

# Center for Healthcare Transparency

## Subgroup Meeting Highlights

(phone meetings in September and October)

### Clinical Data Subgroup

**Group members identified a number of reasons they were interested in moving towards greater standardization of measures and their current strategies for reducing variation including:**

- Using NQF endorsed measures for numerators, converting to a community-determined denominator when needed
- Using HEDIS based national standards
- Encouraging multi-stakeholder Measurement Committees to resist the temptation to “tweak” measures by communicating the benefits of using standard national and endorsed measures
  - improve accuracy
  - enable benchmarks (which most stakeholder want)
  - reduce time and resources required from those providing data and from the data center
  - make feasible to for NCQA provider recognition

**Members also offered up specific tactics for potential inclusion in the 2020 Implementation Plan and/or resource library, such as:**

For greater data input consistency:

- Work one on one with new practices/systems as they come online for reporting and on-going and provide different types of support based on who is inputting data in different settings
- Provide data finishing guidelines
- Incorporate brief description of each field directly in the in spreadsheets being filled in to improve consistency
- Remind providers they don’t get “credit” for practices that meet standards unless they are coded correctly

For greater measure reporting consistency:

- Work towards standard measurement protocols when relevant, for example, for taking blood pressure at the point of care
- Require a “denominator certification form” to be approved before data can be submitted
- Involve community working group to work through patient attribution methodologies
- Provide detailed guidance instructing practices on how to do their own patient attribution (See MNMCM guidelines)
- For Quality Control
  - Use external auditors to vet data for each plan and facility before it is submitted for aggregation, ideally auditors specialized in data for Pay for Performance if that is the Use Case
  - Perform audits on random samples of 30-35 patients to check that every element was reported

For Quality Improvement:

- If needed, go through a process of “Mixing and matching” numerators and denominators to find a combination that is meaningful to the provider

## Center for Healthcare Transparency: Subgroup Meeting Highlights

### The group identified specific barriers to address for a robust 2020 Implementation Plan, including:

- Degree of consistency: even without intentional tweaking of measures, there is still lots of room for different interpretation of how to provide the data on any given measure and inconsistent data, which lead to lots of “noise” and measures being produced with small but relevant differences
- How to handle grey areas:
  - Measures/guidelines don’t always change as fast as practice – how to handle new codes or new tests which aren’t yet accepted by the measure developer but reflect what’s happening on the ground
  - There are different degrees of latitude/specificity for different measures
- Challenges of EHR systems
  - EHRs that “don’t speak the same language”
  - For composite codes, for example, some elements are harder to “find” in records than others
- Differences in attribution methodologies within and across regions

## Center for Healthcare Transparency: Subgroup Meeting Highlights

### Patient Reported Data Subgroup

Group members are very intrigued with the possibilities offered by different types of patient generated data but also identified current barriers to using such data to its full potential including:

#### *Patient Generated Health Data - General*

- Integrating use of Patient Generated data into provider workflow
  - How do providers get notified about changes in data?
  - Who pays for the time it takes to do the integration?
  - What happens when remote patient generated data comes in “after hours”?
- Education of providers on how to use this data
- Provider concern over quality of patient data generated outside of a clinical setting
- Provider concerns about liability once data is received
- Difficulty of validation when there is no second source
- Lack of standards for how data gets incorporated into EMRs, how provenance is tagged
- Lack of standards for untethered Personal Health Records, not covered under HIPAA
- Multiple steps for information moving to/from untethered Personal Health Records
- Proliferation of apps and sources of data
- Accessibility issues for patients to use portals, etc. for contributing, validating data
- Incompatibility of many in-home medical devices with options for uploading information

#### Patient Reported Outcomes

- Challenge of getting sufficient responses from paper tools
- High cost of some attractive measurement tools like PROMIS

#### Patient Experience

- Costs of running surveys
- Limits on questionnaire length and how much can ask
- More efficiently getting information input
- Figuring out how information gathered can be used for meaningful improvement
- Setting expectations for what will change and when as a result of patient input

#### **Topics for Further Discussion**

- Greater detail in patient experience reporting
- Liabilities associated with receiving patient reported data
- Challenges differentiating between shared decision-making and shared consent (one member is researching and will report back)

## Center for Healthcare Transparency: Subgroup Meeting Highlights

### Public Reporting Subgroup

**Members suggested the following characteristics of exemplary Public Reporting today:**

- Data is presented in a way that consumers understand
  - Simple presentation, simple (5<sup>th</sup> grade) language
  - Symbols when possible (members are using stars, bar graphs)
- Less is more – reports streamlined to include only what is actionable
- Use of composite scores to assist consumer decision making
- Methodologies behind the numbers are as simple as possible
- Reports include clear explanations and educational content
  - Legends to explain symbols
  - Videos, particularly for explaining “why does this matter to me”
  - Multiple layers of explanations for stakeholder who want a more detailed understanding
- Data on quality laid out in relation to cost/resource use/price and with context
- Interactive tools for greater personalization
- Potential for different sites for consumer and for provider audiences

**The group identified challenges they currently faces as they strive to improve their public reporting today, including:**

- Master Provider Index
- Data display, especially for consumers
  - Getting stakeholders comfortable with symbols
- Getting customers to engage, be interested
  - Campaigns help, how do you keep traffic high?
  - Quality information may not be sufficient
- Making sure public reporting goes beyond the lowest common denominator both for consumers and purchasers, making sure it’s actionable for benefit design, etc.
- Still in the early stages of taking advantage of mobile apps