



**Department
of Health**

Transparency, Evaluation, and Health Information Technology Workgroup

Meeting #7

September 18, 2015



Agenda

#	Topic	Time	Leader
1	Welcome and Introductions	10:05 – 10:10	Patrick Roohan
2	Opening Remarks	10:10 – 10:15	Paul Francis
3	SHIN-NY Update <ul style="list-style-type: none"> • RHIO Update • Statewide Patient Lookup • Regs Update 	10:15 – 10:50	Jim Kirkwood Paul Wilder, NYeC Inez Sieben, NYeC Steve Allen, HealthLink
4	APD Update <ul style="list-style-type: none"> • APD RFP • Health Foundation APD Report • Policy Considerations 	10:50 – 11:50	Chris Nemeth
5	Transparency Update	11:50 – 12:10	Patrick Roohan
6	HIT Report <ul style="list-style-type: none"> • Due 12/1 	12:10 – 12:30	Patrick Roohan
7	Advanced Primary Care Measures Update	12:30 – 12:50	Anne-Marie Audet, UHF
8	Discussion and Next Steps	12:50 – 1:00	Patrick Roohan

SHIN-NY Update

James Kirkwood, Director, Health Information Exchange
Bureau, Office of Quality and Patient Safety

Paul Wilder, Chief Information Officer, NYeC

Inez Sieben, Chief Operating Officer, NYeC

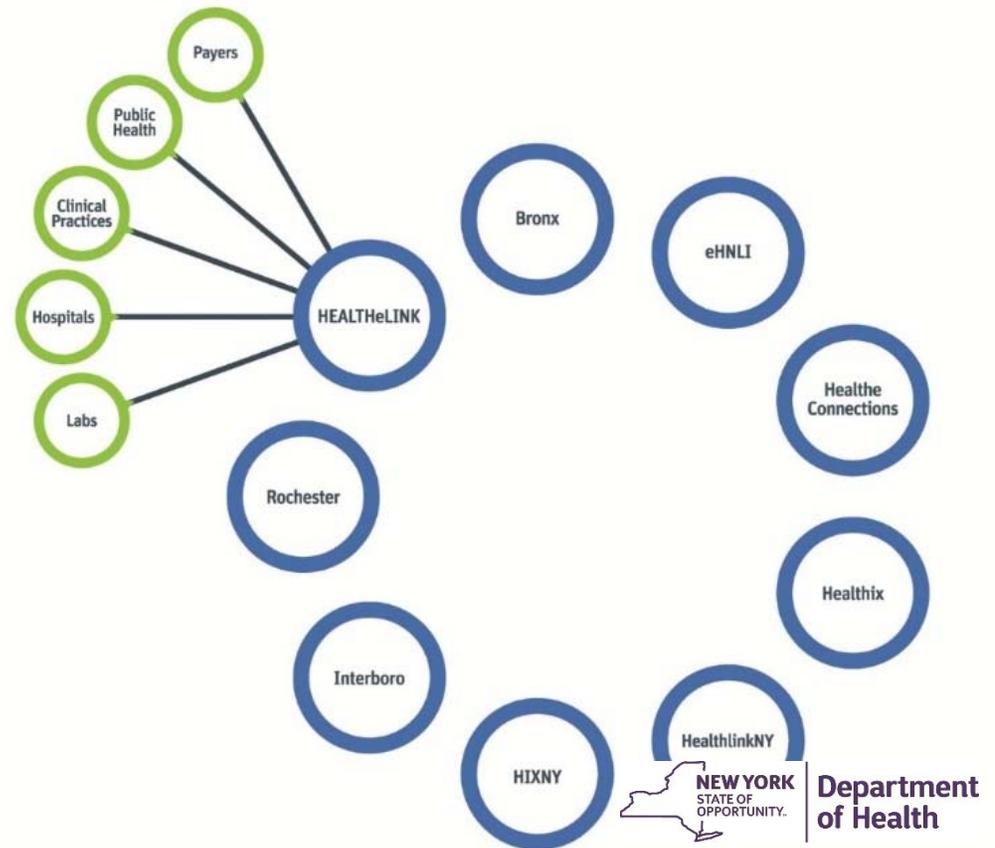
Steve Allen, Director of Operations, HealtheLink

Update on SHIN-NY Regulation and Policy Guidance

- Regulations are going through the internal review process (attached)
- SHIN-NY Policy guidance was put out for review from July 1st-August 31st
 - Requested comment from SHIN-NY stakeholders including associations, PPSs.
 - Some comments:
 - Simplify process and ensure flexibility in participation
 - Ensure alignment with federal requirements(Meaningful Use)
 - Ensure there is an open process for decision making and SHIN-NY policy development
 - Liability issues should be addressed

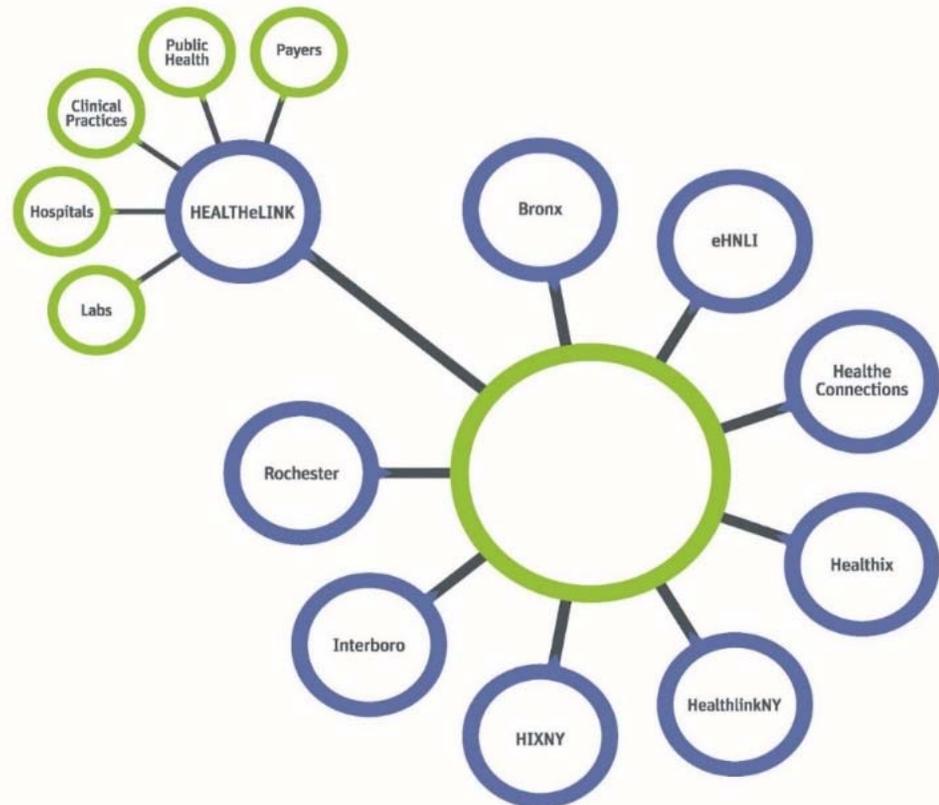
SHIN-NY Structure Yesterday

- Each RHIO connects to its local participants as shown here with HealtheLink (Western NY of New York)
- Data is shared between all regional participants



SHIN-NY Structure Today

- Now, RHIOs are also connected to each other via a central bus (the green ring in the middle)
- Data from a participant of any RHIO is available to any other RHIO's participant statewide
- This system is called Statewide Patient Record Lookup (sPRL)



Implementing sPRL

- RHIOs began connecting to the statewide “Bus” in 3 waves on July 7th

- Wave groupings were chosen by their likelihood to have patient overlap

- **Wave 1: (1st Half of August)**

Southern Tier (Binghamton), Hudson Valley, Central (Syracuse),

Capital District (Albany)

- HealthlinkNY (STHL & THINC, previously)
- HealtheConnections
- Hixny

- **Wave 2: (2nd Half of August)**

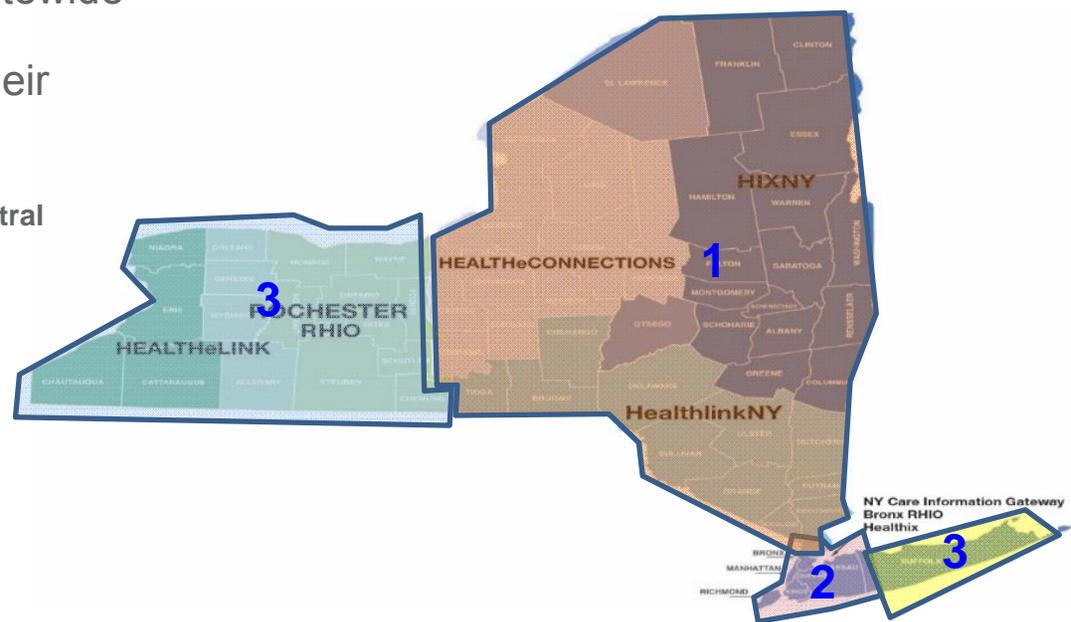
NYC and Long Island

- NY Care Information Gateway 1 (legacy Interboro)
- Healthix
- Bronx RHIO

- **Wave 3: (Mid September)**

Western Region, Finger Lakes, Eastern Long Island

- NY Care Information Gateway 2 (legacy eHNLI)
- Rochester RHIO
- HEALTHeLINK



Status of sPRL

- Wave 1 and Wave 2 are connected and exchanging data
 - There are a couple participants of a Wave 2 QE that are not connected to sPRL but they are expected to be connected by the end of the month
- Patient demographics have been integrated into a statewide master patient index (sMPI)
 - Over 25 million unique patient MPIs are now in the statewide network
- Wave 3 connected 2 out of 3 QEs this week
 - New York Care Information Gateway 2 (legacy HIE eHealth Network of Long Island) is not connected yet
- Current Net Result: 8 out of 9 systems are connected

Near Term Enhancements

- Image Exchange
 - Radiology and Cardiology as well as many other image types
- Cross-RHIO Alerts: notifications of inpatient admits and ED visits for participant's patient panels
 - Alerts are currently works between RHIO's local participants
 - This is a common enhancement request from DSRIP PPSs
 - An architecture to support cross-RHIO alerts is in development and will likely be a statewide standard after a pilot deployment is completed
- Patient Portals
 - HIXNY (Capital Region) released theirs to their community
 - Others are looking into options including an ONC/DoH funded patient portal technology from NYeC



HEALTHeLINK™

Engagement with DSRIP

September 18, 2015

PPS's Operating in Western New York

- Millennium Collaborative Care (MCC) - Lead is ECMC
 - Operates exclusively in the 8 counties in WNY
- Community Partners of WNY (CPWNY) - lead is Sisters of Charity Hospital
 - Operates exclusively in 3 counties in WNY
- Finger Lakes Performing Provider System (FLPPS)
 - Operates across Central NY with overlap in 3 WNY counties

HEALTHeLINK PPS Engagement

- Support for MMC and CPWNY PPS Grant submission process
- Facilitate various collaboration meetings:
 - Monthly Joint PPS meetings
 - Joint Medicaid Health Home meetings
 - Data gaps and standards requirements process
 - Claims data
 - Incremental hospital data, e.g. discharge medications, ED summaries
 - Patient data from each practice at the close of an encounter
- Participate as a member in the MCC Target Operating Model workshops
- Participate as a member in CPWNY IT Governance committee

Opportunities to Leverage the QE Investments

- EMR bi-directional interoperability – FINAL MILE CONNECTION
- Query access to all a patients data for treatment purposes
 - Local data sources
 - SHIN-NY
 - VA
- Notification alerts of patient events and care transitions
 - ED visits
 - Hospital discharges
 - EMS calls
 - Abnormal results
- Access to Care/Treatment Plans
- Population health analytics
 - QE as a data source leveraging a comprehensive clinical and claims data view of the patient
 - Analytics tools/services offered

APD Update

Chris Nemeth, Director
All Payer Database Development Bureau
Office of Quality and Patient Safety

APD RFP Update:

- RFP Amended and re-released 6/15
- Amendment Questions & Answers Posted in August
- 8 Proposals Received by September 3 due date
- Product Demonstrations by Top Ranked
- Bidders scheduled for mid-October
- Anticipated Contract Start Date: January (dependent on bidder protests/ OSC approval time)

Study Update: Health Foundation/APCD Council

Priority issues queried through stakeholder interviewers, other states' APD experience:

Price and Quality Transparency

- Transparency tools in use by other states
- Mechanisms to address concerns that price transparency may disclose proprietary information.

Stakeholder Utility

- Ways to maximize utility of APD data for the broadest range of stakeholder groups.

Data Release, Use and Governance

- Data governance mechanisms for the collection, linkage and release of data

Draft Report Findings Discussed at August Preview:

Key Findings:

1. Reliable and trusted price and quality data for consumers are scarce.
2. Pricing data versus charge data are required for true transparency.
3. Transparency is more complex than price shopping.
4. The State's vision, goals, and timeline for the APD are unclear to stakeholders.
5. The New York APD is viewed as a public utility with unclear governance.
6. A broad consumer strategy across state agencies will require concerted effort and coordination.
7. Fiscal and programmatic sustainability will likely be challenged.

APD Policy Considerations: Data Governance and Release

Governance

Governance covers a broad array of aspects of the APD, including authorizing legislation, defining rules and regulations to guide operations, designating of an oversight entity (or entities) for the APD, and composing a governance structure (e.g., a board or commission) providing policy guidance and oversight. These components form the foundational structure of the APD and have bearing on all aspects of the build and use of the APD. The components of a governance structure typically address:

- APD legislation
- Governing body and oversight
- Scope of the data collection effort
- Privacy and confidentiality
- Interagency agreements

Governance Structures of Other States:

Who makes the decisions and who has input?

What processes are used in governance decision making, including data release?

Colorado

- Has a “Data Release Review Committee” comprised of 11 representatives from:
 - Private payers
 - Public payers
 - Hospital
 - Physician
 - Four “additional perspective” organizations: University, Health Institute, Policy Center, data firm
- Review Process: Committee reviews applications monthly, and upon approval, data is usually provided to the user within 30-60 days

Governance Structures (cont'd)

Massachusetts

- “Data Release Review Committee” in regulation - comprised of representatives from health care plans, health care providers, health care provider organizations and consumers. Appointed by the APCD Executive Director
- “Data Privacy Committee” advises the Executive Director on data release
- Review Process:
 - The “Data Release Committee” has public meetings on as needed basis; frequency based on past appears to be monthly
 - Website includes a data request/release flow chart and a fee schedule
 - Request and application statuses posted publicly on website; allows public to comment on pending requests

Governance Structures (cont'd)

New Hampshire

- Has a “Claims Data Release Advisory Committee” which in their regulation:
 - “The department shall establish a claims data release advisory committee to provide non-binding advice and opinion on the merit of applications for limited use data sets. The committee, selected by the commissioner, shall consist of the following members:
 1. One member representing carriers;
 2. One member representing facilities;
 3. One member representing health care practitioners;
 4. One member representing the general public;
 5. One member representing purchasers of health insurance;
 6. One member representing health care researchers; and
 7. Two members of the department”
- Review Process: Advisory Committee has 45 days to review and comment on requests; Commissioner signs DUAs for limited datasets

APD Governance Structure and Process

Broad stakeholder participation	→→→→→→→→	Degree of Centralized Control	←←←←←←←←	Stakeholder participation limited
Publicly Appointed Board	Publicly Appointed Board	Internally Designated Committee w/ Some External Stakeholder Participation	Internally Designated Committee Only	No Board or Committee
Board Authority to Approve/Make Decisions	Board Makes Recommendations Only; Decisions Made By Commissioner or Designee	Committee Authority to Approve/Make Decisions	Committee Makes Recommendations; Decisions only by Commissioner or Designee	APD Director Authority to Approve/Make Decisions
Hold Public Meetings for Feedback AND:	Hold Public Meetings for Feedback AND:	Hold Internal Meetings Only BUT STILL:	Hold Internal Meetings Only	No Public Feedback
Publish Records of Data Requests and Approvals	Publish Records of Data Requests and Approvals	Publish Records of Data Requests and Approvals	No Publication of Data Requests or Approvals	No Publication of Data Requests or Approvals

Data Access

Broad Release	Moderate Release (Similar to SPARCS)	Limited Release
Produce Public Use Aggregated Files/Reports	Produce Public Use Aggregated Files/Reports	Produce Public Use Aggregated Files/Reports
NYS Agency Use of all Levels of Data	NYS Agency Use of all Levels of Data	NYS Agency Use of all Levels of Data
Limited Identifiable and Identifiable Data Files Publicly Available	Limited Identifiable and Identifiable Data Files Publicly Available – <u>though not for first 18 months of operation to refine data quality and security controls</u>	*No Release of Partially Identifiable or Identifiable Data
Broad Range of Requestors with Limited Parameters for Requests	Narrow Range of Requestors, Based Upon Application for Prescribed Uses Only	N. A.
Subject to Approved Data Use Agreement	Subject to Review/Approval of Project Purpose and Approved Data Use Agreement	N. A.



Handling & Release of Pricing Data

Prices may equate to charges from a consumer or payer perspective, or to payments from a provider perspective. Clearly the best benefit for consumer transparency speaks awareness of actual payment amounts to providers. However, many APCD's have largely shied from direct, non-aggregated price reporting given Federal Trade Commission (FTC) antitrust guidelines and an unwillingness to buck the proprietary concerns of payers and providers. Some states are assessing release options that range from the release of data to public users to restricting access via secure portals. Each approach has benefits and trade-offs for stakeholders to consider. Three state examples for illustration:

Colorado

- “1. The data we provide will either be derived from data that are at least 3 months old or, if raw data, it will be at least 3 months old. Currently the most recent data in the Colorado APCD at any given time is at least 6 months old; and
2. With respect to the calculation or other derivation of statistics in relation to claims:
- a. The data used in such calculations will be comprised of data from 5 or more organizations. At present, the Colorado APCD currently houses data from 14 commercial insurance carriers and the Colorado Medicaid Program;
 - b. No individual organization will represent more than 25 percent of the data supporting the calculation or other derivation of a particular statistic or data field; and
 - c. The data used will be sufficiently aggregated as to prevent identification of any one entity through reverse engineering or other manipulation of the data.”

Source: <http://www.civhc.org/getmedia/283ca0d2-a3f9-4f73-95f4-ec8bc05a3c0c/COAPCD-Data-Release-and-Price-Model-Guide-for-Payers-Providers.pdf.aspx>

Handling & Release of Pricing Data

Massachusetts:

Relative Price (RP) is a calculated measure that compares different provider prices within a payer's network for a standard mix of insurance products (e.g. HMO, PPO, and Indemnity) to the average of all providers' prices in that network. **RP data is submitted annually to Center for Health Information and Analysis (CHIA) by commercial and public payers. Payers also separately submit the corresponding dollar values for network average RPs for each provider type. Payer data submissions are not available as a public record.** As the Commonwealth strives toward greater price transparency in the health care market, it is increasingly important to monitor variation in provider prices and the relationship between price and market dynamics.

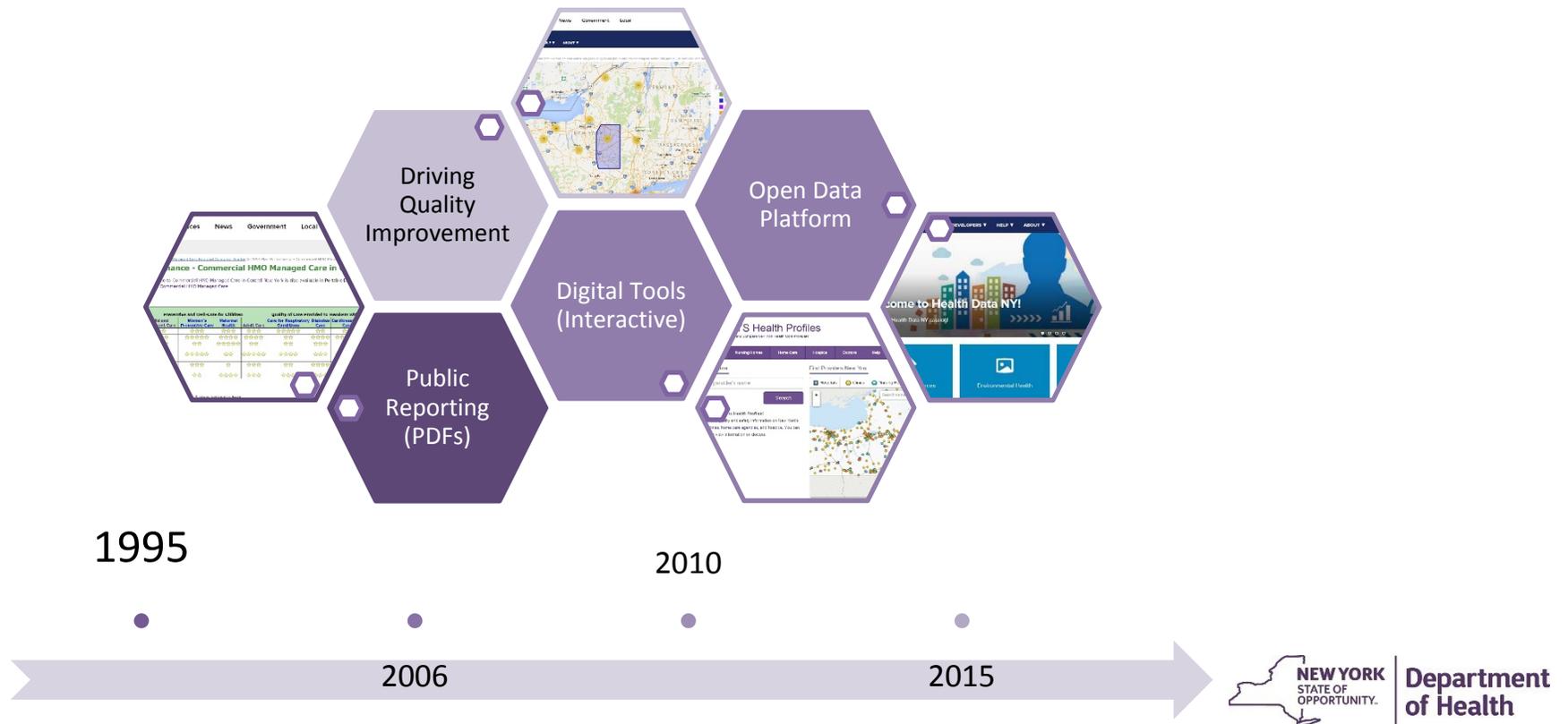
New Hampshire:

The HealthCost tool's estimates are based on the **median amounts paid** (by both the insurance carrier and the patient) using claims data. The median treatment cost based on patient experience is reported instead of the average. ***The median is a better measure of central tendency when predicting the cost liability to the patient and health plan.*** The median is influenced less than the average by outlier observations that may skew the results. **The median also makes determining actual contract terms for payments between the insurer and the provider more difficult.** Risk adjustment is used in HealthCost by adding a column called *Patient Complexity*. **Risk adjustment provides a relative measure for the difference in the illness burden of patients in the analysis and treated by the selected providers.** However, **the rates provided in HealthCost are not risk adjusted.** They are the actual calculated rates based on the claims data and the HealthCost algorithms.

Transparency Update

Patrick Roohan
Director
Office of Quality and Patient Safety

Current DOH Data-driven Transparency Efforts



Significant Use of Medicaid Managed Care Data Over Time

- Commitment to public reporting of quality measures in 1995, which lead to:
 - Incentive to perform well (competition among plans)
 - Data used to drive quality improvement efforts
 - Quality performance is part of plan annual survey
 - Quality Incentive – a pay for performance program that rewards plans with high quality (\$300M+ annually + auto-assignment)

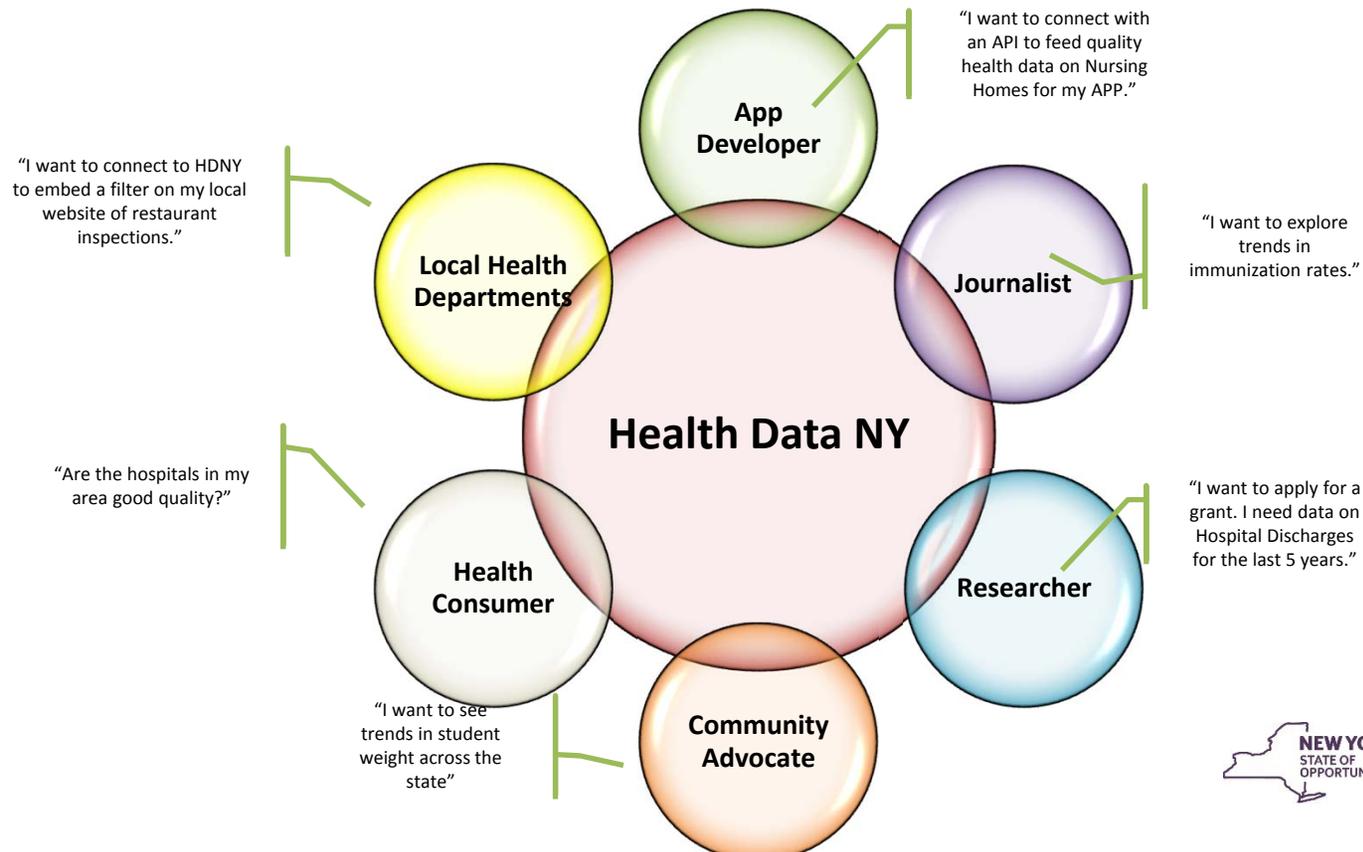
Health Profiles

- Redesigned DOH website for hospital, home care and nursing home performance
 - Includes measures on quality, utilization, surveillance and services provided
 - Includes both NYS and national measures of provider quality
 - Ability to compare facilities and quality measures
 - Measures from Health Profiles are being used for the Nursing Home Quality Initiative and the proposed Hospital Incentive Program for Medicaid

Health Data NY

- NY's Open Data Portal
 - Currently 150+ data sets available to the public
 - Portals' capability includes APIs, embed function, and light visualizations
 - Includes financial, utilization, quality, public health, surveillance, provider network data and vital statistics
 - Includes some de-identified discharge level data (SPARCS inpatient)
- Other digital tools include: eQARR & Managed Care Consumer Guides

Health Data NY Stakeholder View



Future Capability with the APD

- Quality, Utilization and Costs. Building off the experience using Medicaid data the APD will be able to:
 - Create provider measures of performance at various levels of aggregation (plan, region, municipality, PPS, ACO, provider, practice, etc.)
 - Compare quality, utilization and costs across various levels of aggregation
 - Provide evidence based quality measurement across payers, essential for the success of DSRIP and SIM

Future Capability with the APD

- **Safety.** The APD will compliment current DOH programs like NYPORTS and Office Based Surgery (OBS).
 - Measures could be calculated using APD
 - Cross validation of reportable events
- **Public Health.** The APD will augment the multiple public health data streams including:
 - Use by registries for initial case finding and validation
 - Add important claims data to rich clinical data (e.g. Adding Rx, radiology and chemotherapy information to the cancer registry)
- **Population Health.** The APD with data on all NYers will help in multiple ways monitoring chronic conditions across the state

HIT Report

Patrick Roohan
Director
Office of Quality and Patient Safety

Workgroup Charge

(ii) The commissioner shall convene a workgroup to:

(A) evaluate the state's health information technology infrastructure and systems, as well as other related plans and projects designed to make improvements or modifications to such infrastructure and systems including, but not limited to, the all payor database (APD), the state planning and research cooperative system (SPARCS), regional health information organizations (RHIOs), the statewide health information network of New York (SHIN-NY) and medical assistance eligibility systems; and

(B) develop recommendations for the state to move toward a comprehensive health claims and clinical database aimed at improving quality of care, efficiency, cost of care and patient satisfaction available in a self-sustainable, non-duplicative, interactive and interoperable manner that ensures safeguards for privacy, confidentiality and security;

(iii) submit an interim report to the governor, the temporary president of the senate and the speaker of the assembly, which shall detail the concerns and issues associated with establishing the state's health information technology infrastructure considered by the workgroup, on or before December first, two thousand fourteen; and

(iv) submit a report to the governor, the temporary president of the senate and the speaker of the assembly, which shall fully consider the evaluation and recommendations of the workgroup, on or before December first, two thousand fifteen.



Proposed Report Outline

1. Workgroup Membership
2. Workgroup Background and Charge
3. Executive Summary
4. Overview of New York State's Health IT Infrastructure
 - A. SPARCS
 - B. Medicaid
 - C. All Payer Database
 - D. SHIN-NY
5. How these systems fit together – New York's vision
6. Issues and Challenges
7. Recommendations
8. Conclusion
9. Appendices

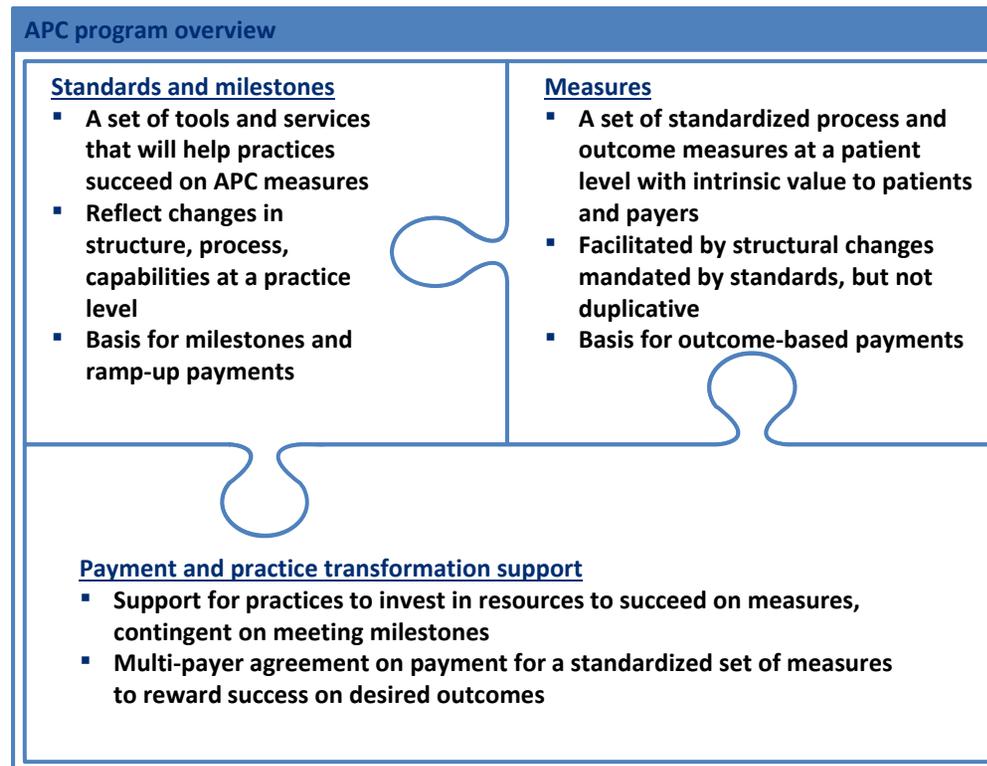
Timeline of the Report

Date	Status
October 15, 2015	Draft report for workgroup members for comment
October 29, 2015	Comments due back to DOH
November 6, 2015	HIT workgroup meeting to review report
November 15-30, 2015	DOH - Executive approval
December 1, 2015	Report release date

APC Measures Update

Anne-Marie Audet
Vice President, The Quality Institute
United Hospital Fund

APC is defined by standards and measures, and supported by practice transformation support and innovative payment strategies



Principles and Criteria for APC Measure Selection

- Measures fit to purpose(s)
 - Evaluate whether APC standards are in place and working effectively
 - Evaluate patient experience, clinical quality, and avoidable costs
 - Use for ‘value based’ payments
- Strive towards alignment and parsimony
 - Same measures across payers
 - Measures that serve multiple purposes within APC, and without
 - Aligned to other federal, state, regional data collecting and reporting programs (e.g. PQRS, MU, QARR)
- Endorsed (valid, reliable, tested, used)
 - Avoid completely new measures
 - NQF, NCQA, PCPI

Principles and Criteria for APC Measure Selection (continued)

- Meaningful to:
 - Patients
 - Payers
 - Providers
- Opportunity:
 - To meaningfully improve health
 - Influenced by health care providers/system
- Feasible/Practical (lowest burden)
 - Data exists (relatively easy to ‘mine’)
 - Methodologically sound (numerators/denominators)
 - Mix of administrative, clinical/EHR, survey
- Relevant across broad population(s)
- Balance:
 - Acute/Prevention/Chronic
 - Utilization

Draft APC Core Measure Set

- Reviewed existing measure sets – other states, regions, national programs, NYS.
- Selected 20 measures as start point - vetted according to principles and criteria.
- Further vetting re. principles with ICW members, providers and payers.

Current APC Common Measure Set draft

Proposed core measure	
Prevention	<ol style="list-style-type: none"> 1. Colorectal Cancer Screening 2. Chlamydia Screening 3. Influenza Immunization - all ages 4. Childhood Immunization (status) 5. Fluoride Varnish Application
Chronic Disease (Prevention and Management)	<ol style="list-style-type: none"> 6. Tobacco Use Screening and Intervention 7. Controlling High Blood Pressure 8. Diabetes A1C Poor Control 9. Appropriate Medication Management for People with Asthma 10. Weight Assessment and Counseling for nutrition and physical activity for children and adolescents and adults
BH / Substance Abuse	<ol style="list-style-type: none"> 11. Depression screening and management 12. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Patient Reported	<ol style="list-style-type: none"> 13. Record Advance Directives for 65+ 14. CAHPS Access to Care, Getting Care Quickly
Appropriate Use	<ol style="list-style-type: none"> 15. Use of Imaging Studies for Low Back Pain 16. Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis 17. Avoidable Hospitalization 18. Avoidable readmission 19. Emergency Dept. Utilization
Cost of Care	<ol style="list-style-type: none"> 20. Total Cost of Care



Draft Measure Set Fit to Criteria

- Alignment with other measurement programs:
 - NQF endorsed: 16/19
 - EMR Specs: 13/16
 - QARR:14/16
 - DSRIP:12/19
- Note: # DSRIP projects focused on tobacco (27), flu immunizations (26), depression (42) and 3 utilization measures (99).
 - MU:15/16
 - MSSP: 10/19
 - PQRS: 15/19
 - CPC or MAPCP: 12/16
- Ease of collection:
 - Claims only: 8
 - Hybrid (Claims and MR): 8
 - Survey:2
 - MR: 1
- Balance: Age groups
 - All: 7 ; Adults only: 7; Adult/Adolescents: 3; Child/Adolescents:1; Child only: 2
- Balance: Type of Care
 - Prevention:5
 - Chronic disease prevention and management:5
 - BH/Substance Abuse:2
 - Patient reported:2
 - Appropriate Utilization:6
- Opportunity: Performance trends (NYS in progress)
 - No change: 7
 - Worst: 6
 - Improved: 4 (3 utilization)
 - Below goals (DSRIP): All
 - Below national benchmark: 3/4



Mapping APC Standards (core competencies) to APC Core Measure Set

APC Standard	Major Competencies	Core Measure Set
Patient Centered Care: 2 Major Competencies	i. Access to care in a timely way	14. CG-CAHPS – Getting Care Quickly
	ii. Advanced directives	13. Record Advanced Directives
Population Health: 5 Major Competencies	i. Proactive management of panel of patients who need preventive care	1. Colorectal Screening 2. Chlamydia Screening 3. Influenza Immunization 4. Childhood Immunization 5. Fluoride Varnish
	ii. Proactive management of panel of patients who need chronic care management	6. Tobacco Use Screening and Intervention 7. Controlling High Blood Pressure 8. Diabetes A1C Poor Control 9. Appropriate Medication Mngt for People with Asthma 10. Weight Assessment and Counseling for Nutrition and Physical Activity for Child, Adolescent and Adult
	iii. Providing patients with self-management resources (in-house, community)	No direct measures, these competencies are part of management of patients with chronic conditions and others as appropriate.
	iv. Providing patients with appropriate community-based services	All measures apply here, since performance on the full core set can be assessed by various groups by age, ethnicity, income, other.
	v. Reducing disparities	
Care Management: 2 Major Competencies	i. Proactive management of high risk patients (5% who consume 50% of services)	17. Avoidable Hospitalizations 18. Avoidable Readmissions 19. Emergency Dept. Utilization 20. TCOC
	ii. Management of patients with BH and substance abuse	11. Depression Screening and Management 12. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Care Coordination: 2 Major Competencies	i. Proactive management of patients during care transitions	18. Avoidable Readmissions 19. Emergency Dept. Utilization
	ii. Proactive management of specialty referrals	No direct measures of quality; this competency will be reflected in outcomes of care, in TCOC, and could be tracked with CG-CAHPS: getting referral care quickly
Access to Care	i. 24/7 access to provider – in-person, phone, tele-video, asynchronous	14. CG-CAHPS

APC Core Measure Set Vetting Feedback

- Positives:
 - Parsimony/balance.
 - Measures already in wide use among practices, commercial and public payers.
 - More or less on track re. individual measures selected (likely some changes at the margin, retiring measures, substitution to more appropriate measure – e.g. avoidable vs all cause readmissions).
- Issues raised:
 - Appropriateness of set for special practice settings/special populations (e.g. peds, ob/gyn, geriatrics, socially and clinically complex).
 - Methodological challenges: level of measurement (physician, practice, other) - valid numerators and denominators (especially for utilization measures).
 - Ease of collecting and reporting (claims, MR, survey).
- Providers:
 - Cannot be yet “another” set of parsimonious measures, has to be aligned across payers.
 - Small “n” challenges and statistical significance.
 - Risk adjustment.
 - Need for comprehensive and timely patient data– ED visits, admissions, referrals.
 - Where will resources for data collection come from (e.g. CAHPS, patient reported items)?
 - How will data about their panel performance re. the core measures be made available to practices?
 - Core set not applicable to quality of care for complex, multi-morbid patients.
- Payers:
 - Ability to tailor for population-specific healthcare priorities – menu approach within the core set vs expanding the set
 - Resources for data collection and reporting beyond claims
 - Performance-based payment models
 - Small ‘n’ challenges and statistical significance



Next Phase for APC Core Measure Set

Vetting (with providers and plans) – from principles to implementation.

- Goals to understand and create a feasible path from A) current practice re. quality measure collection, reporting and use to B) full adoption of proposed APC core measure set.
- Seeking input on following implementation issues:
 - Availability and ease of collection (main source of data): 1/3 of core set can be measured with claims only. Current state of EHR-based data collection?
 - Feasibility and value in aggregating data across a practice to solve small numbers challenge.
 - Total Cost of Care measure.
 - Measure collection strategy adapted to measures: e.g. advanced directives collected from medical record in small defined cohort.
 - Data reliability: issues with coding consistency, member misdiagnoses, low numerators needed when long look-back (colorectal screening), missing data (lab, BP), member low response rate (surveys)
 - Risk adjustment methods.
 - Financial reward/penalty: about 1/3 of core measures are incentivized by plans.

Questions for discussion

Operational Issues to Resolve

- 1) What is the detailed design for the reporting system?
- 2) How do we ensure measures are quality controlled (e.g., sufficient sample size for statistical validity)?
- 3) Thresholds and improvement goals: which benchmarks are available and could be used to assess performance (from within State or external)?
- 4) Method to streamline data collection from health records, claims and surveys.
- 5) Which measures will be standardized or pooled across payers, and which must be tailored to each.
- 6) Should collection and reporting be centralized or disaggregated? What are the options technologically and potential tradeoffs?
- 7) How can regions that are ready to operationalize the scorecard be supported?
- 8) Who should be able to see reports?



Discussion and Next Steps

Patrick Roohan
Director
Office of Quality and Patient Safety

Next meeting November 6, 2015