Crossing the Chasm Between Quality and Administrative Data

Crystal Kallem, Lantana Consulting Group
Executive Director, Analysis & Policy

Crystal Kallem

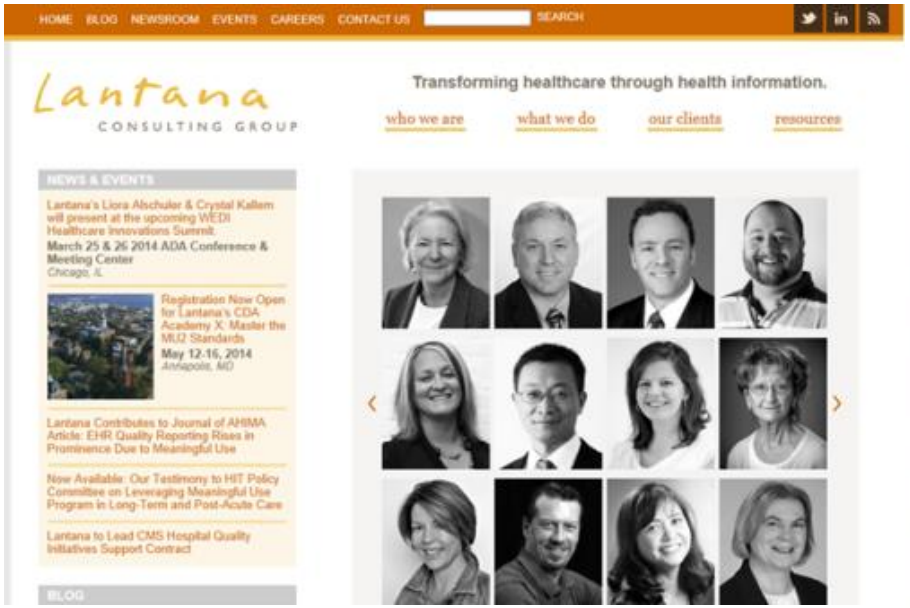
About Me

- Executive Director of Analysis & Policy, Lantana Consulting Group
- CDA Academy Faculty (www.cdaacademy.com)
- Leads Lantana's Policy Center of Excellence
- Directs multiple client projects on healthcare quality
- Co-chair, HL7 Clinical Quality Information Work Group

Lantana Consulting Group

Mission: Information driven healthcare

- Staff of 35, 26 consultants
- Interoperability experts
  - Over two dozen standards developed, including key requirements in Meaningful Use.
  - Services include quality reporting, implementation, standards development, interoperability architecture, strategy, compliance and certification, terminology, and training.
  - Clients include startups, Fortune 100 companies, public and private organizations.



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Objectives

- Discuss the use of administrative and clinical data for quality and continuity of care
- Review Health IT standards enabling automated quality measurement and continuity of care

Crossing the Quality Chasm

A Call to Action in 2001

- Improve healthcare quality and safety while reducing costs
- Apply advances in health information technology to improve administrative and clinical processes
- Remove healthcare silos and provide care with complete information about a patient's condition, health history, services provided, and medications
- Improve patient experiences with care

National Research Council. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: The National Academies Press, 2001.

2013 WEDI Report

Data Harmonization & Exchange

Recommendations for data harmonization are:

- Identify and promote consistent and efficient methods for electronic reporting of quality and health status measures across all stakeholders, including public health, with initial focus on recipients of quality measure information.
- Identify and promote methods and standards for healthcare information exchange that would enhance care coordination.
- Identify methods and standards for harmonizing clinical and administrative information reporting that reduce data collection burden, support clinical quality improvement, contribute to public and population health, and accommodate new payment models.

2013 WEDI Report - http://www.wedi.org/topics/2013-wedi-report#areas

Quality Measurement

Using Administrative Claims Data

- Advantages
  - Easily accessible / less expensive to acquire
  - Encompass large populations
  - Long been used for assessing performance of healthcare providers
- Limitations
  - Difficult to discern duration or severity of chronic conditions
  - Exact timing of events is difficult to discern
  - Contains incomplete information on care received
    - Some diseases are under-diagnosed
    - Not all services received are billed
    - Patients change insurance payers
    - High percentage of U.S. patients do not have stable insurance coverage (thus no claims data)

Quality Measurement

Using Manually Abstracted Clinical Data

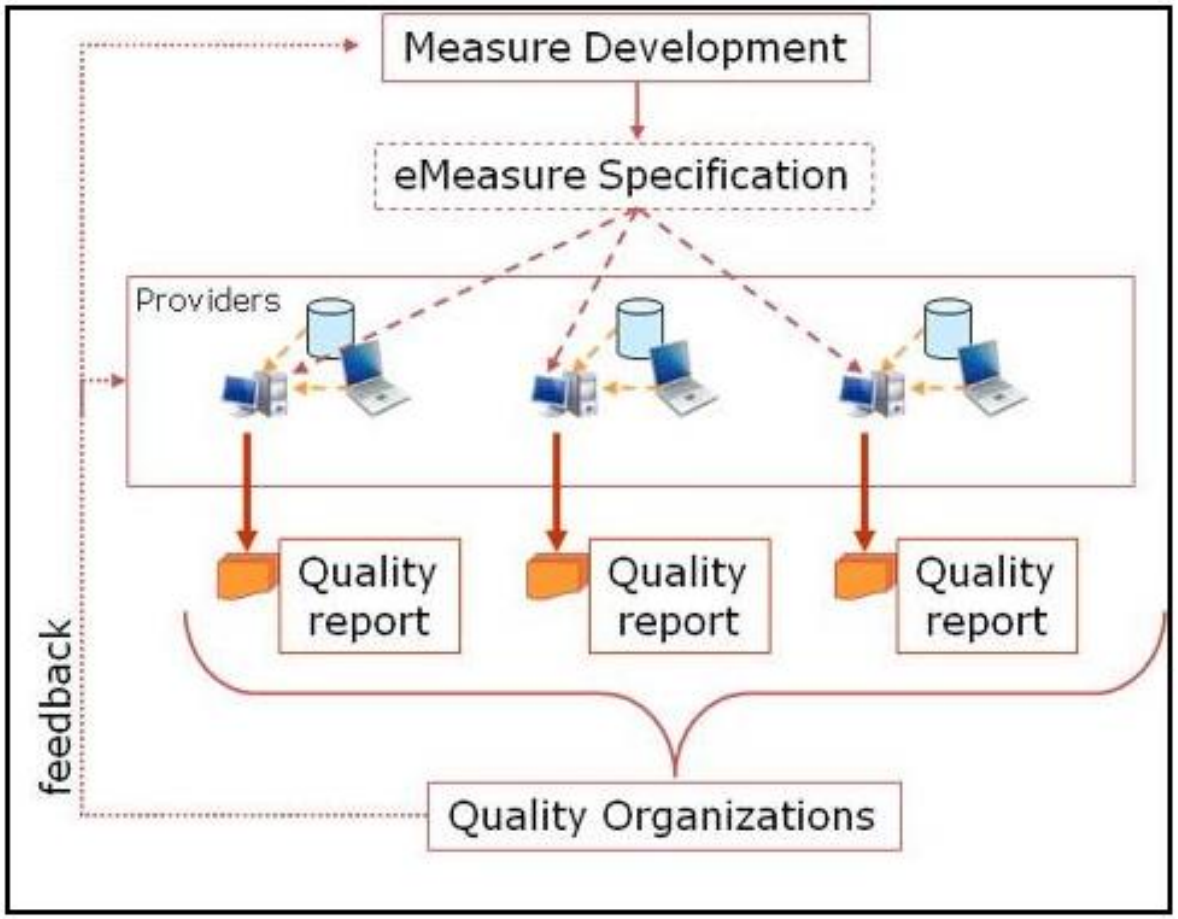
- Advantages
  - Provides access to relevant clinical data
  - Provides more complete picture of care provided
- Limitations
  - Requires qualified staff to abstract data
  - Time consuming and expensive to collect and validate
  - Measurement feedback delayed

Push Toward Automation

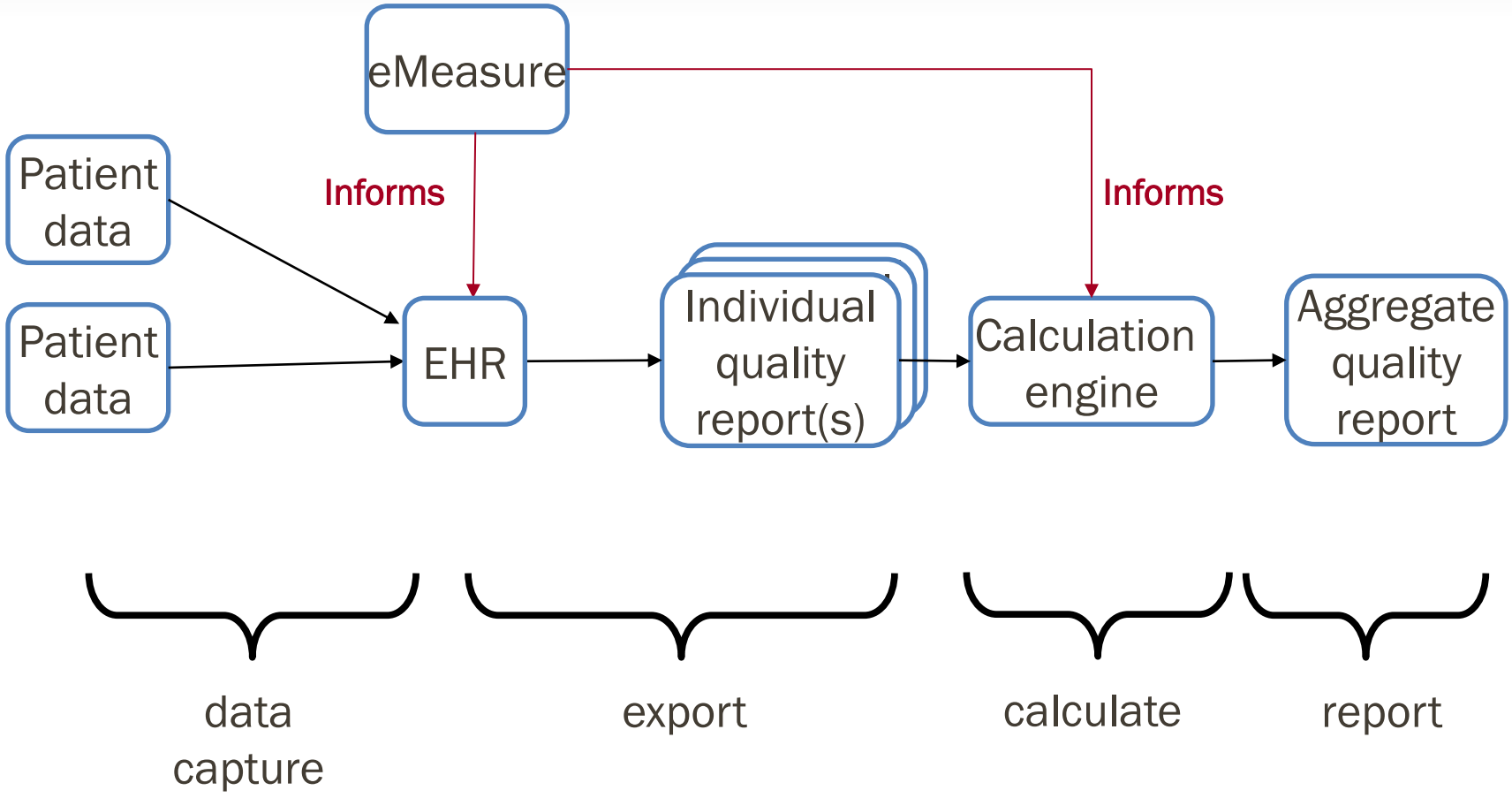
Meaningful Use

- Use certified EHR technology to:
  - ***Improve quality, safety, efficiency, and reduce health disparities***
  - Engage patients and families
  - ***Improve care coordination, and population and public health***
  - Maintain privacy and security of patient health information

Quality Reporting Lifecycle



Quality Reporting in MU2



Quality Measurement

Using Electronic Health Record Data

- Advantages
  - Growing availability of electronic clinical information
  - Anticipated cost savings associated with automated data collection and reporting from EHRs
  - Enables healthcare providers to have and use their own tools for real-time tracking of changes to their practice
  - Opportunities to more closely align clinical quality measures with clinical decision support to impact decisions at the point of care

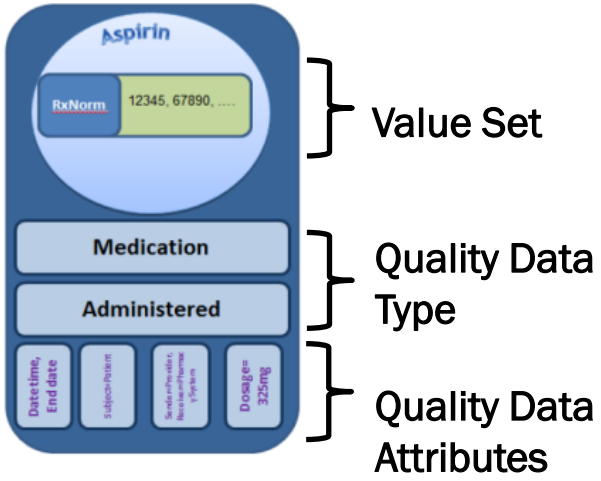
Quality Reporting Standards

Meaningful Use Stage 2

- National Quality Forum (NQF)
  - Quality Data Model (QDM)
- Health Level Seven International (HL7)
  - Health Quality Measure Format (HQMF/eMeasure)
  - Clinical Document Architecture (CDA)
    - Quality Reporting Document Architecture (QRDA) Category I
    - QRDA Category III

Data Capture: Quality Data Model

- A model of information used to express patient, clinical, and community characteristics as well as basic logic required to express quality measure criteria.
- Describes the data elements and the states (or contexts) in which data elements are expected to exist in clinical information systems.
- QDM is a “domain analysis model”.
- HL7 has implemented QDM in eMeasures and QRDA.



Calculate: HQMF (eMeasure)

Health Quality Measure Format (HQMF)

- The first international standard for the formal representation of clinical quality measure as an electronic document (including metadata, data elements, and logic)
- An HL7 Draft Standard for Trial Use (DSTU) since 2009 (Release 1)
- Release 2 recently published
- Provides quality measure consistency and unambiguous interpretation
- Describes the syntax, but doesn't tell you what data is needed and how it should be constructed for a quality measure

eMeasure

- A quality measure encoded in HQMF format
- Often called an eCQM in Meaningful Use

Export/Report: QRDA

QRDA is a Clinical Document Architecture (CDA)-based standard for reporting patient quality data for one or more quality measures.

- QRDA Category I (Single-Patient Report):
  Individual patient-level report containing data defined in the measure
- QRDA Category II (Patient List Report)*:
  Multi-patient report across a defined population that may or may not identify individual patient data within the summary
- QRDA Category III (Calculated Report):
  Aggregate quality report with a result for a given population and period of time

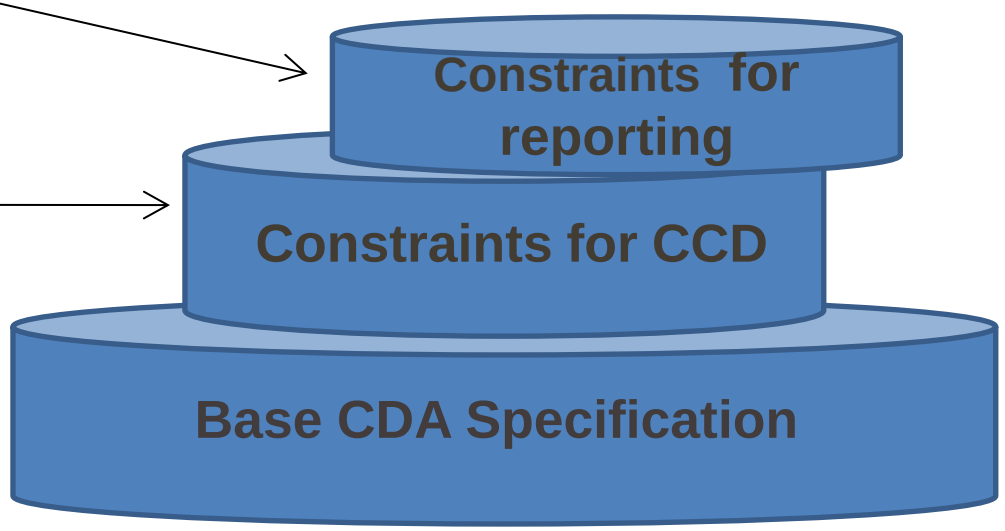
*Not a DSTU

QRDA is a Type of Templated CDA

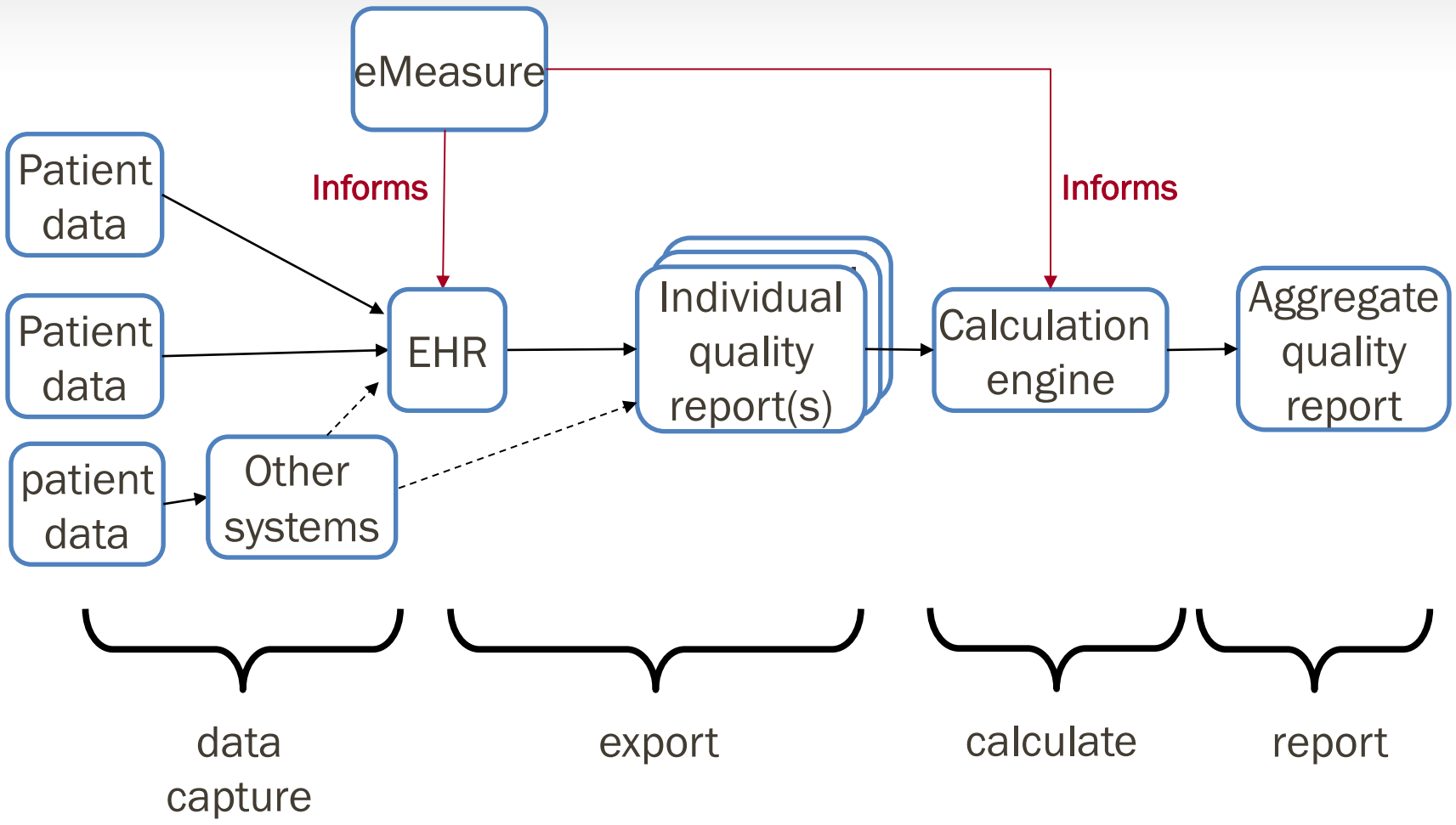
QRDA is a CDA-based implementation guide (IG) that contains those data elements needed for quality measurement.

QRDA Category I

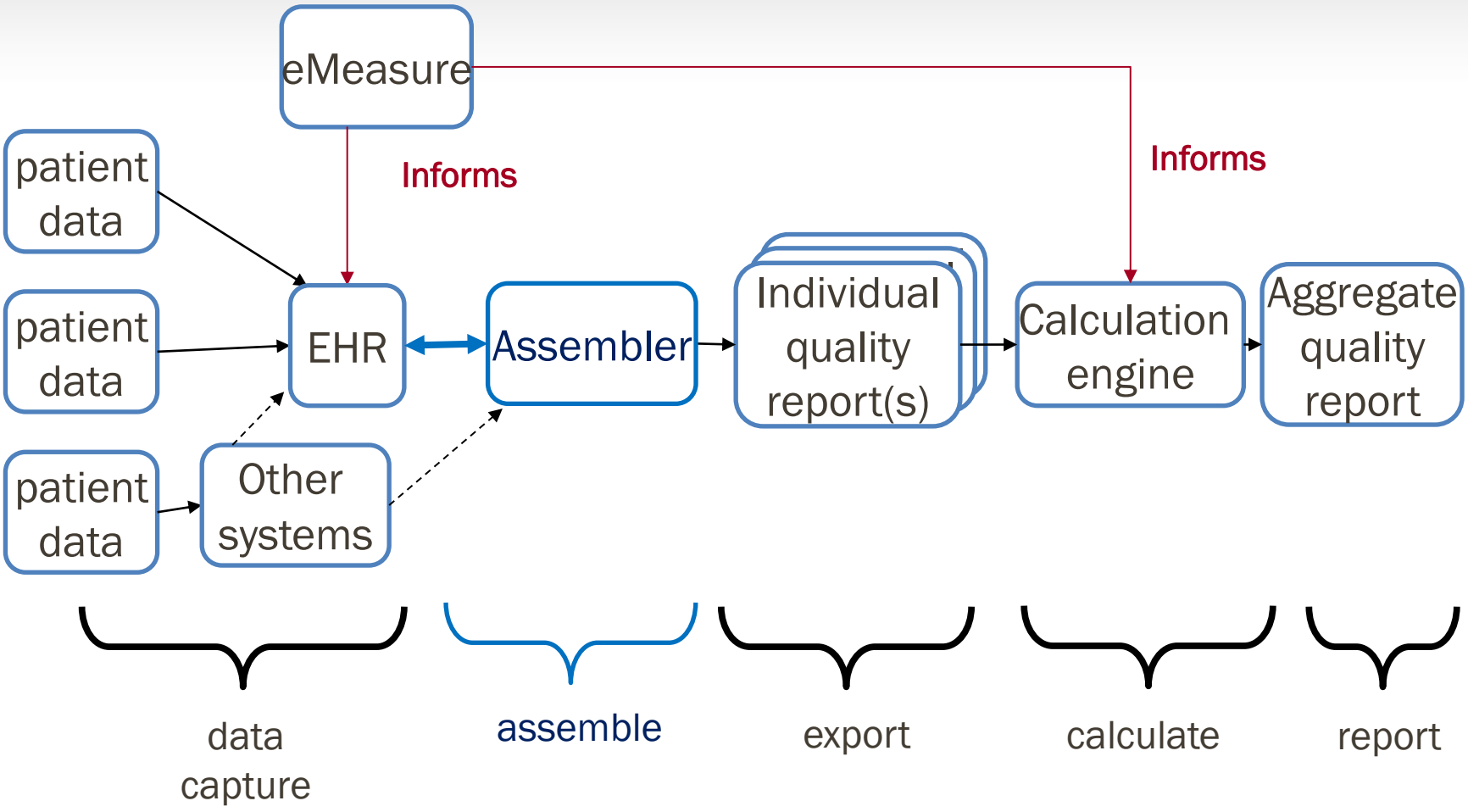
Continuity of Care Document (CCD)



Quality Reporting in MU2



Quality Reporting Beyond MU2



Quality Measurement

Using Electronic Health Record Data

- Limitations
  - Feasibility of capturing/extracting some data from EHRs is challenging
  - Clinical workflow and quality measure requirements don’t always align
  - Not all data required for quality measurement is contained in EHRs
  - Validation of the accuracy of EHR-based quality measurement data is not yet occurring

Beyond Meaningful Use

While considerable effort has gone into defining end-to-end quality reporting processes and technology for Meaningful Use, these efforts will fall short without:

- A common approach to quality measurement and reporting (alignment of measures and reporting specifications)
- Alignment of quality measurement with decision support and transitions of care
- Patient engagement in quality measurement and improvement

Thank you!

Crystal Kallem
Executive Director, Analysis & Policy

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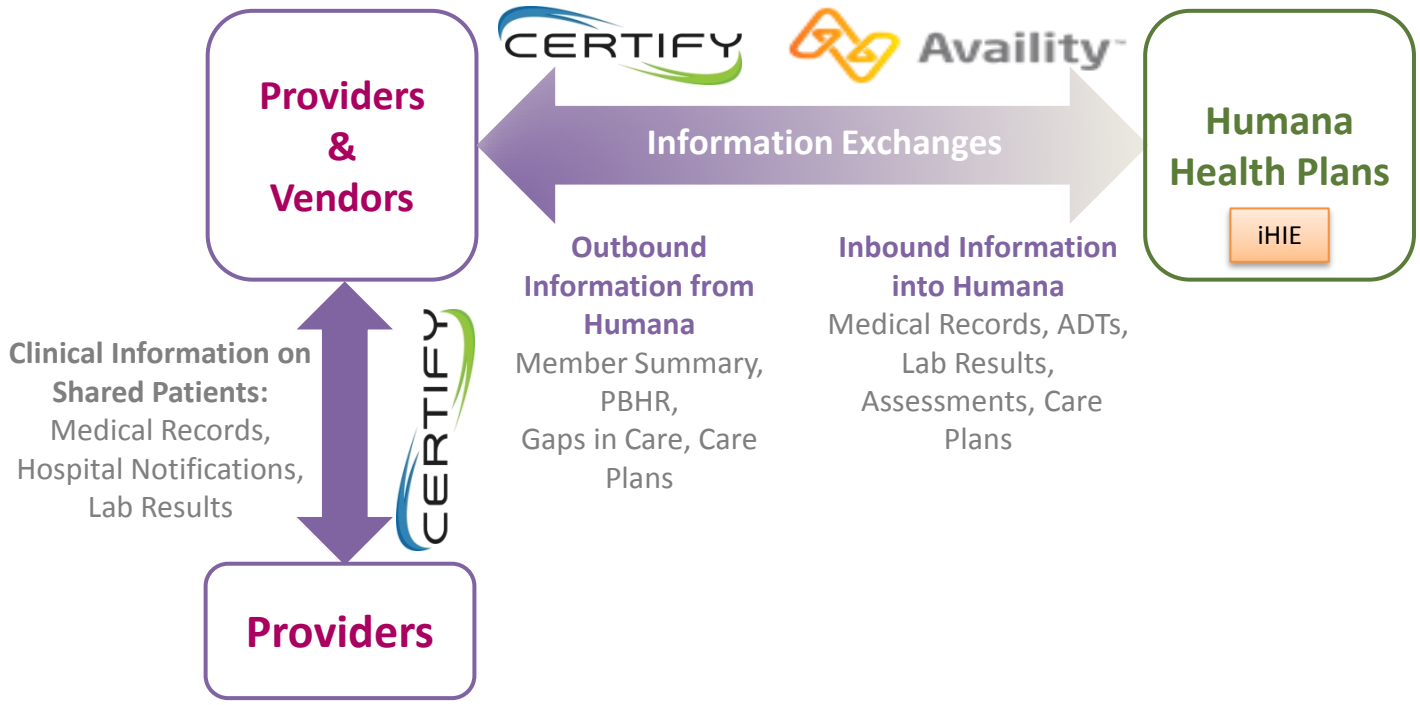
Humana's Clinical Integration Model

We put ***delivery*** in Integrated Care Delivery

Julia Hood, Humana
Manager, Health IT Business Solutions

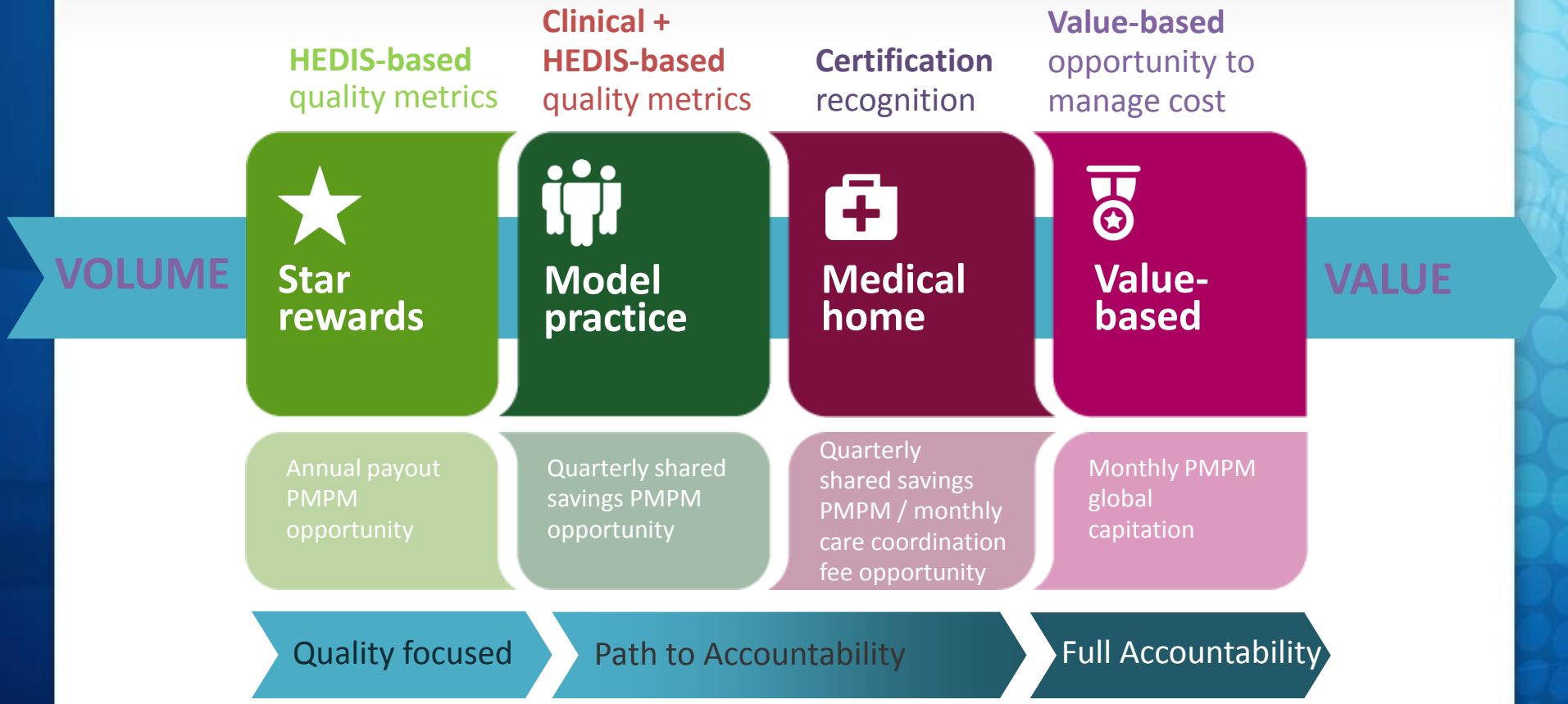
HIT Mission

Facilitate valuable bi-directional clinical information exchange between key external and internal stakeholders across the healthcare ecosystem

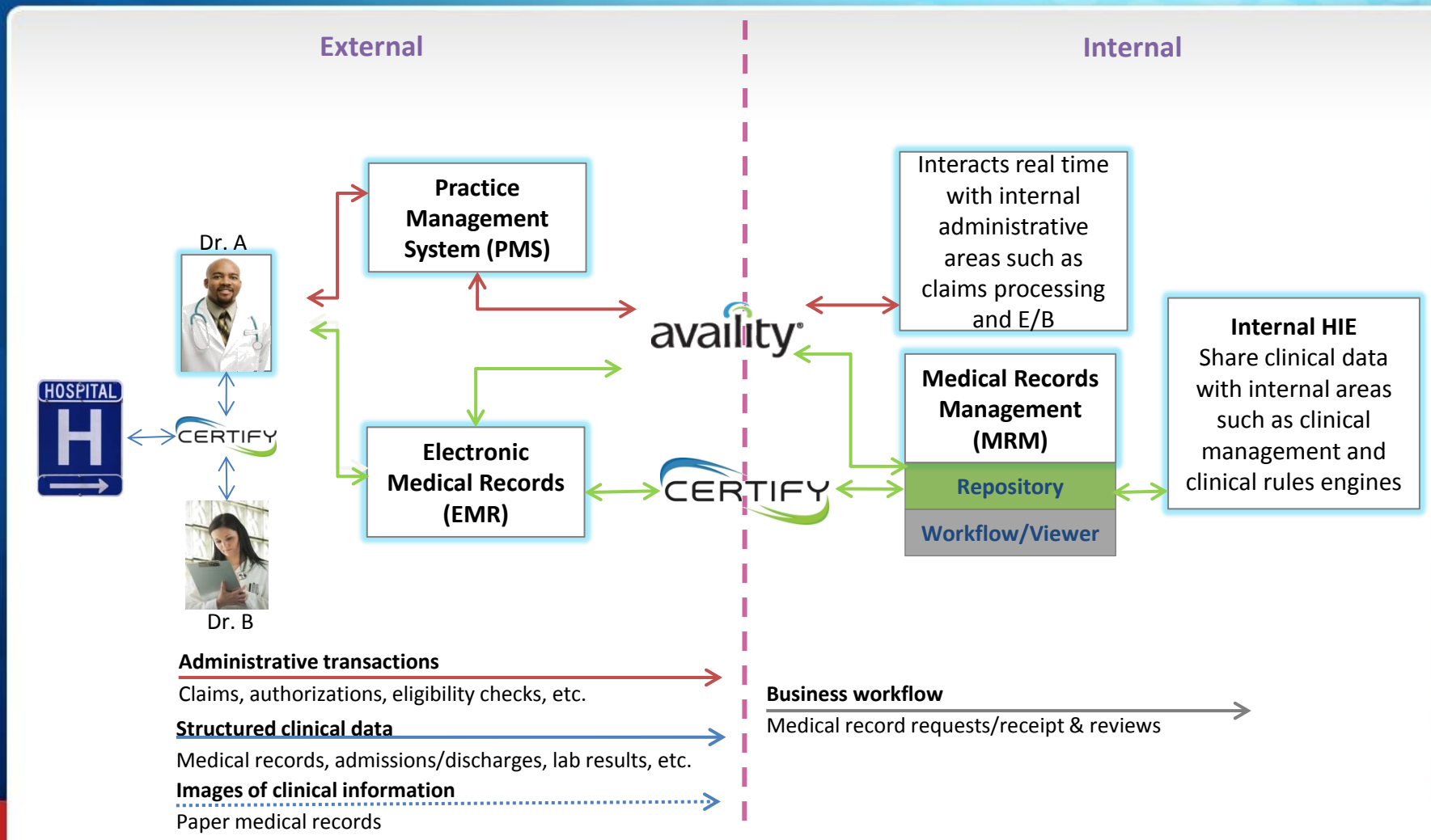


Humana's Accountable Care Continuum

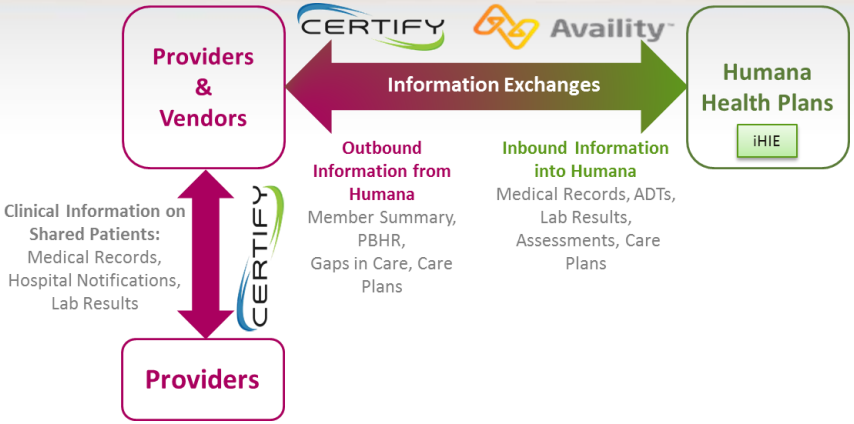
From Pay for Production to Pay for Value



Humana's HIT Ecosystem



Bi-directional Exchange of Health Information



- **Payer-Based Health Record (Member Summary)**
  - Longitudinal health history based
  - Shows history of filled prescriptions (assists in drug adherence)
  - Provides results for labs performed outside of the group's practice
  - Facilitates an improved sharing of health information among clinicians to identify treatment gaps, reduce duplicate treatments and improve patient safety
- **Health Alerts**
  - Opportunities for intervention by providers
  - Identified by Humana's rules engine
  - Based on claims data for each patient
  - Focused on HEDIS measures and best practice guidelines
- **Hospital Notifications**
  - Admission, discharge and transfer (ADT)
- **Physician and Hospital Medical Records**
  - Encounter Data
  - Medications
  - Procedures and Results
  - Vital Signs
  - Problem List
  - Immunizations
  - Allergies
  - Progress Notes
  - Assessments
  - Plan of Care
  - Provider and Member Demographics

Provider's Plan for the Data – Humana Member Summary

Plan of Care

Member Summary

Member Demographic Information

NAME:	Doe, Jane	DOB	6/6/1966
HUMANA ID:	H999999999	GENDER	Female
PLAN:	Medicare Risk	CITY/STATE:	Louisville/KY
POLICY EFFECTIVE:	37987	PHONE:	999-99-9999
PCP/PROVIDER	Broward Medical LLC		

Patient Quality

STAR MEASURE	COMPLIANT	COMPLIANCE DATE	SCREENING FREQUENCY	DATE OF LAST TEST
Care for Older Adults - Funcational Status Assessment (COA-FSA)	N		Every 12 Months	7/5/2012
Glaucoma Screening in Older Adults (GSO)	Y	09/28/29012	Every 24 Months	9/28/2012

Health Condition History

HCC	DOS: 01/01/2012 - 12/31/2012	DOS: 01/01/2011 - 12/31/2011
Renal Failure - 131		CMS Accepted
Vascular Disease - 105		CMS Accepted

DIAGNOSIS (Period 365 Days)	CODE	TYPE	DATE OF SERVICE
Stricture of Artery	447.1	CHRONIC	7/5/2012
Preglaucoma Not Otherwise Specified	365	CHRONIC	8/2/2012

Prescription History — Period Reported: 365 Days

DATE FILLED	DRUG NAME	DOSAGE	DAYS OF SUPPLY	TIMES FILLED	PRESCRIBING PHYSICIAN	EQUIVALENT DRUG NAME
1/17/2013	CAPTOPRIL	250.000 - MG	7	1	Paul Simon	

Lab Results — Period Reported: 365 Days

DATE	LOINC DESCRIPTION	LOINC CODE	LAB RESULT	LAB VALUE	NORMAL RANGE
11/19/2012	Calcium	17861-6	9.6		8.6-10.2

Patient Admission/Readmission Summary — Period Reported: 365 Days

No information available for this member at this time

Member Summary Disclaimer

The information contained in this Member Summary is not a medical report, nor is it intended to be a complete record of a patient's health information. Certain information