Report: AHIC Quality Workgroup

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Advancing Health IT and Quality Improvement

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Bottom Line

- In 2006 we *believed* health IT would enhance health care quality and value

- We have created a clear path forward

- The devil is in the details

Context: Moving to Value-Driven Health Care

- Costs increasing much faster than quality

- Payment rewards *volume*, not value

- Current focus on transparency re quality and cost, incentives to reward high performance, 'hard wiring' quality

- Health IT could reduce burden and help accelerate improvement

- Needed: a clear path aligning quality and health IT

Vision for Coordinating Health IT and Quality Improvement

- Transparent reporting of meaningful quality performance informs choices and focuses improvement efforts

- Quality information is patient-focused

- Health IT can reduce reporting burden and drive improvements in care when it is delivered

- Requirement: ONE set of priorities for quality

A Two-Track Process: Long- and Short-Term

Short-term Charge:

Recommendations to AHIC that specify how HIT should:

- Capture, aggregate and report data for a core set of ambulatory and inpatient quality measures (AQA and HQA)

A Two-Track Process: Long- and Short-Term

Long-term Charge:

Recommendations to AHIC that allow HIT to:

– Provide data to develop quality measures useful to patients, providers and others

– Automate the measurement and reporting of a comprehensive, current and future set of quality measures

– Accelerate use of clinical decision support that improves performance on those quality measures

Key Themes from the Vision Guided the Workgroup

- **Patient-focused quality measurement**
  - Payment changes and reforms that accelerate the pace of quality improvement
  - Importance of data exchange and aggregation
  - Alignment with national priorities for quality of care
- **Proactive consideration of health IT in supporting quality measurement**
- **Support for use of data from multiple sources**
- **Adoption of EHRs and other applications**
- **Support for evidence-based care and quality improvement through effective use of Clinical Decision Support (CDS)**

Conceptual Roadmap for Achieving the Vision of the Quality Workgroup

Future State Components	2008	2009	2010	2011	2012	2013
Policy: Incentive	Small but increasing evidence base from existing P4P/VBP programs	Payment principles established	Consensus reached on paying for value	Payment changes and reforms created and tested		Payment changes and reforms implemented
Legal Framework for Data Sharing	HISPC reports released (2007)		States agree on common framework		States harmonize regulations and statutes addressing privacy and security for data sharing	
Data Stewardship	Broad agreement on need	Policies & procedures developed	Sample HIE agreements developed	Stewards identified — Stewards certified & compliance w/ rules established		
Data Exchange and Aggregation	Limited aggregation (primarily claims data)	Increased aggregation for P4P (increased use of clinical data)	Scalable data model exists	Established longitudinal aggregation (multi-source patient-centric data used including clinical and claims data)		
Infrastructure: Clinical Decision Support	CDS use is not standardized	Pilot studies of standardized CDS implemented	Best practices for patient-centric CDS established	Best practices for patient-centric CDS incorporated into certification criteria	EHRs w/CDS and other CDS tools certified	
Measure Set Evolution*	Setting-specific metrics used; NQF exploring episodic measures	Consensus-based patient-centric quality metrics identified and field tested		Single set of patient-centric quality metrics used		
Data Element Standardization	NQF HITEP identifies data element types	Standards identified for elements needed for quality measurement on an ongoing basis		Standards for quality measurement incorporated into EHR certification process		
Quality Data Set	Preliminary efforts by CMS (CARE tool) and NQF (HITEP)	Minimum QDS established for core measures	QDS expanded for additional measures (e.g., structural, outcome)	QDS includes data elements for longitudinal, patient-centric measures		
Coding Improvements	Classification systems (e.g., ICD-9) that facilitate billing are used for quality reporting	Ongoing efforts to improve coding of diagnoses and clinical care, mapping across coding systems, and guidance		CMS regulates conversion to ICD-10		
Patient & Provider Record Matching	Multiple methods used; demos and pilots in place	Technical principles and best practices established		Accountability for matching methods established		

*Potential Accelerant

Key Recommendations from the Workgroup

1. **Facilitate the alignment of initiatives to develop and implement measures for quality improvement**

2. **Develop and implement a quality data set to support quality measurement and reporting**

3. **Prioritize the creation of standards for structuring selected clinical data**

Interface Opportunities

- A multitude of interface options exist between the health IT and quality measurement/reporting communities. For example:
    - ONC, AHRQ, QASC, AHIC 2.0 and other HHS entities will work together to align quality improvement and health IT initiatives
    - HHS agencies including CMS and AHRQ will collaborate with key private sector stakeholders to define a quality measurement data set that would be automated, patient-centric and longitudinal
    - In expanding its set of quality measures, CMS plans to work with the Indian Health Service to test effectiveness of harmonized data types to capture and aggregate data from electronic health records

Continued Public-Private Action Needed to Realize Vision

- Quality Workgroup focused 2008 recommendations on areas with substantive short-term and sustainable progress

- Recommendations to AHIC on infrastructure components:
  - ➢ Data Element Standardization
  - ➢ Quality Data Set
  - ➢ Most impact in short term

- Quality Workgroup's recommendations will need continued attention by public and private entities, such as AHIC 2.0 and National Quality Forum

- Policy oriented components of the Vision Roadmap, such as Incentives and Data Stewardship, will need further attention

Connecting 'Achievability' and Reliability…

- A robust health care system must include capacity for:
  - Rapid translation of beneficial advances or breakthroughs
  - Connectivity with the biomedical enterprise

Achievability: What can work under ideal circumstances for some people

Reliability: Getting it right for all patients every time – the first time
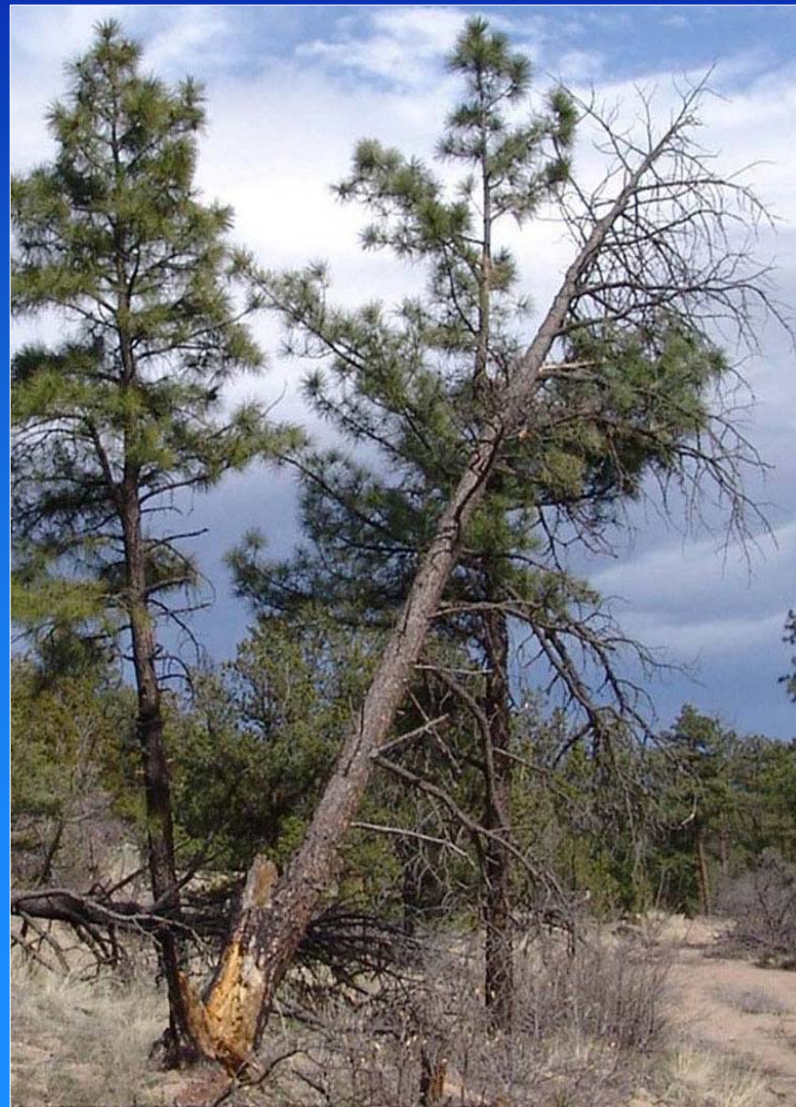
Questions?

http://www.hhs.gov/healthit/ahic/quality

http://www.ahrq.gov
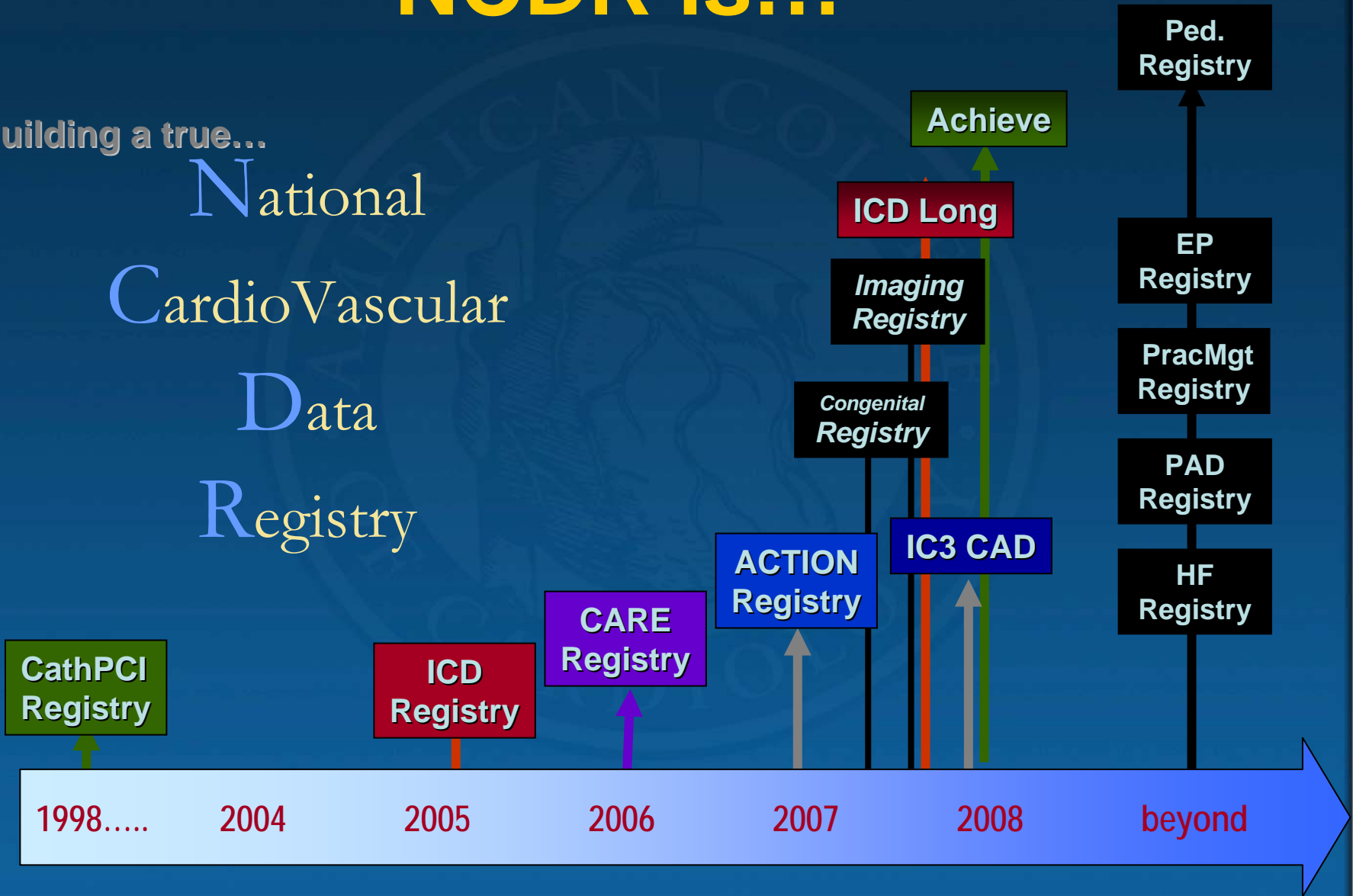
ACTION Registry®-GWTG™

- most comprehensive cardiovascular patient database ever developed
- collaboration between NCDR® and American Heart Association Get With The Guidelines[SM]-CAD Registry
- high-risk ACS patients with STEMI and NSTEMI

3

IC³ Program®

- Office-based/ambulatory program
- PM-CAD, HF, HTN, Diabetes, AF, Cardiac Rehab
- 211 offices
- EMR integration, need for decision support critical

ACC/AHA/STS/Brookings Collaboration

- National strategy and infrastructure for two-way exchange of data between CV registries and claims databases

Combination Therapy for Cancer: Using Medical Records and Insurance Claims for Quality

November 24, 2008

Two Different Sources for Cancer

Medical Records

+ Cancer staging
+ Prognostic markers
+ Exact dosages of medications
- Limited to one specialty
- No cost information
- No drug information from other sources
- Expensive collection
- Not timely

Insurance claims data

+ Longitudinal
+ Includes all specialties
+ Includes all drugs
+ Cost analysis
- Can't identify stage
- Can't compare clinically comparable groups

An Early Attempt

187 breast cancer patients receiving trastuzumab

8%   HER2/neu underexpressed

4%   No HER2/neu test performed

Primary source report required
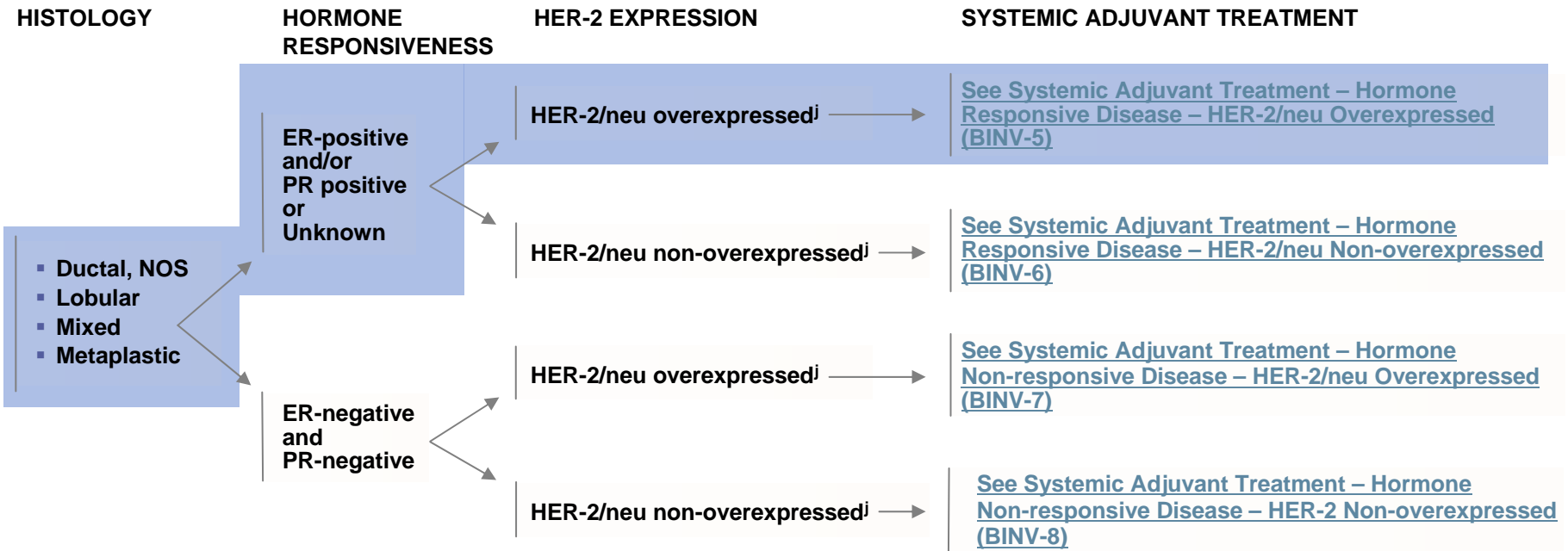
Trastuzumab Therapy Examples 1-2

Current Projects

- Ohio cancer profiles
  - Collaboration with American College of Surgeons, UnitedHealthcare and Wellpoint
- Brookings Institute
  - Concordance of medical records and tumor registry
- Data sharing with oncologists
  - 61% voluntary compliance with requests for stage, prognostic factors and status

Measuring Concurrence with Mixed Data

UnitedHealthcare®
Healing health care. Together.™

NCCN® Practice Guidelines in Oncology – v.2.2006

Invasive Breast Cancer

HISTOLOGY	HORMONE RESPONSIVENESS	HER-2 EXPRESSION	SYSTEMIC ADJUVANT TREATMENT
▪ Ductal, NOS ▪ Lobular ▪ Mixed ▪ Metaplastic	ER-positive and/or PR positive or Unknown	HER-2/neu overexpressed[j]	See Systemic Adjuvant Treatment – Hormone Responsive Disease – HER-2/neu Overexpressed (BINV-5)
		HER-2/neu non-overexpressed[j]	See Systemic Adjuvant Treatment – Hormone Responsive Disease – HER-2/neu Non-overexpressed (BINV-6)
	ER-negative and PR-negative	HER-2/neu overexpressed[j]	See Systemic Adjuvant Treatment – Hormone Non-responsive Disease – HER-2/neu Overexpressed (BINV-7)
		HER-2/neu non-overexpressed[j]	See Systemic Adjuvant Treatment – Hormone Non-responsive Disease – HER-2 Non-overexpressed (BINV-8)

Creating the Physician's Value Case: Aligning Performance Measures with Clinical Guidelines

Paul Tang, MD
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Stanford University School of Medicine

Creating the Physician's Value Case
### *Performance Life Cycle*

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Performance vs. Reporting
Diabetes Example

- Guideline: Check HbA1c every <u>3-6 months</u>
  - Reporting: 92% <u>1 yr (??)</u>
- Guideline: Lower <u>HbA1c < 7.0%</u>
  - Performance (2004 NCHS, survey): 49%
  - Reporting: 12% <u>HbA1c>9% (??)</u>
- Guideline: Maintain <u>BP <130/80</u>
  - Performance (2000 NHANES): 36%
  - Reporting (2004 NCHS, <u>140/80 (??)</u>): 57%

JAMA 2004; 291:335, AHRQ MEPS, 2004, NCHS, 2004

Clinical Decision Support
Diabetes Example
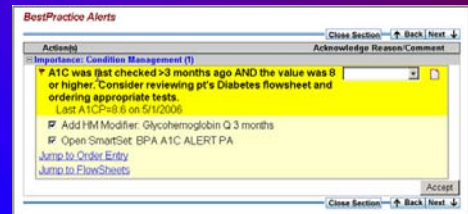
Quality Measures
HbA1c Control
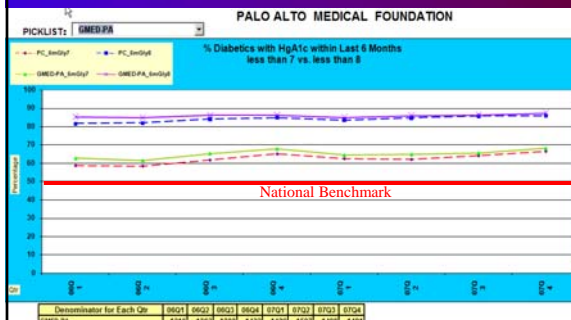
Summary
Strategy of Aligning Goals, Efficiently

- Align quality measures with clinical guidelines → physician engagement (what *they* believe)
- Base quality measures on clinical data (believable)
- Standardize quality measures → lower burden
- Incorporate quality data elements in EHRs → 'F7'