

Quality Alliance Steering Committee, Measure Implementation Strategy Work Group March 31, 2011 – Conference Call Notes

The following is a high-level review of the discussion points that were touched upon during the MIS Work Group's conference call on Thursday, March 31.

Kerri Petrin and Ayodola Anise of Brookings and Work Group co-chairs Lew Sandy and Paul Tang welcomed participants to the call and walked through the call's agenda, starting with an update on QASC activities since the Work Group last met. The Work Group also heard an overview of the National Performance Measurement Strategy from Joachim Roski, and reviewed the results of a survey of the Brookings-Dartmouth ACO pilot sites regarding their approaches to clinically-enriched measurement. The Work Group provided input on potential audit strategies as well as considerations for ensuring the representativeness of sample-based measures.

Participants: Lew Sandy, Paul Tang, Aparna Higgins, Jennifer Faerberg, Jennifer Eames Huff, Tanya Alteras, Gerry Shea, Michael Painter, Jennifer Shevchek, Steve Bandeian, Jayne Chambers (for Chip Kahn)

QASC Update

- The QASC met in-person in March to review its role and mission, particularly in light of the multiple provisions within the Affordable Care Act that speak to the need for an increased focus on quality and associated performance measurement.
- Additionally, QASC members heard four presentations addressing the use of community-level performance measurement and reporting to support quality improvement, payment reform, and consumer engagement. The presenters included:
 - Marc Bennett (HealthInsight)
 - Jim Chase (Minnesota Community Measurement)
 - Harold Miller (Network for Regional Healthcare Improvement)
 - Chris Queram (Wisconsin Collaborative for Healthcare Quality)
- In addition, QASC heard updates on Work Group activities and took action on a membership proposal

National Performance Measurement Strategy

- Joachim Roski presented an overview of the National Performance Measurement Strategy. The strategy seeks to build on AHIPF's successful pilots in Florida and Colorado, which demonstrated the ability of private payers to aggregate data using a distributed approach for performance measurement. This addresses a provision in the Accountable Care Act that calls for data collection and aggregation approaches through public-private partnerships, making performance information more widely available nationally to support quality improvement.
- Briefly, the goals of the strategy are:
 - To build on AHIPF's distributed data collection and aggregation approach
 - To begin establishing an infrastructure for wide-scale data collection and aggregation approaches through public-private partnerships to support quality improvement
 - To make important data about physician practices, medical groups, and other providers widely available
 - To have performance information that can support improvement, consumer engagement, and payment reform efforts prioritized through ACA

- Next Steps
 - Align efforts across the public and private health care sectors to make comprehensive performance information available
 - Involve multiple payers in Beacon communities and CMS
 - Identify operational considerations for developing a strategy to integrate data from public and private payers (e.g., measure calculation, data aggregation, data distribution)
 - Identify relevant performance measures (e.g., all cause readmission) and link with available indicators to characterize health/performance for hospital referral regions
- The role of the MIS Work Group in this effort would be to give input and advice on methodological issues that may arise as the work proceeds.
- Work Group members asked for more detail on a potential opportunity to link public and private payer data for performance measurement purposes within select Beacon Communities. Currently, the Beacon Communities will have access to measure results (numerators and denominators, rather than raw claims data) generated from data in the CMS' Chronic Condition Data Warehouse (CCW). The measures will be selected by an ad hoc committee assembled for this purpose. Measure results generated from CMS data are anticipated in July. Discussions with private payers that could participate in future rounds of measurement are ongoing.

Brookings-Dartmouth ACO Pilot Project: Review of Clinically-Enriched Measurement Survey

Presentation Summary

- Ayodola Anise provided an overview of the Brookings-Dartmouth ACO pilot site project which engages five provider groups implementing shared savings programs with commercial payers.
 - Carilion Clinic/TBD; Norton Healthcare/Humana; Tucson Medical Center/UnitedHealthcare; Monarch HealthCare/Anthem; HealthCare Partners/Anthem.

The main goal of the pilot site project is to assess quality through ongoing and consistent performance measurement and reporting.

- Ms. Anise described the performance measurement implementation trajectory of the pilot project, which takes place in three phases. Over time, the measures become progressively more comprehensive to address critical areas and priorities including clinical effectiveness, health outcomes, care coordination, and patient experience.
- Ms. Anise indicated that Phase I and II of the pilot project are building off of AHIP's data aggregation work, which developed a distributed data aggregation methodology. While the ACO and payer partners will be able to exchange patient level data that in some cases the ACO would not otherwise have access to, the ACO and payer partner will use a distributed data model to support reporting to Brookings-Dartmouth. Using the distributed data model will allow Brookings-Dartmouth to receive only numerator and denominator information for each measure, preventing the exchange of PHI.
- Ms. Anise focused her presentation on the clinically-enriched measurement portion of the pilot project. She presented findings from the survey completed by all five pilot sites and payer partners on the data sources used to obtain clinical data, processes used to obtain clinical data, and processes used for measure calculation and data management. Much variation exists among ACOs and payer partners around the data sources, processes used to collect clinical data and measure calculation processes. Several ACOs and payer partners are using both electronic (e.g., lab results from health plan, EHR) and non-electronic sources (e.g., paper registry, patient survey) to collect the clinical data. One ACO and payer partner (Norton/Humana) will use only non-electronic sources to obtain blood pressure data. One site (Carilion) will be using all electronic sources to collect the needed data.

Further, some ACOs would be calculating measures based on their entire population, while other ACOs would be using sample-based approaches to calculate the measures.

- Comparability is a key goal for performance measurement within ACOs. However, Brookings-Dartmouth wanted to allow ACOs and payer partners to identify data collection approaches and processes that were acceptable to their organizations, rather than advocating for a uniform approach. Ms. Anise shared the key principles that were identified to ensure comparability of the different data collection and measure calculation processes used by sites:
 - Timely-How often are data obtained by the ACO and measures calculated?;
 - Reliable-Are the data consistent?;
 - Valid-Are we measuring what we want to measure?;
 - Auditable-What data or measure checks are needed?; and
 - Representative (for sample-based measures)-Are data obtained using a sample-based approach representative of the eligible population?
- Ms. Anise presented information to the Work Group specific to auditability and representativeness, since the timeliness of data was already established (i.e., reporting would occur every 6 months) and reliability and validity would be discussed under auditability.
- Ms. Anise presented examples of audit processes used by Monarch, NCQA, IHA, and CMS.
 - Monarch HealthCare uses a three-pronged audit approach:
 - Perform audit on overall data collection and management process by auditing body
 - Verify concordance of electronic data with data in patient records determined by an audit of a sample of patient records pulled by the auditing body
 - Perform internal chart audit (in Monarch's Standard Operating Procedures), based on sample that is separate from those pulled by the auditing body to confirm data validity
 - NCQA HEDIS has established a two-part audit process to ensure that health plans calculating HEDIS measures are complying with established data collection and measure calculation standards.
 - Ensure information systems capabilities: health plans must demonstrate adequate capabilities for collecting, storing, analyzing, and reporting health information
 - Ensure compliance with HEDIS specifications standards: auditors will design verification audit steps pertaining to specific HEDIS measures to ensure compliance with measure specifications
 - The Integrated Healthcare Association (IHA) has worked with NCQA to create an audit process similar to the HEDIS Compliance Audit for its pay for performance (P4P) program in California. Like the HEDIS audit, the P4P audit assesses the capability of an organization's information systems as well as its adherence to specifications for specific clinical measures. The P4P audit process has three parts: an off-site process, onsite process, and post-on site and reporting. Below are key components of this process:
 - Manual source code review
 - Supplemental data verification
 - Audit of organizations systems and processes
 - Audit of compliance with measure specifications

- CMS Hospital Outpatient Quality Data Reporting Program randomly selects a sample of patient episodes of care per year for validation.
- Ms. Anise presented potential criteria for representativeness:
 - Sampling of appropriate population for each measure (e.g., sampling only pediatric clinics for pediatric vaccination measures)
 - Sample size for each measure
 - Sampling strategy to ease burden of data collection

Discussion on Audit Processes

- One Work Group member indicated that audit processes are built into meaningful use requirements. EHRs must be certified to produce quality measures. EHRs could produce these measures and plans could certify that they used criteria defined by HHS to calculate the measures. Further, ACOs and payer partners could certify system capabilities, as well as certify data abstraction process.
- Joachim Roski commented that the participating sites have differing IT system capabilities and capacities. Many are still using legacy systems, which creates issues when trying to transfer information across a whole system.
- A Work Group member commented that the American College of Surgeons National Surgical Quality Improvement Program could also provide some information about audit processes, particularly for training of abstractors, which is a key issue when auditing data.
- Another Work Group member asked about the frequency with which the audits would take place. He suggested a three-year cycle.

Discussion on Representativeness

- Work Group members commented that sample-based approaches could introduce a lot of bias. The criteria used for sampling should address abstractors not collecting data properly (e.g., an abstractor is to obtain data and is instructed to have a sample size of 40 across eight sites and the abstractor stops at site six because they cannot find the data needed). The selected sampling frame should be comprehensive to avoid this type of bias.
- One Work Group member indicated that IHA's performance reporting initiative in California does not publicly report performance results with a reliability score of less than 0.70. The work done here may be useful in determining appropriate sample sizes for certain measures.
- The same Work Group member also suggested the use of composites. She stated that the work of NQF in this area is unfolding.

Next Steps

- Present and discuss options for audit processes and representativeness of sample-based measures to ACOs and payer partners
- Present discussion and approaches selected by ACOs and payer partners at the June 2 MIS Work Group call

Next Call

The next MIS Work Group call is scheduled for 6/2 from 3-4pm EDT.