Innovation Breakout Session Notes

April 26, 2012; 10:45am – 2:00pm ET

Attendees: Dwight Brown, Heather Budd, Kathleen Connors de Laguna, Carolyn Constantin, Del Conyers, Maria Feaster, Shawn Griffin, James Holly, Crystal Kallem, Janice Kelly, Thomson Kuhn, Dorinda Leutnik, Robert McClure, Ravi Nerella, Rebecca Roper, Samantha Shugarman, Robert Stephenson, Dave Stumpf, Charlene Underwood

NQF Staff: Beth Carey, Rosemary Kennedy, Lindsey Tighe

Dave Stumpf:

- Emphasis on innovation, recognition of existing gaps and solutions for those gaps
- Need to look at the big picture for direction in innovation
- Four questions for the collaborative to answer (slide 4)
  - Certainly innovation will happen in all other workgroups
- Charge for the innovation group (slide 5); need common themes that can be summarized and presented to the larger session
  - Ways to measure what we are requesting from the future state
  - Quality measurement and data workflow-how do they come together?

Vignette - Dorinda Leutink and Dwight Brown, Mayo Clinic

- Topic matter is heart failure
- Background on the practice-Mayo Clinic has 3 main sites, affiliated health system (70 communities). Slide 9
- Renewed effort in 2006 for core measures (heart failure, AMI, coronary, SQIP measures)
- Looking to increase VBP scores through an electronic format to get feedback to the providers at the point of care. Driving force of their efforts.
- Developed a framework to get to e-measurement (slide 10); very young in this process. Current state of direction. “Peeling back the onion”
  - Retrospective review-administrative data supplemented with manually abstracted data
  - Concurrent analysis and review-can’t just jump into e-measures. Though it is argued that you can do this analysis with clinical decision support rules, we aren’t there yet. They are testing the clinical decision support rules while still performing concurrent analysis. Amalga is the software being used for the testing ground currently; natural language processing (NLP) will be the next step.
- Dorinda-history of addressing heart failure
  - Slide 12
- Blaze Rules: alerts can show lab results, alert to an RN that heart failure education is needed when it is indicated that a patient has heart failure (being piloted-positive feedback)

- Moving processes to the next level-concurrent project utilizing Amalga (triggers pull patients into Amalga, ex. med combination, lab values, etc.)
    - Discovered that 90% or greater of the patients in heart failure not pulled by the trigger into Amalga had echocardiograms
    - Planning to test Amalga with 4 participating nursing units, with report backs every 2 weeks
- Next Steps
    - What is the global application? (Slide 16)
        - Will need options for large and small practices
        - Clinical decision support is where these elements will be collected and will allow this information to be put in front of providers in real time
        - Need to leverage the data pieces to calculate the e-measures

Vignette - Heather Budd, Blackstone Community Health Care

- See about 11,000 unique patients every year
- Data is really the greatest asset-managing with data was the key to the future. Moving from volume based payment to value based payment.
- Introduction to the technology infrastructure
    - 3 networks now that add up to
- Slide 21
    - Basic report generated out of the quality data warehouse; operates as decision support in the hands of the care team
- Performance improvement-focus on diabetic measures
    - Need to have a focus-look at one measure per month, see how the team does against the set goal as well as how they can improve
    - Need to be careful not to focus on something (one measure) and then have it drop off when the focus shifts
- Advent of EHR has resulted in providers becoming more administrative
    - Need to be careful to provide support to the providers so that they can treat the patients without the administrative burden
- Where are we going with this? Need to connect with statewide HIEs, benchmark across them, and integrate hospital and claims data.
- HIE in the Rhode Island Beacon Community (slide 26)
    - Want the data to be accessible by all providers treating the patient
        - To do this, need automation. Can't rely on humans to input the information.
        - Need to standardize the information
        - Need to simplify the transport (direct protocol from ONC)
- Summary cost can be an indicator of risk, may need to be a patient who needs intervention (readmission problem, patient who has frequent ER visits)
    - For this to work, need to get this information to the care team.
- Cost and Quality (Slide 29)

    - Neither can be evaluated separately. Only looking at cost leads to restriction of services.
- Have been looking at cost and quality together (slide 30) -there is a predominant payer.
    - Lighter yellow bar is the premium
    - Darker yellow bar is the actual cost of the patient
    - The difference is the profit that the insurance company is making
    - Healthcare systems need to be compensated for lowering costs b/c EHR is such a large investment.

Comments and Questions:

- James Holly: Data aggregated electronically, provider does nothing to aggregate it. Presented to the provider at the point of care. The data is reported by provider name-has resulted in a stampede to excellence, as public display of the quality metrics forces the provider to improve on the metrics.
- James Holly: Concept of a frequent flyer patient is actually a failure in care. Improved processes and outcomes are required to keep the patient out of the healthcare system. Need to design processes that capture the learning that takes place-providers learn as they are providing care, that it is easier to do it right than to not do it at all, and that the information is available to the provider at the point of care. Plan of care/treatment plans now disclose to the patients the conditions they have, the e-measures applicable to the patient, and the provider's performance on the metrics with respect to the patients. This makes the information understandable to the patient. Need to make a team-educate, inform and empower the patient in order to solve the triple aim.
- Dr. Stumpf: Mayo presentation-workflow defect in identifying problems. Before you can trigger the e-measures, need the diagnosis to get the patient on the problem list.
- Dr. Stumpf: Rhode Island-issue of not having all the data in EHR. Also the ability to integrate the financial information with the clinical information. Payers get the claims data from the providers-providers have lost track of the link. How to merge the two in order to get the value equation.
- Shawn Griffin: Getting claims data from the insurers, point of care data from the providers. Disheartening the data from the insurers-isn't always correct. There is a need for data normalization and improvement that insurers need to go through. Insurers get the data from the office, not necessarily the providers…part of the issue is the differing incentives (getting money vs. clinical care).
- Heather Budd: things that the payer wants sent, which is not what happens with respect to clinical treatment (that information is in EHR). In reality, the information is from all of the facilities caring for the patients. Need to be able to bring that all together-provider documents toward patient care, coder documents toward maximum reimbursement.
- Shawn Griffin: smaller practices-what are the unique challenges?
- Dwight Brown: majority of issues, big or small, are data compatibility between EHRs

- Heather Budd: need to train providers on where to capture the data in the EHRs. Need to think about these measures as a cycle of evolution-can't leave the manual process behind, as need to train people where the information is coming from.
- Dwight Brown: Process for identifying the key data elements that need to be captured? Excel spreadsheet.
- Ravi Nerella: need to educate the providers on how to use the EHR, particularly physicians in training. Need to demonstrate the benefits of the tool and educate on how to better use the tool.
- Robert Stephenson: Need to look at internal systems and find out how to integrate with behavioral health.
- Robert McClure: CMO at Apelon. Would like the group to consider how to change the process so that measures aren't refactored from the initial design to fit a new system. Outcome of the collaborative should include statements about expectations of consistency-practitioners trying to implement should be able to look upon a common model that people can easily understand. Need a recommendation with a defined clinical model. Secondly-how important is it that quality measures be shareable? Sense is that it is very important-need measures crafted so that anyone can understand them-implementers, physicians, etc. Need to say what is meant by that.
- Dave Stumpf: QDM is a common part of the model for e-measures and the QRDA; being implemented there. Also part of the foundation of the clinical decision support document and the workflow document on utilization framework. Can possibly be used in a lot of other areas-ontologic element that could be rolled up. With respect to shareability-folks are in agreement that it is necessary to share measures.
- Dwight Brown: Need the quality measures to be understood by <u>everybody</u>. The measures need to be meaningful to the patients. Need to identify and monopolize on high value data. The data elements don't really change from core measure sets-different diagnoses, problems, treatments, interventions, etc.
- Rosemary Kennedy: Have made progress capturing structured data in EHR; how to capture unstructured data?
- James Holly: need to analyze and build a tool to capture unstructured data-in essence, structure the unstructured data
- Dwight Brown: 3-5 year plan with a focus on being able to move to e-measures at Mayo. Identifying the data elements that need to be elementized. 76% of the elements have been identified to capture all of the measures electronically.
- Dave Stumpf: what do we mean by usability? Need to have all providers happy with using EHR/e-measures. Also, want to get to a point of plug and play-configure systems rather than coding for a specific task. Don't want to be building one offs for everything that comes along.
- James Holly: even with a very sophisticated system, mapping one system to another so that data can be transferred is extremely time consuming. Need the systems to be able to easily communicate with each other.

- Maria Feaster: need to consider the IT aspect of this-IT needs to be onboard and educated, it won't matter if you have e-measures or EHR without IT support.
- Ravi Nerella: need to give the IT folks perspective on the clinical usefulness of the EHR so that it is set up in a way that providers can use it beneficially.
- Robert Stephenson: need to harmonize e-measures; can't have these measures that vary minimally. Need measure developers and code writers to work together and learn from each other. Need cross collaboration on how to write code for measures so that it is harmonized-very near future, this needs to be done now. Could NQF support this or convene a workgroup that brings clinicians, EHR vendors, IT people, etc.? Need to look at what is out there right now-the measures that will go to Stage 2. Need to address the potential areas for harmonization for the coding for the e-measures. "knowledge library" for coding sets/value sets.
- Heather Budd: have an opportunity to influence the data sets-need to simplify the coding, not complicate it (icd-10, icd-11, where definitions become increasingly complex). Needs to be focused on patient care and what has value.

Best Practices

- Physician Report cards (Memorial Hermann)
  - Blinded data is less helpful, as it doesn't have the same impetus to action as everyone knowing everyone else's information. At a minimum, need the individual provider to know where he/she is in relation to the others. May need to blind initially, except to the provider. Then move toward unblinded.
  - Recognize the data is imperfect; some providers get quite upset. There is a cycle for improving the data
- Need community benchmarking of like practices (can be done at the level of the associations of physicians)
- Minnesota-published aggregate per practice. Data was bad, but it was a start. Need metrics that are without fault. Need transparency at the provider level
- EHR needs to be measured as well
- EHR vendors need advance input on what measures are coming and up-to-date metrics. Vendors are open to being responsive to collecting the data; however, they need a roadmap of what is coming to be responsive rather than reactive. Need to work between the providers and the vendors to come up with standards in the way that things are collected. For example, one of the biggest barriers is the reason why something wasn't done-need a standard way to capture the reason why not. May need the rule to come with a CDA so that it is embedded in the EHR without having to go to EHR and code for it. Automatic process vs. a one off solution.
  - Money is an issue in developing these things-need a business model to get funding for this.
  - More money won't solve the structural problems. For example, developing different care transition models when one exists. Need to share information and build on other models rather than reinventing the wheel.
- There is not a business model for improving EHR and using e-measures-until there is incentive, it's hard to move this forward. The money is already being spent, it just is being 'misused'.

Innovative Ideas for EMR and e-measures

- All e-metric vendors, developers, clinicians have a common data dictionary that is implemented across all measures (BP or blood pressure, not both).
- QDM as the common ontology for EHD, workflow, etc.
- Vendors should have a standardized way of updating the quality measures
- Registry based reporting-broad registry, not specialty specific
- Statutory requirements to require EHR vendors to standardize
- Population management and case management-integrate into EHR
- HIEs collect data and report 1 measure per highest cost condition (standardized opt-out code)
- Vendors need single source of truth library
- Common interfaces for devices to talk with EHRs
- Patient centered input AND physician centered data
- Need collaboration (clinicians, patients, vendors, specialty societies, insurance companies etc.).
- Need to align the quality process with data that is going to travel with patients-currently the fragmentation process is not being well met.
- Metrics capturing patient compliance/adherence-like a credit score, it can change with changes in behavior. Part of patient centered care is making patients accountable for their care.
- Lack of a universal personal health identifier prevents patient centered care.

High Level Concepts

- Universal personal health identifier (caveat that there are community based interventions that the patient and the provider need to be aware of and utilize)
- Public transparency of provider performance on quality metrics, cost data, and the overall value equation (care coordination model-service agreement)
- Knowledge library, including harmonization of extant and future measures, accessible at point of care
- QDM as common integrated knowledge model (ontology+)
- Align with clinical decision support-"make doing the right thing easier than not doing it at all"
- Measures of patient goals and participation in care
- Capturing of quality metrics should be incidental to care, not the goal
- Sustainable business model for HIT in general (measure developers, payors, providers, professional orgs, advocacy groups)
- Standardization across EHR vendors-the concept of "plug and play"
- Creating the value proposition at the practice level (increased quality, decreased cost)
- Be mindful of personal preferences and privacy (caveat that this should not bar progress-stay abreast of these issues though)
- Standardized quality reporting
- Transparency of value equation components
- Provide tools to help EHR vendors understand quality measures.

-Individual providers have to own this. The business model may not be self apparent-payment has become disengaged from making patients healthy. Providers need to bring them back together.