NCVHS Presentation

AHIC Quality Workgroup and Draft Detailed Quality Use Case

Kristine Martin Anderson
Bethesda, MD
June 21, 2007

This document is confidential and is intended solely for the use and information of the client to whom it is addressed.

The AHIC Quality Workgroup was formed to address how HIT can be used for the development of quality measures

- **Broad charge of the AHIC QWG:**
  - Make recommendations to the AHIC so that HIT can provide the data needed for the development of quality measures that are useful to patients and others in the health care industry, automate the measurement and reporting of a comprehensive current and future set of quality measures, and accelerate the use of clinical decision support that can improve performance on those quality measures
  - Make recommendations to the AHIC for how performance measures should align with the capabilities and limitations of HIT

- **Specific charge of the AHIC QWG:**
  - Make recommendations to the AHIC that specify how certified health information technology should capture, aggregate and report data for a core set of ambulatory and inpatient quality measures

Based on its charge the Workgroup developed a vision to guide its recommendations to the AHIC and Secretary Leavitt

- Stakeholders will rely on transparent reporting of quality performance and quality improvement to inform their decision-making about care
- HIT and the sharing of health information across a network of regional HIE will use data from EHRs, PHRs, and strong CDS systems will assist providers in ensuring the right care is delivered to the right patient – every time
- Consumers and policymakers will use these same systems to understand how well the nation as a whole and individual providers are doing in improving care and health status in accordance with national, regional, and local priorities
- National agenda will be in alignment with state and regional health care reform policies
- Performance information will be timely, comprehensive, and trusted as a true measure of how well the nation is addressing high-priority gaps in quality and safety
- Performance and quality improvement will be accelerated because information systems increase the ability to make optimal care decisions
- Results will demonstrate significant progress on the nation's quality goals reinforced by public reporting on metrics and a payment framework that aligns expectations and resources among providers, employers, public and private payers, and consumers

The vision included characteristics for a National Quality Enterprise and building blocks to make the Enterprise functional

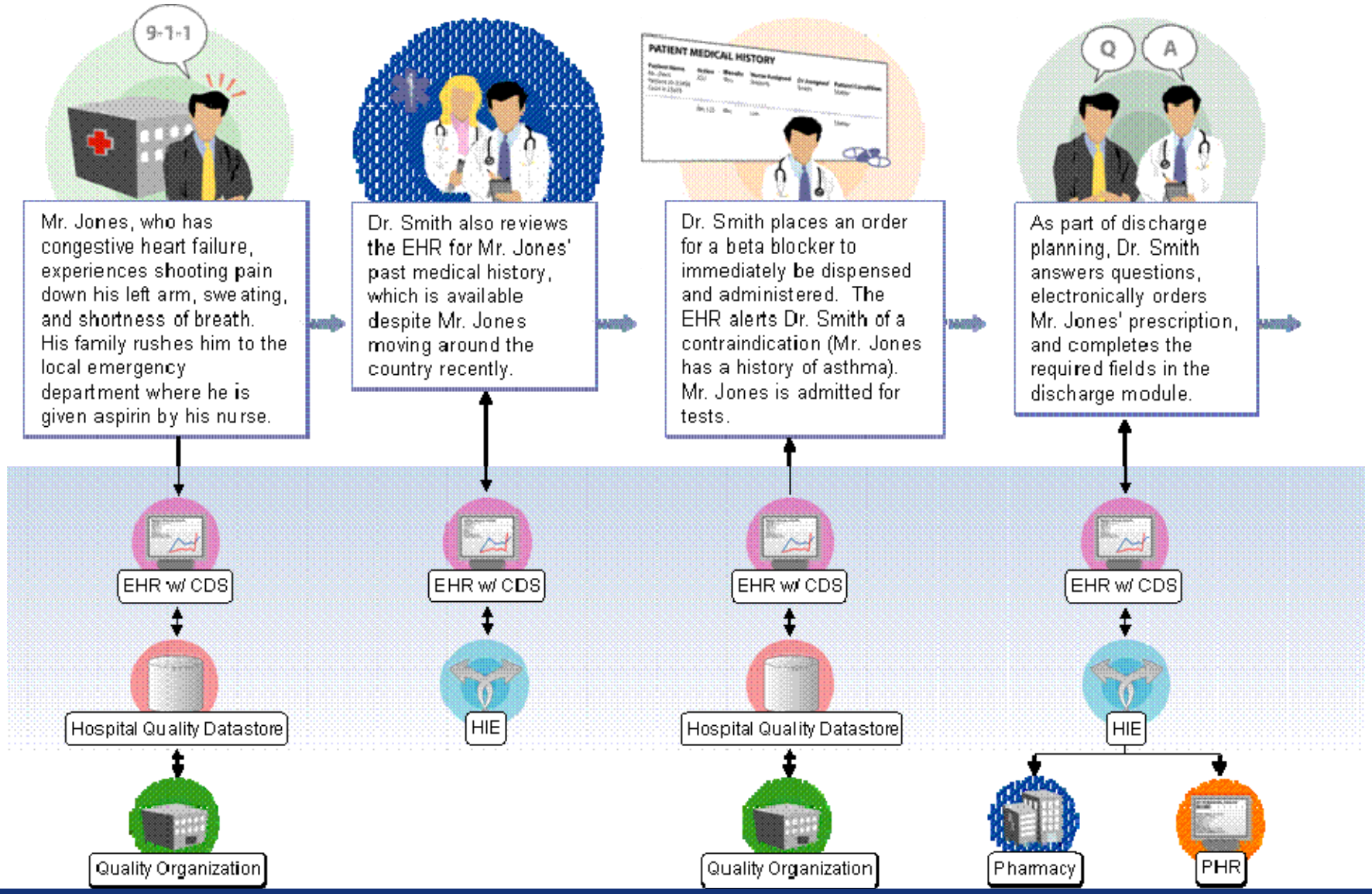
Characteristics of the Health Care System – National Quality Enterprise

- Information dissemination
- Information sharing
- Population health management
- Care Coordination
- Quality improvement
- Quality measurement and reporting
- Payment alignment with quality

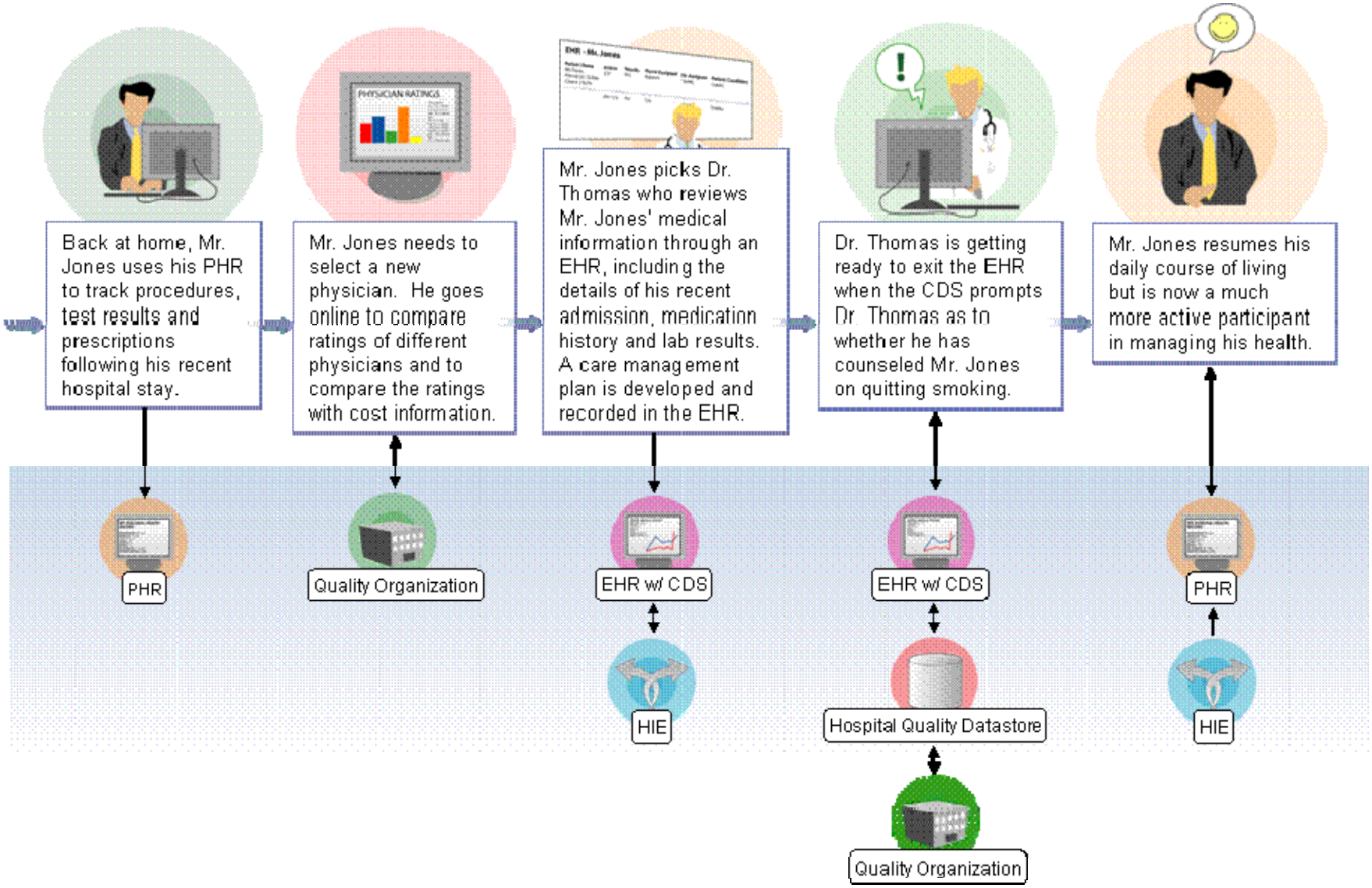
National Quality Enterprise Building Blocks

- Consensus quality metrics
- EHR adoption
- EHR products that enable quality measurement
- Data stewardship
- Data aggregation
- Population reporting and public feedback
- Health Information Exchange and Intermediaries
- Privacy and Security Policies, including secondary uses

Case Study: A Patient's Perspective of the Future Vision



Case Study: A Patient's Perspective of the Future Vision (cont'd)



The 1st set of AHIC recommendations focused on improving information flow during a health care encounter to ensure delivery of quality care and to enable automated quality measurement…

1. Automate data capture and reporting from electronic health records to support a core set of AQA clinician-focused and HQA quality measures

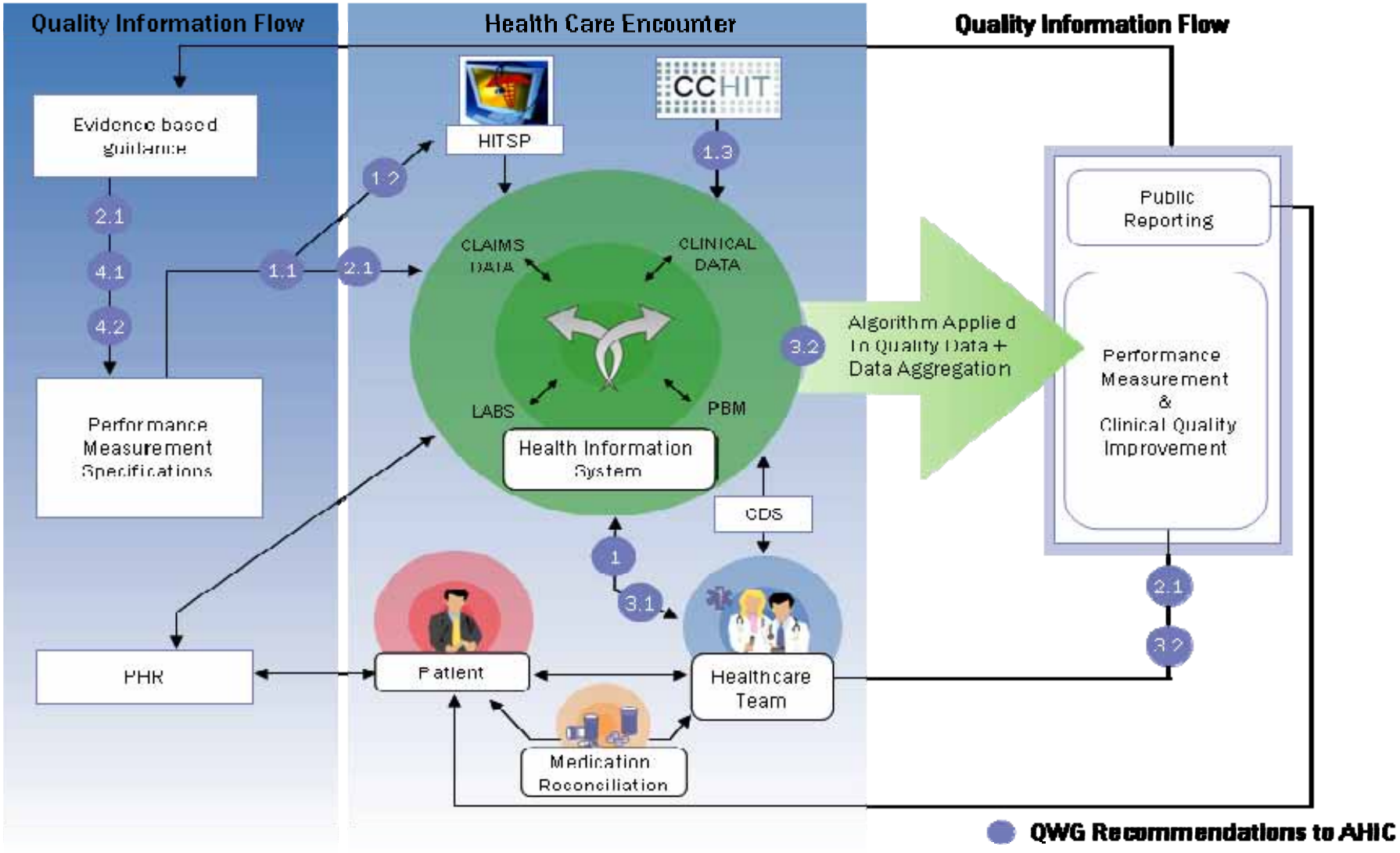
2. Establish a unified framework and enhanced collaborations for gathering key data from care processes and delivering key information to providers to help improve outcomes

3. Enable data aggregation for public reporting of quality metrics based on data that pool payer & provider data and can merge with other data sources while protecting privacy

4. Align quality measurement with the capabilities and limitations of health information technology

. . .but did not specifically address the area of privacy and security which is a requirement of the Quality Enterprise

Privacy, security, and uses of data are issues that impact the flow of information both into and out of a patient encounter

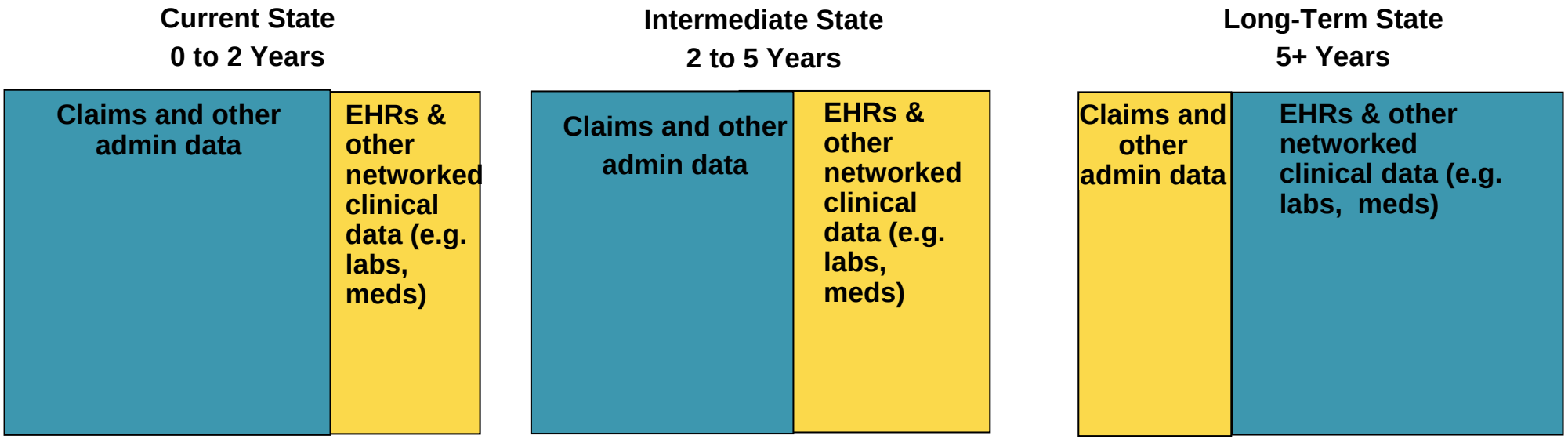


An environmental scan is being conducted to inform the next set of recommendations using longitudinal measurement as the framework

- As recognized by the QWG vision, quality measurement must shift from the viewpoint of one care setting at one point in time to measurement that can assess quality of care across the spectrum of care settings from a longitudinal / episodic perspective
- Longitudinal measurement is particularly important when considering chronic illnesses, though there are also many cases where it is needed for acute care as well
- For example: Current diabetes care measurement only looks at treatment from a single lens, either inpatient or outpatient, and focuses on only one aspect of the full spectrum of treatment a diabetes patient may require, usually an encounter at a time
  - Measurement of HbA1c control for an individual visit provides information on current status
  - Measurement of HbA1c levels over the course of the year provides information on how well the patient is managing their illness and will help the physician determine what course of actions to take to help control the diabetes

A longitudinal measurement focus addresses the issues around the integration of multiple data sources to inform measures

- The QWG hopes to help define a path from predominantly sole-source measurement to multi-source measurement



The environmental scan will use a specific set of questions targeted at longitudinal measures to guide the data collection process

High-level Categories of Questions

- Business and financial drivers
- Collection and aggregation of data from multiple sources
- Collection and aggregation of data across multiple organizations
- Database storage, hosting and ownership
- Data availability and reliability
- Provider feedback / quality improvement
- Data use and data sharing agreements
- Privacy and security

Quality Workgroup Meetings and Activities

1. Public meetings
   - *May 3*
   - *June 22*
   - *August 30*
   - *October 3*
2. Publish Federal Register questions *(June 2007)*
3. Stakeholder interviews

The Quality Use Case which details the data flows to support quality measurement and improvement was developed by the NHIN Use Case Team

- The Draft Detailed Quality Use Case addresses four key areas based on AHIC's recommendations:
  - Integration of data to support quality measurement
  - Feedback and reporting into EHRs
  - Use of quality measures to support clinical decision-making
  - Aggregation of quality information across multiple providers and entities to support public reporting

- The Draft Detailed Quality Use Case depicts two scenarios related to quality measurement, feedback and reporting with respect to a patient's encounter with the health care delivery system
  - Quality measurement of hospital-based care
  - Quality measurement of ambulatory-based case

We identified several areas related to the data flows depicted in the Draft Detailed Quality Use Case that may be of interest to the ad hoc workgroup

- The following slides include a ★ where the following issues would intersect with the data flows
  - Privacy and security
  - Data access / sharing
  - Data identification, anonymize or pseudonimize
  - Provider feedback
  - Data validation for de-identified data
  - Roles of peer review across organizations
  - Data uses
  - Data stewardship and ownership

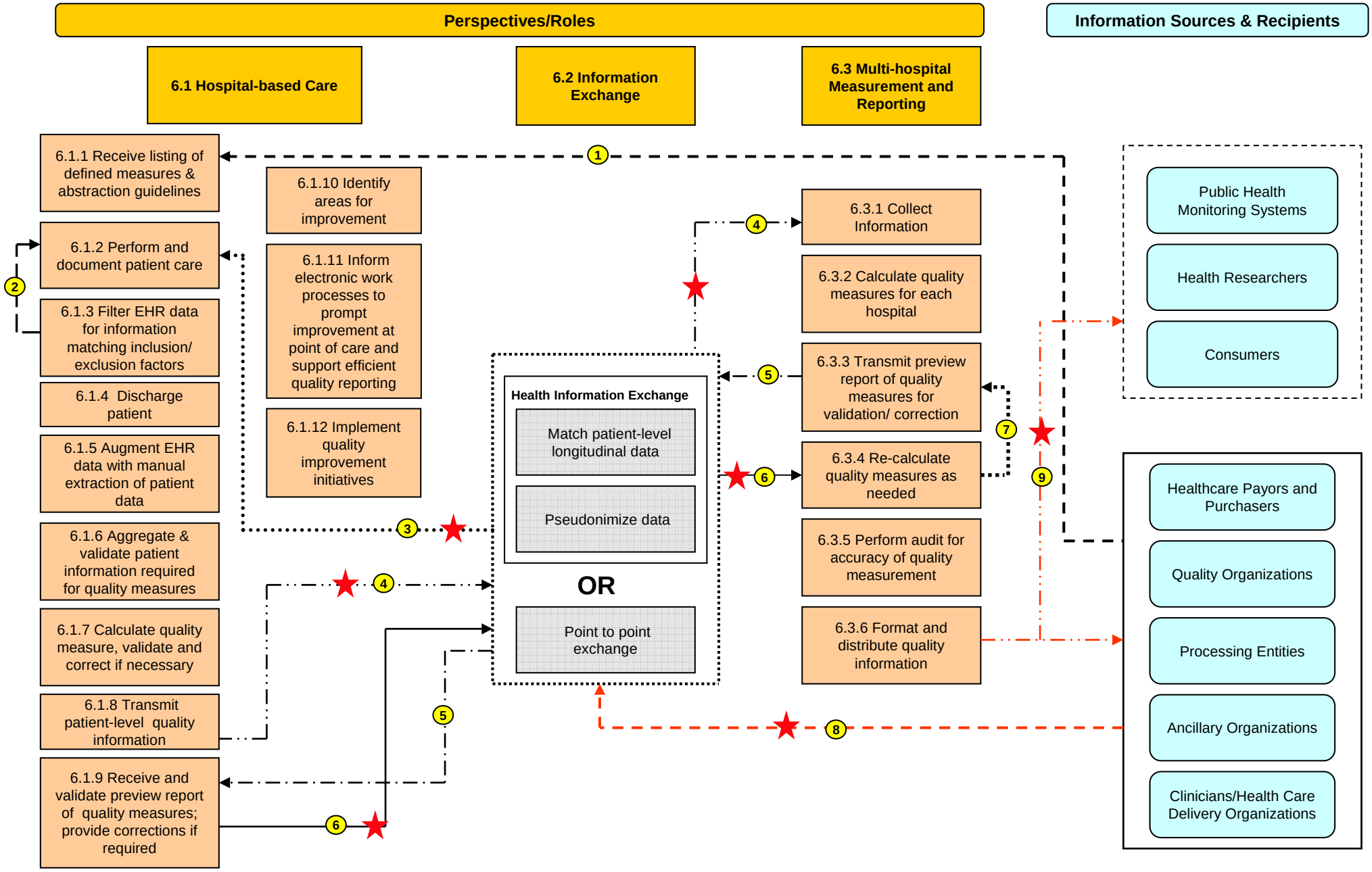
Draft Hospital-based Care Quality Information Collection and Reporting Flow

★ = Potential Intersections

Scenario Flows

1. Defined quality measurement specifications to be reported are sent to hospitals.
2. Notice is given to clinicians to support clinical decisions and augment recorded data
3. Longitudinal health information held in associated repositories is forwarded by the HIE (patient-level – identifiable) ★
4. Hospital quality data is sent either via an intermediate entity or point-to-point for onward transmission to the Multi-Hospital Measurement and Reporting entity (patient-level – identifiable) ★
5. Preview report is sent directly for validation and/or correction (aggregated hospital-level data)
6. Corrected quality information is sent directly to the Multi-hospital Feedback and Reporting Entity (patient-level – identifiable) ★
7. Corrected reports are sent for validation and/or correction (aggregate hospital-level data)
8. Claims data is collected from Payors (patient-level – identifiable) ★
9. Distributed data is available to users (aggregate hospital-level data) ★

Draft Hospital-based Care Quality Information Collection and Reporting Flow



There are opportunities for the Workgroup and NCVHS to leverage knowledge from each other's efforts on specific topics

- What are allowable approaches for use of data for quality measurement and reporting as specified by AHIC Quality Workgroup and Quality Use Case?
- How does an HIE or the NHIN verify identities and authority of data users?
- If longitudinal data is aggregated for quality, where in the work flow should that data be identified, anonymized or pseudonimized?
- How do we make explicit tradeoffs between using the data for clinical decision support (where identifying which persons require identification) is important, and the privacy risks?
- How can provider feedback loops be maximized while privacy is still protected?
- How can measure result validation be performed if the data is not identified?
- Who should be able to access what form of data for longitudinal data management?
- Is data that is aggregated across providers and institutions still protected by peer review?

Appendix A: AHIC Quality Workgroup Recommendations

Recommendation 1: Automate data capture and reporting from electronic health records to support a core set of AQA clinician-focused and HQA quality measures

- Recommendation 1.1: The Quality Alliance Steering Committee, with support from HHS and other relevant federal agencies, should convene an expert panel that would accelerate the current efforts to identify a set of common data elements to be standardized in order to enable automation of a prioritized set of AQA and HQA measures through electronic health records and health information exchange. The Quality Alliance Steering Committee, with support from HHS and other relevant federal agencies, should establish the priority order for the measures. This panel will build on work already done by NQF and others. The first group of recommendations from the expert panel should be shared with the Community by June 5, 2007

- Recommendation 1.2: The Health Information Technology Standards Panel (HITSP) should use the work of the Quality Workgroup's expert panel recommended in 1.1 to identify the data standards to fill identified gaps for data elements required for automation of core sets of AQA and HQA quality measures

- Recommendation 1.3: CCHIT should develop appropriate criteria necessary to support the reporting of core sets of AQA and HQA measures in the next round of criteria development

Recommendation 2: Establish a unified framework and enhanced collaborations for gathering key data from care processes and delivering key information to providers to help improve outcomes

- Recommendation 2.1: The expert panel convened by the Quality Alliance Steering Committee in Recommendation 1 should gather, synthesize and refine clinical workflow maps, focusing on care processes related to the care underlying the conditions targeted by the prioritized set of AQA and HQA measures
  - The Quality Alliance Steering Committee, with support from HHS and other relevant federal agencies, should establish the priority order for the measures
  - The panel should determine mechanisms and opportunities within these workflows for identifying patients who are eligible for inclusion in the AQA and HQA measure populations, for gathering performance measurement data, and for providing clinical decision support to optimize performance in targeted areas
  - A generic framework that could be used across many clinical conditions, the deliverable should include at least one scenario for how the workflows operate for AQA/HQA targeted conditions
  - Measure inclusion mechanisms must protect privacy and confidentiality. The results of this analysis should be reported to the Community by September 18, 2007

Recommendation 3: Enable data aggregation for public reporting of quality metrics based on data that pool payer & provider data and can merge with other data sources while protecting privacy

- Recommendation 3.1: HHS, working with relevant public and private sector leaders and the BQI projects, should identify and articulate the key challenges associated with linking claims data from multiple sources (e.g., physician IDs, claims adjudication processes, data storage/purge policies), and the benefits and challenges of linking clinical data to other data sources, including claims. A report should be submitted to the Quality Workgroup by June 30, 2007.
- Recommendation 3.2: HHS should enable, through the NHIN contracting process and Value Exchanges, efforts to combine clinical and non-clinical electronic data for quality measurement and timely reporting of results.

Recommendation 4: Align quality measurement with the capabilities and limitations of health information technology

- Recommendation 4.1: HHS, through the Centers for Medicare & Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ), along with major measure developers, should identify opportunities to enhance measure development by considering the data needs at the time a measure is developed, especially for measures targeted for public reporting. This effort should also include clinical practice guideline developers and should coordinate their role in developing performance measures.
- Recommendation 4.2: The National Quality Forum, through its endorsement process, should apply criteria that reinforce the use of standardized data elements in measures to allow quality measures to be embedded in EHRs. The NQF may do so by incorporating such criteria into its endorsement criteria for new measures.