good thing that the family doctor I saw paid attention to my family history of diabetes, noticed my swollen ankles, and asked about my eating habits.

I just thought I’d been on my feet at work too long. I didn’t realize that my diet, or lack thereof, and blood pressure were actually beginning to kill me.

But if I thought I was lucky, I didn’t realize how much and how quickly the diagnosis would change my life.



Living alone, it was more than I could manage, so I moved from the city closer to family. But it was a more remote, quieter area and I no longer had access to the doctor that I had seen on and off over the years.

I didn't realize how hard it was going to be to find a new doctor that I was comfortable with, much less find a good nephrologist (or any nephrologist!) near me. I'd never even heard of that kind of doctor before. The one I could find gave me different information and advice than my prior doctor.

Completely overwhelmed and confused, I struggled to make sense of all the information. Because of my move, I could no longer be

treated by my prior doctor even with all the advances and the confusing "patient portal" where, I could sometimes message him.

My disease got worse. More complications meant more doctors. It was hard on me and my family trying to get to all the visits. None of them ever spoke to each other. I had to relay all the information which, even though it was now electronic, seemed even harder to keep track of and make sense of. Despite all the time I spent filling out paperwork for every visit, no one had access to my medications.

I had to give up shifts trying to get from appointment to appointment and all I could think about was the wages

and tips I was losing filling out similar but different paperwork and telling the same information over and over again. I was terrified that I might forget one medication and have some horrible complication. I was constantly having to ask doctors what they were telling me versus what the other doctor said. Frankly, they seemed just as frustrated not to know what the other was saying or prescribing but didn't have the time to really address it. They seemed as exhausted as I was.

One day one of my doctors said, "You should have told your other doctor you were taking this medication. He would have never given you that prescription."

That was the last straw. I looked at him and said, "Sorry, I didn't go to medical school. I work in a diner where the cooks and waiters actually talk to each other."

How can the whole team—me, my caregivers, my doctors, and nurses—work better together to help me heal?

“Would my son be alive today if his mental health and addiction were treated as a disease?”

Sean was such a good son, really caring towards everyone, but he suffered from anxiety. As he grew older, he began self-medicating and, whether from his genetics or anxiety, was predisposed to addiction. Yet while other kids were embraced by our community for their battles with diseases such as diabetes or cancer, we and Sean felt ashamed about the struggles of his disease. We suffered in silence. It was uncomfortable talking about it with others.

We felt isolated and struggled to heal in a vacuum of support and information.



One drug after another, Sean's disease took hold until he was addicted to opioids. We stuck by our beloved son going from one program to another. Most of the programs treated Sean as if he was a broken individual, subjecting him to scrubbing toilets with a toothbrush to build character or kicking him out onto the streets if he didn't comply.

We finally found a treatment center he liked. Unlike the others, this one prescribed suboxone to actually treat the addiction. It was working well, and Sean was smiling again and excited about living a drug-free life. But it didn't last.

As he transitioned to outpatient treatment, his next psychiatrist didn't believe in the use of medications to treat addiction. Sean's medical history didn't follow him. Scores of NIH-funded research and evidence that we learned about later couldn't change the doctor's perspective on the most effective care for our son.

Despite this, Sean was able to stay sober for 12 straight months and getting ready to celebrate his birthday. Then one night, he sat down and wrote us a long letter. He thanked us, said how bad he felt about what he put us through, and how ashamed he was of himself. And then, he committed suicide.

Now we look back and wonder why nobody ever thought to address his anxiety issues during all his addiction treatments. Why couldn't his care teams follow his medical history to see what was working and what wasn't? Why is it that physical health conditions like diabetes are treated like a disease to actively manage, but Sean's mental health was treated like a character flaw?

“How could we have learned more and been better partners with his care teams?”

“Everyone was so busy saving my life, we forgot to think about my quality of life.”

The darkest day of my life wasn't finding out that I had cancer. It wasn't leaving career, friends and family to seek treatment at a hospital in another city. It wasn't the day that doctors told me that I likely wouldn't survive. No, the darkest day was when I survived, when I was finally released and realized that I had nothing. No job, no husband, no career and no team to help me plan how to get back to life.

The journey all started when my husband and I wanted to have a second child through IVF. A routine blood test showed a high white blood cell count and my doctor insisted on additional tests.



Suddenly, I went from being a career woman trying to have a second child to a cancer patient trying to survive Acute Myeloid Leukemia. We picked up house and home to go to the best place for a bone marrow transplant. Luckily my husband found a job an hour away from the medical center. We agreed that I would take care of myself and the treatments and he would work, take care of our son and take care of me. Jose worked days, drove an hour each way to see me, raised our son, attended to me on my brief stays at home, all while trying to hope and hang on.

The medical care I received was exceptional. I survived

against all odds. But we didn't survive as a family. Everything was falling apart as I was getting better. My husband lost his job. We had no way to support the family and no way to cope with the stress and anxiety we were experiencing. At the moment when I realized I had beaten death, I thought I was better off dead.

Throughout my treatment experience, we were all about the blood counts. But what really counts is the quality of life during and after treatment. Nobody ever checked to see if we were coping, cracking or just checking out. The healthcare system I experienced was good at

beating back death, but not at helping me anticipate what else was likely to come and helping me find the resources or tools to get my life back—purpose, employment, dealing with financial stress, or even simple counseling on how to help your husband move from being a caregiver to a husband again.

When you're finally released from the hospital they say, "Bye, see you for flare-ups and follow-ups." Job done. Good luck. There has to be something more. I might not have been dead, but I was broken. I mean, when you're released from prison you at least get a parole officer. Why shouldn't my patient experience think

about the whole me and my life? I'd never experienced cancer before, but they see hundreds of patients like me, and from talking to my friends in the ward, I was far from alone or unique in my struggles. They must know what I was likely to experience.

Why couldn't they help me anticipate that? Why couldn't they tell me where to get the counseling support we obviously needed?

We have to learn how to care for the whole person and help people get back to their whole lives. It's not just about medical care, but spiritual, emotional, family—everything care—during and after medical treatment.

My care team saved my life. I still need help getting back to a functional life.

“Healthier and happier patients
will create a healthier and
happier healthcare system”

JOAN MAXWELL, PATIENT

IN THE 20 YEARS since seminal efforts such as *To Err is Human* and *Crossing the Quality Chasm* launched a national movement to establish safe, high quality care, the field has made important strides in measuring quality and improving patient safety. The country has achieved notable reductions in hospital-acquired infections, fall-related injuries in hospitals, and preventable deaths. These results proved that measuring quality is possible and can have a real impact saving lives. These early efforts also mobilized the quality community to establish a culture that values and expects safe, patient-centered care. Healthcare leaders and systems across the country embrace processes, programs, and improvement priorities designed to consider care and outcomes from the perspective of the patient.

Several exemplar health systems have proven quality is measurable and can be improved. After implementing efforts to prevent avoidable harmful events, Ascension—a large nonprofit healthcare delivery system in the U.S.—reported a total of 57,123 lives saved from 2004 to 2016. Another example is the Essential Hospitals Engagement Network, which reported preventing 4,051 medical errors from 2012 to 2014, at a cost savings of \$40 million.³ Yet, despite the progress, significant work remains to arrive at the point that every person in every community can expect to consistently and predictably receive high quality healthcare. Medical errors are still the third-leading cause of death, after heart disease and cancer, and 250,000 people in the U.S. still die every year from medical errors.⁴

Among U.S. surgeons participating in a recent survey, 8.9 percent reported the belief that they made a major medical error within the last three months, and 1.5 percent believe their error resulted in a patient's death.⁵

To the frustration of all, medical errors persist, health disparities are rising, healthcare professional well-being is a widespread concern, and healthcare spending is still increasing despite an alarming prevalence of chronic diseases and infant mortality rates. Further, stakeholders—notably consumers—have gained little ground in their ability to make informed decisions with confidence regarding their care based on indicators of quality and value.

These and other shortcomings have been documented widely in reports and the research literature. Most concerning is the lack of an aligned vision and a set of shared priorities to achieve this goal. Together, we can build on 20 years of concerted effort and progress to make care safe, appropriate, and high value for all people—especially the most vulnerable.

To achieve this, the National Quality Forum convened almost 100 healthcare executives to identify the highest-yield, actionable opportunities to address persistent barriers, scale proven improvements, and identify innovations to drive value for quality improvement by 2030. This group formed the National Quality Task Force. It assembled regularly over the course of 2019 to identify high impact, actionable steps for the next decade of quality.

The Task Force focused on addressing healthcare quality, safety, value, and experience. In light of active legislative and regulatory efforts and debates, we should note that a few key issues highly concerning to all stakeholders—specifically healthcare pricing and affordability (both services and pharmaceuticals), and coverage—were not included in the scope of the Task Force. These challenges are top of mind for many, notably consumers, when discussing the value of our healthcare delivery system. As efforts continue, the

IMPROVING QUALITY: RESULTS THAT MATTER

A 17 percent decrease in U.S. hospital adverse events from 2010 to 2014 resulted in **87,000 lives saved, 2.1 million incidents of harm averted, and \$19.8 billion saved**³

From 2000 to 2016, more than two-thirds of patient safety measures were demonstrating overall improvement. Measures showing the most important results included reduced adverse events among hospital patients receiving knee and hip joint replacement³

³ Eastman, P. Has anything changed in the 15 years since 'To Err is Human'? *Oncology Times*. 2016;38(1):17-18.

⁴ Johns Hopkins Medicine. Study Suggests Medical Errors Now Third Leading Cause of Death in the U.S. https://www.hopkinsmedicine.org/news/media/releases/study_suggests_medical_errors_now_third_leading_cause_of_death_in_the_us. Last accessed January 30, 2020.

⁵ Shanafelt, T, West, C, Sinsky, C, et al. Changes in burnout and satisfaction with work-life integration in physicians and the general US working population between 2011 and 2017. *Mayo Clin Proc*. 2019;94(9):1681-1694.

Strategic Objectives

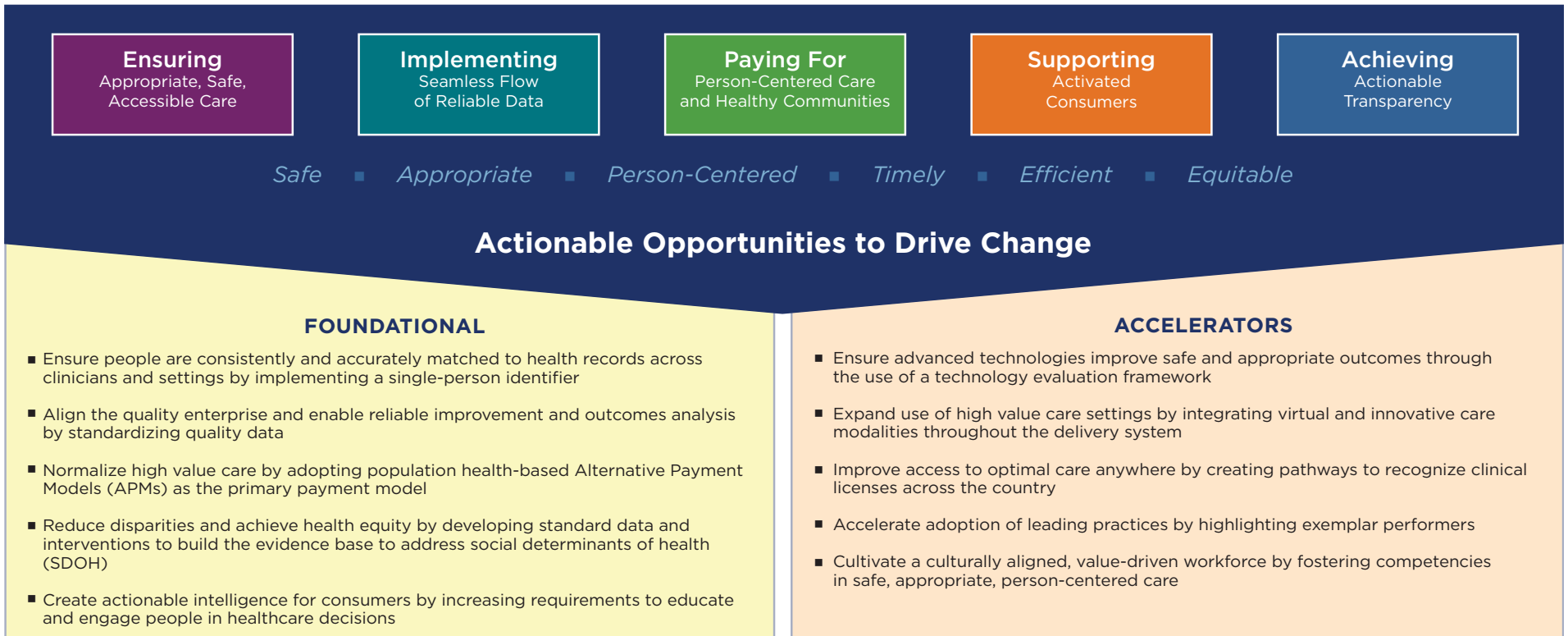


FIGURE 1. NATIONAL QUALITY TASK FORCE RECOMMENDATIONS

Task Force encourages policymakers to use our vision as a guide to address the unsustainable relationship between the nation's spending and health outcomes.

The 10-year horizon to make high value care the norm purposely focuses all stakeholders on achievable opportunities. Considering the current and target states of quality, the Task Force acknowledges the enduring relevance of the quality principles described in *Crossing the Quality Chasm*, and advocates for a discrete set of objectives to focus the next decade's quality priorities.

The Task Force recommendations reflect the shared priorities advocated by the diverse panel. Representing payers, health systems, clinicians, purchasers, patients, consumers, policy, community leaders, and more, the Task Force includes participation from a variety of clinical specialties and geographic regions. Motivated to make care universally safe and effective for every person in every community, the Task Force set five strategic objectives that can be achieved by acting on 10 specific, actionable opportunities.

Delivering high value care requires all players to work as part of one system of care. No one recommendation, no one stakeholder can normalize person-centered, quality care. The recommendations in this report emphasize our interdependent system of care and the importance of shifting from a system optimized to treat the sick, to a system focused on keeping people healthy and well. Progress relies on a collective commitment wherein many leaders embrace their role and ability to influence the drivers of this system change.

The National Quality Task Force calls on all public and private leaders—in policy, public programs, business, and community—to come together, each playing their unique role, to take action on the opportunities identified. We can all move forward together to make sure that within the next 10 years, the healthcare quality movement will see the day when all people consistently and predictably receive the high quality care we need.

VISION:

Every person in every community can expect to consistently and predictably receive high quality care by 2030.

MISSION:

Identify actionable opportunities to improve alignment across the delivery system to achieve better health outcomes and value for every person.

22 | Purpose of the National Quality Task Force

NQF CONVENED THE NATIONAL QUALITY TASK FORCE

after extensive discussion with diverse healthcare leaders who agreed the nation needs an aligned set of priorities to guide the next stage of healthcare quality improvement.

In 1999, the report, *To Err is Human*, stated that 44,000-98,000 people die in hospitals each year due to a preventable medical error. The goal set at the time was a 50 percent reduction in medical errors by 2004.

Recommendations at that time included creating the Center for Patient Safety within the Agency for Healthcare Research and Quality (AHRQ) to lead safety improvement goals, developing a national public reporting system, and raising performance and safety standards across the healthcare system by implementing safety systems and metrics.

Since then, many of these actions have been implemented. AHRQ innovated and worked with many partners to decrease medical errors and reported a 13 percent decline in healthcare associated infections from 2014 to 2017, which resulted in 20,500 lives saved. The Joint Commission's Center for Transforming Healthcare initiated a nationwide effort to decrease hospital falls and succeeded: fall-related injuries diminished by 62 percent. The Institute for Healthcare Improvement's 100,000 Lives Campaign decreased preventable deaths by 122,000 lives during the 18-month campaign starting in 2006.⁶ From 2010 to 2014, adverse events in U.S. hospitals decreased by 17 percent, translating to 87,000 lives saved, 2.1 million incidents of harm averted, and \$19.8 billion saved.⁷

These statistics demonstrate that actions taken by the diverse stakeholders comprising the quality community over the last two decades resulted in compelling successes. These successes give us hope that we can now make even greater progress when aligned behind a common set of objectives.

Stakeholders agree that the current pace of progress frustrates and disheartens all of us, because life and health are at stake. Simply put, the quality community's efforts to date—while essential—have not gone far enough. *Together, we can build on 20 years of concerted effort and progress to make care safe, appropriate, and high value for all people—especially the most vulnerable.* Concern that value-driven, high quality, person-centered care is elusive undermines trust in the system's ability to care for people in communities across the country. Overcoming this perceived stasis requires radical alignment across all stakeholders.

Uniquely positioned to convene diverse players to drive measurable health improvements, NQF partnered with leaders from the many stakeholders of the quality community to bring together key experts, innovators, and leaders to form the National Quality Task Force. Our common mission was to identify actionable opportunities to improve alignment across the delivery system to achieve better health outcomes and value for each person. The Task Force worked toward the vision that every person in every community can expect to consistently and predictably receive high quality care by 2030. The almost 100 top experts supporting the Task Force aimed to put forth priority recommendations to boost the trajectory of healthcare quality in the United States.

The Task Force focused on addressing healthcare quality, safety, value, and experience. In light of active legislative and regulatory efforts and debates, we should note that a few key issues highly concerning to all stakeholders—specifically healthcare pricing and affordability (both services and pharmaceuticals), and coverage—were not included in the scope of the Task Force. These challenges are top of mind for many, notably consumers, when discussing the value

⁶ Beckershospitalreview.com. 4 Major Advances in Patient Safety since "To Err is Human." <https://www.beckershospitalreview.com/quality/4-major-advances-in-patient-safety-since-to-err-is-human.html>. Last accessed January 30, 2020.

⁷ Eastman, P. Has anything changed (see p.17, footnote 3)

of our healthcare delivery system. As efforts continue, the Task Force encourages policymakers to use our vision as a guide to address the unsustainable relationship between the nation's spending and health outcomes.

To achieve this aim, the Task Force was organized into five subcommittees with an overarching Core Committee to establish subcommittee goals and provide critical feedback on Task Force recommendations. A panel of nationally recognized expert advisors also gave vital input to the overall direction of the Task Force and its scope. The five subcommittees of the Task Force convened regularly to discuss the progress in quality improvement since the 1999 IOM report *To Err is Human* as well as what work remains.

Each subcommittee had a unique focus and comprised a diversity of voices, from patient representatives to providers to payers to employers. The intent was to include all relevant perspectives to tackle these important issues.

The Core Committee established the Task Force priorities and set subcommittee goals and scope. They reviewed and analyzed subcommittee recommendations to provide feedback for cohesion across subcommittees. The Core Committee also addressed comments provided by the Expert Advisors.

The Expert Advisors provided high-level direction and feedback on what the Task Force must consider and provided a detailed review of the recommendations.

The Promotion & System Change subcommittee aimed to define critical system changes to support the implementation and uptake of successful population health management capabilities which include promoting and embedding structural, cultural, and behavioral change necessary to drive an aligned, high quality learning system.

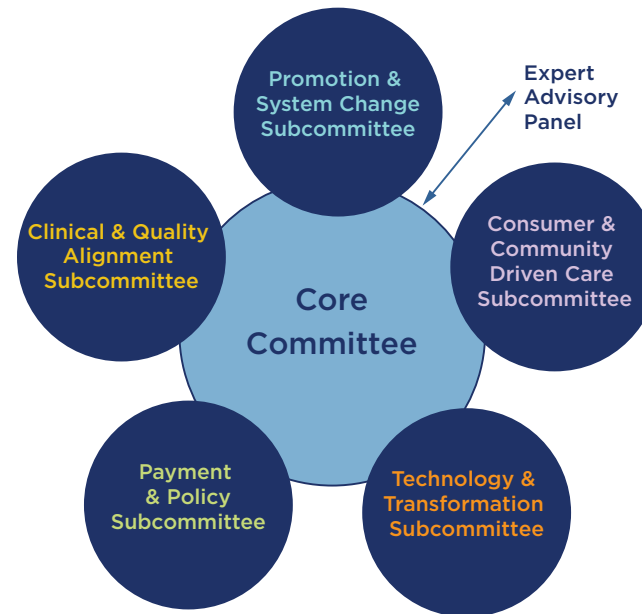


FIGURE 2.
NATIONAL QUALITY TASK FORCE COMMITTEE STRUCTURE

The Consumer & Community-Driven Care subcommittee

focused on advancing quality of life measures for person-centered and consumer-defined outcomes as well as driving transparency of care decisions and improving performance data (validity, impact, and integration).

The Technology & Transformation subcommittee considered opportunities in which to focus advancements in the next generation of healthcare delivery and medical technologies including artificial intelligence, robotics, wearables, seamless EHR integration, new pharmaceuticals, and devices. In addition, this subcommittee focused on personalized care and data regulation, privacy, and transparency.

The Payment & Policy subcommittee focused on creating aligned performance incentives and penalties throughout the delivery system and weighing key considerations, e.g., performance reporting, risk, and social determinants of health (SDOH).

The Clinical & Quality Alignment subcommittee

concentrated on establishing clinical priorities and aligning measurement, workflow, and improvement efforts to produce better outcomes and reduce burden. This included discussions of data and measure standardization versus adaptation. Other topics included high-impact outcomes, total cost of care (TCOC), prevention, and SDOH.

The goal of the Task Force was to produce an actionable roadmap for all stakeholders from the public and private sectors, as well as patients, employers, technology experts, and community-based organizations. These diverse actors were identified as critical to the implementation of the Task Force recommendations ([Appendix B](#)).

The next section of this report presents the recommendations. The opportunities and measures of success described in the following section serve as

actionable steps to monitor the progress made on each recommendation.

To achieve the Task Force vision by 2030, we call for implementation to start for each opportunity within the next one to two years by developing statutory, regulatory, and technical approaches; identifying and funding authoritative agents; and completing business processes and implementation planning.

The Task Force encourages all stakeholders to embrace their unique roles in moving these recommendations forward either by supporting implementation efforts or promoting relevant ideas and endeavors.

Recommendations: A Roadmap to Personalized, Population-Driven Care

WE, THE TASK FORCE, identified several contemporary realities representing both opportunities and challenges that must be considered to achieve greater progress.

- *Technological innovation in healthcare delivery*: rapid advancements and evolution of technologies from artificial intelligence to virtual care to genomics are changing healthcare delivery
- *Proliferation of measures*: the current state of the quality enterprise is unintentionally confusing, burdensome, and dissatisfying to a myriad of system stakeholders and users
- *Changing business models*: consolidation and integration of healthcare stakeholders, alternative payment models, and innovative delivery models with new market entrants are disrupting traditional roles and healthcare delivery
- *Continued lack of value-driven care*: costs continue to rise at unsustainable rates and care is still not value driven
- *Continued lack of person-centered care*: consumers are not sufficiently educated, engaged, or empowered in their care decision making

Reflecting on the current drivers for action, we consistently returned to the enduring Aims for Quality and Rules for Redesign articulated in *Crossing the Quality Chasm*. We advocate using critical levers of change (**Appendix A**) to systematically recognize the whole person at the center of care and keep people well, to sharply reduce low-value and inappropriate care, to commit to improving health equity, to establish standards and practices that establish a culture of transparency, and to offer simpler paths that systems of all sizes can support to improve quality.

To drive value through the next generation of quality, the Task Force roadmap builds off these original principles, identifying a set of essential changes and strategic objectives to focus action and implementation efforts.

CONTEMPORARY CHANGES—QUALITY AIMS

We confirm the continued relevance of the six IOM aims (safe, effective, patient-centered, timely, efficient, and equitable) for improving quality, and broaden the perspective of two to reflect evolved thinking:

- **Appropriate** – Care must be appropriate as well as effective. In determining if care is appropriate, the intervention itself (clinical and nonclinical) should be considered, as well as the setting and unique considerations of the person. It must be recognized that on many occasions the safest, most appropriate care considering an individual's goals may constitute no intervention at all.
- **Person-Centered** – Healthcare must evolve to support consumers who are encouraged and able to pursue better health outcomes before they become patients requiring treatment. This evolution from “patient-centered care” to “person-centered care” recognizes and values the whole person and the context for their health status. Healthcare must promote wellness, considering the comprehensive needs of the whole person while addressing episodic and chronic illness.

“Visibility is a challenge. There is no highly catastrophic event to draw attention to the number of avoidable deaths we know occur on a daily basis. Together, we can bring forward solutions to change this.”

ANNA ROTH, RN, MS, MPH,
CONTRA COSTA HEALTH
SERVICES

2000

2020

DRIVERS FOR ACTION

Medical Error Rates Limited Culture of Quality and Safety Rising Healthcare Costs Health Disparities No Transparency Limited data	Medical Error Rates Inconsistent Cultures of Quality and Safety Rising Healthcare Costs Health Disparities Ineffective Transparency Data Silos Access Clinician Burnout Measure Proliferation and Burden Increasing Consumer Share of Spend
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AIMS FOR QUALITY IMPROVEMENT

Safe Effective Patient-Centered Timely Efficient Equitable	Safe <i>Appropriate</i> <i>Person-Centered</i> Timely Efficient Equitable
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INSTITUTE OF MEDICINE
RULES FOR REDESIGN



TASK FORCE
STRATEGIC OBJECTIVES

<ol style="list-style-type: none"> 1. Care is based on continuous healing relationships 2. Care is customized according to patient needs and values 3. The patient is the source of control 4. Knowledge is shared and info flows freely 5. Decision making is evidence-based 6. Safety is a system property 7. Transparency is necessary 8. Needs are anticipated 9. Waste is continuously decreased 10. Cooperation among clinicians is a priority 	<ol style="list-style-type: none"> 1. Ensure appropriate, safe, accessible care 2. Implement seamless flow of reliable data 3. Pay for person-centered care and healthy communities 4. Support activated consumers 5. Achieve actionable transparency
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STRATEGIC OBJECTIVES AND SYSTEM CHANGE NEEDS

We concluded that private and public sector leaders should focus on accomplishing the following five Strategic Objectives to address the critical changes needed throughout the healthcare delivery system.

Ensuring Appropriate, Safe, Accessible Care: Leaders across the delivery system must build a culture and a proficient workforce driven to deliver the safest, most appropriate, and efficient person-centered experience as a standard of care. The cultural transformation must motivate the whole healthcare system to innovate continually and improve reliability of care processes—using proven virtual care capabilities to remove place of service barriers and advanced analytics to address misuse, overuse, and underuse.

Implementing Seamless Flow of Reliable Data: The growth and ubiquity of data are overwhelming us, both creating opportunities and complicating effective, safe, appropriate use of personal and clinical information. Consistent, comprehensive, high value care requires providers, payers, and other system stakeholders to have real-time access to standardized, valid information from a variety of clinical and nonclinical data sources while safeguarding people from harm and bias. The seamless flow of reliable information is necessary to optimize the healthcare experience, efficiently improve health outcomes for individuals, reduce burden, and enable true, comparative benchmarks.

Paying for Person-Centered Care and Healthy Communities: Insufficient progress has been achieved toward creating a value-driven system of care that considers the whole person, prioritizes keeping people well, and addresses health disparities. Investing more in primary care and prevention and accelerating the transition to population health models

FIGURE 3. CONTEMPORARY FRAMEWORK FOR QUALITY IMPROVEMENT PRIORITIES

can promote more efficient use of public and private resources, and liberate systems to implement person-centered strategies that integrate community resources and care across modalities and settings to deliver care. Such care will produce better care experiences and outcomes that deserve payment and improve health equity across diverse communities. Only when payment is designed to support this integration will appreciable progress be made.

Supporting Activated Consumers: Consumers, patients, and caregivers lack the inclusion and actionable information they need to become effective care partners. The healthcare delivery system must redefine quality and value from the perspective of educating an engaged consumer. To help consumers make informed healthcare decisions, care options must consider evidence as well as individual goals and needs. Evidence-driven information and consumer priorities must define what quality is and how it is measured and reported.

Achieving Actionable Transparency: Healthcare must advance to the stage of other high-performing industries that continually raise quality performance and expectations. Progress demands the transparency that provides actionable intelligence and valid value comparisons. Healthcare must establish transparent, consistent, and verifiable safety and quality standards that motivate all stakeholders to pursue the best value by providing effective, transparent comparisons of consumer experience ratings, clinical outcomes, and total cost as essential to achieving this goal.

Actionable Opportunities

WE IDENTIFIED a reinforcing set of actionable opportunities to achieve the vision of this Task Force. Driven by the strategic objectives, these opportunities take advantage of proven **levers of change** to drive value throughout the healthcare system by improving the health of communities and personalizing care appropriately. Achieving the ultimate vision of an improved healthcare system by 2030 is a challenge we must accept. It

requires a prioritized approach to improvement across all roles in the healthcare ecosystem.

Improvement requires focus. We recommend the following 10 actionable opportunities to drive change. Each recommendation includes measures of success for the short term (one to two years), midterm (four to six years), and long term (seven to 10 years).

While presented individually, these actionable opportunities represent a coherent, mutually reinforcing set of actions to drive system change. The potential impact of these recommended opportunities is optimized by acting on all of them. Task Force members strongly agreed that achieving measurable progress in all 10 of the next 10 years would revolutionize healthcare delivery as we know it.

Strategic Objectives

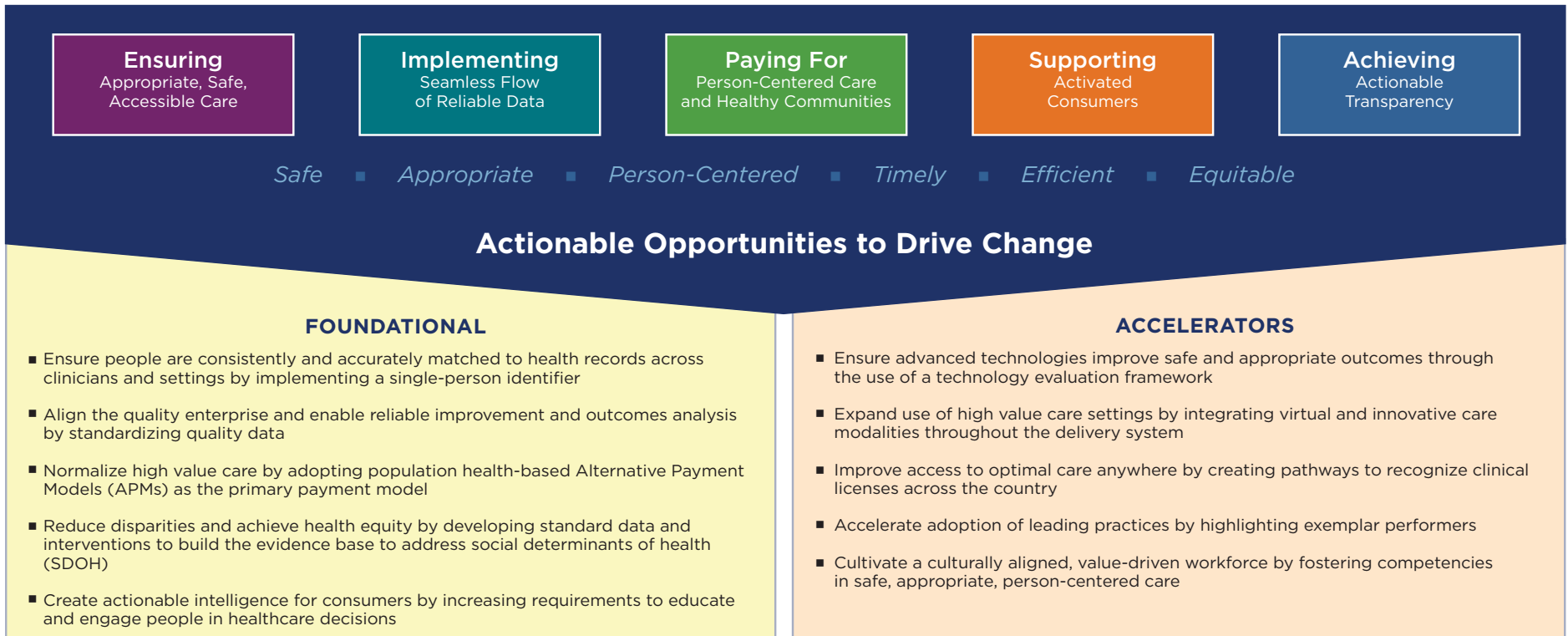


FIGURE 4. IDENTIFIED OPPORTUNITIES

WE DEEMED FIVE RECOMMENDED OPPORTUNITIES as foundational to creating a personalized, population-driven healthcare delivery system. These opportunities represent structural changes to the healthcare delivery system that are necessary to drive better outcomes and value. In particular, these recommended opportunities support an agenda for comprehensive and integrated high value care, total quality and cost transparency, and true interoperability throughout the system.

Foundational Opportunities represent structural changes to the healthcare delivery system that are necessary to drive better outcomes and value

OPPORTUNITY 1:

Ensure people are consistently and accurately matched to health records across clinicians and settings by implementing a single-person identifier

MEASURES OF SUCCESS

Midterm: Statutory, regulatory, and technical approach to match disparate health data to singularly identified individuals approved

Long term: 100 percent of healthcare claims and records in the EHR use and share data tied to an individual

OPPORTUNITY 1: Ensure people are consistently and accurately matched to health records across clinicians and settings by implementing a single-person identifier

The ability to accurately match health data to the individual at the center of care is essential to drive value and improve outcomes.⁸ With estimated savings of almost \$80 billion, the ability to easily link and share healthcare information across a disparate array of providers, settings, and modes of care is deemed critical to enabling a comprehensive and longitudinal view of a person's health experience and status. This potentially minimizes inappropriate care and reduces medical errors that can range upward of 20 percent.⁹

We acknowledge that consumer privacy protections are paramount as implementation options are considered. We advocate for a commitment to seize this opportunity, while recognizing the risks of electronic data sharing. Whether from digital health or online banking, we must continue to find ways to enable optimal sharing of health records while protecting consumers' privacy.

This opportunity will require action from players across the healthcare field, notably policymakers, HHS, the health technology community, and privacy and security experts.

⁸ RAND Corporation. Identity Crisis? Approaches to Patient Identification in a National Health Information Network. https://www.rand.org/pubs/research_briefs/RB9393.html. Last accessed January 30, 2020.

⁹ Bipartisan Policy Center. *Challenges and Strategies for Accurately Matching Patients to Their Health Data*. Washington, DC: Bipartisan Policy Center; 2012. <https://bipartisanpolicy.org/report/challenges-and-strategies-accurately-matching-patients-their-health-data/>. Last accessed January 30, 2020.

OPPORTUNITY 2:**Align the quality enterprise and enable reliable improvement and outcomes analysis by standardizing quality data****MEASURES OF SUCCESS:**

Midterm: 50 percent of measures tied to payment are eCQMs from identical data sets aligned across public and private payers that integrate with the care workflow and reliably represent care outcomes

Long term: 100 percent of measures tied to payment are aligned across public and private payers, are accurately derived electronically without manual processes, and include a limited identical set used by all

OPPORTUNITY 2: Align the quality enterprise and enable reliable improvement and outcomes analysis by standardizing quality data. Data standards should include definitions and minimum required data sets to harmonize use across all payers, and serve as the foundation for parsimonious expanded data sets that accommodate specific geographic and population variations (e.g., consumer-defined measures, SDOH)

Innovation in measurement is necessary, and many acknowledge that the inventory of existing measures may not represent the best thinking in how to assess quality, capture and respond to consumer and patient priorities, and focus on improvement efforts to produce better value and outcomes simultaneously.

Currently, both an abundance of measures and gaps in data vital to the future of quality abound. For example, the Task Force discussed the need for new methods of measuring the quality of primary and preventive care emphasizing comprehensiveness, continuity and coordination of care, quality of life, first contact, personal well-being, as well as modernizing key definitions such as access.

We believe that standardizing quality data definitions can underpin interoperable electronic data sources and measurement across the enterprise. Integrating information across corresponding data repositories—while challenging—is fundamental to a value-driven healthcare system and essential for truly effective,

comparative analysis and monitoring of valid data. Standardization reduces the administrative burdens associated with current quality measurement and reporting programs while also allowing organizations and providers to focus on performance improvements. Standardizing quality data and definitions to support and expand electronic clinical quality measurement is possible and will help ensure consistent and accurate coding that currently drives additional burden through the quality enterprise. By taking advantage of innovations such as new modeling languages for user interfaces such as QML, the quality enterprise can become more efficient and responsive.

When looking at the different measure areas, we believe that quality measurement data need to systematically address all six IOM quality aims. In addition, we identified the following key principles for data and measure innovation:

- Measures should be built on standardized data definitions to take advantage of new approaches to support measure innovation and quality improvement through advanced technology such as artificial intelligence
- Measures should be standardized for use across the ecosystem
- A set of standardized SDOH and other disparity measures is needed
- Measures should be transparent and shared across all users

- Measure usage should be linked across the healthcare delivery system to the individual person where appropriate to enable continuity of care across the continuum
- Measures should capture consumer perspectives and definitions of quality as well as the data recommended by consumers to best inform the measure
- There should be requirements and standards for all measures to achieve validity from the point of data capture
- Measures should be accessible and available electronically to make the process as seamless as possible for healthcare provider workflow
- Measures should take into account new delivery modes such as virtual care

“Reliable, electronically derived clinical quality measures are where we need to be. It is fundamental to building an empowering consumer-driven mindset that the person is the record at the center of care.”

SHANNON PHILLIPS, MD, MPH, INTERMOUNTAIN HEALTHCARE

OPPORTUNITY 3:**Normalize high value care by adopting population health-based Alternative Payment Models (APMs) as the primary payment model****MEASURES OF SUCCESS**

Near term: 25 percent of Medicaid and Commercial healthcare reimbursement and 50 percent of Medicare is tied to population health-based shared accountability APMs (categories 3B and 4)¹⁰

Midterm: 50 percent of Medicaid and commercial healthcare reimbursement and 100 percent of Medicare is tied to population health-based shared accountability APMs (categories 3B and 4)¹⁰

Long-term: At least 80 percent of all healthcare reimbursement is tied to population health-based shared accountability APMs (categories 3B and 4)¹⁰

OPPORTUNITY 3: Normalize high value care by adopting population health-based Alternative Payment Models (APMs) as the primary payment model for the healthcare delivery system.

The Task Force supports moving to models of care that embed high quality patient experience and outcomes as central to the definition of value and dramatically accelerate the transition away from fee for service.¹⁰

This includes advocating for population health-based payment models as the primary method across all populations and programs—both private and public—to build consistent expectations, competencies, processes, and infrastructure to better serve all people, regardless of demographic or payer. With the emphasis on improving health outcomes across populations, episodic and condition-specific bundled payment models can be integrated more purposefully and better coordinated with broader population health-based payment models to achieve more comprehensive, high value care.

For the majority of the healthcare delivery system, we align with the recent update to the goals set by Health Care Payment and Learning Action Network. These goals establish that the bulk of healthcare payment is predicated on population health-based alternative payment models (APMs) as a means of providing greater flexibility and encouraging

efficient, impactful innovation in delivering better outcomes.

*The goals correspond with the Healthcare Payment Learning and Action Network Categories:

CATEGORY 1: Fee for Service – No Link to Quality and Value

CATEGORY 2: Fee for Service – Link to Quality and Value

CATEGORY 3: APMS Built on Fee for Service Architecture (Category 3B: APMS Built on Fee for Service with Downside Risk)

CATEGORY 4: Population-Based Payment

Such an approach emphasizes wellness and prevention through comprehensive, coordinated primary care as well as embracing and integrating appropriate virtual solutions and interventions to address SDOH in care delivery. The approach also emphasizes comprehensive care integrating both physical and mental/behavioral health. The Task Force recognizes the value of continuing patient-clinician relationships through primary care. The recommended approach considers proven research that patients with primary care receive higher quality care and experience better healthcare access and critical preventive care.¹¹

Additionally, as part of adopting population health-based payment as the primary model,

¹⁰ The goals correspond with the Healthcare Payment Learning and Action Network Categories:

Category 1: Fee for Service – No Link to Quality and Value

Category 2: Fee for Service – Link to Quality and Value

Category 3: APMS Built on Fee for Service Architecture (Category 3B: APMS Built on Fee for Service with Downside Risk)

Category 4: Population-Based Payment

¹¹ Levine, D, Landon, B, Linder, J. Quality and experience of outpatient care in the United States for adults with or without primary care. *JAMA Intern Med.* 2019;179(3):363-372.

we see a significant opportunity to emphasize appropriate, comprehensive, and coordinated care that is informed in two ways: from a population perspective to better address chronic disease management, and based on individual patient experiences and goals. Such models recognize that the best care, informed by patient goals, may sometimes constitute no intervention, and these models also disincentivize underuse or misuse of care driven by evidence-based outcomes.

We acknowledge that significant work remains to consistently assess, calculate, and understand total cost of care, an effort viewed as fundamental to improve our understanding of value-based care and outcomes. We also recognize that fee for service will continue to be an appropriate payment model for a limited set of circumstances, and that moving to population health-based APMs that take on additional financial risk will continue to challenge many providers in smaller practices as well as disadvantaged health systems. Policymakers need to continue efforts that recognize the unique challenges and resource limitations of specific providers, while steadfastly establishing consistent expectations for quality and safety, and supporting efforts that encourage improvements in safety, quality, and value for all people.

“Across Kentucky, every key stakeholder is supportive of a core set to focus our quality efforts. All of our major health plans, Medicaid, health systems, independent rural physicians, and healthcare purchasers are at the table. People are on board looking at how to incentivize improving what will make the greatest impact for all in our communities versus trying to measure ALL of quality.”

RANDA DEATON, MA, KENTUCKIANA HEALTH COLLABORATIVE

OPPORTUNITY 4:**Reduce disparities and achieve health equity by developing standard data and interventions to build the evidence base to address social determinants of health (SDOH)****MEASURES OF SUCCESS**

Near term: Develop an SDOH and Disparities Monitoring Program that near-term assesses impact of interventions and outcomes based on defined indicators, and long-term assesses impact based on aligned, standard sets of measures

Midterm: 50 percent of the health systems and Community-Benefit Organizations covering 50 percent of the total population use nondiscriminatory standard SDOH screening data aligned across payers and community resources and closed loop protocols

Long term: Over 50 percent of healthcare systems and payers report measurable improvements in outcomes tied to SDOH and other disparities (e.g., transportation, housing, and food insecurity)

OPPORTUNITY 4: Reduce disparities and achieve health equity by developing standard data and interventions to build the evidence base to address social determinants of health (SDOH) in relationship to quality performance, outcomes, and payment to determine the optimal role for the health delivery system.

Addressing SDOH more systematically is considered a highly promising path to improve health outcomes and health equity. Achieving equitable care is one of the original IOM quality aims that many argue has seen the least progress.

We envision a future in which addressing SDOH is embedded in healthcare delivery through the development of community networks that help fulfill needs identified through routinized SDOH screening, closed-loop referrals, and outcomes tracking. However, much work remains to standardize essential data, build the evidence base to see which types of interventions work best, and understand the unintended consequences and potential harm and bias various approaches present to consumers and patients.

We advocate making the best collective use of our healthcare delivery system and community resources by systematically studying and addressing SDOH and health disparity interventions as well as the relationship to improved health outcomes as part of a systemwide commitment to improving health equity, outcomes, and value. We recommend moving diligently yet thoughtfully to build the

foundations of standardized data, both clinical and nonclinical, that are necessary to sharing data bidirectionally across disparate networks of providers and community resources.

The historical roles of health systems in improving health and wellness are evolving, and we recognize that defining the optimal role of the healthcare system in addressing SDOH requires continued analysis and evidence. Furthermore, we encourage addressing SDOH through payment models recommended in Opportunity 3, population health-based APMs, and using other financial flexibilities as opposed to building additional payments into fee-for-service models.

“We have long recognized the unique clinical factors that impact health outcomes. We need to finally systematically recognize and address the non-clinical factors that we know play an even larger role in population health outcomes and individual well-being.”

SHANTANU AGRAWAL, MD, MPhil, NQF

OPPORTUNITY 5:**Create actionable intelligence for consumers by increasing requirements to educate and engage people in healthcare decisions.****MEASURES OF SUCCESS**

Midterm: 100 percent of clinicians publicly disclose patient comments collected as a part of their survey and measurement activities, and shared decision making is required for at least the top five agreed-upon procedures most susceptible to inappropriate care

Long term: 50 percent of healthcare payments are tied to consumer-defined measures and shared decision making

OPPORTUNITY 5: Create actionable intelligence for consumers by increasing requirements to educate and engage people in healthcare decisions. Strengthen approaches to developing consumer-defined measures, increase transparency and usage of information desired by consumers, and integrate evidence-based shared decision making into prioritized care processes.

Quality data and information, while helpful, still do not respond to consumer and patient information needs in a meaningful way. Such information should educate consumers and patients to improve health literacy and help them make informed care decisions—both on where they receive care and the interventions most appropriate to their goals.

The Task Force advocates for dramatically improving the usefulness of quality data and information. Certainly, consumers need to be able to do quick research to find quality information relevant to them. For example, they should be able to perform filtered searches based on condition-specific experiences and their own priorities. Beyond this, we advocate actions to accelerate engagement and enable people to be equal partners in making their care decisions.

We acknowledge the need to better reflect consumer priorities by expanding and strengthening quality measures driven from the consumer perspective. To close a critical gap, we advocate for establishing a standard set of principles and practices to include consumers

and patients as key partners through each phase of quality reporting to reflect consumer priorities: measure concept and design, development, testing, and reporting. As part of this recommendation, the Task Force discussed the growing burden on patients, as the quality enterprise increasingly relies on patient-reported outcome measures for assessment. Several experts shared that Patient, Family, and Engagement models can help identify the most efficient means of capturing data and reducing the reporting burden, and these models have proven that they promote well-being and appropriate care throughout life.

As the quality enterprise expands its commitment to consumer-defined measures, we emphasize the power of transparency broadly—and specifically transparency of patient comments—to encourage quality improvement and to respond to consumer information needs.

We agree that evidence-based shared decision making adds real value. Shared decision making educates and engages patients in setting goals that inform care decisions. It activates consumers to achieve better outcomes as well as helping them avoid inappropriate care. For many patients struggling with cancer diagnoses or dialysis patients, for example, shared decision making helps patients better understand the implications of various care options, including the option to decline care that does not align with their individual goals.

These recommended opportunities will achieve maximum impact when implemented in combination with the foundational, structural changes. Accelerator opportunities hasten the rate of improvement to drive better outcomes and value throughout the healthcare delivery system.

Accelerator opportunities provide the greatest benefit and hasten the rate of improvement when implemented in conjunction with foundational opportunities.

OPPORTUNITY 6:

Ensure advanced technologies improve safe and appropriate outcomes through the use of a Technology Evaluation Framework

MEASURES OF SUCCESS:

Midterm: Healthcare delivery systems can verify which technology solutions are proven to support high value care based on objective review by an independent organization that credits technology using the development principles and measurement standards published in a Technology Evaluation Framework

Long term: Avoidable safety events and high-cost, inappropriate care are substantially reduced by widespread adoption of a Technology Evaluation Framework

OPPORTUNITY 6: Ensure advanced technologies improve safe and appropriate outcomes through the use of a Technology Evaluation Framework so that artificial intelligence, machine learning, natural language processes, virtual care, personalized medicine, genomics, and other advanced technologies objectively improve safe and appropriate outcomes by including patient and safety improvements, reducing inappropriate care, and improving outcomes while minimizing administrative burden

As consumer burden for healthcare costs increases and the delivery system seeks innovative means to improve access and increase consumer engagement, shifts in traditional healthcare delivery will accelerate.

While encouraging innovation—whether digital health, remote monitoring, artificial intelligence, or precision medicine—the Task Force remains concerned that the promises of innovations are often unproven or difficult to assess. Additionally, we need to assess and better understand patient safety concerns and consumer protections from harm and bias.

We encourage the use of advanced technology, yet want reliable means to assess the technology’s evidence-based ability to address priority challenges. In particular, we identified the need to use advanced technology seamlessly throughout the care continuum to address a number of issues:

1. Inefficient healthcare practices that encumber value-based care (e.g., administrative burdens that have lower clinical consequence such as prior authorization)
2. High-impact interventions to improve outcomes (e.g., predictive analytics for high-cost, chronic care patients/conditions)
3. Variations in care, inappropriate care, and diagnostic errors

As innovation and disruption continue, we advocate for the development of a Technology Evaluation Framework to encourage accountability consistently across all actors—both traditional stakeholders as well as new entrants—in addressing cost, quality, safety, and consumer experience priorities. While work remains to develop the framework and its criteria, we deem it essential to assess the adherence of innovations to the foundational six aims for quality, the use of standard data, promoting interoperability, demonstrating the ability to improve outcomes safely, as well as safeguarding patient protections. Additionally, as traditional care delivery evolves, new entities and actors must be equally accountable for improving outcomes and delivering value.

“Less activated patients are... three times as likely to have unmet medical needs, and twice as likely to delay medical care, compared with more activated patients. Highly activated patients are two or more times as likely as those with low activation levels to prepare questions for a visit to the doctor; to know about treatment guidelines for their condition; and to seek out health information, including comparisons of the quality of health care providers.”

JUDITH HIBBARD

Hibbard, J. (2009). Using Systematic Measurement to Target Consumer Activation Strategies. *Medical Care Research and Review*, 66(1_suppl), pp.9S-27S.

OPPORTUNITY 7:**Expand use of high value care settings by integrating virtual and innovative care modalities throughout the delivery system****MEASURES OF SUCCESS:**

Midterm: Create consumer-defined measures reported by more than 50 percent of healthcare delivery systems that assess virtual and nontraditional care (promoters, community-based screening sites) on improvements in patient experience, consumer engagement, and outcomes for discrete, acute national health priorities (e.g., rural health, maternal mortality and morbidity, and mental and behavioral health)

Long term: All consumers are able to routinely use care deemed clinically and socially appropriate for improving safety, value, and outcomes (e.g., virtual care modalities, nontraditional care) as standard, integrated care processes

OPPORTUNITY 7: Expand use of high value care settings by integrating virtual and innovative care modalities throughout the delivery system to improve patient engagement, close access gaps, and improve outcomes (e.g., virtual and community-based care settings)

The Task Force widely supports the potential for new modalities and virtual solutions to improve outcomes and better respond to consumer needs and preferences. In supporting the call to emphasize population health and consumer priorities, the healthcare delivery system must take advantage of new mechanisms and delivery innovations proven appropriate and efficient—both clinically and socially—in activating consumers and patients in their care and improving outcomes.

To encourage a rapid transition away from fee for service, we overwhelmingly support providing greater flexibility to use innovative modalities in the most appropriate setting preferred by patients. Such innovations recognize the value of virtual health solutions as well as nontraditional care settings such as many community-based settings that are more comfortable, convenient, and accessible for people, particularly disadvantaged individuals. While emphasizing the importance of monitoring new modalities for safety and effectiveness in improving outcomes as well as the importance of safeguarding consumer protections, we advocate efforts to implement such approaches seamlessly into care delivery processes that promote high value care.

Seamless integration requires careful attention to the care delivery and data flow process, workforce training and development, and the patient and consumer experience. Experts advised that effective implementation of such innovations requires a keen understanding of how consumers, patients, and various healthcare professionals will intersect with and support new modalities to achieve the desired outcomes and avoid creating confusion or burden. When implemented with a thoughtful review and a plan to address these factors, such approaches can and should be used to improve consumer and patient experience, improve population health and individual outcomes, reduce costs, and improve resource efficiency, as well as enhance care team well-being.

OPPORTUNITY 8:**Improve access to optimal care anywhere by creating pathways to recognize clinical licenses across the country****MEASURES OF SUCCESS:**

Near term: Expand authority to address access issues for emergent health crises and for underserved communities

Midterm: A statutory and regulatory roadmap to evolve licensure to minimize administrative and geographical barriers to care is approved

Long term: Nationwide license portability/recognition established to allow clinical professionals (MDs, DOs, NPs, RNs, and PAs) to seamlessly practice across state lines while preserving states' responsibilities to ensure residents are medically safe

OPPORTUNITY 8: Improve access to optimal care anywhere by creating pathways to recognize clinical licenses across the country. Create pathways to support recognizing clinical licenses across the country, such as through expanded professional licensing compacts, interstate agreements, and/or other solutions

The Task Force recommends building on current efforts and mechanisms to address geographic barriers to care and patient safety concerns. We do so in light of increasingly acute concerns regarding access to care and in recognition of modern delivery and engagement mechanisms enabling high value care.

Access-to-care concerns hold true for primary care as well as specialty care needs. We particularly emphasize mental and behavioral health as key areas as well. Many states have established interstate compacts¹² or other mechanisms to facilitate the portability of clinical licenses across the country. Existing mechanisms vary but all significantly reduce the administrative barriers and redundancies associated with obtaining authorization to practice in multiple states. These models are designed to provide residents of these jurisdictions with access to necessary care while fulfilling their responsibility to ensure that their residents are medically safe and that there is accountability among health professionals caring for them. Additionally, as the nation builds a more resilient emergency response system—whether for natural disasters, epidemics, or other catastrophic events—states

have developed models to expand authorities to authorize clinicians to treat their residents during public health crises. The models have been relied on to address the needs of geographically disadvantaged people and provide critical care to people in response to public health emergencies.

We also identified critical patient safety concerns when the practicing history of a clinician is not considered; the system should protect against clinicians who have had their licenses revoked or restricted due to patient concerns from easily re-establishing themselves in a different geography.

Taking advantage of modern capabilities and building off of existing models to provide high value care to all people, regardless of location, was deemed an imperative to achieving the Task Force vision.

“As we seek to address persistent and emerging challenges with innovative approaches and technology, we need to be thoughtful and vigilant to understand the adverse effects, build the supporting evidence base, and maintain patient protections from harm or bias.”

LUCIA SAVAGE, JD, OMADA HEALTH

¹² Chaudhry, HJ. Improving access and mobility – the interstate medical licensure compact. *NEJM*. 2015;372(17):1581-1583

OPPORTUNITY 9:**Accelerate adoption of leading practices by highlighting exemplar performers****MEASURES OF SUCCESS:**

Near term: Establish a governance forum and process to identify exemplars, curate proven practices and tools, and disseminate learning

Midterm: Performers representing diverse segments and populations are competing to have their successes serve as repeatable models for others

Long term: A national, knowledge-based resource library is curated with the lessons of exemplar performers, and other systems use it to guide quality improvement

OPPORTUNITY 9: Accelerate adoption of leading practices by highlighting exemplar performers who are achieving equal or better outcomes with greater efficiency to generate positive competitive dynamics among providers and systems and promote learning communities.

The Task Force identified the need for greater leadership commitment and accountability for delivering high value care. As part of this, many felt that we must advocate for actions that will inspire improvement and build a learning community that helps organizations of all profiles progress in their quality journey. We discussed the need to meet organizations where they are in their quality efforts. Experts advocate for investing in a learning community that enables organizations to learn from one another. We identified the need to help organizations evolve from one quality maturity level to the next, from normalizing quality fundamentals to driving better outcomes and higher value care.

In discussing the most effective and actionable ways to highlight exemplars, we deemed it important to take advantage of models that create positive, competitive dynamics. As part of this, we believe an evaluation process must consider patient and population complexity and risk as well as the varying profiles of performers in the delivery system. For example, many disadvantaged and under-resourced systems are capable of impressive, person-centered care improvements, often demonstrating that more can be done with less. As such, we advocate for developing a well-regarded process to solicit, select, and celebrate those performers delivering

high value care, so they can set examples from which peers can learn. Additionally, we encourage the evaluation to consider meaningful incentives for recognized exemplars, such as reduced reporting requirements.

Recognizing the variation in resource levels and capabilities across the delivery system as well as the diversity of nontraditional and new delivery system entrants, we recommend creating a process that highlights exemplars at various levels and categories of delivery. Critical to success would be choosing an entity to lead the effort, specifying evaluation criteria, and selecting evaluators. We support a highly diverse cohort of evaluators and envision criteria heavily informed by the Task Force recommendations.

Finally, experts advocated for meaningful incentives for the recognized exemplars for their contributions delivering high value care as well as contributing to the learning community. Ideas for incentives included financial rewards and reduced reporting requirements.

OPPORTUNITY 10:**Cultivate a culturally aligned, value-driven workforce by fostering competencies in safe, appropriate, person-centered care****MEASURES OF SUCCESS:**

Near term: Develop common set of competencies that will be appropriate for healthcare professionals for the next 10 years, based on anticipated demographics (language, aging), payment reform, promoting comprehensive, person-centered care and accelerated digital technology in healthcare

Midterm: Education accreditation and licensing bodies for healthcare professions endorse a common set of competencies

Long term: Education accreditation bodies report 100 percent achievement in meeting common competencies.

OPPORTUNITY 10: Cultivate a culturally aligned, value-driven workforce by fostering competencies in safe, appropriate, person-centered care by developing programming that emphasizes appropriate care, shared decision making, high reliability, quality fundamentals, advanced and virtual care technologies, and population health-based payment models of care. Set associated targets for accreditation, licensure, certification, and continuing education.

The Task Force recommends action to normalize a culture of quality. Experts identified the need to strengthen critical leadership and workforce capabilities universally to achieve a systemwide safety culture and advance a 21st-century model of care.

Most systems are not sufficiently resourced to lead their workforce through the wide-ranging changes associated with delivering value-driven, outcomes-focused care and take advantage of relevant innovations. Recognizing this, we considered many ideas for instilling cultural norms fundamental to high value care such as enhancing Boards' responsibilities that evidence the fiduciary accountability for improving outcomes. Other suggestions included curating improvement-focused quality maturity models.

In assessing the highest-impact, actionable opportunity to normalize leadership and workforce value-driven competencies and culture, we advocate for defining a widely acknowledged, common set of competencies needed to deliver

person-centered, high value care. We recognize the power of healthcare professional accreditation bodies in driving consistent expectations and skills at all levels of licensure.

“The powerful role that culture has on performance and outcomes is well established. To consistently deliver high value care, we must ensure there is a unifying culture of safe, appropriate, person-centered care.”

KENNETH W. KIZER, MD, MPH, ATLAS RESEARCH

Implementation Roadmap

Twenty years of experience has demonstrated that enormous progress can be accomplished when each unique stakeholder is aligned and collaborates toward a common objective. To this end, the Task Force—representing one of the broadest and most diverse convenings—has identified the highest-yield opportunities to ensure that, within the next 10 years, every person consistently experiences safe, appropriate high value care.

Achieving this vision requires a clear, actionable roadmap that diverse stakeholders take

coordinated action on to implement and drive forward. For each opportunity, we have specified the meaningful measures of success over the near, mid, and long term to guide aligned efforts. Additionally, **Appendix B** provides a thoughtful discussion of the range of diverse actors needed to both lead and support the implementation of these opportunities based on each actor’s unique expertise and sphere of influence.

Normalizing high value care for every person requires a concerted, united commitment from policy leaders, to the full range of providers and

health professionals, public and private health leaders, payers, employers and purchasers, technologists, consumers, patients, and more. We encourage each stakeholder—those identified as well as the many others—to embrace their unique, valuable role in driving value and quality to make these opportunities a reality for the nation.

Within 1- 2 Years

Foundational Opportunities:	<ul style="list-style-type: none"> • Statutory, regulatory, and technical approaches approved • Authoritative agents identified and funded • Business processes and implementation planning complete • Develop guidelines and standards for appropriate care 	<ul style="list-style-type: none"> • 25 percent of Medicaid and Commercial healthcare reimbursement and 50 percent of Medicare is tied to population health-based shared accountability APMs (categories 3B and 4) • Develop an SDOH and Disparities Monitoring Program that near-term assesses impact of interventions and outcomes based on defined indicators, and long-term assesses impact based on aligned, standard sets of measures
Accelerator Opportunities:	<ul style="list-style-type: none"> • Statutory, regulatory, and technical approaches approved • Authoritative agents identified and funded • Business processes and implementation planning complete • Develop guidelines and standards for appropriate care • Expand authority to address access issues for emergent health crises and for underserved communities 	<ul style="list-style-type: none"> • Establish a governance forum and process to identify exemplars, curate proven practices and tools, and disseminate learning • Develop common set of competencies that will be appropriate for healthcare professionals for the next ten years, based on anticipated demographics (language, aging), payment reform, promoting comprehensive, person-centered care and accelerated digital technology in healthcare

Within 3-7 Years

Foundational Opportunities:

- Statutory, regulatory, and technical approach to match disparate health data to singularly identified individuals approved
- 50 percent of measures tied to payment are eCQMs from identical data sets aligned across public and private payers that integrate with the care workflow and reliably represent care outcomes
- 50 percent of Medicaid and Commercial healthcare reimbursement and 100 percent of Medicare is tied to population health-based shared accountability APMs (categories 3B and 4)
- 50 percent of the health systems and Community-Benefit Organizations covering 50 percent of the total population use non-discriminatory standard SDOH screening data aligned across payers and community resources and closed loop protocols.
- 100 percent of clinicians publicly disclose patient comments collected as a part of their survey and measurement activities, and shared decision making is required for at least the top five agreed upon procedures most susceptible to inappropriate care

Accelerator Opportunities:

- Healthcare delivery systems can verify which technology solutions are proven to support high-value care based on objective review by an independent organization that credits technology using the development principles and measurement standards published in a Technology Evaluation Framework
- Create consumer-defined measures reported by more than 50 percent of healthcare delivery systems that assess virtual and non-traditional care (promotores, community-based screening sites) on improvements in patient experience, consumer engagement, and outcomes for discrete, acute national health priorities (e.g. rural health, maternal mortality and morbidity, and mental and behavioral health)
- A statutory and regulatory roadmap to evolve licensure to minimize administrative and geographical barriers to care is approved
- Performers representing diverse segments and populations are competing to have their successes serve as repeatable models for others
- Education accreditation and licensing bodies for healthcare professions endorse a common set of competencies

Within 7-10 Years

<p>Foundational Opportunities:</p>	<ul style="list-style-type: none"> • 100 percent of healthcare claims and records in the EHR use and share data tied to an individual • 100 percent of measures tied to payment are aligned across public and private payers, are accurately derived electronically without manual processes, and include a limited identical set used by all • At least 80 percent of all healthcare reimbursement is tied to population health-based shared accountability APMs (categories 3B and 4) 	<ul style="list-style-type: none"> • Over 50 percent of healthcare systems and payers report measurable improvements in outcomes tied to SDOH and other disparities (e.g. transportation, housing, and food insecurity) • 50 percent of healthcare payments are tied to consumer-defined measures and shared decision making
<p>Accelerator Opportunities:</p>	<ul style="list-style-type: none"> • Avoidable safety events and high-cost, inappropriate care are substantially reduced by widespread adoption of a Technology Evaluation Framework • All consumers are able to routinely use care deemed clinically and socially appropriate for improving safety, value, and outcomes (e.g. virtual care modalities, non-traditional care) as standard, integrated care processes 	<ul style="list-style-type: none"> • Nationwide license portability/recognition established to allow clinical professionals (MDs, DOs, NPs, RNs, and PAs) to seamlessly practice across state lines while preserving states' responsibilities to ensure residents are medically safe • A national, knowledge-based resource library is curated with the lessons of exemplar performers, and other systems use it to guide quality improvement • Education accreditation bodies report 100 percent achievement in meeting common competencies

Conclusion

The National Quality Task Force provides a consensus-based perspective on actionable opportunities to overcome the most vital challenges in healthcare. The diverse perspectives that came together to develop this roadmap represent a broad range of relevant and experienced experts. This group believes that we can make tangible progress with the right commitment from leaders and stakeholders. We can seize the opportunities presented in this report and successfully implement them.

We must act. For two decades, we have agreed that our healthcare delivery system should aim to achieve safe, appropriate, person-centered, timely, efficient, and equitable care for all. With growing health disparities, rising burnout rates increasing among healthcare professionals, increasing care fragmentation, ineffective transparency, data silos, and many other rising problems in healthcare today, we must accelerate progress through an aligned commitment. Policy leaders, health professionals, and organizations can act on the recommendations in this report. Together, we can achieve better health outcomes and value for every person by 2030.

Appendix A: Critical Levers of Change

Advancing the next generation of quality must recognize the “system” nature of healthcare delivery and enact change using all critical levers in concert. The path forward requires many stakeholders to embrace their unique, respective role and ability to drive change by acting on the Task Force recommendations.

The Task Force identified several cross-cutting levers of change acknowledging the interrelationship among many of these. While some leaders play a substantial role in effecting change, dependencies across healthcare delivery require the engagement, cooperation, and support of many actors to drive enduring change. The Task Force encourages all actors—policy leaders, employers and purchasers, public and private health leaders, consumers, technologists, and more—to lead and support efforts to drive the strategic objectives forward through the following levers:

Policy: This change lever is necessary to support the cross-cutting statutory and regulatory architecture and requirements that pursue the Task Force objectives weighing the unique concerns of stakeholders and constituents at federal, state, and local levels.

Data/Information: This change lever is crucial in creating seamless, standards-driven, reliable data and information sharing processes. It will aid in accelerating technology-enabled processes to improve data sharing, utilization, and communication among stakeholders, help strengthen requirements to capture and publicly report measures that address consumer priorities and standardize quality data to move beyond claims data. In addition, this lever of change is

critical in supporting bidirectional exchange of data, safeguarding consumers from harm and bias, integrating performance measurement, clinical workflow, clinical decision support, and quality improvement tools so that EHRs can output interoperable, real-time, and reliable information across avenues of care.

Payment: This change lever is needed to invest in practices that move toward value-based care and disincentivize low-value care. Payment is needed to set systemwide targets for moving to population-based and value-based payment models in all public and private insurance. This change lever is critical in creating incentives to move quickly away from fee for service and take on risk, which encourages practices and interventions that achieve better outcomes and person-driven priorities.

Consumers: Consumers, including patients and caregivers, play an invaluable role defining and assessing quality, particularly in light of their increased financial responsibility. When effectively engaged and empowered, activated consumers can drive extraordinary change based on the information they demand, how they define and assess quality, and the care they pursue. Consumers are essential to establishing a human-centered standard set of principles. They must be involved as equal partners in the phases of measure design and development as well as ensuring person-centered care throughout the entire care continuum.

Technological Innovation: The advancement of technology is a critical lever in empowering organizations and individuals to use new tools and

capabilities to improve the safety, efficiency, and appropriateness of care. Advanced technologies can improve health outcomes and reduce costs by addressing processing inefficiencies by expanding IT-enabled services that address consumer preferences for expanded timely access to effective care, and closing access gaps as well as improving resource utilization, workforce productivity, and the care experience for consumers and patients.

Culture and Leadership: This change lever is crucial in establishing leadership commitment, values and ethics, and high standards in all aspects of healthcare quality. Culture and leadership—including Board responsibilities and community engagement—will help establish leadership and workforce development priorities, consistent leadership expectations and requirements for the healthcare delivery system, and leadership programming to develop effective public-private community partnerships to improve community health outcomes.

Workforce Development: The workforce is a change lever critical to building capacity and competencies for the modern healthcare workforce through education, training, licensing, and accreditations. This change lever is relevant to setting and achieving professional development targets supported by accreditation, licensure, certification, and continuing education across health professionals to work effectively, developing workforce competencies to deliver optimal health outcomes and to most efficiently personalize care based on data and desired health outcomes.

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Key Actors Identified**

The following is a list of key actors identified for the adaptation, adoption, and implementation of the National Quality Task Force opportunities. This list is not an exhaustive one of every organization or type of individual that should be involved. It provides specific suggestions for the

mix of players that should be involved in order to make each recommendation a reality. We encourage those identified as well as the many others to embrace their unique, valuable role driving quality and value to lead and support the implementation of these opportunities.

OPPORTUNITY	Impact/Benefit	Measures of Success	Actors
<p>1. Ensure people are consistently and accurately matched to health records across clinicians and settings by implementing a single-person identifier</p>	<ul style="list-style-type: none"> • Enable accurate and easier access to EHR data linked to individuals • Improve coordination of care • Improve patient safety • Reduce consumer burden in filling out medical information • Enable assessment of care across the continuum • Improve consistency, understanding, and reliability of risk adjustment • Enable interoperability • Improve ability to consistently leverage and integrate EHRs with accurate, valid, real-time data wherever possible • Improve integration, management, and interventions for addressing SDOH • Provide better care experience across settings of care to understand whole-person health experience 	<p>Midterm: Statutory, regulatory, and technical approach to match disparate health data to singularly identified individuals approved</p> <p>Long term: 100 percent of healthcare claims and records in EHR use and share data tied to an individual</p>	<p>Centers for Medicare and Medicaid Services (CMS), AARP, Health and Human Services (HHS), privacy experts, American Health Information Management Association (AHIMA), Office of the National Coordinator for Health Information Technology (ONC), American Pediatrics Association, Bipartisan Policy Center (BPC), CARIN Alliance</p>

OPPORTUNITY	Impact/Benefit	Measures of Success	Actors
<p>2. Align the quality enterprise and enable reliable improvement and outcomes analysis by standardizing quality data</p>	<ul style="list-style-type: none"> • Close key data gaps (e.g., consumer-provided data, SDOH, TCOC) • Create a foundation for transparency • Ability to capture appropriateness of care • Improve management of costly, chronic diseases • Improve focus on functional status/quality of life measures that have a greater impact on workforce productivity and community engagement • Enable true comparative benchmarks • Create a foundation for interoperability across platforms • Achieve seamless electronic data capture • Reduce the number of measures and reporting burden • Create alignment across public and private programs • Increase number of reliable eCQMs 	<p>Midterm: 50 percent of measures tied to payment are eCQMs from identical data sets aligned across public and private payers that integrate with the care workflow and reliably represent care outcomes</p> <p>Long term: 100 percent of measures tied to payment are aligned across public and private payers, are accurately derived electronically without manual processes, and include a limited identical set used by all</p>	<p>Public and private payers, employers and purchasers, consumer and patients, providers</p>

OPPORTUNITY	Impact/Benefit	Measures of Success	Actors
<p>3. Normalize high value care by adopting population health-based Alternative Payment Models (APMs) as the primary payment model</p>	<ul style="list-style-type: none"> • Incentivize comprehensive care and better care • Improve coordination across clinicians • Incentivize efficient resource use • Improve functional well-being of individuals and experience of patients • Incentivize better integration of resources across community resources • Narrow the resource-based relative value scale (RBRVS) value gap between procedural and nonprocedural services <p><i>*The goals correspond with the Healthcare Payment Learning and Action Network Categories:</i></p> <p><i>Category 1: Fee for Service - No Link to Quality and Value</i></p> <p><i>Category 2: Fee for Service - Link to Quality and Value</i></p> <p><i>Category 3: APMS Built on Fee for Service Architecture (Category 3B: APMS Built on Fee for Service with Downside Risk)</i></p> <p><i>Category 4: Population-Based Payment</i></p>	<p>Near term: 25 percent of Medicaid and commercial healthcare reimbursement and 50 percent of Medicare is tied to population health-based shared accountability APMs (categories 3B and 4) *</p> <p>Midterm: 50 percent of Medicaid and commercial healthcare reimbursement and 100 percent of Medicare is tied to population health-based shared accountability APMs (categories 3B and 4) *</p> <p>Long term: At least 80 percent of all healthcare reimbursement is tied to population health-based shared accountability APMs (categories 3B and 4)*</p>	<p>Centers for Medicare and Medicaid Services (CMS), American Medical Association (AMA), Health and Human Services (HHS), clinicians, payers, American Academy of Family Physicians (AAFP)</p>

OPPORTUNITY	Impact/Benefit	Measures of Success	Actors
<p>4. Reduce disparities and achieve health equity by developing standard data and interventions to build the evidence base to address social determinants of health (SDOH)</p>	<ul style="list-style-type: none"> • Standardize SDOH data and measures for research, analysis, and reporting • Determine appropriate relationship of SDOH factors to quality performance • Determine most influential interventions for health outcomes • Determine highest-impact repeatable, scalable healthcare delivery system practices • Establish measures of health equity • Reduce health disparities and improve health of disadvantaged people and communities • Reduce correlation of health outcomes across ZIP codes • Increase access to care for disadvantaged people 	<p>Near term: Develop an SDOH monitoring program that in the near-term assesses impact of interventions and outcomes based on defined indicators, and in the long term assesses impact based on aligned, standard sets of measures</p> <p>Midterm: 50 percent of the health systems and community-based organizations covering 50 percent of the total population use nondiscriminatory standard SDOH screening data aligned across payers and community resources and closed loop protocols</p> <p>Long term: Over 50 percent of healthcare systems and payers report measurable improvements in outcomes tied to SDOH (e.g., transportation, housing, and food insecurity)</p>	<p>National Governors Association, state and local public health, Robert Wood Johnson (RWJ), National Association of County and City Health Officers (NACCHO), Association of State and Territorial Health Officials (ASTHO), America’s Health Insurance Plans (AHIP), Centers for Medicare and Medicaid Services (CMS), Health Resources and Services Administration (HRSA), patients and caregivers, grass-roots community groups</p>
<p>5. Create actionable intelligence for consumers by increasing requirements to educate and engage people in healthcare decisions</p>	<ul style="list-style-type: none"> • Increase consumer engagement and experience • Promote a culture that puts the person at the center • Educate and engage individuals in the process of making care decisions • Promote well-being and appropriate care throughout the life course • Improve utilization and effectiveness of public reporting 	<p>Midterm: 100 percent of clinicians publicly disclose patient comments collected as a part of their survey and measurement activities, and shared decision making is required for at least the top five agreed-upon procedures most susceptible to inappropriate care</p> <p>Long term: 50 percent of healthcare payments are tied to consumer-defined measures and shared decision making</p>	<p>Payers, healthcare service researchers, consumer experience experts, consumers, patients</p>

OPPORTUNITY	Impact/Benefit	Measures of Success	Actors
<p>6. Ensure advanced technologies improve safe and appropriate outcomes through the use of a Technology Evaluation Framework</p>	<ul style="list-style-type: none"> • Create more efficient healthcare practices • Increase in appropriate care (addressing misuse, underuse, overuse) • Improve patient safety and health outcomes • Improve efficiency of healthcare processes • Create better outcomes per dollar spent for high-cost conditions 	<p>Midterm: Healthcare delivery systems can verify which technology solutions are proven to support high value care based on objective review by an independent organization that credits technology using the development principles and measurement standards published in a Technology Evaluation Framework</p> <p>Long term: Avoidable safety events and high-cost, inappropriate care are substantially reduced by widespread adoption of a Technology Evaluation Framework</p>	<p>NQF, Healthcare Information and Management Systems Society (HIMSS), Food and Drug Administration (FDA), Agency for Healthcare Research and Quality (AHRQ)</p>
<p>7. Expand use of high value care settings by integrating virtual and innovative care modalities throughout the delivery system</p>	<ul style="list-style-type: none"> • Increase efficiency of care • Increase patient satisfaction and engagement • Increase access to care, especially primary care • Improve health outcomes • Deliver appropriate care more efficiently for better, more affordable outcomes • Address health disparities in rural, homebound, and/or elderly populations 	<p>Midterm: Create consumer-defined measures reported by more than 50 percent of healthcare delivery systems that assess virtual and nontraditional care (promotores, community-based screening sites) on improvements in patient experience, consumer engagement, and outcomes for discrete, acute national health priorities (e.g., rural health, maternal mortality and morbidity, and mental and behavioral health)</p> <p>Long term: All consumers are able to routinely use care deemed clinically and socially appropriate for improving safety, value, and outcomes (e.g., virtual care modalities, nontraditional care) as standard, integrated care processes</p>	<p>Payers, providers, hospitals, and health systems, health researchers, AI/telehealth experts, employers, state and federal policymakers,</p>

OPPORTUNITY	Impact/Benefit	Measures of Success	Actors
<p>8. Improve access to optimal care anywhere by creating pathways to recognize clinical licenses across the country</p>	<ul style="list-style-type: none"> • Increase the quality, availability, and ease of care delivered to individuals across communities • Enable healthcare delivery systems to expand access to deliver the right, high value care • Increase access to quality care, especially primary care • Increase patient safety by ensuring clinical professionals with revoked or restricted licenses cannot practice in other places 	<p>Near term: Expand authority to address access issues for emergent health crises and for underserved communities</p> <p>Midterm: A statutory and regulatory roadmap to evolve licensure to minimize administrative and geographical barriers to care is approved</p> <p>Long term: Nationwide license portability/ recognition established to allow clinical professionals (MDs, DOs, NPs, RNs, and PAs) to seamlessly practice across state lines while preserving states' responsibilities to ensure residents are medically safe</p>	<p>Health and Human Services (HHS), American College of Physicians (ACP), Federation of State Medical Boards (FSMB), American Medical Association (AMA), American Nurses Association (ANA), American Optometric Association (AOA), national regulatory bodies with state oversight (e.g. National Council of State Boards of Nursing, Association of State and Provincial Psychology Boards, etc.)</p>
<p>9. Accelerate adoption of leading practices by highlighting exemplar performers</p>	<ul style="list-style-type: none"> • Promote a culture that incentivizes value • Create more awareness of successful models to help scale and proliferate proven practices 	<p>Near term: Establish a governance forum and process to identify exemplars, curate proven practices and tools, and disseminate learning</p> <p>Midterm: Performers representing diverse segments and populations are competing to have their successes serve as repeatable models for others</p> <p>Long term: A national, knowledge-based resource library is curated with the lessons of exemplary performers, and other systems use it to guide quality improvement</p>	<p>NQF, Families USA, Health and Human Services (HHS), Academy Health, AARP, Press Ganey, The Alliance of Community Health Plans (ACHP), Congress, and National Conference of State Legislatures (NCSL), American Hospital Association (AHA), America's Physician Groups, American Nurses Association, American Board of Internal Medicine, American Board of Medical Specialties</p>

OPPORTUNITY	Impact/Benefit	Measures of Success	Actors
<p>10. Cultivate a culturally aligned, value-driven workforce by fostering competencies in safe, appropriate, person-centered care</p>	<ul style="list-style-type: none"> • Create and support a culture of safe, value-driven, person-centered care • Build workforce capacity allowing individuals to operate at the top of their license in population health-focused models of care • Improve workforce proficiency in quality improvement practices, as well as integrating advanced technologies into care processes 	<p>Near term: Develop common set of competencies that will be appropriate for healthcare professionals for the next 10 years, based on anticipated demographics (language, aging), payment reform, promoting comprehensive, person-centered care and accelerated digital technology in healthcare</p> <p>Midterm: Education accreditation and licensing bodies for healthcare professions endorse a common set of competencies</p> <p>Long term: Education accreditation bodies report 100 percent achievement in meeting common competencies</p>	<p>Liaison Committee on Medical Education (LCME), National League for Nursing (NLN), American Medical Association, American Nursing Association (ANA), National Institute of Standards and Technology (NIST), Homeland Security, consumer technology experts outside of healthcare, American Association of Colleges of Nursing (AACN), state boards of medicine, state boards of nursing (Federation of State Medical Boards (FSMB) and National Council of State Boards of Nursing (NCSBN)</p>

Appendix C: Key Terms

As the Task Force deliberated, it became clear that the following key terms needed to be defined for purposes of clarity. The Task Force commonly defined our perspectives on the key terms below and included additional sources as appropriate.

Advanced Technology: Innovative technologies and approaches capable of improving efficiency and effectiveness, including but not limited to, artificial intelligence, augmented intelligence, natural language processing, machine learning, personalized/precision medicine, genomics

Appropriate Care: Recommended care that avoids overuse, underuse, and misuse of healthcare resources. The selection of intervention from a body of available interventions that have been shown to be effective for a disorder that is most likely to produce the outcomes desired by the individual patient¹³

Consumer: All who have the potential of purchasing healthcare and weighing the cost versus quality of care¹⁴

Consumer-Defined Measures: Defining measures that are driven and informed from the consumers' perspective of quality and value

Social Determinants of Health: Community-level conditions in the environments in which people live, learn, work, play, worship, and age, e.g., transportation, housing, food insecurity

Patient: An individual receiving care from one or more healthcare professionals¹⁵

Population Health-Based Payment: Consistent with the Health Care Payment Learning Action Network (HCPLAN), the categories for payment correspond to these Healthcare Payment Learning and Action Network Categories:

Category 1: Fee for Service – No Link to Quality and Value

Category 2: Fee for Service – Link to Quality and Value

Category 3: APMS Built on Fee for Service Architecture (Category 3B: APMS Built on Fee for Service with Downside Risk)

Category 4: Population-Based Payment

Precision Medicine: Medical care designed to optimize efficiency or therapeutic benefit for particular groups of patients, especially by using genetic or molecular profiling¹⁶

Virtual Care: Any IT-enabled service capable of integrating alternative modalities into care delivery either synchronously or asynchronously, including but not limited to, telehealth, wearables, digital health, and remote monitoring

¹³ What do we mean by appropriate health care? Report of a working group prepared for the Director of Research and Development of the NHS Management Executive. *Qual Health Care*. 1993;2(2):117-123.

¹⁴ Forbes.com. Are You A Patient Or A Healthcare Consumer? <https://www.forbes.com/sites/robertpearl/2015/10/15/are-you-a-patient-or-a-health-care-consumer-why-it-matters/#36b569072b4d>. Published October 15, 2015. Last accessed January 30, 2020.

¹⁵ Becker's Healthcare. Consumers vs. patients: Healthcare's biggest misunderstanding. <https://www.beckershospitalreview.com/healthcare-information-technology/consumers-vs-patients-healthcare-s-biggest-misunderstanding.html>. Published February 18, 2015. Last accessed January 30, 2020.

¹⁶ *The Oxford English Dictionary*. Oxford: Clarendon Press; 2004.

Appendix D: National Quality Task Force Roster

THE CORE COMMITTEE ROSTER

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Vice Chair:

Jody Amodeo, BSN
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Members:

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National Patient Advocate Foundation

Mary Barton, MD
National Committee for Quality Assurance (NCQA)

Laura Blum Meisnere, MA
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Donald H. Crane, JD
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Clif Gaus, ScD, MPH
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America's Health Insurance Plans (AHIP)

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Members:

Ivor Benjamin, MD
American Heart Association

Binoy Bhansali
Sandbox Industries

John Branstetter
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