

CHT Call – Subgroup 1 – Legal, Stakeholder Buy-In October 14

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Strategies that each of you have used to work through and get buyin from constituents to get access for data and information you need. Touched on a number of ways to do this. Now, look at stakeholder by stakeholder – What has worked? What strategies used – how have you come up with a business case with a rationale and what elements are mission-critical for that kind of work. What pitfalls do we need to watch out for? The goal is to inform a set of recommendations – how can regional data centers access and make use of all stakeholders around the table around cost, quality and patient experience. Harriet – could include relationship strategies...what is easier to get and harder

From providers and health systems

Tina – Got provider buyin because was an incentive; measuring quality differently creating chaos in the community; added in administrative costs; value in a consolidated way of doing this. The carrot – for accurate data; doing risk adjustment...have providers at the table – what to measure; what is the methodology? Be sure part of consensus...total buyin was needed and transparency of process helped. What Committee? Measurement Reporting Committee – some at board and at large. It is a group that approves the methodology; approves to go public and then, has a subcommittee – have adequate representation in state – rural clinic or primary care specialty...well represented....
Initial chaos – for different kinds of data...talk about the process went through to get the consistency from the providers? Did you quantify...the cost of providing different data? Did the providers understand that well.

Mike D – There is a lot of kind of information to come. Claims data...easy to get...and can be used because no PHI involved and then, identified data coming; then clinical data...different streams – what takes to get data is different.

Reporting from a purchaser – that requires trusted relationships and business agreement – full PHI – Provider system – less willing to do that; harder to get; providers may submit data to rank quality metrics...the trust that goes with data submission...has to go to a trusted source...limited source. There are different uses, different trust relationships and different ways to get that data. Each situation is different.

So, from the providers – please talk what you just described? At the beginning – first steps? That are different?

Dolores – In terms of chaos – no sure if ever a dollar calculation – having different timelines and different data submission processes – too much for providers...measure specifications different – one might look good on one – Report cards with conflicting information . Confusing. Providers asked the plans – can you do this in a consistent way. Just having the providers contribute more accurate data...involvement in decision making cannot be understated.

We have a separate committee structure from the Board....We have equal number of providers and health plans...Other categories of consumers and purchasers...The providers are always at table – measure specifications...and decision making on public reporting and uses of data we get.

Importance for providers to have benchmarks – consistent set – very helpful to them.

Where did you start out with the consistent benchmarks? We started with quality measures – included clinical quality and patient experience and use of health IT...Quality is more difficult to argue with...Resource and Costs more sensitive.

Others as putting those committees together – How do you do this well?

Galinas – like to get Medicaid together from the beginning...Clinical data in the beginning....Help us to get all to the table

Julie HealthCollaborative in CN – A lot of this is a logical progression building on clinical, claims, etc the importance of scale – starting out small when diving into this scope. In CN, it is voluntary....you need to get the buyin with smaller circles and then, we expanded out.

As providers buyin, able to operationalize across the system.

We also have consumer research groups how should be reported

MD – When people think of submitting data....limited to reporting on specific measures or does it go beyond that? Has anyone done this in a slightly more expanded...

Kai – For us, there is a lot we would like to get to and analytics...start with what we are going to use the data for; where they will be reported; how we will be in a profile – engage them to be part of the conversation

Kristin – Differences between individual MDs and systems....Small group of early supporters – what those early partners characteristics have

Julia – Someone who has a morally compelling reason to be transparent. Not top dog in the community; someone who doesn't have the best data – knowing the improvements to make...Within five years – grew from 40 to 450

Doctors come from a small independent practice. Morally compelling reason.

Kristin – Initial cohort on 40....has there been improvement of cohort?

Julia – I do not have now.

Dolores -Timeline for transparency. Got to see how they are doing before published. Next year doing value...Chartered a course – see results from the beginning...See benchmarks and understand it. Helps give them comfort as well.

Kristin – How long period? Two years? 18 months? How many years worth of data?

Dolores – Four years of data....Two years of testing data got at the same time...Three more years of data...

Tina – There needs a year of testing on a smaller scale to work through bugs and get buyin. In the end, three runs before goes public. On measure development – even if NQF- took a couple of years to agree on the attribution process.

Mike – In reporting cost measures – took a couple of years.

Kristin – Pitfalls?

Jonathan – Echo Michael – the communication; outreach and conversations is vitally important....RHICs and APCDs...opportunity for providers to have a role in the process...opposed to Castlight – private sector organization –pushing out cost and quality without emphasize from providers. This is an opportunity to work with people who care what you think.

Dolores – In our community, there was initiative earlier without the buyin – spent a lot of time . If you don't have process for buyin, it can backfire...

Kristin – High stakes mistakes

Julia – Should assume if build it comes. Walk the talk. No overpromising. Be transparent. Showing the value and being truthful.

Kristin – what would you love to do?

Julia – need to think about this.

Kristin – Setting expectations – other stories?

Harriet – Payer part of discussion. The chaos and different requirements of payers...what strategies to coalesce?

Tina – Getting our payers onboard easy. They wanted to put together pay for performance programs and wanted help with NCA programs...Didn't want to increase staff...having resources in community attracted...submitting data with a trusted source important...even though every health plan had different standards on how they would pay out

Jonathan – Strange relationship with payers....when offered to generate information, the brush off. The argument they know all they need to know on competition from reverse benefit information. They are all playing ball under legislation – no interest in analytics out of APCD....Value we have is to generate reports...our experience – odd to date. We only have claims data

Mike – Closer to your situation. One legislation requiring to do it; Their clients requiring them to do it...There are different kinds of data here....Getting fully IDed data from clients – took serious meetings

Tina – Different – data dump or agreement? Paranoia of dumping all data; might feel you are giving away intellectual property.

Mike – Suspect this is true. In our case, we get data from the carriers as opposed from APCD...We have had to craft detailed data use agreement...in what cases for what kind of analytics...who would see these? Whether disclosure on negotiated rates. We solved through the data use agreement process.

Kristin – How much were the purchasers involved?

Mike – No involved but had a governance committee where we worked through a high level in these agreements...Using language out of HIPPA

Kai – We are different since we are voluntary. For us, the value of participating in these initiatives and working through the process and guide through measures working on.

Galina – Can't understand

Mike – For employers, ID data at patient level. When enter into risk contracts, we can provide a list of trends; for employer. So makes risk transparent and actionable. We can't do this through APCD because by law anonymized.

Katrina – Product can feed back to employers – motivated to work with you...to encourage good quality data coming through

Jonathan – Employer community in CO is paying attention – Still hampered by self-funded claims data. Getting a lot of traction with acute care episode analytics. Created bundles – come a long way in implementing Prometheus logic...Employer community will take notice....Especially interested in having this information.

Calpers – Report – employers say pay no more than 30k

Dolores – Role of community leader – he facilitated....Aetna – are you in or out? Getting commitment after lots of conversation occurred. After the fact, when they are getting their results from a mutual party, fewer challenges and more buyin....Far fewer legal costs...results from a trusted source. Strong business case.

Kristin – Public side...specific strategies helpful there. Encourage buyin to get the data you need.

Mike. Other getting from APCD which does have Medicare and Medicaid. It is big project

Kristin – Consumer pressure – has this worked in your community? On the contrary, respond to when consumers are concerned with privacy issues?

Mike – Consumers in general fragmented. We speak through unions or member organizations within a large purchasers....spend time educating them..transparency around quality and cost. Their advisory boards. The other way legislatively gets played out – deal with data contributed in a clinical setting that could be shared....leads to discussions about optin or optout

Kristin – Engaging consumers to help move and enable data to come to you? Or have you responded when consumer opportunitie have come up/

Julia – Using social media to direct to public reporting site. We have the “Make the Right Call Campaign” to engage consumers when should go to ER, etc.

Jonathan – Follow up with Linda, a consultant in Boston.

Mike – The carriers would prefer to send PHI to APCD compared to us. Once required through legislation, no more risk.

Kristin – Other thoughts you might have attempted? Unusual strategies to get buyin ?

Harriet – I was talking to a Collaborative outside of our group last week. They had a lot of success on behavioral health by having opt-in measures. The consumers don't want all of the protections afforded those sensitive designation because care fragmented. In terms of getting PHI, from facilities that treat sensitive pops...different from acute...but most of health delivered here. Any thoughts on this?

Jonathan. Get PHI on everybody. We are sensitive to substance abuse that we take overzealous approach. Also careful on HIV. On our public website, you will see it broken by categories and service lines....