CENTER FOR HEALTHCARE TRANSPARENCY
Meeting Summary
Regional Data Center Collaborative
SubGroup 3: Clinical Data
October 15, 2014

Attendees: Beth Newsom, CIVHC; Romi Wang, Molly Cahall, GCHC; Deepthi Rajeeve, HealthInsight; Dolores Yanagihara, IHA; Jay Besse, LSUHSC, John Fielding, LHCQF, Matthew Gigot, WCHQ, Jared Nashida, WCHQ

Staff: Kristin Majeska, Mary-Isabel Aromando, Kristy Thornton

Who are the audiences for clinical data? Where is the ultimate source of the clinical data?

The group discussed the challenges of collecting quality data as it relates to diabetes measures. HealthInsight is collecting diabetes information at the medical group level. One of the challenges is the attribution of patients based on the frequency they are seen by the practice. Attribution cuts across a variety of measure types. What is the definition of the denominator population? How do you determine attribution to a practice or a provider? How many times is a patient seen at a practice or by a specific provider?

GCHC provides guidance to practices on how to conduct attribution. It can switch from year to year. It is done on a one to two year cycle and it primarily left up to the medical group to determine their own attribution for clinical quality measures. Wisconsin uses a similar model. LHCQF is receiving diabetes information from the school based health clinics. Attribution is not an issue with this population.

LSU has operated population management programs for quite some time. They are working to expand the scope of what they are measuring. Identifying what tests have been done and what are the results, then expanding from the initial concept measure to what might be possible (treatments chosen based on results, etc).

Wisconsin NQF endorsed measures are used as the numerator. GCHC also uses NQF endorsed measures as the numerator. IHA is using a national standard wherever possible (HEDIS based) for measures. Although they don't have access to all clinical data. Providers are mentioning how resource intensive it can be to provide data. Standardization and streamlining of processes is becoming more important. HealthInsight noted how important standardization is for community benchmarking.

Consistency of information coming from providers? There is a lot of room for interpretation. Tweaking the measures may or may not be ideal. In Wisconsin provider and payer measures are not aligned. There is still a lot of "noise" and measures that have small differences. No one really documents how the measures are interpreted and if they are standardized. GCHC requires a denominator certification form be completed before data is submitted to their portal. MNCM also requires this type of certification. **If it is not proprietary, the group would like to see the denominator certification form.** The form/worksheet is reviewed and if data is found not to comply with the agreed format it may be rejected. CHPI uses an auditor for each plan and facility to vet the data before it is submitted. GCHC has experience with codes for colorectal cancer screening. Providers may not get credit for screenings that are happening if they are using an unacceptable code. If facilities are using screening methodologies that are not standardized they also may not "count" toward the measure.

Technical challenges associated with diabetes measures? There are different sources for the information that needs to go into the measure (tobacco use, BP, aspirin use, retinal eye exam, etc.). Things that are not easily discovered (labs, BP) are the much harder elements in a composite score to collect. There are variations in the locations of the pieces of the composite measure. If documentation in good the measure will be better for that practice.

There was a discussion of the challenges posed by using different data sources and methods. There is a lot of variation in BP measures in both the process and documentation. It may be best to require that this measure be submitted only by primary care providers (or cardiologists as well?). Working toward a standard BP measure protocol in practices/systems can be helpful. Are we measuring BP only to report on a measure or to diagnose a condition? Some clinics may put little effort into the process of obtaining the reading to be used in the measure.

How do group members feel about the level of detailed information being provided?

- Individual interaction is beneficial between CHT staff and group members. Gives an opportunity to discuss issues and ask questions.
- Distributing summary information sooner would be helpful.
- When there are next step assignments please include in body of email so members can quickly discern what is required before the next meeting.