The Office of the National Coordinator for Health Information Technology

Is it Time to Re-Focus on the Practice? Strategies and Support for Reliable Quality Measurement

Craig Jones – ONC Resource Center
Hans Kastensmith – Capitol Health Associates
Patrick Gordon – Rocky Mountain Health Plan

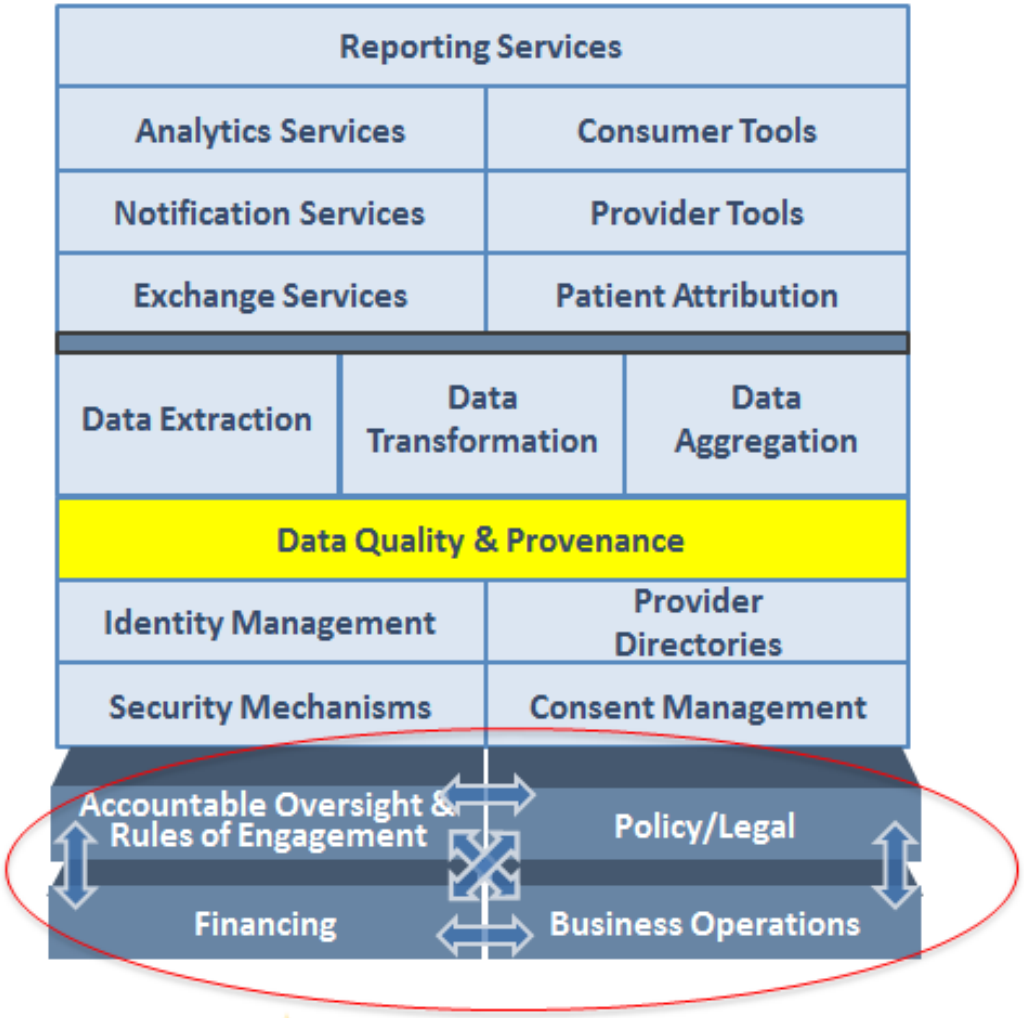
Context

- **Value based payment models** are driving traditionally segregated provider groups to enter into new business arrangements, where they work together to improve coordination and quality of services, and health outcomes
- **Growing need to evaluate variation and comparative performance** across settings, a process that depends on aggregation of reliable data (e.g. claims, clinical).
- **Aggregating reliable clinical data from EHRs has proven challenging**, particularly for independent practices that don't have substantial administrative and technical support.
- **These challenges have stimulated interest and innovation** around how to support practices in order to assist with changes in workflow, and to improve the ability to evaluate outcomes while reducing measurement burden.

ONC Support of the State Innovation Models Initiative

- ONC is providing technical assistance to CMS and State Innovation Model States.
- This involves one-on-one subject matter expertise as well as the creation of tools and resources that can be leveraged to support health IT innovation in care delivery and payment systems.
- Materials Cover:
  - Privacy and Security
  - Alerting
  - ID Management
  - Behavioral Health
  - Provider Directories
- Materials are published at: https://www.healthit.gov/providers-professionals/state-innovation-model-health-it-resource-center

Health IT Modular Functions

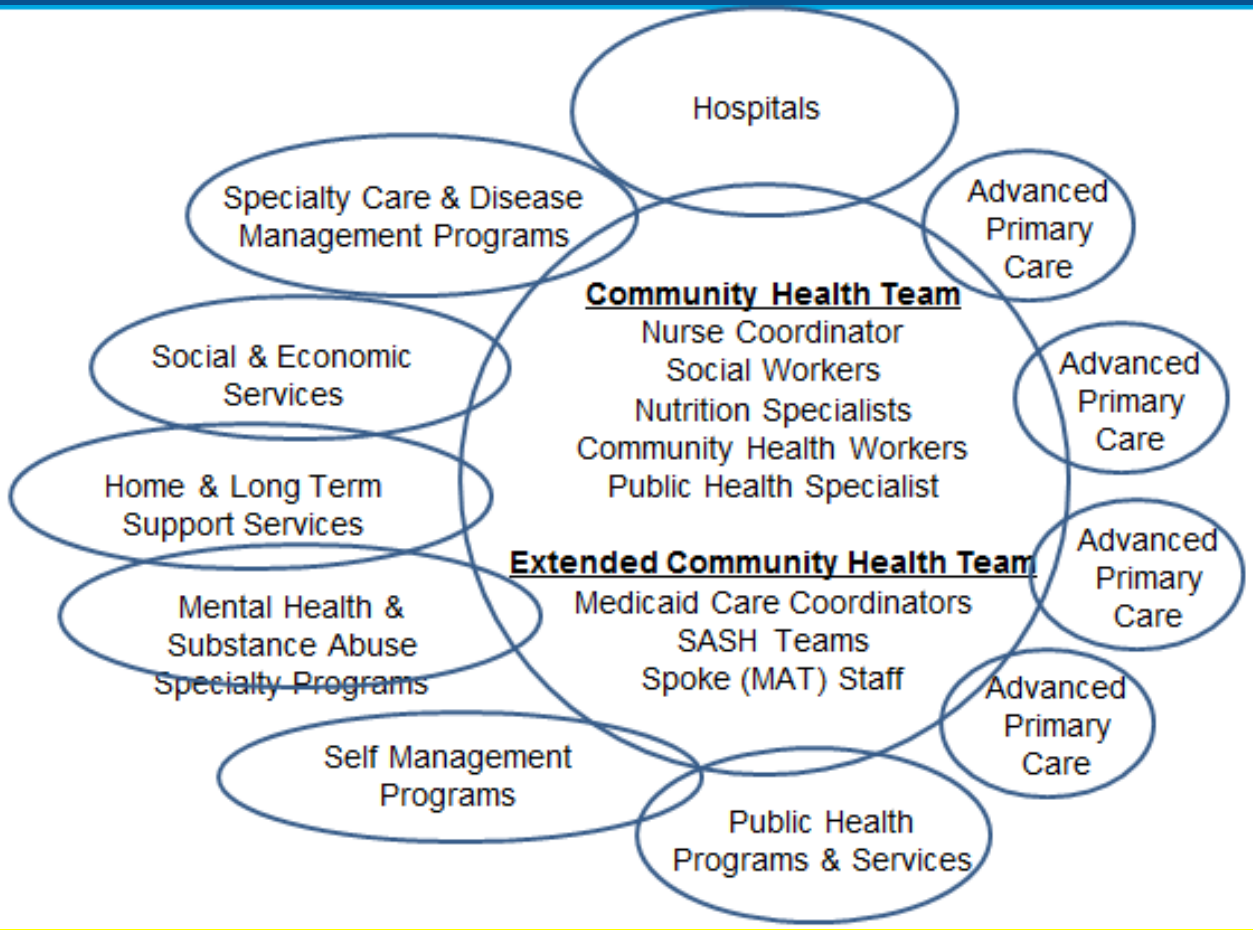


Additional Tools Being Developed

- Strategic planning and implementation guide for health IT enabled quality measurement in support of alternative payment models
- Decision guide to assist with selection of data extraction and measurement strategies
- Content enhanced based on recent HITeQM in-person meeting with SIM States

← Foundation for a 'healthy' Health IT Stack

Vermont's Community Oriented Medical Home Model



All-Insurer Payment Reforms

Transformation Network

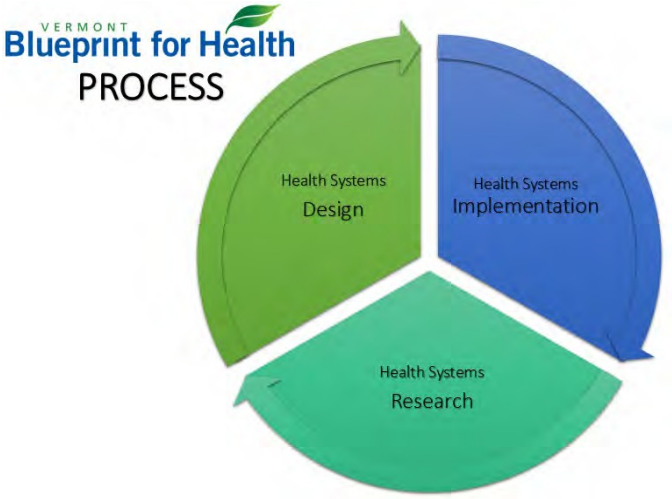
Service Area & Statewide Collaboratives

Data Infrastructure

Evaluation & Comparative Reporting

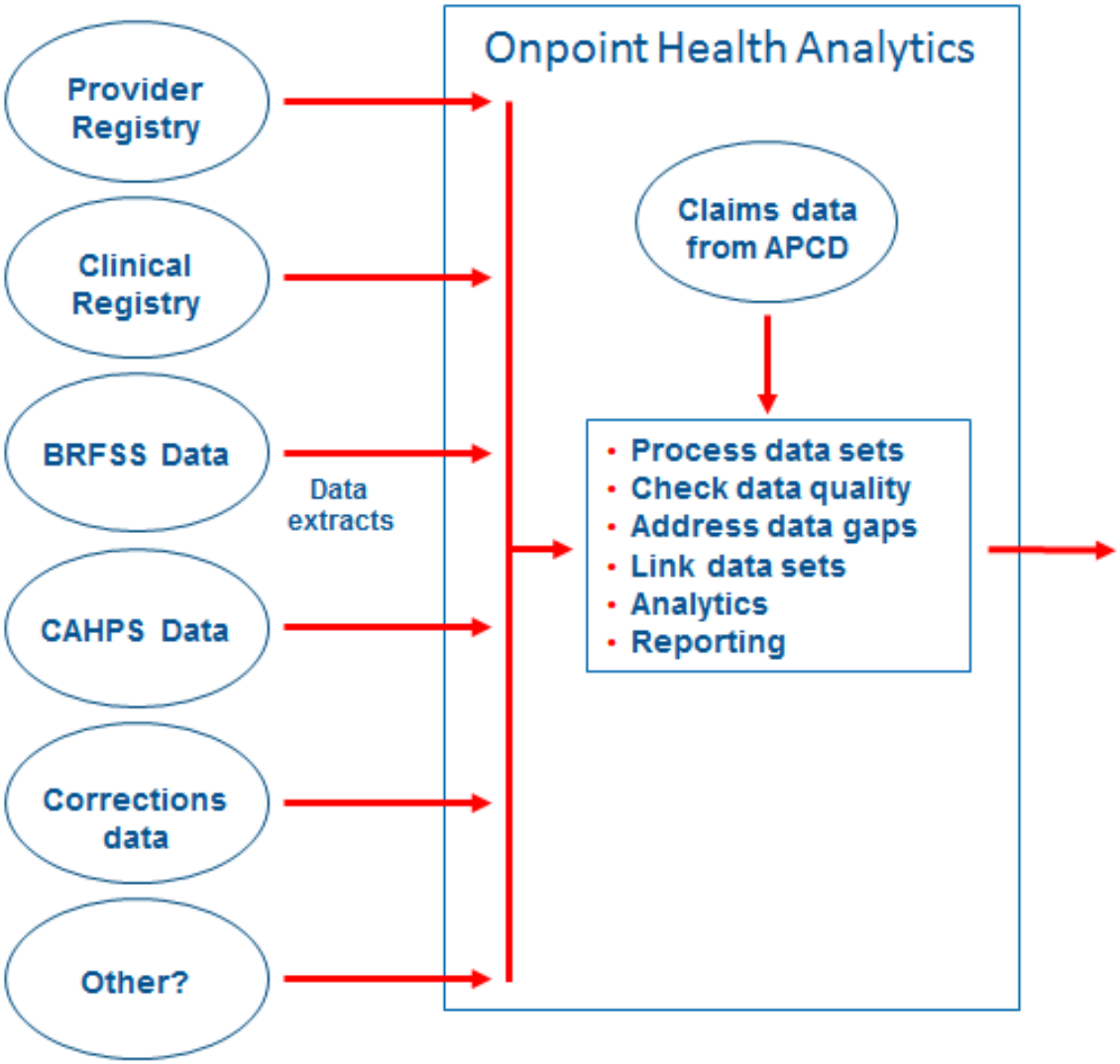
Statewide Network for Comparative Learning

- 31 Community Health Team Leaders
- 19 Blueprint Practice Facilitators
- 14 Blueprint Project Managers
- 4 ACO Clinical Quality Leaders
- 6 ACO Clinical Consultants



Practice Profiles Evaluate Care Delivery Commercial, Medicaid, & Medicare

Data Use for a Learning Health System



Measurement

- Utilization
- Expenditures
- Unit Costs
- Quality
- Patient Experience
- Social, Economic, Behavioral
- Variation & Associations

Products

- Practice Profiles
- HSA Profiles
- Learning System Support
- Performance Payments
- Program Impact & Publications
  - PCMH + CHT
  - Opioid Program
- Predictive Models

Use of Federal & State Funding Streams

- State HIT Fund
- 1115 Waiver
- IAPD
- SIM

- HIE Infrastructure
- Clinical Registry
- Provider Registry
- All Payer Claims Database
- Patient Experience Survey
- Data Processing
- Analytics
- Reporting

Collecting Reliable EHR Data for Quality Measurement

Core Measure Set Defines Priority Data Elements

- Capture elements in EHR system
- Extract elements from EHR system
- Transmit to intermediary systems
- Aggregate priority data elements
- Establish patient level records

Evaluate Completeness & Utility of Data from each Source System

Improve Completeness & Utility of Data from each Source System

Dedicated Team for Data Quality

'EHR Capture to Aggregation to Assessment to Improvement'

Vermont Blueprint Data Quality Initiative

SPRINT Program

VERMONT Blueprint for Health
Smart choices. Powerful tools.

Capitol Health Associates LLC
Hans C. Kastensmith
Managing Partner

Introduction

- Clean Reliable End to End Data
  - The goal of the Blueprint Sprint is to establish end to end data extraction, transmission, and registry reporting in support of health services
- Results Oriented Team Approach
  - The Sprint Program utilizes a results oriented approach where all participants engage in ownership and responsibility for achieving the stated measure of success.
  - The individuals work together as a complete team, with regular direct communication, until the goal is achieved.
- Intensive Interaction to Completion
  - A focus and intensity is maintained by all partners so that this process is accelerated and completed at each site as soon as possible.
- Completion and Verification
  - Data is verified and accepted by the lead clinicians
  - Analysis can be run and HSA Profiles Produced

High Level Sprint Process

- Blueprint Community Evaluation
- Build Team
- Initial Site Evaluation
- Action Plan
- First Sprint Meeting Reviews Goals and Defines Roles
- Weekly Progress Meetings on Continuing Work
- Final Data Continuity and Validation
- Ongoing Maintenance

Sprint Team

- Multi-Disciplinary Teams
  - Representatives from the community and practices are selected and dedicated to the process from beginning to end.
- Lead Clinicians
  - A lead clinician from each practice
- Lead Site IT Representatives
  - An individual or group that have access and insight to the sources of data
- Vermont Information Technology Leaders (VITL)
  - HIE interface team and eHealth Specialist members
- BPCR Team
  - Program and Project management team
  - Onboarding and support team members
- Blueprint
  - BP Director, Sprint Program Team, BP Assistant Directors, Project Managers, others
- Bi-State representative (where applicable)

Initial Site Evaluation

- An initial evaluation is conducted with the site(s) on Demographic and Clinical data collected.
  - Review of EMR data transmission and format capabilities
  - Review of connectivity issues and capabilities
  - Review workflows and procedures around data entry
  - Assess the quality and consistency of data at the source
  - Compare the data transmitted to the V-HIE/BPCR (where applicable.)
  - Generate exception report to identify issues in the feed

Initial Data Verification

- An exception list is generated that gives the team a detailed view of data related issues
  - Shows % of good and bad data elements
  - Permits identification of mapping issues
  - Allows for translation and missing elements to be addressed
  - Identifies data entry issues
- Promotes situational awareness
- Sets up the basis for Action Plan

Data Verification Report

MeasureID	MeasureName	TotalMeasures	TotalValid	PctlValid	ReqMap/Trans	ReqMap/Trans
594	Foot Exam - Visual Inspection	2	2	100.00%	-	0.00%
635	Height (inch)	16,120	16,097	99.86%	23	0.14%
636	Weight (lb)	19,250	19,171	99.59%	79	0.41%
637	Body Mass Index	16,111	16,100	99.93%	11	0.07%
678	BP SBP	19,223	19,222	99.99%	1	0.01%
679	BP DBP	19,221	19,221	100.00%	-	0.00%
800	Lipids-fasting	1	1	100.00%	-	0.00%
1855	HDL - Female	4,658	4,651	99.85%	7	0.15%
2144	Asthma Classification (at diagnosis and between treatment)	118	112	94.92%	6	5.08%
2310	What, if anything have you done about these feelings?	2	2	100.00%	-	0.00%
2367	PHQ 9 Total Score	80	79	98.75%	1	1.25%
2552	Exercise Duration (minutes per day)	198	1	0.51%	197	99.49%
2588	Total Cholesterol	9,753	9,704	99.50%	49	0.50%
2763	Exercise (# days/week)	9,076	3,696	40.72%	5,380	59.28%
3138	Hep A	40	-	0.00%	40	100.00%
3506	Triglycerides	9,073	9,050	99.75%	23	0.25%
3517	LDL	9,347	9,222	98.66%	125	1.34%
3620	Tetanus	9,326	68	0.73%	9,258	99.27%
3983	a. little interest or pleasure in doing anything?	2	2	100.00%	-	0.00%
3984	b. feeling down, depressed or hopeless?	2	2	100.00%	-	0.00%
4339	Do you still have these feelings	2	-	0.00%	2	100.00%
4412	Today's Visit Type	4,473	536	11.98%	3,937	88.02%
4463	Are they as strong as they were when you were diagnosed with depression	2	-	0.00%	2	100.00%
4525	Foot Exam Monofil / Visual / Pulse	424	342	80.66%	82	19.34%
4575	HDL - Male	4,640	4,637	99.94%	3	0.06%
4903	Pneumovax	3,868	421	10.88%	3,447	89.12%
5009	Influenza vaccine	10,699	446	4.17%	10,253	95.83%
5138	IPV	63	-	0.00%	63	100.00%
5140	MMR (min age 12 months)	80	-	0.00%	80	100.00%
5142	Varicella (min age 12m)	33	-	0.00%	33	100.00%
5147	Pneumococcal (PCV) (min age 6 weeks)	9	-	0.00%	9	100.00%
5391	Rotavirus	1	-	0.00%	1	100.00%

Action Plan

- Based on the findings of the previous steps an action plan is generated
  - Details of issues that require action on data quality and mapping
    - ADT – Provider/Patient Attribution – Active/Inactive – Dups – Field Integrity
    - CCD – Coded Measures – Style Sheets for Message Processing
    - Flat File Feeds – Expanded Measure Capture – Extraction Issues
    - Establish Translation Requirements
    - Death Registry – Consistent Source of Reliable Information
  - Engage upstream data systems representatives if necessary
  - Establish changes in work flow and data entry at the practice level
  - Integrate ongoing known issues and items from other Sprints that are in process for global continuity
  - Establishes the definitive path to completion of the Sprint

Weekly Progress Reports

PCP Assignment	PCP Assignments improving. 60% of patients at CHCRR are missing a PCP in the Registry.	Track improvements as other fixes are applied	On hold until data clean up and reload occurs.
	MedFusion Portal Creating Duplicate Patients - ISSUE HAS BEEN SOLVED Registry Remediation Required	Remediate bad data in Registry	Rick - update on resolution
		Run Duplicates Report in Registry	Rick - update on resolution after MPI reload
	Building PCP De-Activation List - Problem with PM/EMR interface cause	Remediate Bad Data on PCPs in Allscripts EMR	This may be resolved
	Doctor on Call being Investigated to ensure we have proper assignment of urgent care patients and a clean Active patient panel, Issue related to Provider/Patient Attribution	HOLD UNTIL POPULATION VERIFICATION Rutland will send two patient records that are known urgent care - will add a TEST provider and track through the system to determine effects - "Fake NPI"	Hans - update on work underway

ADT Verification Report

Bennington ADT Values				
ADT value	**Description**	**Centricity**	**Meditech**	**Allscripts Pro**
MSH Segment	message header values	y	y	y
PID segment				
PID-3	Patient ID	y	y	y
PID-5	Name	y	y	y
PID-7	DoB	y	y	y
PID-8	Sex	not processed in DocSite	not processed in DocSite	y
PID-10	Race	y	y	y
PID-11	Address	y	y	y
PID-13	Phone	y	y	y
PID-15	Language	y	n	not required
PID-18	Pt Account No	n		y
PID 19	SSN	not processed in DocSite	not processed in DocSite	n
PID-22	Ethnic Group	y	most not entered	y
PID-29	Death Date/Time	y	not generally entered	y
PID-30	Death Indicator	y	not generally entered	y
PV1 Segment				
PV1-3	Assigned Location	y	y	y
PV1-7	Atttending Doc (NPI)	y	y	y
IN1	mapped to table			

Measures of Success

- The site has optimized data quality for all purposes including health services, quality, evaluation
- The site has high quality data transmission into the HIE network and clinical registry
- The site can produce results of key metrics (ACO, UDS, NCQA, CQM meaningful use)

Types of Sprints

- **Remediation**
  - » Sites currently sending data to VHIE/DocSite
- **Onboarding**
  - » Sites that are about to send data to VHIE/DocSite
- **Field Team**
  - » New Initiative
  - » Sites that are earlier in the process of EHR deployment

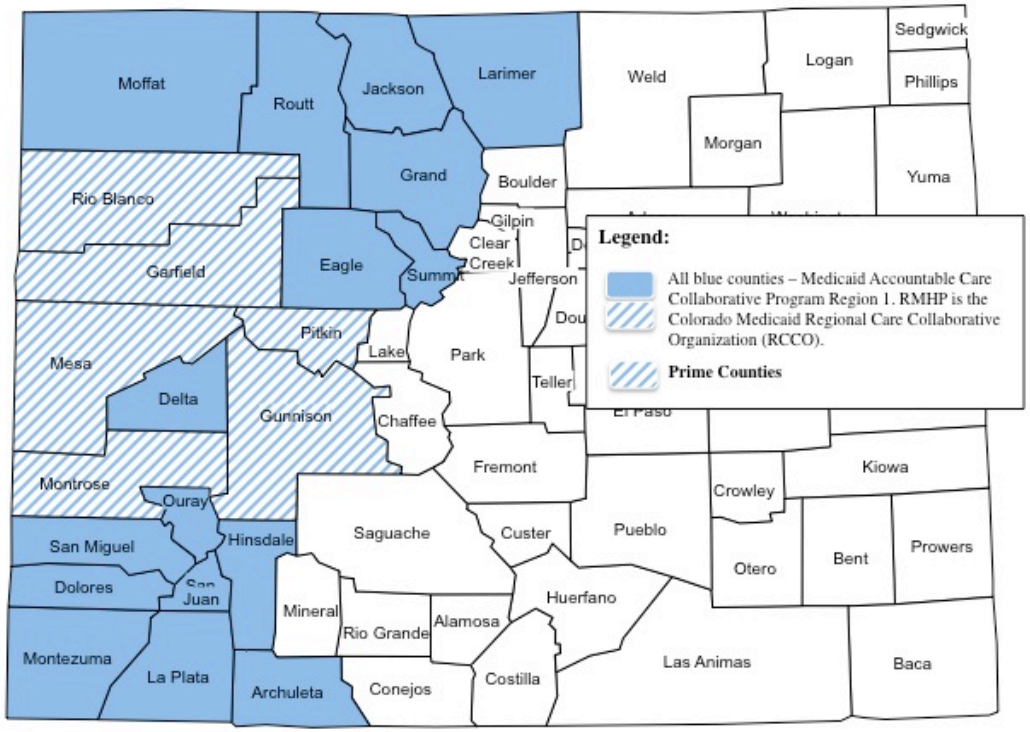
Data Quality: People, Process and Performance Outcomes

ONC Learning Webinar | September 27, 2016

The Office of the National Coordinator for Health Information Technology

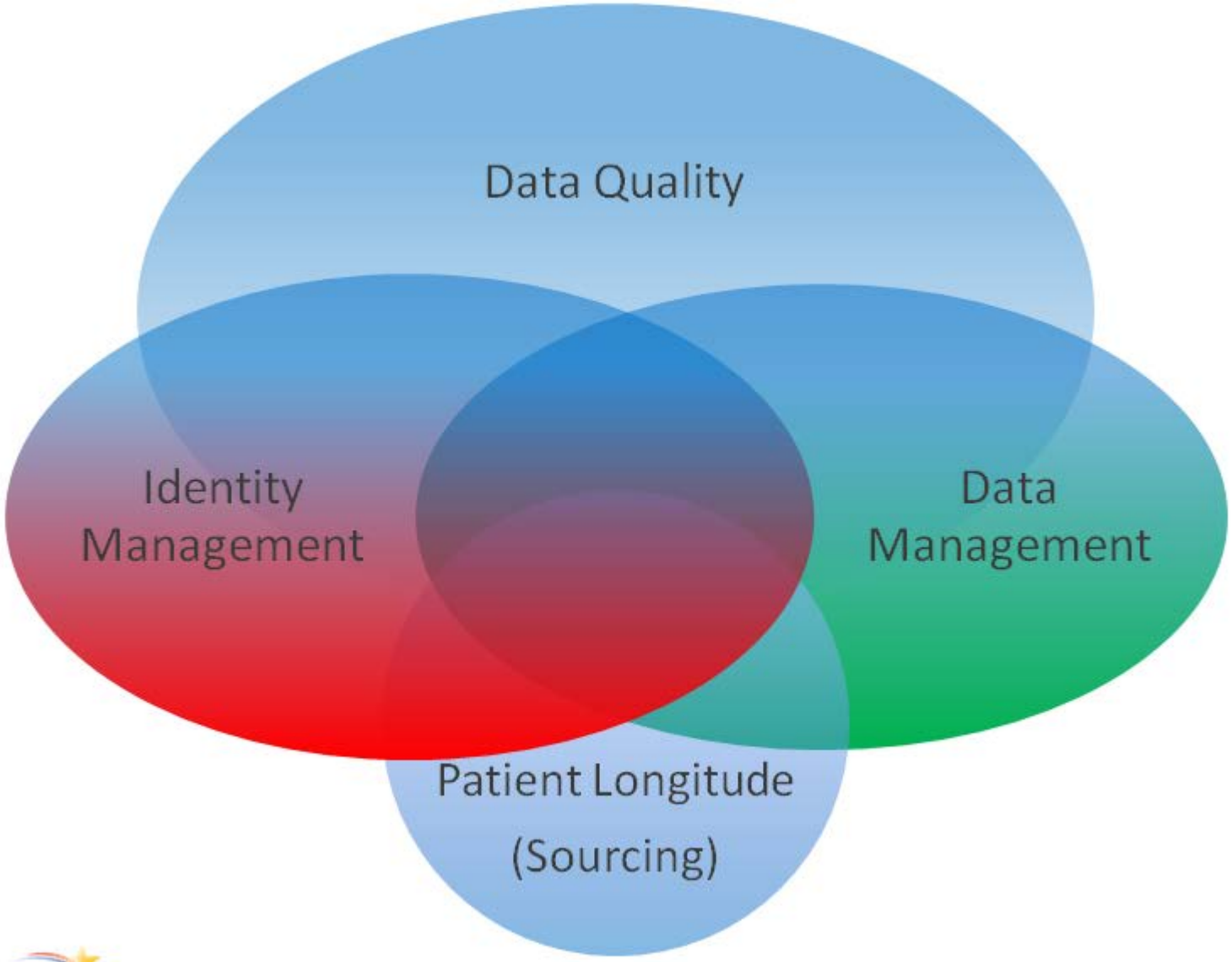
Rocky Mountain Health Plans®
We understand Colorado. We understand you.

Brief Introduction



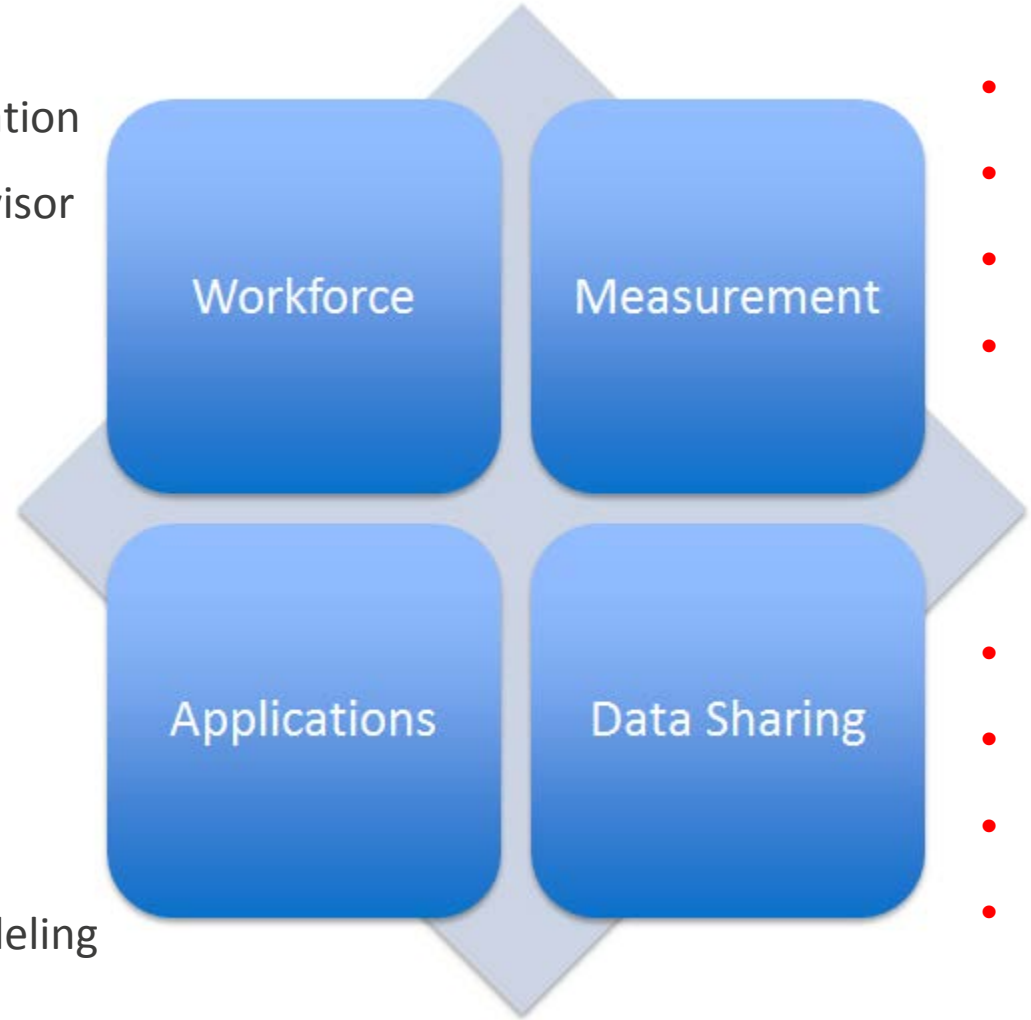
- Independent, network model health plan, with provider and HIE partners;
- Serving ~350,000 people;
- Extensive participation in ONC and CMMI technology and transformation initiatives;
- Focused on Western Colorado; and,
- Committed to health equity.

Critical Health Information Network Services



Data Quality Drivers

- Practice Facilitation
- Clinical HIT Advisor (”CHITA”)
- Leadership



- Focused eCQMs
- Aligned HEDIS
- Total Cost & Utilization
- Patient Activation

- Benchmarking
- Gaps in Care
- Stratification
- Predictive Modeling

- EHR
- Community / HIE
- (Multi) Payer
- Patient Reported

The “CHITA”

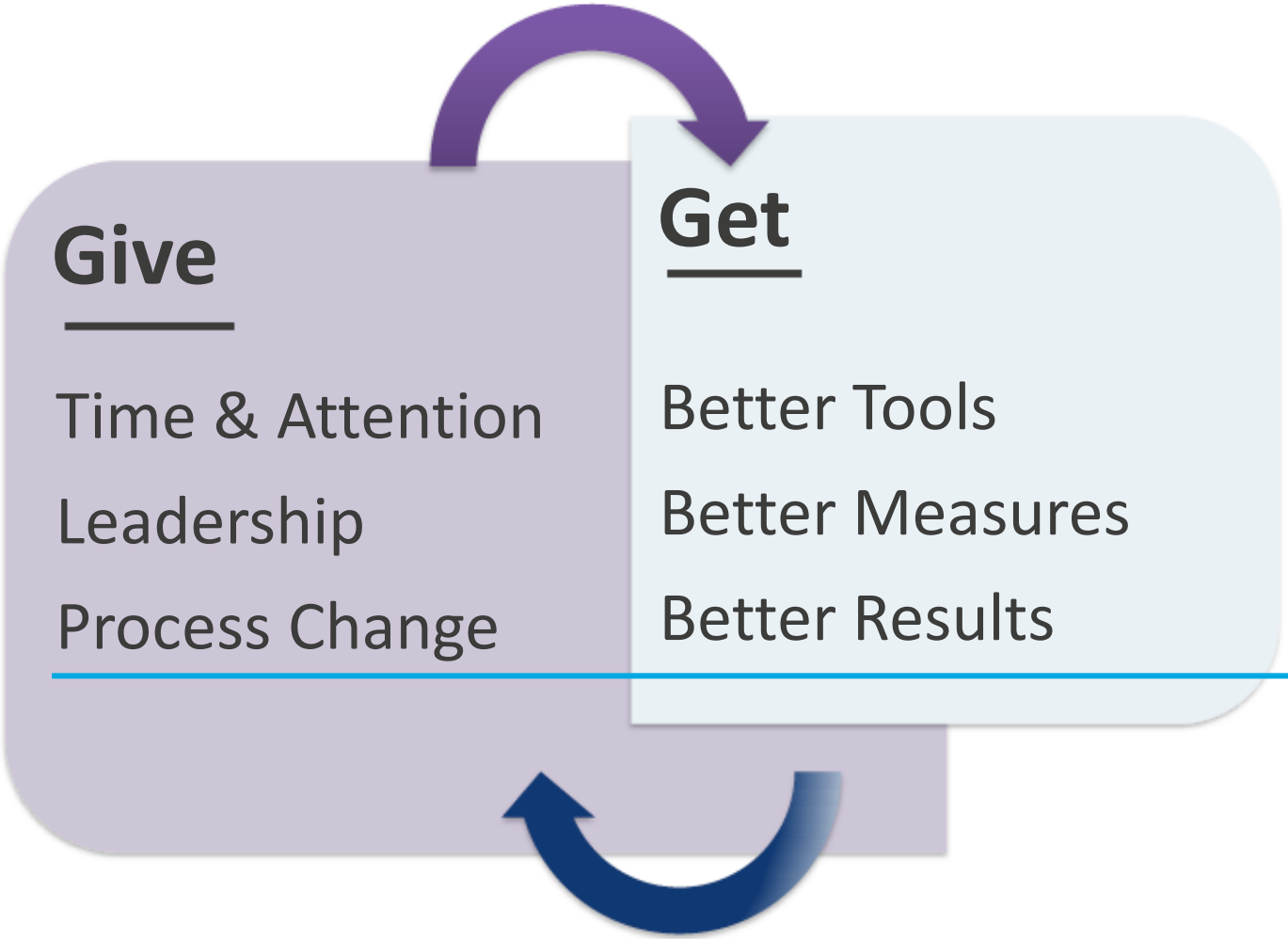
- **Clinical Health Information Technology Advisor (CHITA)** An expert in data capture and data reporting
- The CHITA becomes familiar with the electronic health record (EHR) platform in each practice to understand how best to report clinical data that document measures that matter to the practice
- The CHITA supports practice workflow as it relates to effective data capture in the EHR, provides oversight and analysis of consistent data entry across practices to enhance the ability to accurately measure and report on key metrics
- The CHITA and the practice facilitator/coach work together closely to optimize their respective skills for the benefit of the practice

Data Quality Steering - Key players

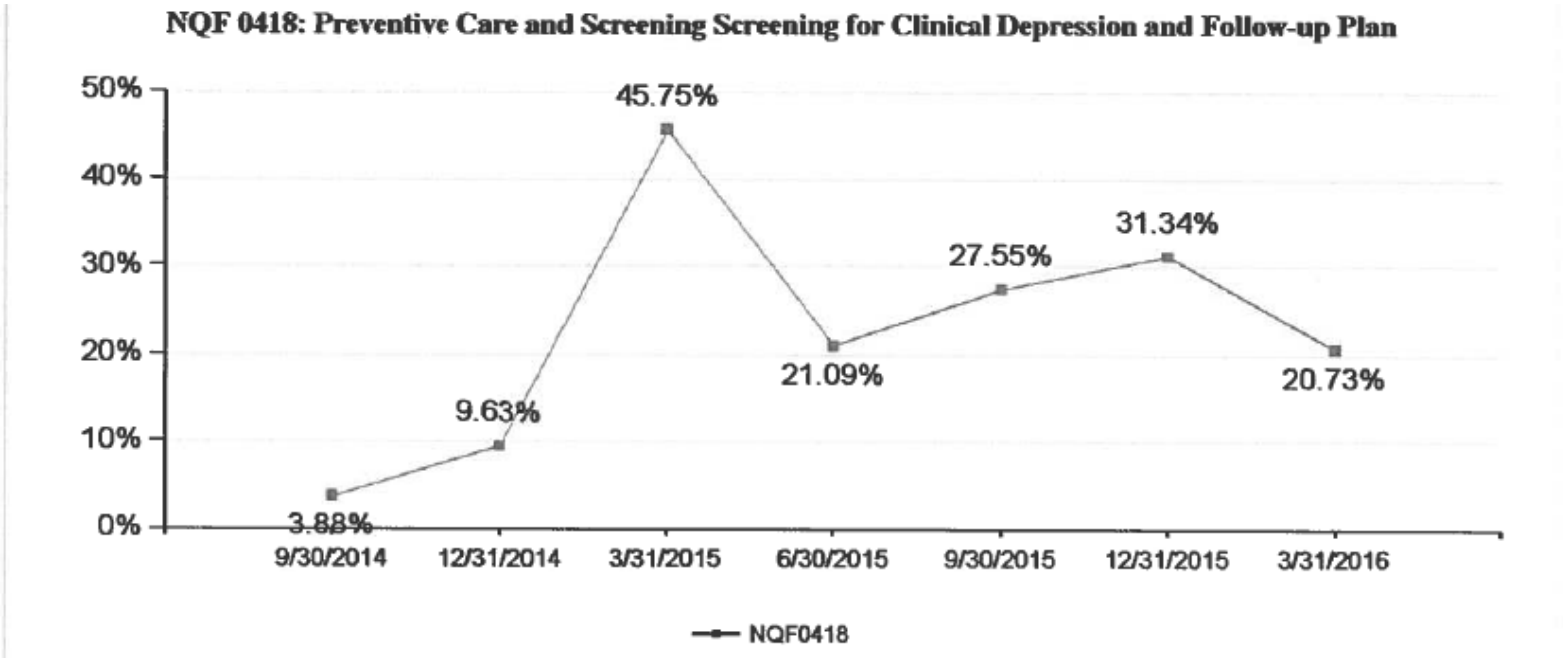
- People
  - Leaders / sponsors
  - Measurement / application experts
  - IT/Technology
  - Practice Facilitators

- Process
  - Regular
  - Feedback driven
  - Continuous

Data quality: creating a virtuous cycle

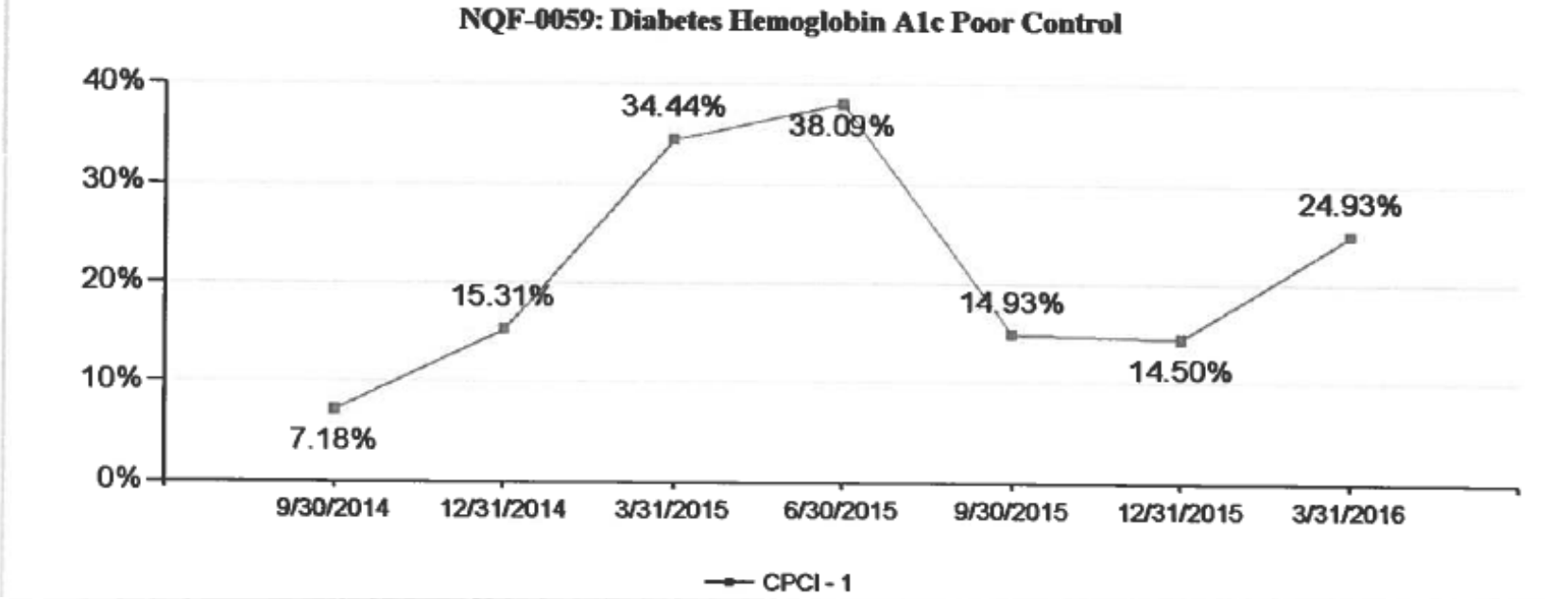


Data quality: Continuous Feedback



Practice ID	Practice Name	Numerator	Denominator	Rate
30	Foresight Family Physicians	437	1823	23.97%
46	Peach Valley Family Medical Center	228	2477	9.20%
49	Roaring Fork Family Physicians	474	1902	24.92%
57	Western Colorado Pediatric Associates/PCP (GJ)	0	1349	0.00%
158	Uncompahgre Medical Center	142	456	31.14%
171	Mountain Medical Center	736	1317	55.88%

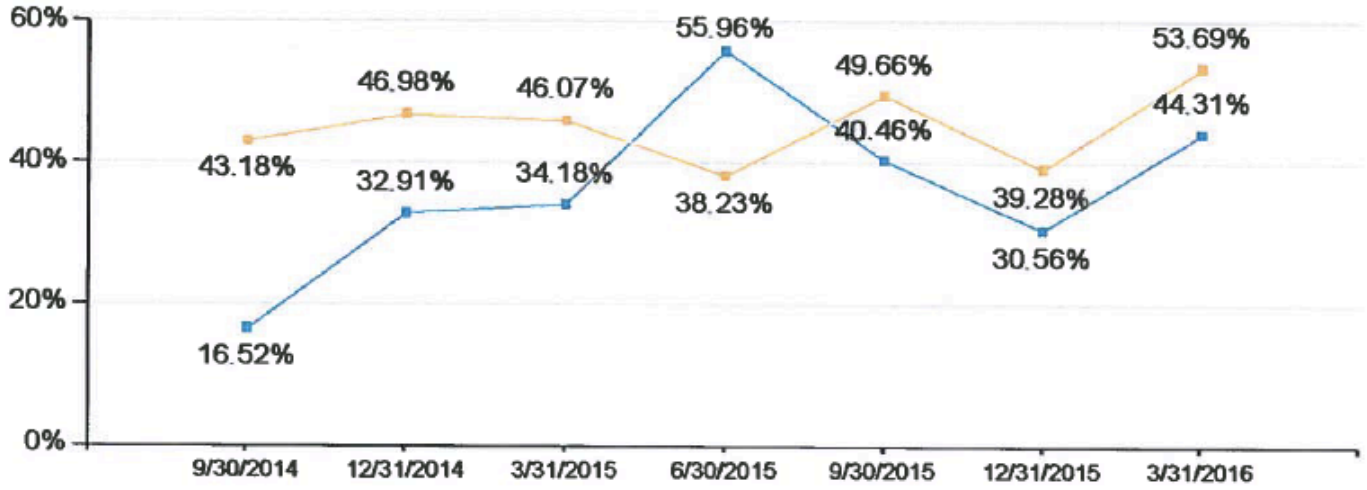
Data Quality: Continuous Validation



Cohort	Practice ID	Practice Name	Numerator	Denominator	Rate
1	75	Family Physicians of Western Colorado/PCP	5	728	0.69%
	30	Foresight Family Physicians	83	185	44.86%
	40	MidValley Family Practice	20	36	55.56%
	46	Peach Valley Family Medical Center	45	144	31.25%
	49	Roaring Fork Family Physicians	11	67	16.42%
	65	Western Colorado Physician Group/PCP	3	386	0.78%

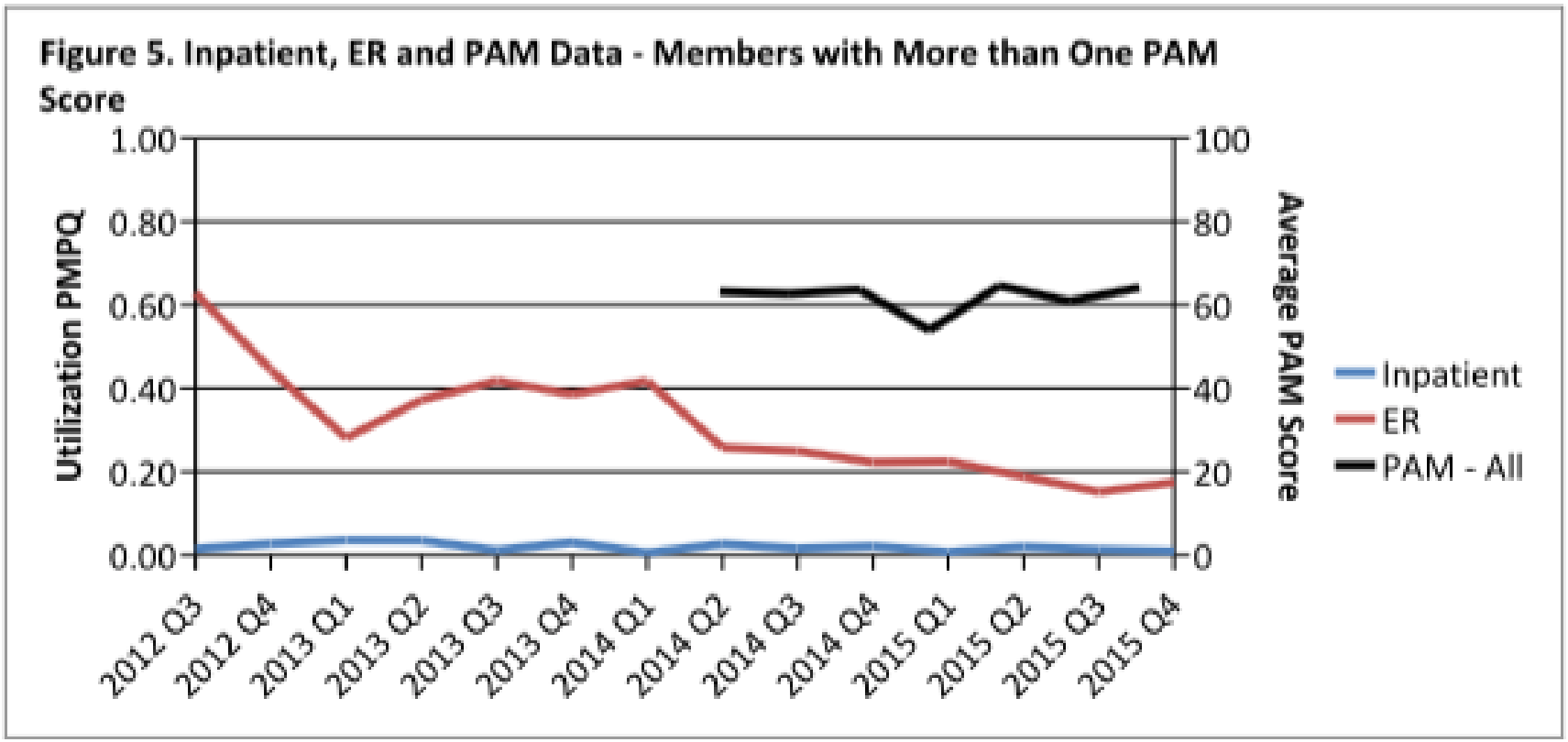
Data quality: Trajectory matters

NQF 0421: Preventive Care and Screening Body Mass Index Screening and Follow-up Plan



rt	Practice ID	Practice Name	Numerator	Denominator	Rate
1	75	Family Physicians of Western Colorado/PCP			
		Ages 18 - 64	1623	4521	35.90%
		Ages 65+	1461	2378	61.44%
	30	Foresight Family Physicians			
		Ages 18 - 64	517	999	51.75%
		Ages 65+	370	594	62.29%
	40	MidValley Family Practice			
		Ages 18 - 64	79	132	59.85%
		Ages 65+	149	382	39.01%

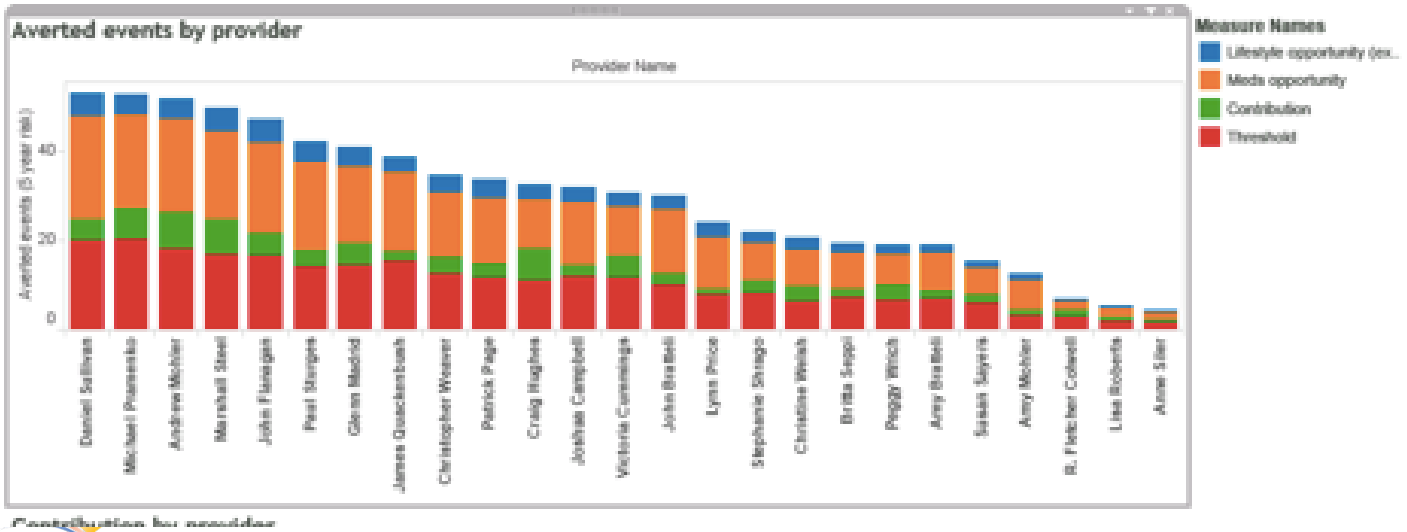
Data quality: Continuous learning



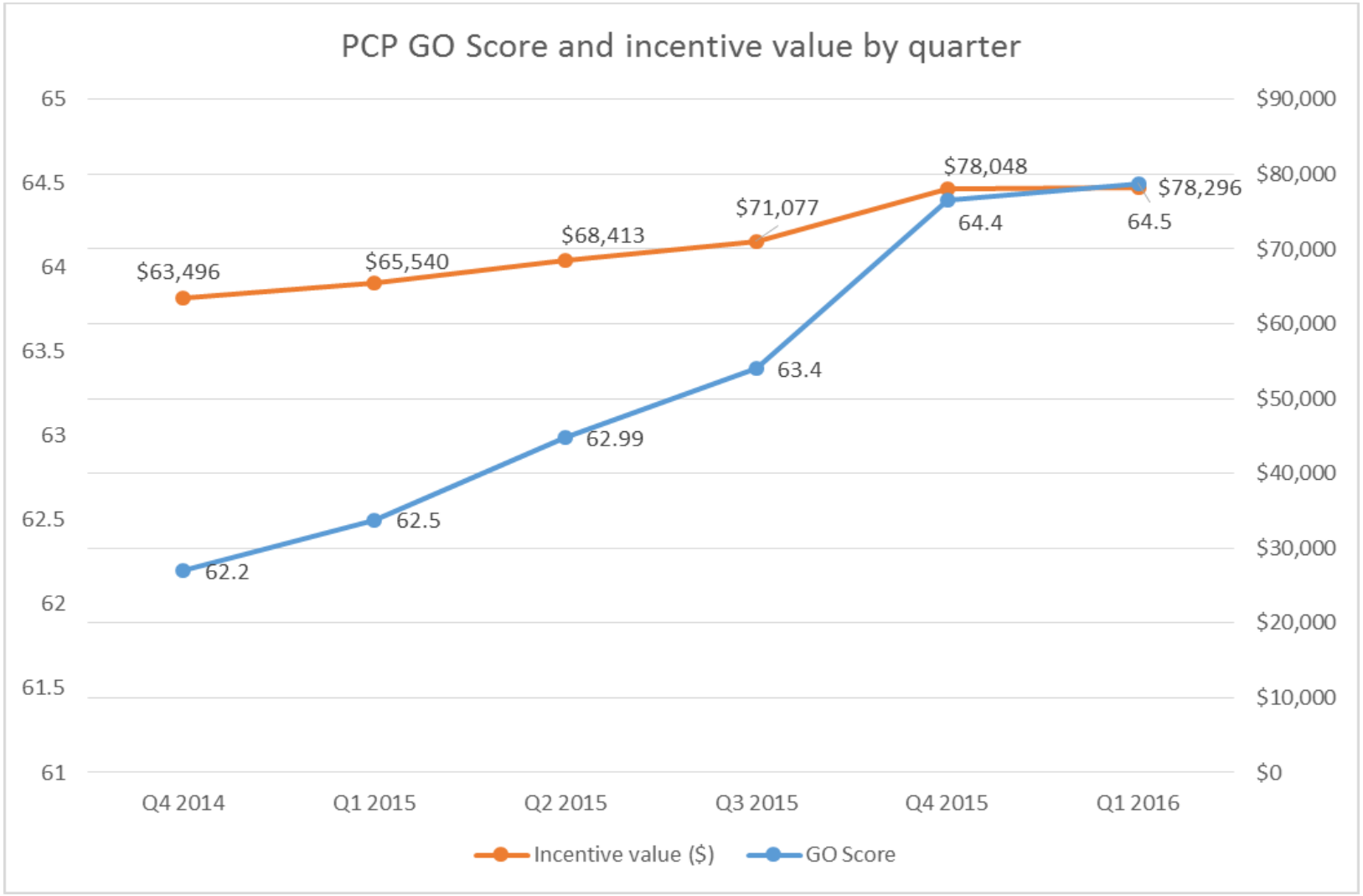
Data Quality: Clear Value Proposition

Averted events by current treatment	**356 (August 353)**
Averted events over 50% guideline threshold (356 – 0.5 x 537):	**87.4 (August: 85)**
Quarterly Incentive payment (Averted over threshold x $1000)	$87,418

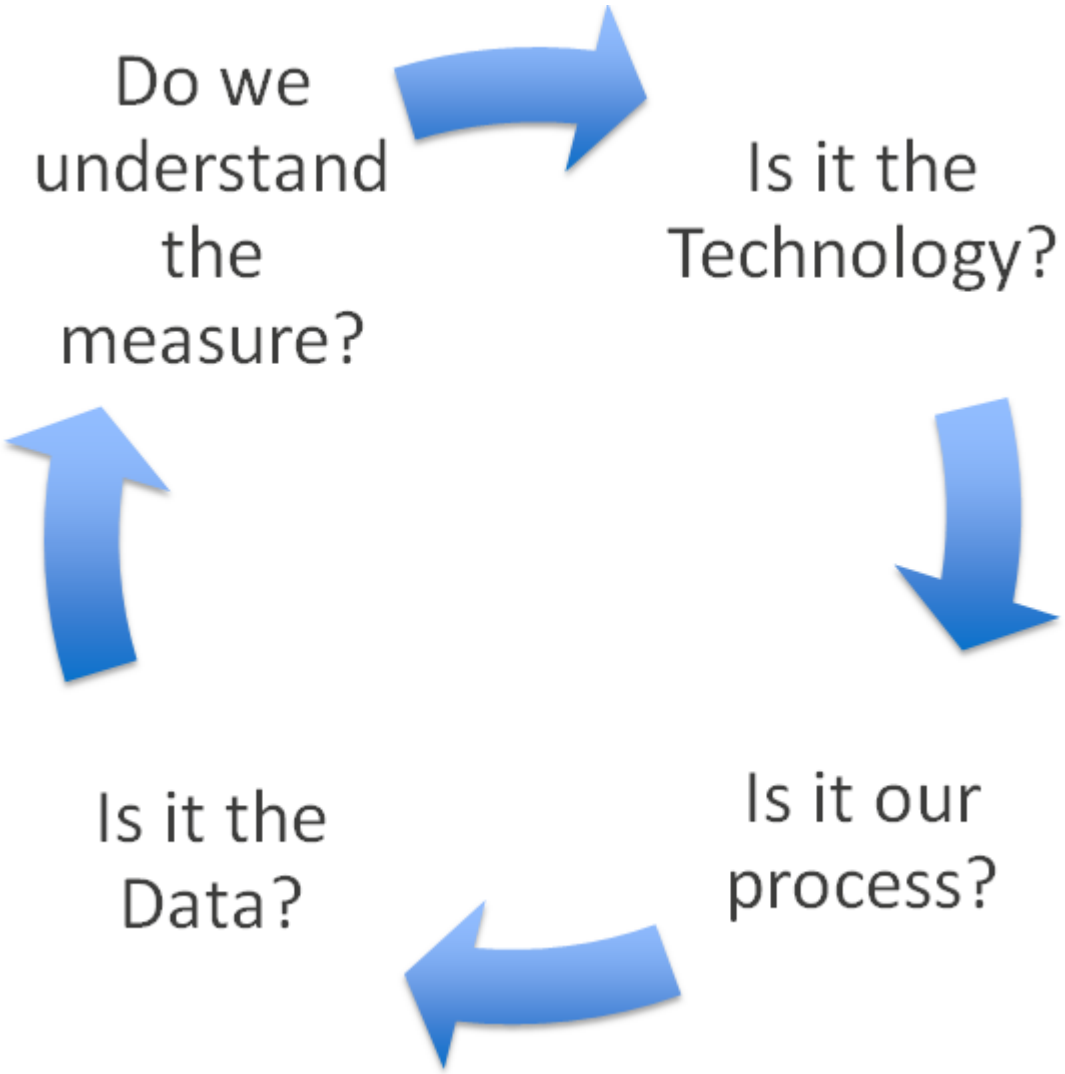
Averted events and contribution by provider:
Each provider contributed some amount to the total calculated as his averted events minus his threshold (50% of guideline for is population). The bar graph and table below show each provider's threshold, averted events above threshold and their percent of the total events above threshold.



Data quality: creating a virtuous cycle



Data Quality: Steering Process



Interoperability from the ground up

- **Value sets & specs:** Development of community and statewide data specifications that reflect the elements required to support defined value sets

- **Use & re-use:** Can be repurposed for a wide variety of measurement, analytic and clinical use cases

- **Policy & scale:** This is the essence of the ONC's Common Clinical Data Set concept

The Office of the National Coordinator for Health Information Technology

Is it Time to Re-Focus on the Practice? Strategies and Support for Reliable Quality Measurement

- **Craig Jones - ONC Resource Center**
  craigjvermont@gmail.com
  802 881 1710

- **Hans Kastensmith – Capitol Health Associates**
  hck@capitolhealthdc.com
  703 622 6896

- **Patrick Gordon - Rocky Mountain Health Plans**
  patrick.gordon@rmhp.org
  720 515 4129

The Office of the National Coordinator for Health Information Technology

Follow-Up Listening Event Information

Date: Wednesday, September 28

Time: 4-5 pm EDT

Link: https://global.gotomeeting.com/join/691653741
You can also dial in using your phone.
United States (Toll-free) 1 877 309 2070
United States +1 (312) 757-3119
Access Code: 691-653-741

@ONC_HealthIT HHSONC HealthIT.gov