May 7, 2012

Dear Consumer Representative,

We have many exciting things in store at the upcoming Aligning Forces for Quality (AF4Q) National Meeting and are pleased you will be joining us in New Orleans. There will be opportunities for peer-to-peer learning, hearing from national leaders on innovation, and gathering ideas from other AF4Q communities – as well as many chances to connect and network with others from across the country. As you prepare for the meeting, we wanted to share a few reminders, tips, and resources.

Travel/Expenses: Your travel confirmation is enclosed. Please remember to save your boarding passes and all relevant receipts, and plan to mail those in to us soon after you return from the meeting. While in New Orleans at the meeting, we will be providing hot breakfasts and lunches each day, as well as dinner on Wednesday evening. We are enclosing the form you will need to be reimbursed for any additional expenses, like cab fare. If you have any questions about your travel or other logistics, please feel free to contact us at events@forces4quality.org.

Consumer Representatives' Pre-Meeting: As a consumer representative from an AF4Q community (also called an "Alliance"), your meeting experience begins with the pre-meeting, which starts at 11:00 AM on Wednesday, May 16. Lunch will be provided. The pre-meeting agenda is enclosed.

Premeeting Reading Material. A part of the consumer pre-meeting will include discussion of the AF4Q Alliances' quality and cost goals. Each of the 16 Alliances has developed a set of goals they are striving to achieve by September 2013. Each Alliance identified its own goals, based upon the health conditions and the segments of the health system on which that Alliance focuses. A copy of your Alliance's current quality and cost goals is enclosed. If you have not seen these goals before, please take a look, and feel free to come to the pre-meeting with questions. You do *not* need to be an expert on the goals before the meeting, but it will help if they look familiar to you.

The AF4Q project is currently in its third phase of funding (sometimes called "AF4Q 3.0"). Alliances will apply for the fourth phase of funding in October of this year. This fourth phase ("AF4Q 4.0") will include, among other things, an increased focus on Alliance-developed quality and cost goals. For your information, the Request for Proposals (RFP) for AF4Q 4.0 is enclosed.

If you have any questions about the consumer pre-meeting, please feel free to contact Deborah Roseman, droseman@gwu.edu or 202-994-4268.

About the National Meeting: We also are enclosing the agenda for the full AF4Q meeting, which formally begins with a dinner and social event Wednesday evening, followed by meeting sessions all day Thursday and through lunch on Friday.

After hearing a keynote from self-described "serial innovator" Jay Walker of priceline.com and TedMed, the 300 or so expected attendees from all over the country will engage with one another in panels pulled from their areas of interest – and the areas in which some communities have Bright Spots to showcase. Over these two days, the sessions from which you can choose include an engaging conversation with health plans about working together, discussion of translating the patient-centered medical home model to safety net clinics, and a look at how hospital leaders have been positioning themselves for value-based purchasing. You will hear innovative ideas from Alliance peers on topics such as avoiding emergency hospital admissions and working with labor unions and other health care purchasers. One session will explore using payment incentives as motivation, and another will focus on reducing waste in the health care system.

Our closing keynote speaker on Friday is in intense demand across the country. His newest book is *Where Good Ideas Come From: The Natural History of Innovation*. From Darwin to YouTube, Johnson asks the questions, What kind of environment fosters the development of good ideas? What sparks the flash of brilliance? How does groundbreaking innovation happen? His answers are never less than enlightening, convincing, and inspiring as he identifies the seven key principles to the origin of such ideas and traces them across time and disciplines.

This speech should be riveting – don't miss it.

There is ample and purposeful time set aside for networking throughout the meeting. We hope you will take advantage of that time to make new connections and strengthen old ones.

AF4Q believes in the importance of having patient/consumer voices in the panel discussions. You will see consumers both as panelists and as responders. It will be important for you to think about where you feel comfortable adding your voice to the conversation. The consumer pre-meeting will include a review of the full meeting agenda and discussion of opportunities for consumer meeting attendees to add their voice to any or all sessions. We look forward very much to your participation.

If you have not had a chance to participate in one of the recent AF4Q orientation webinars or would like additional background information, please visit the AF4Q website at www.forces4quality.org. You can find a recording of the orientation webinar at http://forces4quality.org/dashboard/events/show/225. Enclosed for your reference are two glossaries of some terms and acronyms you might hear at the meeting.

My colleagues and I look forward to seeing you in New Orleans, and I particularly look forward to hearing your voice in sessions, as well as in the evaluation of how we are doing. Please do not hesitate to contact us if you need any additional information.

Sincerely,

Robert Graham MD

Robert Graham, MD

Director, Aligning Forces for Quality

National Program Office

Robert Wood Johnson Foundation

Aligning Forces for Quality
National Meeting ● May 16-18, 2012

cultivating innovation

consumer representative meeting

Welcome to New Orleans!

The consumer representative meeting will be held in Pelican I and II on the third floor of the Intercontinental Hotel. If you need anything, please ask an NPO staff member – we are here to make both this premeeting and the national meeting engaging and enjoyable for you.

11 – 11:30 am	**welcome and introductions** Susan Mende, Robert Wood Johnson Foundation (RWJF) • Katherine Browne, George Washington University (GW)/Aligning Forces for Quality (AF4Q) National Program Office (NPO) • Deborah Roseman, NPO
11:30 – 12 noon	**discussion: state of consumer engagement in AF4Q** Deborah Roseman, NPO (moderator) A discussion of the results of the survey of consumers engaged in the 16 AF4Q Alliances.
12:00 – 12:15 pm	**overview: AF4Q quality & cost goals** Deborah Roseman, NPO (moderator)
12:15 – 12:45 pm	**networking lunch** Attendees are encouraged to connect with new people and to discuss how consumers in their Alliances are working toward achieving quality and cost goals.
12:45 – 1:15 pm	**presentations and discussion: bright spots** Deborah Roseman, NPO (moderator) Mary Brown, Memphis • Mary Ann Peugeot, Nashville, TN • Sherry Reynolds, Puget Sound • Amber Twitty, Cincinnati • This session will offer inspiring presentations from consumers actively engaged in alliance work toward quality and cost goals. You are welcome to continue eating lunch during the Bright Spot presentations.

cultivating innovation

consumer representative meeting

1:15 – 2 pm

breakout groups: innovation through integration

Attendees whose Alliances have some similar quality and cost goals will meet in small groups to discuss key questions based upon their experience and on the results of the AF4Q consumer engagement survey.

- How are consumers engaged in meeting my alliance's quality and cost goals?
- What are challenges to increasing engagement?
- What is needed to bridge gaps in engagement identified in the survey?
- What can (and will) I myself do – as an individual consumer, or a representative of a group?

2 – 2:10 pm

break

2:10 – 2:45 pm

getting the most out of the national meeting

Attendees should choose one of the two groups, depending on their interest and experience with prior AF4Q national meetings.

- blue group: engage in a deeper review of the full meeting agenda with National Program Office staff
- orange group: network with one another, and discuss plans for attending breakout sessions.

2:45 – 3 pm

wrap up and close

Robert Wood Johnson Foundation

Aligning Forces for Quality

Cultivating Innovation

May 16–18, 2012
New Orleans, LA

meeting at-a-glance
as of May 8, 2012

Follow the meeting on Twitter with #AF4Q
New to Twitter? Pick up an AF4Q 101 Guide to Twitter and get started today!

Complimentary hotel wifi login is AF4Q2012

wednesday, may 16

project directors' meeting
by invitation only • poydras room
8 am–3:30 pm
Breakfast and lunch will be provided.

consumer representatives' meeting
by invitation only • pelican I and II
11 am–3 pm
All consumers who are attending the national meeting are invited to this premeeting, along with Alliance consumer engagement staff. Lunch will be provided.

AF4Q app challenge judges meeting
by invitation only • la salle c
3:30–5 pm
AF4Q App Challenge judges will view demos from the five finalists. All five demos will be available on Thursday in the registration area outside the sessions for attendees to see.

networking in NOLA! : welcome reception and dinner
open to all attendees • the foundry
5–9 pm
Please join us for the first event of the national meeting! We will meet downstairs at the hotel at 5 pm and will leave at 5:30 pm for a short walk to the event location. Don't be late—you will *not* want to miss the surprises we have in store! We will have buses available to take you back to the hotel or drop you on Bourbon Street at the conclusion of the event if you feel the night is still young.

thursday, may 17

fun run in the French quarter
6:15 am
Interested runners (and walkers) should meet at the main entrance at St. Charles Ave. (bottom of the escalators) to explore the French Quarter and riverfront.

networking breakfast and registration
le salon pre-function
7 –8:15 am
Come eat a hot breakfast and catch up with old friends—or meet some new ones. Are you a first-time meeting attendee? Sit at one of the tables marked "FIRST-TIME ATTENDEES" to get a casual overview of the meeting and AF4Q from NPO and RWJF staff.

innovative technology demonstrations
le salon pre-function
7 am–3 pm
Take a moment throughout the day to see demonstrations from the five finalists in the AF4Q App Challenge and get a close-up look at NQF's Quality Positioning System and new Community Tool to Align Measurement.

thursday, may 17 (continued)

opening plenary: cultivating innovation
la salle ballroom
8:15 am–10:10 am
Welcome from RWJF and the NPO
Keynote: Jay Walker, founder of priceline.com and curator of TedMed

break
10:10 am–10:30 am

concurrent breakout sessions, set #1

meet the payers: a frank dialogue with health plans & policy experts
pelican I
10:30 am–12:30 pm
Anne Weiss, RWJF (introduction)
Melissa Kennedy, Cincinnati (moderator)
Tom James, Humana | Allan Korn, BCBSA | Sharon Siler, Avalere | Chris Stanley, United Healthcare
This session will provide a look inside the minds of commercial health plan executives and federal policy makers to help you anticipate changes to expect over the next 12-24 months, and think about best taking advantage of these opportunities.

innovations in reaching the underserved: cultivating the PCMH model in the safety net
pelican II
10:30 am–12:30 pm
Bob Graham, GWU (introduction)
Edward H. Wagner, MacColl Center (moderator)
Lander Cooney, Community Health Partners, Montana | William H. Pankey, Swope Health Services, Kansas City | Joan Pernice, Massachusetts League of Community Health Centers | Janina Shayne, Humboldt
The PCMH model is being implemented across the country in innovative health systems and primary care practices with success. Hear about how this model is being applied in the safety net.

value-based purchasing looming large: lessons for providers, payers, patients
poydras
10:30 am–12:30 pm
Mike Painter, RWJF (introduction)
David Shute, Q-Corps (moderator)
Susie Dade, Puget Sound | Nancy Foster, AHA | Mary Ann Brown Peugeot, Vanderbilt Patient and Family Advisory Council | Gerry Shea, AFL-CIO
This session will explore how industry leaders have been transforming and improving hospital care quality to best position themselves for value-based purchasing. What is the opportunity for other purchaser coalitions to begin incorporating similar payment reforms into private health plan reimbursement systems?

networking luncheon
la salle ballroom
12:30 pm–1:30 pm
Katherine Browne, GWU (welcome and greetings)

Robert Wood Johnson Foundation

thursday, may 17 (continued)

break
1:30–1:45 pm

concurrent breakout sessions, set #2

consumers & purchasers driving change
pelican I
1:45 pm–3:45 pm
Anne Weiss, RWJF (introduction)
Gerry Shea, AFL-CIO (moderator)
Jerry Burgess, HC21 Knoxville | Betty Hilton, University of Maine | Brett Hoskins, AFSCME | Frank Johnson, SEHC
This panel will showcase the power and potential of purchaser coalitions and labor management groups in transforming local health care delivery and payment. Whether your community has strong labor groups, large private or public employers, or a variety of smaller purchasers, the combined strength of consumer voices and purchasing leverage can launch remarkable change.

innovations in reducing emergency department visits
poydras
1:45 pm–3:45 pm
Susan Mende, RWJF (introduction)
Laura McEwen, Humboldt (moderator)
David A. Hnatow, Greater San Antonio Emergency Group, Texas | Jennifer Kemp, Albuquerque | Jamie Kopiczko, Detroit | Lisa Mason, Detroit | Pat Montoya, Albuquerque
Reducing avoidable visits to the emergency department is a community problem that requires a collaborative solution – and engaging providers, payers, and consumers. This session will highlight three innovative approaches: engaging consumers, engaging providers, and engaging the community.

smarter spending: reducing waste and controlling cost
pelican II
1:45 pm–3:45 pm
Marcia Wilson, GWU (introduction)
Suzanne Delbanco (moderator)
Katrina Kahl, Oregon | Mary McWilliams, Puget Sound | Cally Vinz, Minnesota
Panelists will present approaches to reducing waste and controlling cost. By improving transparency, reducing unnecessary services, and reducing unwarranted variation, these Alliances are making great progress in addressing this difficult issue.

alliance "team time"
la salle ballrooms b and c
4 pm–5 pm

break
5 pm–5:30 pm

networking reception
la salle ballroom a
5:30 pm–6:30 pm

dinner on your own
6:30 pm

thursday, may 17 (continued)

networking breakfast
le salon pre-function
7 am-8 am

concurrent breakout sessions, set #3

improving ambulatory quality by engaging providers through practice coaching
pelican I
8 –10 am
Susan Mende, RWJF (introduction)
Jen Powell, IPIP (moderator)
Kate Ebersole, Western New York | Elizabeth Foley, Maine | Rush Gross, SCPA | Keith Mandel, Cincinnati Children's Hospital | Dick Simpson, SCPA | Kimbra Wells Metz, Washington Academy of Family Physicians
Learn from those who have benefited from practice coaching and examine why this strategy can be effective in driving quality improvement and demonstrating value for patients, providers and your Alliance.

get inspired: innovation grantees
pelican II
8 –10 am
Bob Graham, GWU (moderator)
Sara Butterfield, Western New York | Margie Namie, Cincinnati | Mickey Reid, Minnesota
The Center for Medicare and Medicaid Innovation (CMMI) has been tasked with testing innovative payment and service delivery models to reduce cost while preserving or improving quality. Come talk with some communities who have been selected to participate in CMMI programs and who are using the opportunity to do truly inspiring work.

friday, may 18

friday, may 18 (continued)

concurrent breakout sessions, set #3

fun with payment incentives
poydras
8–10 am
Michael Painter (moderator)
Chris Amy, SCPA | Don Bradley, BCBS North Carolina | Suzanne Delbanco | Karen Timberlake, Wisconsin
Discover how data can help drive the payment reform conversation in your market. Learn how other Alliances have used data to identify opportunities and create productive discussions among key stakeholders in your market. This session will focus on strategies and lessons learned on stimulating payment incentives through programs such as medical homes, flat fee, or bundled payments. Panelists will share how data and collaborative conversations have stimulated and empowered their markets to move forward with their payment initiatives.

break
10 am–10:20 am
Finalize hotel checkout if you need to, but hurry back for our closing plenary speaker!

closing plenary: sparking good ideas
la salle ballroom
10:30 am–12:30 pm
Keynote: Steven Berlin Johnson
Johnson is the best-selling author of seven books on the intersection of science, technology, and personal experience. His newest book is Where Good Ideas Come From: The Natural History of Innovation. From Darwin to YouTube, Johnson asks the questions: What kind of environment fosters the development of good ideas? What sparks the flash of brilliance? How does groundbreaking innovation happen? His answers are never less than revelatory, convincing, and inspiring.

networking lunch: all attendees
la salle ballroom
12:30 pm–1:30 pm
Attendees may enjoy lunch in the ballroom or take it to go – boxes will be available for those who want or need to pack lunch for the road.

post-meeting activities, friday, may 18

networking lunch: project directors
AF4Q Project Directors only • acadian I and II
12:30 pm–1:30 pm

networking lunch: consumers
consumer representatives only • pelican I
12:30 pm–1:30 pm

ambulatory quality improvement leadership consortium
by invitation only • poydras
1:30 pm–3:00 pm
Dessert and coffee will be available.

travel and lodging

Aligning Forces for Quality National Meeting • **May 16-18, 2012**

Location

Hotel & Meeting
InterContinental New Orleans
444 St. Charles Avenue
New Orleans, LA 70130

Reservations

Rooms are being held under:
GW University Aligning Forces for Quality
Reserve rooms by Monday, April 16, 5 pm CT to guarantee a room & to receive the negotiated rate.
NOTE: Block rooms early. You can always cancel rooms you don't need a week prior to the check in date.

Room rates
Single occupancy: $169, Double: $169,
$30 each additional person, per room, per night
Check in: 4 pm; Check out: 12pm
The group rate will be honored three days before and after the meeting if you wish to extend your stay in New Orleans.

Phone reservations 1-800-235-4670

Online reservations: https://resweb.passkey.com/Resweb.do?mode=welcome_ei_new&eventID=6979435

Getting There

Airport Information
Louis Armstrong New Orleans International Airport - MSY
(~20-30 minutes)

Transportation to the Hotel

- Shuttle. Airport shuttle transportation is available via: www.airportshuttleneworleans.com
  Shuttle fare from the airport to the hotel is $20.00 (*per person, one-way*) or $38.00 (*per person, round-trip*). Call 1-866-596-2699 or (504) 522-3500 for more details or to make a reservation. Ticket booths are located on the lower level in the baggage claim area.
- Taxi. Flat rate of $33 from airport to hotel for up to two people. Additonal $14 per passenger for three or more people.
- Parking. – Valet parking, $32 daily; Self parking available in facilities surrounding the hotel ranging from $7-$20/day.

Meeting Information

Agenda Overview* **cultivating innovation**

Wednesday, May 16	• Project Directors Meeting (by invitation)	8am – 5pm*
	• Consumer Representatives Meeting (by invitation)	11am-3pm*
	• Casual coffee with first timers	3pm-4pm
	• Reception and Dinner (National Meeting begins) Will be held offsite, a short walk from the hotel	5pm-8pm
Thursday, May 17	• Networking Breakfast	7am – 8am
	• Meeting Sessions	8:15am – 5pm
	• Reception (Dinner on your own)	5:30pm – 6:30 pm
Friday, May 18	• Networking Breakfast	7am – 8am
	• Meeting Sessions	8am – 12pm
	• Post-meeting lunches for PDs and Consumers	12pm – 1pm
	• Ambulatory Quality Improvement Leadership Consortium (by invitation)	1pm-3pm

*Please note that start and end times for some activities may be subject to slight change. Invitation-only pre-meetings may not fill the whole 8-5 slot.

Breaks and Meals Breakfast, lunch, morning and afternoon refreshments will be provided.

Attire Business casual.

New Orleans Restaurant Recommendations

Upscale Dining

Arnaud's	813 Bienville	523-5433	Traditional Creole $$$
Bayona	430 Dauphine	525-4455	Mediterranean $$$$
Brigtsen's*	723 Dante	861-7610	Modern Louisiana $$$
Chophouse New Orleans	322 Magazine	522-7902	Steakhouse $$$$
Cochon	930 Tchoupitoulas	588-2123	Modern Cajun $$$
Commander's Palace*	1403 Washington	899-8221	Modern Creole $$$$
Dickie Brennan's Steakhouse	716 Iberville	522-2467	Local Steakhouse $$$
Domenica	123 Baronne	648-6020	Rural Italian $$$
Emeril's	800 Tchoupitoulas	528-9393	New American $$$$
Emeril's Delmonico*	1300 St. Charles	525-4937	Modern Creole $$$$
G.W. Fins	808 Bienville	581-3467	Modern seafood $$$
Galatoire's	209 Bourbon	525-2021	French Creole $$$$
Herbsaint	701 St. Charles	524-4114	Modern Louisiana $$$
K Paul's	416 Chartres	524-7394	Cajun $$$$
Le Foret	129 Camp	553-6738	French $$$$
Luke	333 St. Charles	378-2840	Louisiana French $$$
Mike's on the Avenue	628 St. Charles	523-7600	Asian American $$$
MiLa	817 Common	412-2580	Modern Southern $$$
Nola	534 St. Louis	522-6652	Modern Louisiana $$$
Pelican Club	615 Bienville	523-1504	Modern Louisiana $$$
Restaurant August	301 Tchoupitoulas	299-9777	Louisiana French $$$$
Stella!	1032 Chartres	587-0091	Global Modern $$$$
Ste. Marie	930 Poydras	304-6988	Modern French $$$$

$$ (12-20) $$$ (18-30) $$$$ (25-35)

***** indicates restaurants not within walking distance of the hotel

New Orleans Restaurant Recommendations

Casual Dining

Acme	724 Iberville	522-5973	Seafood $$
Bon Ton Café	401 Magazine	524-3386	Cajun $$$ Mon-Fri only
Bourbon House	144 Bourbon	522-0111	Creole Seafood $$$
Café Beignet	334 B Royal	524-5530	Breakfast / Sandwiches $
Café Maspero	601 Decatur	523-6250	Sandwiches Creole $
Crescent City Brewhouse	527 Decatur	522-0571	American / Creole $$
Deanie's	841 Iberville	831-4141	Seafood $$
Drago's	2 Poydras	584-3911	Seafood $$
Gordon Biersch	200 Poydras	552-2739	Brewery restaurant $$
Grand Isle	575 Conv. Ctr. Blvd.	520-8530	Seafood / Oyster Bar $$$
Green Goddess	307 Exchange Alley	301-3347	Breakfast / Lunch $$
Gumbo Shop	630 St. Peter	525-1486	Creole $$
Jacques Imo's*	8324 Oak	861-0886	Southern $$
Johnny's	511 St. Louis	524-8129	Poor Boys $
Leonardo	709 St. Charles	558-8986	Italian $$$
Mother's	401 Poydras	523-9656	N. O. Diner $
Mr. B's Bistro	201 Royal	523-2078	Modern Creole $$$
Palace Café	605 Canal	523-1661	New Orleans Seafood $$$
Redfish Grill	115 Bourbon	598-1200	Cajun & Seafood $$
Ruby Slipper	200 Magazine	525-9355	Breakfast / Lunch $$
Stanley	541 St. Ann	593-0006	Sandwiches / Dessert $$
Walk-On's Bistreaux	1009 Poydras	309-6530	Louisiana / Sports Bar $$

$ (8-15) $$ (12-20) $$$ (18-30) $$$$ (25-35)

***** indicates restaurants not within walking distance of the hotel

April 2012 (all area codes 504)

Travel/Expense Guidelines for Reimbursement

Please use the following guidelines for completion of reimbursement Report. In order to be reimbursed for expenses incurred at business travel, complete the Expense Reimbursement Report and submit all **original receipts** pertaining to travel expenses to the Executive Aide. Please submit the Expense Reimbursement Report and **original receipts** to *the Executive Aide* no later than 30 days upon completion of travel (please make a copy of your report and all receipts for your own records before submitting the documents to *the Executive Aide*). All reports and receipts as well as any questions regarding expense reimbursement should be directed to:

Katherine Bryant
Center of Health Care
Department of Health Policy
2121 K St. NW, Suite 200
Washington, DC, 20037
Phone: 202.994.8642
Fax: 202.973.3500
E-mail: Katherine.bryant@gwumc.edu

Travel

1. The *travel policy* stipulates the use of the Robert Wood Johnson Foundation's travel cost estimate of up to $1,110 for a one night-one day meeting and $1,360 for a two night-two day meeting where air travel is necessary. This sum includes all travel related expenses including, but not limited to airfare, lodging, ground transportation, and meals. Reasonable travel expenses associated with activities of the traveler will be reimbursed. Meals are not to exceed $100 per day and $65 for dinner. First-class, business class and seat upgrades will not be reimbursed. Only the cost of the first checked bag may be reimbursed.

   The cost of flight changes/adjustments may not be reimbursed unless the change is weather related.

2. Please submit all original receipts on standard letter size paper, affixing them with scotch tape if smaller than 8 ½ X 11 inch size or place all original receipts in an envelope. For missing receipts, please make note of the amount and include "receipt missing" on the form. Check cab receipts for completeness: date, destination and amount.

3. Please include any airline boarding passes with your original receipts.

4. For local travel, you should use the mileage reimbursement rate approved by The George Washington University. Please include a Google map documenting mileage traveled.

Aligning Forces for Quality
Expense Reimbursement Report

Name _____

SSN _____

Home Address _____

_____

Phone _____

E-mail _____

Purpose of Travel _____

Location of Meeting _____

Travel Dates _____

Expenses	**S (__/__/__)**	**M (__/__/__)**	**T (__/__/__)**	**W (__/__/__)**	**Th (__/__/__)**	**F (__/__/__)**	**S (__/__/__)**	**Total**
Air								
Lodging								
Breakfast								
Lunch								
Dinner								
Ground Transportation								
Mileage @$.485 per mile (include google map doc)								
Parking								
Other (please specify)								

Total Payment Due _____

Signature _____ **Date** _____

Notes: _____

_____

Quality/Equality Web Site
Glossary of Related Terms

A

Acute Care – Acute Care is short-term medical treatment, most often in a hospital, for people who have a severe illness or injury, or are recovering from surgery.

Admission or Hospital Admissions – Admission or Hospital Admissions is the process of being admitted to a hospital as a patient. The rate and quality of this process may be a good indicator of the local health system's performance and the effectiveness of health plans in managing care.

Agency for Healthcare Research and Quality (AHRQ) – The Agency for Healthcare Research and Quality (AHRQ) is the nation's lead federal agency for research on health care quality, costs, outcomes and patient safety. AHRQ is the health services research arm of the U.S. Department of Health and Human Services (HHS), complementing the biomedical research mission of its sister agency, the National Institutes of Health. The agency is home to research centers that specialize in major areas of health care research, including: clinical practice and technology assessment, health care organization and delivery systems, and primary care. AHRQ is a major source of funding and technical assistance for health services research and research training at leading U.S. universities and other institutions. As a science partner, the agency works with the public and private sectors to build the knowledge base for what works —and does not work—in health and health care and to translate this knowledge into everyday practice and policy-making.

Aligning Forces for Quality **(AF4Q)** – *Aligning Forces for Quality*, a Robert Wood Johnson Foundation (RWJF) initiative, brings together those who get care, give care and pay for care to improve the quality of health care that Americans receive. RWJF's unprecedented commitment of resources, expertise and training is turning proven practices into real results in 14 communities, including Cincinnati, Cleveland, Detroit, Humboldt County (Calif.), Kansas City (Mo.), Maine, Memphis, Minnesota, Seattle, South Central Pennsylvania, West Michigan, Western New York, Willamette Valley (Ore.) and Wisconsin. For more information, visit www.rwjf.org/qualityequality/af4q.

Alliance for Specialty Medicine (ASM) – The Alliance for Specialty Medicine (ASM) is a nonpartisan coalition of 11 national medical specialty societies representing more than 200,000 physicians. ASM is dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care.

Ambulatory Care – Ambulatory Care is medical care provided on an outpatient basis—therefore, not requiring a person to be admitted to the hospital. Ambulatory Care is provided in physicians' offices, clinics, emergency departments, outpatient surgery centers and hospital settings that do not involve a patient staying overnight.

Ambulatory Care Quality Alliance (AQA) – The Ambulatory Care Quality Alliance (AQA) is a broad-based coalition of physicians, consumers, purchasers, health insurance plans and others who seek to improve health care quality and patient safety through a collaborative process in which key stakeholders agree on a strategy for measuring performance at the physician or group level; collecting and aggregating

data in the least burdensome way; and reporting meaningful information to consumers, physicians and other stakeholders to inform choices and improve outcomes.

American Academy of Family Physicians (AAFP) – The American Academy of Family Physicians (AAFP) is one of the largest national medical organizations, representing more than 94,000 family physicians, family medicine residents and medical students nationwide. Founded in 1947, its mission is to preserve and promote the science and art of family medicine and to ensure high-quality, cost-effective health care for patients of all ages.

American Health Quality Association (AHQA) – The American Health Quality Association (AHQA) is an educational, nonprofit national membership association dedicated to promoting and facilitating fundamental change that improves the quality of health care in America. AHQA represents Quality Improvement Organizations (QIOs) and professionals, sharing information about best practices with physicians, hospitals and nursing homes. Working together with health care providers, QIOs identify opportunities and provide assistance for improvement.

American Hospital Association (AHA) – The American Hospital Association (AHA) is a national organization, founded in 1898, that represents and serves all types of hospitals, health care networks, and their patients and communities. The AHA provides education for health care leaders and is a source of information on health care issues and trends. Through representation and advocacy activities, the AHA ensures that members' perspectives and needs are heard and addressed in national health policy development, legislative and regulatory debates, and judicial matters. Our advocacy efforts include the legislative and executive branches and include the legislative and regulatory arenas. Nearly 5,000 hospitals, health care systems, networks, other providers of care and 37,000 individual members come together to form the AHA.

American Medical Association (AMA) – The American Medical Association (AMA) helps doctors help patients by uniting physicians nationwide to work on the most important professional and public health issues. The AMA seeks to promote the art and science of medicine and the betterment of public health.

American Nurses Association (ANA) – The American Nurses Association (ANA) is the only full-service professional organization representing the nation's 2.9-million registered nurses (RNs) through its 54-constituent member associations. The ANA advances the nursing profession by fostering high standards of nursing practice, promoting the rights of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public.

America's Health Insurance Plans (AHIP) – America's Health Insurance Plans (AHIP) is the national association representing nearly 1,300 member companies providing health insurance coverage to more than 200 million Americans. Member companies offer medical-expense insurance, long-term care insurance, disability-income insurance, dental insurance, supplemental insurance, stop-loss insurance and reinsurance to consumers, employers and public purchasers. AHIP's goal is to provide a unified voice for the health care financing industry; to expand access to high-quality, cost-effective health care to all Americans; and to ensure Americans' financial security through robust insurance markets, product flexibility and innovation, and an abundance of consumer choice.

B

Benchmark (Benchmarking) – Benchmarking is a way for hospitals and doctors to analyze quality data, both internally and against data from other hospitals and doctors, to identify best practices of care and improve quality.

Best Practices – Best Practices are the most up-to-date patient care interventions, which result in the best patient outcomes and minimize patient risk of death or complications.

C

Center for Health Care Strategies (CHCS) – The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving the quality and cost effectiveness of health care services for low-income populations and people with chronic illnesses and disabilities. CHCS works directly with states and federal agencies, health plans, and providers to develop innovative programs that better serve people with complex and high-cost health care needs.

Center for Health Improvement (CHI) – The Center for Health Improvement (CHI) is a national, independent, nonprofit health policy and technical assistance organization dedicated to improving population health and encouraging healthy behaviors. Since its inception in 1995, CHI has used evidence-based research to help public, private and nonprofit organizations strengthen their capacity to improve the quality and value of health care and enhance public health at the community level.

Centers for Medicare & Medicaid Services (CMS) (formerly: Health Care Financing Administration: HCFA) – The Centers for Medicare & Medicaid Services (CMS) seeks to ensure effective, up-to-date health care coverage and to promote quality care for beneficiaries. Ultimately, CMS is working to transform and modernize the health care system.

Center for Studying Health Systems Change (HSC) – The Center for Studying Health Systems Change (HSC) is a nonpartisan policy research organization located in Washington, D.C. HSC designs and conducts studies focused on the U.S. health care system to inform the thinking and decisions of policy-makers in government and private industry. In addition to this applied use, HSC studies contribute more broadly to the body of health care policy research that enables decision-makers to understand change and the national and local market forces driving that change.

Chronic Care Model – The Chronic Care Model is a model developed by Edward Wagner and colleagues that provides a solid foundation from which health care teams can operate. The model has six dimensions: community resources and policies; health system organization of health care; patient self-management supports; delivery system redesign; decision support; and clinical information system. The ultimate goal is to have activated patients interact in a productive way with well-prepared health care teams. Three components that are particularly critical to this goal are adequate decision support, which includes systems that encourage providers to use evidence-based protocols; delivery system redesign, such as using group visits and same-day appointments; and use of clinical information systems, such as disease registries, which allow providers to exchange information and follow patients over time.

Chronic Disease – A Chronic Disease is a sickness that is long-lasting or recurrent. Examples include diabetes, asthma, heart disease, kidney disease and chronic lung disease.

Clinical Practice Guidelines – Clinical Practice Guidelines are a set of systematically developed statements, usually based on scientific evidence, that help physicians and their patients make decisions about appropriate health care for specific medical conditions. Clinical practice guidelines briefly identify and evaluate the most current information about prevention, diagnosis, prognosis, therapy, risk/benefit and cost effectiveness.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) – The Consumer Assessment of Healthcare Providers and Systems (CAHPS) develops and supports the use of a comprehensive and evolving family of standardized surveys that ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. CAHPS originally stood for the Consumer Assessment of Health Plans Study, but as the products have evolved beyond health plans, the name has evolved as well to capture the full range of survey products and tools.

Consumer-Driven (or Directed) Care – Consumer-Driven (or Directed) Care is a form of health insurance that combines a high-deductible health plan with a tax-favored Health Savings Account, Flexible Spending Account or Health Reimbursement Account to cover out-of-pocket expenses. These accounts are “consumer-driven” in that they give participants greater control over their own health care, allowing individuals to determine on a personal basis how they choose to spend their health care account funds.

Consumer Engagement – Consumer Engagement is the situation in which consumers take an active role in their own health care, from understanding their own conditions and available treatments, to seeking out and making decisions based on information about the performance of health care providers.

Consumer – A Consumer is an individual who uses, is affected by, or is entitled or compelled to use a health-related service.

Consumer-Purchaser Disclosure Project (CPDP) – The Consumer-Purchaser Disclosure Project (CPDP) is a group of leading employer, consumer and labor organizations working toward a common goal to ensure that all Americans have access to publicly-reported health care performance information. CPDP's shared vision is that with this information, Americans will be better able to select hospitals, physicians and treatments based on nationally standardized measures for clinical quality, consumer experience, equity and efficiency.

Coordination of Care – Coordination of Care comprises mechanisms that ensure patients and clinicians have access to, and take into consideration, all required information on a patient's conditions and treatments to ensure that the patient receives appropriate health care services.

Core Measures – Core Measures are specific clinical measures that, when viewed together, permit a robust assessment of the quality of care provided in a given focus area, such as acute myocardial infarction (AMI).

D

Data Collection – Data Collection is the acquisition of health care information or facts based upon patient and consumer race, ethnicity and language. Data Collection provides health care providers with the ability to perform benchmarking measures on health care systems to determine areas where improvement is needed in providing care.

Department of Health and Human Services (HHS) – The Department of Health and Human Services is the U.S. government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

Disease Management – Disease Management is an approach designed to improve the health and quality of life for people with chronic illnesses by working to keep the conditions under control and prevent them from getting worse.

Disease Registry – A Disease Registry is a large collection or registry belonging to a health care system that contains information on different chronic health problems affecting patients within the system. A Disease Registry helps to manage and log data on chronic illnesses and diseases. All data contained within the Disease Registry are logged by health care providers and are available to providers to perform benchmarking measures on health care systems.

Disparities (in care) – Disparities in care are differences in the delivery of health care, access to health care services and medical outcomes based on ethnicity, geography, gender and other factors that do not include socioeconomic status or insurance coverage. Understanding and eliminating the causes of health care disparities is an ongoing effort of many groups and organizations.

E

Effective Care – Effective Care includes health care services that are of proven value and have no significant tradeoffs. The benefits of the services so far outweigh the risks that all patients with specific medical needs should receive them. These services, such as beta-blockers for heart attack patients, are backed by well-articulated medical theory and strong evidence of efficacy, determined by clinical trials or valid cohort studies.

Electronic Health (Medical) Record (EHR or EMR) – The Electronic Health (Medical) Record (EHR or EMR) is a computerized medical file that contains the history of a patient’s medical care, commonly abbreviated as “EHR,” in contrast to “PHR,” which stands for personal health record. An EHR or EMR enables patients to transport their health care information with them at all times.

Emergency Department – The Emergency Department is the department within a health care facility that is intended to provide rapid treatment to victims of sudden injury or illness. Emergency Departments across the nation struggle with overcrowding, long patient wait periods and shortages of health care professionals.

Evidence-Based Medicine – Evidence-Based Medicine is the use of the current, best available scientific research and practices with proven effectiveness in daily medical decision-making, including individual clinical practice decisions, by well-trained, experienced clinicians. Evidence is central to developing performance measures for the most common and costly health conditions. The measures allow consumers to compare medical providers and learn which ones routinely offer the highest quality, safest and most effective care.

F

Fee Schedule – A Fee Schedule is a complete listing of fees used by health plans to pay doctors or other providers.

Fee-for-Service – Fee-for-Service is an arrangement under which patients or a third party pay physicians, hospitals, or other health care providers for each encounter or service rendered.

G

Group Health Plan – A Group Health Plan is a health plan that provides health care coverage to employees, former employees and their families, and is supported by an employer or employee organization.

H

Health Information Technology (HIT) – Health Information Technology is a global term (which encompasses electronic health records and personal health records) to indicate the use of computers, software programs, electronic devices and the Internet to store, retrieve, update and transmit information about patients' health.

Health Plan Employer Data and Information Set (HEDIS) Measures – The Health Plan Employer Data and Information Set (HEDIS) Measures are a set of health care quality measures designed to help purchasers and consumers determine how well health plans follow accepted care standards for prevention and treatment. Formerly known as the Health Plan Employer Data Information Set, health plans can receive accreditation on HEDIS measures from certain organizations, such as the National Committee on Quality Assurance.

Health Resources and Services Administration (HRSA) – The Health Resources and Services Administration (HRSA) is an agency of the U.S. Department of Health and Human Services and is the primary federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable.

Hospital CAHPS (H-CAHPS or CAHPS Hospital Survey) – Hospital CAHPS (H-CAHPS or CAHPS Hospital Survey) is a standardized survey instrument and data collection methodology for measuring patients' perspectives of hospital care. While many hospitals collect information on patient satisfaction, there is no national standard for collecting or publicly reporting this information that would enable valid comparisons to be made across all hospitals. H-CAHPS is a core set of questions that can be combined with customized, hospital-specific items to produce information that complements the data hospitals currently collect to support improvements in internal customer service and quality-related activities.

Hospital Discharge – Hospital Discharge is the process by which a patient is released from the hospital by health care professionals.

Hospital Quality Alliance (HQA) – The Hospital Quality Alliance (HQA) is a public-private collaboration seeking to improve the quality of care provided by the nation's hospitals by measuring and publicly reporting on that care.

I

Improving Chronic Illness Care (ICIC) – Improving Chronic Illness Care (ICIC) is an organization that has worked for almost 10 years with national partners toward the goal of bettering the health of chronically ill patients by helping health systems, especially those that serve low-income populations, improve their care through implementation of the Chronic Care Model.

Improving Performance in Practice (IPIP) – The Improving Performance in Practice (IPIP) initiative is a project within the North Carolina Academy of Family Physicians. The program seeks to establish a designated Quality Improvement Consultant (QIC) to work onsite with the practice leadership team to develop a practice-specific redesign plan utilizing the resources of collaborating experts.

Informed Decision-Making (IDM) – Informed Decision-Making is a term to describe a process designed to help patients understand the nature of the disease or condition being addressed; understand the clinical service being provided including benefits, risks, limitations, alternatives and uncertainties; consider their own preferences and values; participate in decision-making at the level they desire; and make decisions consistent with their own preferences and values or choose to defer a decision until a later time.

Inpatient Care – Inpatient Care is the delivery of health care services to a person who has been admitted to a hospital or other health facility for a period of at least 24 hours.

Input – Input is the flow of patients into a medical facility, such as an emergency department.
Institute for Healthcare Improvement (IHI) – The Institute for Healthcare Improvement (IHI) is an independent nonprofit organization helping to lead the improvement of health care throughout the world. Founded in 1991 and based in Cambridge, Mass., IHI works to accelerate improvement by building the will for change, cultivating promising concepts for improving patient care, and helping health care systems put those ideas into action.

Institute of Medicine (IOM) – The Institute of Medicine (IOM) is a nonprofit organization and honorific membership organization that works outside the framework of government to ensure scientifically informed analysis and independent guidance on matters of biomedical science, medicine and health. The Institute provides unbiased, evidence-based and authoritative information and advice concerning health and science policy to policy-makers, professionals, leaders in every sector of society and the public at large. IOM's book on quality and safety, *Crossing the Quality Chasm: A New Health System for the 21st Century*, partially funded by the Robert Wood Johnson Foundation, reported that a huge divide exists between the care we should receive and the care that we get. The Quality Chasm introduces the notion that health care needs to take a page from industry and use its engineering improvement methods to aim for top quality, efficiency and safety. The report lays out six goals that would become akin to a mantra for

the quality improvement movement: care should be "safe, effective, patient-centered, timely, efficient and equitable." IOM's 2003 landmark report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* demonstrates the reality and effect of health disparities and quality-of-care differences for persons of racial and ethnic minorities.

J

Joint Commission (JCAHO) formerly: Joint Commission on Accreditation of Healthcare Organizations – The Joint Commission (JCAHO) is a private, nonprofit organization that evaluates and accredits hospitals and other health care organizations providing home care, behavioral health care, ambulatory care and long-term care services.

K

L

M

Medical Error – A Medical Error is a mistake that harms a patient. Adverse drug events, hospital-acquired infections and wrong-site surgeries are examples of preventable medical errors.

Misuse – Misuse occurs when an appropriate process of care has been selected, but a preventable complication occurs and the patient does not receive the full potential benefit of the service. Avoidable complications of surgery or medication use are misuse problems. A patient who suffers a rash after receiving penicillin for strep throat, despite having a known allergy to that antibiotic, is an example of misuse. A patient who develops a pneumothorax after an inexperienced operator attempted to insert a subclavian line would represent another example of misuse.

Models of Care – A Model of Care is a conceptual object or diagram that provides an outline of how to plan all current and future facility and clinical service. It is important that the Model of Care be designed and evaluated for its ability to be replicated within the health care system. Models of care can help guide and direct a patient's experience within a health care system.

Multi-disciplinary Teams/Multidisciplinary – Multi-disciplinary Teams are health care teams made up of health care professionals as well as health educators or community leaders.

N

National Committee on Quality Assurance (NCQA) – The National Committee on Quality Assurance (NCQA) is a private, nonprofit organization dedicated to improving health care quality through measurement, transparency and accountability. NCQA has been a central figure in driving improvement throughout the health care system, helping to elevate the issue of health care quality to the top of the national agenda. The organization has helped build consensus around important health care quality issues by working with large employers, policy-makers, doctors, patients and health plans to decide what's important, how to measure it and how to promote improvement.

National Institutes of Health (NIH) – The National Institutes of Health (NIH) is a part of the U.S. Department of Health and Human Services, the primary federal agency for conducting and supporting medical research. Helping to lead the way toward important medical discoveries that improve people's health and save lives, NIH scientists investigate ways to prevent disease as well as the causes, treatments, and even cures for common and rare diseases.

National Program Office (NPO) – The National Program Office (NPO) is the national headquarters of the Robert Wood Johnson Foundation's *Aligning Forces for Quality* initiative. The NPO is located at The George Washington University Medical Center School of Public Health and Health Service in Washington, D.C.

National Quality Forum (NQF) – The National Quality Forum (NQF) is a nonprofit membership organization created to develop and implement a national strategy for health care quality measurement and reporting. Established as a public-private partnership, the NQF has broad participation from all parts of the health care system, including national, state, regional and local groups representing consumers, public and private purchasers, employers, health care professionals, provider organizations, health plans, accrediting bodies, labor unions, supporting industries and organizations involved in health care research or quality improvement. Together, the organizational members of the NQF work to promote a common approach to measuring health care quality and fostering system-wide capacity for quality improvement. Quality improvement measures endorsed by the NQF are considered the gold standard.

"Never-Events" – "Never-Events" are medical mistakes that should never occur under any circumstance.

National Health Plan Collaborative (NHPC) – The National Health Plan Collaborative (NHPC) is a project bringing together 11 major health insurance companies, in partnership with organizations from the public and private sectors, to identify ways to improve the quality of health care for racially and ethnically diverse populations. Together, member health plans reach more than 87-million Americans.

O

Outcome – Outcome is the result of a process, including outputs, effects and impacts.

Outpatient Care – Outpatient Care is medical or surgical care that does not include an overnight hospital stay.

Output – Output is the flow of patients out of a medical facility, such as an emergency department.

Overcrowding – Overcrowding is a situation experienced by many emergency departments across the nation where there are too many patients for the number of physicians available. This causes excessive time spent waiting for care, unhappy patients and poor-quality care provided to patients.

Overuse – Overuse provides a process of care in circumstances where the potential for harm exceeds the potential for benefit. Prescribing an antibiotic for a viral infection like a cold, for which antibiotics are ineffective, constitutes overuse. The potential for harm includes adverse reactions to the antibiotics and increases in antibiotic resistance among bacteria in the community. Overuse can also apply to diagnostic tests and surgical procedures.

P

Patient-Centered Care – Patient-Centered Care considers patients' cultural traditions, personal preferences and values, family situations and lifestyles. Responsibility for important aspects of self-care and monitoring is put in patients' hands—along with the tools and support they need. Patient-centered care also ensures that transitions between different health care providers and care settings are coordinated and efficient. When care is patient-centered, unneeded and unwanted services can be reduced.

Patient Experience – The Patient Experience is comprised of research reports and administrative information that reflect quality from the perspective of patients by capturing observations and opinions about what happened during the process of health care delivery. Patient experience encompasses various indicators of patient-centered care, including access (whether patients are obtaining appropriate care in a timely manner), communication skills, customer service, helpfulness of office staff and information resources.

Patient Flow – Patient Flow is the movement of patients who seek care in an emergency department through the admission process. This is the process through which patients are granted entry for care at the hospital and seen by a physician.

Patient Registry – A Patient Registry is a patient database maintained by a hospital, doctors' practice or health plan that allows providers to identify their patients according to disease, demographic characteristics and other factors. Patient registries can help providers better coordinate care for their patients, monitor treatment and progress and improve overall quality of care.

Patient Satisfaction – Patient Satisfaction is a measurement designed to obtain reports or ratings from patients about services received from an organization, hospital, physician or health care provider.

Pay-for-Performance (P4P) – Pay-for-Performance (P4P) is a method for paying hospitals and physicians based on their demonstrated achievements in meeting specific health care quality objectives. The idea is to reward providers for the quality—not the quantity—of care they deliver.

Payers – Payers comprise the entity that assumes the risk of paying for medical treatments. Examples include uninsured patients, self-insured employers, health plans or HMOs.

Payment Reform – Payment Reform seeks to improve current mechanisms for reimbursing providers by including rewards for provider quality in the reimbursement mechanisms.

Performance Measures – Performance Measures are sets of established standards against which health care performance is measured. Performance Measures are now widely accepted as a method for guiding informed decision-making as a strong impetus for improvement.

Personal Health Record (PHR) – A Personal Health Record (PHR) contains the medical and health-related background documents pertaining to a consumer.

Physician Quality Reporting Initiative (PQRI) – The Physician Quality Reporting Initiative (PQRI) is authorized through the Medicare, Medicaid and SCHIP Extension Act of 2007. It is a financial incentive for health care professionals to improve the quality of care that they provide.

Preference-Sensitive Care – Preference-Sensitive Care are treatments that involve significant tradeoffs affecting the patient's quality and/or length of life. Decisions about these interventions—whether to have them or not, which ones to have—ought to reflect patients' personal values and preferences, and ought to be made only after patients have enough information to make an informed choice. At times, the scientific evidence on the main outcome—survival—is quite good; in other cases, the evidence is much weaker.

Preventive Care – Preventive Care is health care services that prevent disease or its consequences. It includes primary prevention to keep people from getting sick (such as immunizations), secondary prevention to detect early disease (such as Pap smears) and tertiary prevention to keep ill people or those at high risk of disease from getting sicker (such as helping someone with lung disease to quit smoking).

Price Transparency – Price Transparency is the ability of consumers to know what it will cost to receive a given health care service at a variety of outlets.

Primary Care – Primary Care is basic or general health care traditionally provided by doctors trained in: family practice, pediatrics, internal medicine and occasionally gynecology.

Process Improvement – Process Improvement comprises techniques and strategies used to make the processes implemented to solve health care problems better. Process improvement can occur in emergency room or hospital settings, as well as in other health-system environments.

Provider Incentives – Provider Incentives serve to induce or motivate the regulation of health care. Examples of incentives include monetary rewards for providers who meet specific benchmark standards for their patient care.

Provider – A Provider is a professional engaged in the delivery of health services, including physicians, dentists, nurses, podiatrists, optometrists, clinical psychologists, etc. Hospitals and long-term care facilities are also providers. The Medicare program uses the term "provider" more narrowly, to mean participating institutions: hospitals, skilled nursing facilities, home health agencies, etc.

Public Reporting – Public Reporting makes information about physician and physician group performance available for consumers to use to compare the performance of local physicians/physician groups. The expectation is that a comparative public report of local physicians' performance in treating people with chronic illnesses will motivate and improve performance.

Purchasers – Purchasers comprise the entity that not only pays the premium for health care costs, but also controls the premium dollar before paying it to the provider. Included in the category of purchasers or payers are patients, businesses and managed care organizations. While patients and businesses function as ultimate purchasers, managed care organizations and insurance companies serve a processing or payer function.

Q

Quality (of Care) – Quality (of Care) is a measure of the ability of a doctor, hospital or health plan to provide services for individuals and populations that increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Good quality health care means doing the right thing at the right time, in the right way, for the right person and getting the best possible results. According to the mantra for the quality improvement movement, care should be "safe, effective, patient-centered, timely, efficient and equitable."

Quality (of Life) – Quality (of Life) is the amount of happiness and balance in an individual's life. Attention to good health will create a better quality of life.

Quality Alliance Steering Committee (QASC) – The Quality Alliance Steering Committee (QASC) is a broad-based coalition of physicians, consumers, purchasers, health insurance plans and others who seek to improve health care quality and patient safety through a collaborative process in which key stakeholders agree on a strategy for measuring performance at the physician or group level; collecting and aggregating data in the least burdensome way; and reporting meaningful information to consumers, physicians and other stakeholders to inform choices and improve outcomes.

Quality Improvement (QI) – Quality Improvement (QI) is a term first coined in the private sector, when corporations began looking at ways to streamline and improve processes and systems. The most well-known example of quality improvement methodology is the "Six Sigma" method of change, developed by engineers at Motorola. In the health care context, the goal of quality improvement strategies is for patients to receive the appropriate care at the appropriate time and place with the appropriate mix of information and supporting resources. In many cases, health care systems are designed in such a way as to be overly cumbersome, fragmented and indifferent to patients' needs. Quality improvement tools range from those that simply make recommendations but leave decision-making largely in the hands of individual physicians (e.g., practice guidelines) to those that prescribe patterns of care (e.g., critical pathways). Typically, quality improvement efforts are strongly rooted in evidence-based procedures and rely extensively on data collected about processes and outcomes.

Quality Indicator – A Quality Indicator is an agreed-upon process or outcome measure that is used to determine the level of quality achieved. A measurable variable (or characteristic) that can be used to determine the degree of adherence to a standard or achievement of quality goals.

Quality Measures – Quality Measures are mechanisms used to assign a quantity to quality of care by comparison to a criterion.

R

Rapid Cycle Change – Rapid Cycle Change is a quality-improvement method that identifies, implements and measures changes made to improve a process or a system. At the onset, the team sets an outcome measure based on the system's goals. Improvement occurs through small, rapid PDSA (Plan, Do, Study, Act) cycles to advance practice change. This model requires targeting a specific area to change; planning changes on the basis of sound science, theory and evidence; piloting several changes with small patient groups; measuring the effects of changes; and acting according to the data. The fundamental concept of rapid-cycle improvement is that health care processes—once defined, in place and in effect—should be continually improved by instituting a constant cycle of innovations or improvements.

Report Card – A Report Card is an assessment of the quality of care delivered by health plans. Report cards provide information on how well a health plan treats its members, keeps them healthy and provides access to needed care. Report cards can be published by states, private health organizations, consumer groups or health plans.

Return on Investment (ROI) – A Return on Investment (ROI) is the amount of improvement in care brought about by a certain investment. ROI can also refer to the theory that if you invest in health care quality now, then the quality of care for patients will improve in the future.

Right Care – Right Care is made up of the treatments that, according to evidence-based guidelines, are effective and appropriate for a given condition. Indicators used to define right care are often grouped into two categories: prevention and chronic care.

S

Self-Management – Self-Management is the ability of individuals to have the necessary knowledge, attitudes and skills to manage their health problems or disorders on a day-to-day basis. It is a skill that enables individuals, and their families, to make improved use of existing health services, as well as make choices surrounding health care providers, medication, diet, exercise and other lifestyle issues that protect or damage health.

Sentinel Event – A Sentinel Event is any unexpected event in a health care setting that causes death or serious injury to a patient and is not related to the natural course of the patient's illness.

Specialty Care – Specialty Care is health care focused on improving the well being of certain specialized categories of health, as opposed to general and overall health and well-being. To improve the quality of health care available to consumers and patients, providers must improve the quality and availability of primary and specialty care.

Standard of Care – The Standard of Care is the expected level and type of care provided by the average caregiver under a certain given set of circumstances. These circumstances are supported through findings from expert consensus and based on specific research and/or documentation in scientific literature.

Supply-Sensitive Care – Supply-Sensitive Care includes excess procedures, hospital admissions and doctor visits driven by the supply of doctors and hospital resources, rather than by need.

T

Throughput – Throughput is the ability of a medical facility, such as an emergency department, to complete a patient input and output cycle (e.g., to provide patients with the full cycle of care).

Transparency – Transparency is the process of collecting and reporting health care cost, performance and quality data in a format that can be accessed by the public and is intended to improve the delivery of services and ultimately improve the health care system as a whole.

U

Underuse – Underuse refers to the failure to provide a health care service when it would have produced a favorable outcome for a patient. Standard examples include failure to provide appropriate preventive services to eligible patients (e.g., Pap smears, flu shots for elderly patients, screening for hypertension) and proven medications for chronic illnesses (steroid inhalers for asthmatics, aspirin, beta-blockers and lipid-lowering agents for patients who have suffered a recent myocardial infarction).

V

Value Purchasing – Value Purchasing is a broad strategy used by some large employers to get more value for their health care dollars by demanding that health care providers meet certain quality objectives or supply data documenting their use of best practices and quality treatment outcomes.

Variation – Variation is an instance of change or deviation. There is unwarranted variation in the practice of medicine and the use of medical resources in the United States. There is underuse of effective care, such as the use of beta-blockers for people who have heart attacks and screening of diabetics for early signs of retinal disease. There is misuse of preference-sensitive care, such as the choice between mastectomy and lumpectomy for early-stage breast cancer. And there is overuse of supply-sensitive care, such as admitting patients with chronic conditions like diabetes to the hospital, rather than treating them as outpatients.

W

Work Flow – Work Flow is a repeatable pattern of activity enabled by the organization of resources, defined roles and information into a process that can be documented and learned. Improvements in work flow for health care providers will lessen the burden of providing health care and will lead to greater quality health care overall.

X

Y

Z

GLOSSARY

Defining the Problem

Cost and Price Transparency

November 2011

Allowed (or Allowable) Amount

The most amount of money that a health plan will pay for a covered good or service. The allowed amount is negotiated between the plan and the provider, reflecting any discount the plan is able to achieve for its members. The allowed amount reflects the "true price" of health care, but allowed amounts usually are considered proprietary information and rarely are released to the public. Often used interchangeably with *cost.*

Example: John has knee replacement surgery at Community General Hospital. The hospital wants to charge $95,000 for the procedure. But John's health plan has negotiated a $20,000 discount for its members with the hospital. Thus, $75,000 becomes the *allowed amount.*

Charge

AF4Q defines charge as the amount of money a provider would seek across the board. This amount often is charged to patients who do not have health insurance; health plans typically negotiate the charge down to the allowable amount on behalf of their members.

Example: If John did not have health insurance, his knee replacement surgery would cost him $95,000. That figure is the *charge*—that is, the amount of money the hospital would charge a paying individual customer.

Claim

A request for payment by a provider; a bill the provider sends to the health plan.

Example: If John did have insurance, the *claim* (based on the charge, before the allowed amount is factored in) is sent by provider to the health plan. The hospital would claim $95,000; however, the ultimate payment is the allowed amount, not the claim.

About Aligning Forces for Quality

Aligning Forces for Quality (AF4Q) is the Robert Wood Johnson Foundation's signature effort to lift the overall quality of health care in targeted communities, as well as reduce racial and ethnic disparities and provide real models for national reform. The Foundation's commitment to improve health care in 16 AF4Q communities is the largest effort of its kind ever undertaken by a U.S. philanthropy. AF4Q asks the people who get care, give care and pay for care to work together to improve the quality and value of care delivered locally. The Center for Health Care Quality in the Department of Health Policy at George Washington University School of Public Health and Health Services serves as the national program office. Learn more about AF4Q at www.forces4quality.org. Learn more about RWJF's efforts to improve quality and equality of care at www.rwjf.org/qualityequality/af4q/.

Claims Database

A database, sometimes created by state mandate, that includes claims data derived from medical, eligibility, provider, pharmacy and or dental files.[1] Many claims databases rely exclusively on administrative claims from commercial insurers (e.g., a private health plan such as BlueCross BlueShield) to create their performance measures. Some cost reporting efforts are based upon *all-payer claims databases*, which include Medicare, Medicaid, and self-pay patients.

Example: If John lives in a state with a publicly reported claims database, the knee replacement surgery would be reported as $95,000, the claim.

Cost

The amount of money actually paid to a health care provider. As a performance measure, cost is a measure of the total health care spending, including total resource use and unit price(s), by payer or consumer, for a health care service or group of health care services associated with a specified patient population, time period, and unit(s) of clinical accountability.[2] This term often can be used interchangeably with *allowed amount*.

Example: See *allowed amount.* The knee replacement surgery's *cost* would be $75,000, not $95,000.

Efficiency

The relationship between a specific product (output) of the health care system and the resources (inputs) used to create the product.[3] Similar to *value.*

Example: Whether he's paying for it out of pocket or through his health plan, John wants the highest quality knee replacement possible. But he doesn't want to pay more than has to for the procedure. Thus, he's seeking the most efficient care possible—the combination of high-quality and low-cost, without waste.

Episode of Care

A grouping of a series of care which quantifies the services (resources used) across multiple settings and providers involved in the diagnosis, management and treatment of specific clinical conditions. Episode-of-care measures can be developed for the full range of acute and chronic conditions, including diabetes, congestive heart failure, acute myocardial infarction, asthma, low back pain and many others. Because episodes of care can be defined more tightly and specifically around aspects of a given clinical condition, it may be easier to determine accountability based on per-episode than on per-capita measurement efforts.[4]

Example: For John's knee replacement, an episode-of-care approach would consider all the office visits and consultations leading up to and following the procedure; the procedure itself; any complications stemming from the treatment; and set one price paid to the provider, thereby rewarding the provider if the procedure is performed in an efficient manner and achieves a good outcome.

---

[1] Love D, Custer W, Miller P. *All-Payer Claims Databases: State Initiatives to Improve Health Care Transparency*. Commonwealth Fund pub. 1439, Vol. 99; September 2010.
[2] National Quality Forum (NQF). *Measurement Framework: Evaluating Efficiency Across Patient-Focused Episodes of Care*. Washington, DC: NQF; 2009.
[3] McGlynn E, et al. *Identifying, Categorizing, and Evaluating Health Care Efficiency Measures*. Prepared for Agency for Healthcare Research and Quality by Southern California Evidence-based Practice Center—RAND Corporation, Santa Monica, CA. AHRQ Publication No. 08-0030; April 2008. (This report acknowledged eight different, commonly used definitions for *efficiency* in health care.
[4] Quality Alliance Steering Committee

Pay-for-Performance (P4P)

The general strategy of promoting quality improvement by rewarding providers (meaning individual clinicians or, more commonly, clinics or hospitals) who meet certain performance expectations with respect to health care quality or efficiency.[5]

Example: Under a P4P reimbursement mechanism, John's hospital and doctor would be paid more if the procedure if it went well—that is, if he did not catch an infection in the hospital, if no errors were committed during the procedure, and if the outcome was successful.

Price

The amount paid for a service or product, typically determined via market mechanisms that take into account the supply of and demand for the service or product.[6] AF4Q defines price as the amount a consumer would pay for a service.

Relative Resource Use

A general term for utilization of health care services. The term *resource use measures* broadly captures indicators of the cost and efficiency of providing health care. Health care resource use measures reflect the amount or cost of resources used to create a specific product of the health care system. The specific product could be a visit or procedure, all services related to a health condition, all services during a period of time, or a health outcome.[7] Resource use also applies to a performance measure from the National Committee of Quality Assurance that quantifies how intensively plans and/or providers use resources such as physician visits, hospital stays, and other resources to care for members/patients identified as having one of five chronic diseases; cardiovascular disease, chronic obstructive pulmonary disease, diabetes, hypertension and asthma. When evaluated alongside quality measures, resource use measures make it possible to consider quality and spending simultaneously.[8]

Value

Often loosely defined as quality divided by price. Simply defined, value is the health outcome per dollar of cost expended.[9] The National Quality Forum (NQF) has defined value of care as "a measure of a specified stakeholder's (such as an individual patient's, consumer organization's, payer's, provider's, government's, or society's) preference-weighted assessment of a particular combination of quality and cost of care performance."[10]

Example: Similar to *efficiency,* John's goal as he pays for his knee replacement (whether out of pocket or through a health plan) is to achieve value—that is, to get the highest possible quality at the lowest possible cost.

[5] AHRQ Patient Safety Network glossary. Available online at www.psnet.ahrq.gov/glossary.aspx?indexLetter=P. Last accessed July 2011.
[6] Scanlon D. *Measurement & Reporting of Cost & Efficiency at the Community Level*. Presentation to RWJF Cost Measurement Meeting, Washington, DC. June 8, 2011.
[7] Romano P, Hussey P, Ritley D. *Selecting Quality and Resource Use Measures: A Decision Guide for Community Quality Collaboratives.* Rockville, MD: Agency for Healthcare Research and Quality (AHRQ); AHRQ Publication No. 09(10)-0073; May 2010.
[8] National Committee for Quality Assurance
[9] Porter ME, Teisberg EO. *Redefining Health Care: Creating Value-Based Competition on Results*. Boston, MA: Harvard Business School Publishing; 2006.
[10] NQF. *Measurement Framework: Evaluating Efficiency Across Patient-Focused Episodes of Care*. Washington, DC: NQF; 2009.

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing the United States. As the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, meaningful and timely change. For nearly 40 years RWJF has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime. Learn more at www.rwjf.org.