

Quality Alliance Steering Committee, Measures Implementation Strategy Work Group
July 6, 2009 – Conference Call Notes

The following is a high-level review of the discussion points that were touched upon during the MIS Workgroup's conference call on Monday, July 6.

Workgroup co-chairs Lew Sandy and Paul Tang welcomed participants to the call. Lew noted that there had been a late change to the agenda because Mark Legnini of Brookings would be unable to participate on the call because of a personal matter. The agenda would be abbreviated for the day, and Mark would return on a future call to discuss his recent work on data integration initiatives as part of the High-Value Health Care Project.

Update on AHIPF data aggregation effort

1. Aparna Higgins of AHIP provided an update on recent efforts and activities related to the data aggregation project. Having reached agreements with several key health plans in the pilot states of Colorado and Florida, project staff began the processes of implementation with several of those health plans. Regularly (often weekly) calls are now underway with these health plans to address technical issues.
2. Aparna also discussed recent outreach activities to key stakeholders in Colorado, including the Colorado Medical Society, employer groups, and the Colorado CVE. Aparna indicated that these discussions were all very productive, and they received largely positive feedback. Project staff will begin a similar outreach effort in Florida in the coming months.
3. One workgroup member noted that Aparna had also presented an overview of the data aggregation effort at the AQA meeting on Tuesday, June 30, and was very well received there.

Overview of Racial/Ethnic Health Care Equity Initiative (REHEI)

1. Kalahn Taylor-Clark of Brookings presented a brief overview of the ongoing REHEI efforts, particularly with respect to how they intersect with the QASC 3-year workplan. She discussed the three efforts focused on indirect estimation of the racial/ethnic classifications of health plans' membership. Project staff and staff and RAND have been working with health plans directly in three states (Massachusetts, California, and Texas), supporting the implementation of RAND's indirect estimation methodology. They have also begun to address the technical and legal issues surrounding the sharing of this information at a summary level for analysis while preserving individual PHI. The pilots will vary by state such that different aspects of this technical process can be assessed contemporaneously. For example, in Massachusetts staff will address integrating indirect estimation methods in the context of state mandates (it is expected that Massachusetts will require health plans to collect these data starting next year), while in California staff will investigate the advantages and technical hurdles of pooling health plan data and resources for the collection and analysis of race and ethnicity data.
2. In response to a workgroup member's question, Kalahn noted that RAND's indirect estimation methodology could certainly be of great interest to many organizations beyond

those currently engaged in these pilot efforts. The methodology is not proprietary and so could also potentially be used in EHR systems.

3. Another workgroup member asked about the legal requirements health plans face at the state level with respect to collecting and analyzing race and ethnicity data, and Kalahn pointed out that currently 22 states require hospitals to record this information, but only two require health plans to record this information. Currently, there are no such requirements in place at the state level for ambulatory care centers and other centers of care.