



Unlocking Quality Information: Understanding the Value of Health IT for Quality Measurement and Improvement

*A Web-based Workshop
1:00 p.m. – 4:00 p.m. (EST)
April 26, 2010*

Workshop Workbook
Presentation Materials and Resources



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Welcome to the AHRQ Medicaid and CHIP TA
Web-based Workshop

***Unlocking Quality Information: Understanding
the Value of Health IT for Quality Measurement
and Improvement***

A Workshop for Medicaid/CHIP Agencies

Monday, April 26, 2010, 1:00–4:00 p.m. Eastern

Presented by:

Rosemary Kennedy, MBA, RN, FAAN, Senior Director Nursing and Healthcare Informatics, National Quality Forum

Jay Buechner, PhD, Director of Evaluation and Improvement, Neighborhood Health Plan of Rhode Island

David Kelley, MD, MPA, Chief Medical Officer, Pennsylvania Medical Department of Public Welfare's Office of Medical Assistance Programs

Funded by the Agency for Healthcare Research and Quality

Overview

- **Welcome** – Lekisha Daniel-Robinson, Health Insurance Specialist, CMS
- **Introductions** – Attendees
- **Presentations**
 - ***Module 1: Automating Quality: Health Information Technology and Quality Measurement at NQF***
 - Presented by Rosemary Kennedy, MBA, RN, FAAN, Senior Director Nursing and Healthcare Informatics, National Quality Forum
 - ***Module 1: Discussion***
 - ***Module 2: Using HEDIS Measures for Quality Assessment, Improvement, and Reporting***
 - Presented by Jay Buechner, PhD, Director of Evaluation and Improvement, Neighborhood Health Plan of Rhode Island
 - ***Module 2: Discussion***
 - ***Module 3: HIT Meaningful Use—Prime Opportunity to Enhance the Measurement of Quality in Medicaid***
 - Presented by David Kelley, MD, MPA, Chief Medical Officer, Pennsylvania Department of Public Welfare's Office of Medical Assistance Programs
 - ***Module 3: Discussion***
- **Closing Remarks** – Lekisha Daniel-Robinson

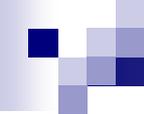


Automating Quality: Health Information Technology and Quality Measurement at NQF

Presented by:

Rosemary Kennedy, RN, MBA, FAAN
Senior Director Nursing and Healthcare Informatics
National Quality Forum (NQF)

Funded by the Agency for Healthcare Research and Quality



National Quality Forum Mission

- Improve the quality of American health care by setting national priorities and goals for performance improvement.
- Endorse national consensus standards for measuring and publicly reporting on performance.
- Promote the attainment of national goals through education and outreach programs.

Quality Measure

$$\frac{\text{numerator}}{\text{denominator} - \text{exclusions} - \text{exceptions}}$$

A given measure contains a numerator, denominator, exclusions, and exceptions.

Anatomy of a Quality Measure

numerator

denominator – exclusions – exceptions



Should have some intervention or action taken

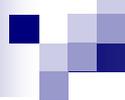
Some group of
people (or person)
who meet some
criteria

–

Evidence or
documentation that
some other exclusion(s)
or exception criteria are
met

Quality Measurement in Evolution

- Drive toward higher performance.
- Shift toward composite measures.
- Measure disparities in all we do.
- Harmonize measures across sites and providers.
- Promote shared accountability and measurement across patient-focused episodes of care:
 - Outcome measures,
 - Appropriateness measures, and
 - Cost/resource use measures coupled with quality measures, including overuse.



Growth of NQF Endorsed Measures

- **Expanded set of measures with several drivers:**
 - Measures needed for pay-for-performance programs
 - Measures that address important gaps:
 - Disparities—sensitive measures
 - Measures of patient experience in multiple settings
 - Cross-cutting areas (e.g., medication management, health care-associated infections)
- **Key issues for NQF portfolio:**
 - Support measurement driver for national priorities
 - Number of measures: too many, too few, right set?
 - Data platform and transition to electronic health records (EHRs)

Problem We're Trying To Solve

Case example: Using HIT to assess performance against the following quality measures?

- The number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given, the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission
- Percentage of heart failure patients discharged home with written instructions or educational material given to patient or caregiver at discharge

Today.....what happens next?

Problem We're Trying To Solve

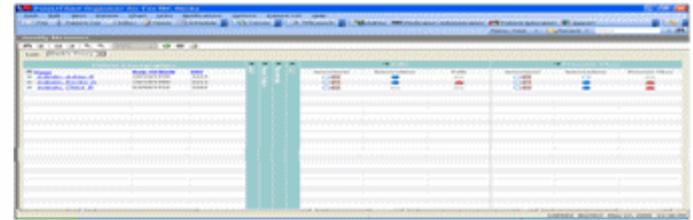
Retrieving Information for Quality Management

It is conservatively estimated that centers spend 22.2 *minutes per heart failure case* to abstract the data, which in aggregate amounts to more than 400,000 person-hours spent each year by US hospitals.

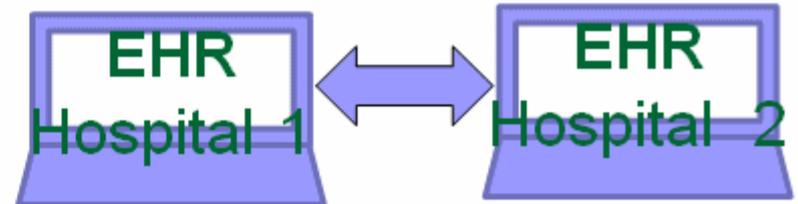
- Mostly retrospective
- Time consuming
- Involves human manipulation of data
- Data are in different sources in different levels of granularity, with varying definitions

HIT Goals for Quality

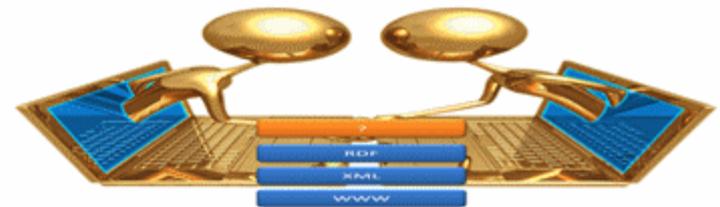
Quality measurement as a byproduct of documentation



Comprehensive management and secure exchange of information



Common language between developers of guidelines, quality measures, HIT, and users



NQF HIT Overview

Quality Data Set (QDS): A framework to describe clinical information needed for quality measurement

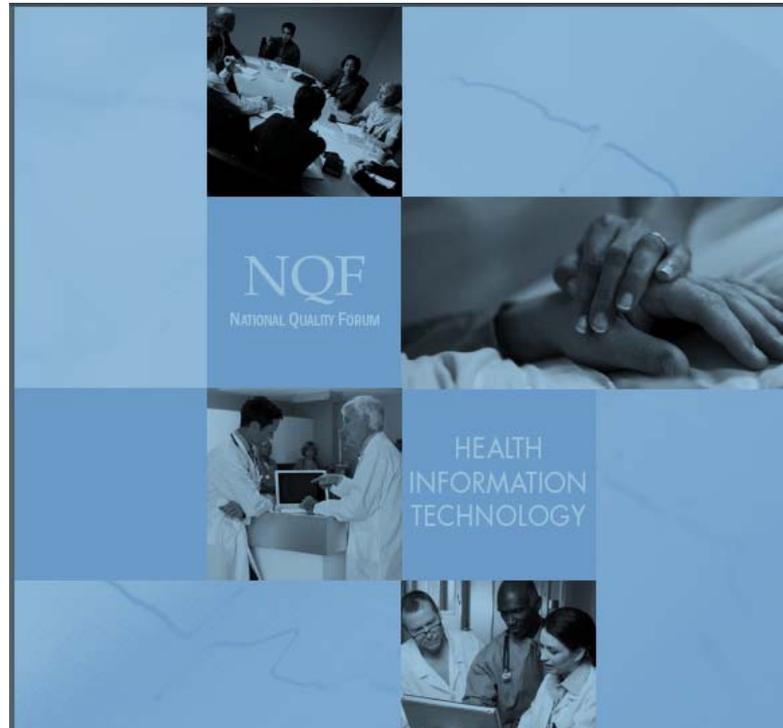
Authoring Tool: A computer program for measure developers to use Quality Data Sets

eMeasure: An electronic format for quality measures that uses quality data sets and includes the measure calculation algorithms

CMS Measure retooling: A process to retool key endorsed performance measures into electronic performance measures readable by EHRs

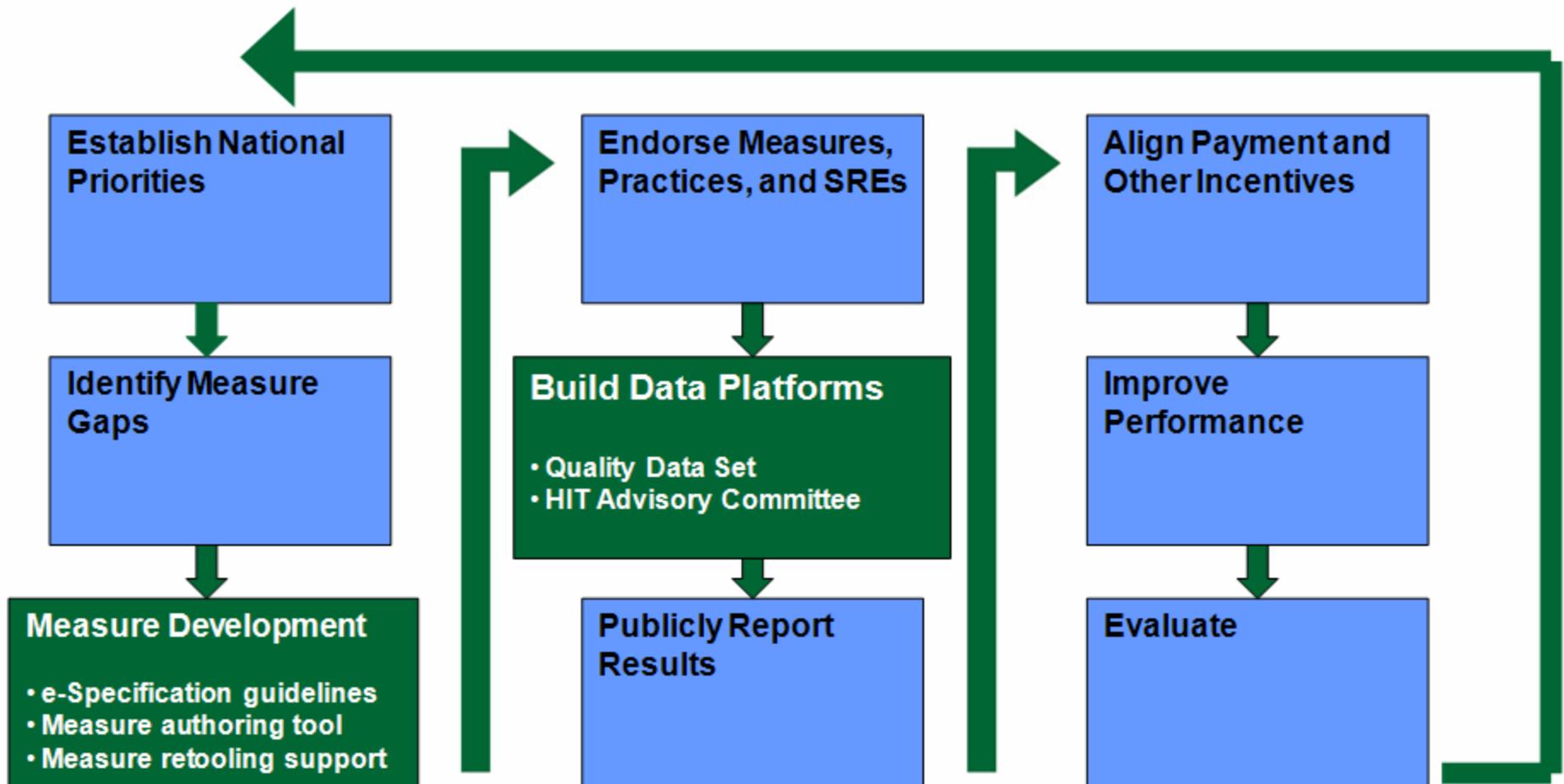
Expert Panels

Enabling Electronic Measurement



Health Information Technology
Automation of Quality Measurement
Quality Data Set and Data Flow

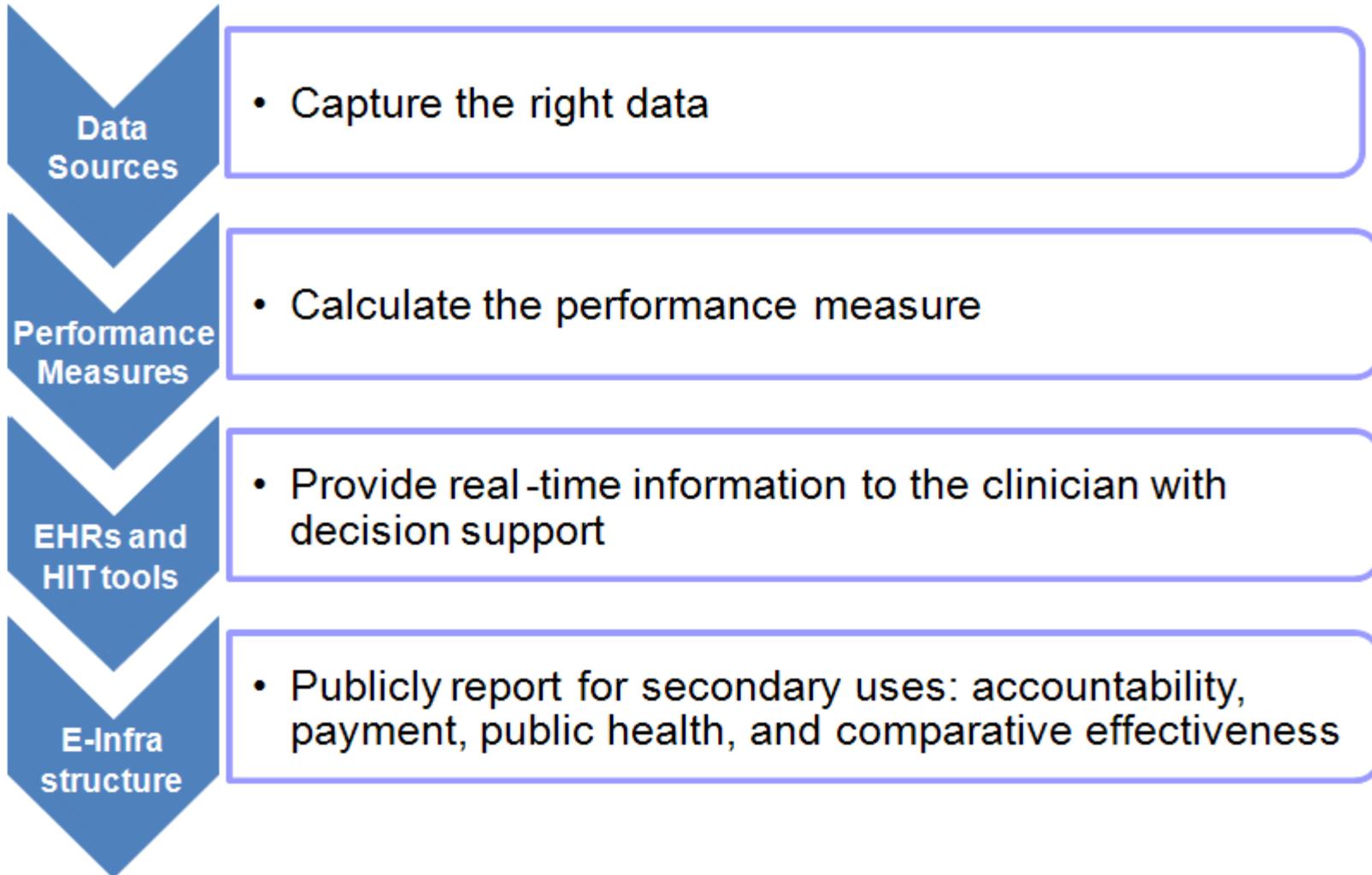
Quality Enterprise Functions: HIT Contributions of NQF



Quality Measurement in Evolution

- Endorsing measures that work for different electronic platforms:
 - Level 1: Single source of claims
 - Level 2: Aggregation of multiple sources of claims (e.g., diagnosis plus pharmacy claims)
 - Level 3: Clinically enriched sources (e.g., claims, plus clinical lab results)
 - Level 4: Electronic health record system data
 - Retooling effort underway

Linkage of HIT and Measurement



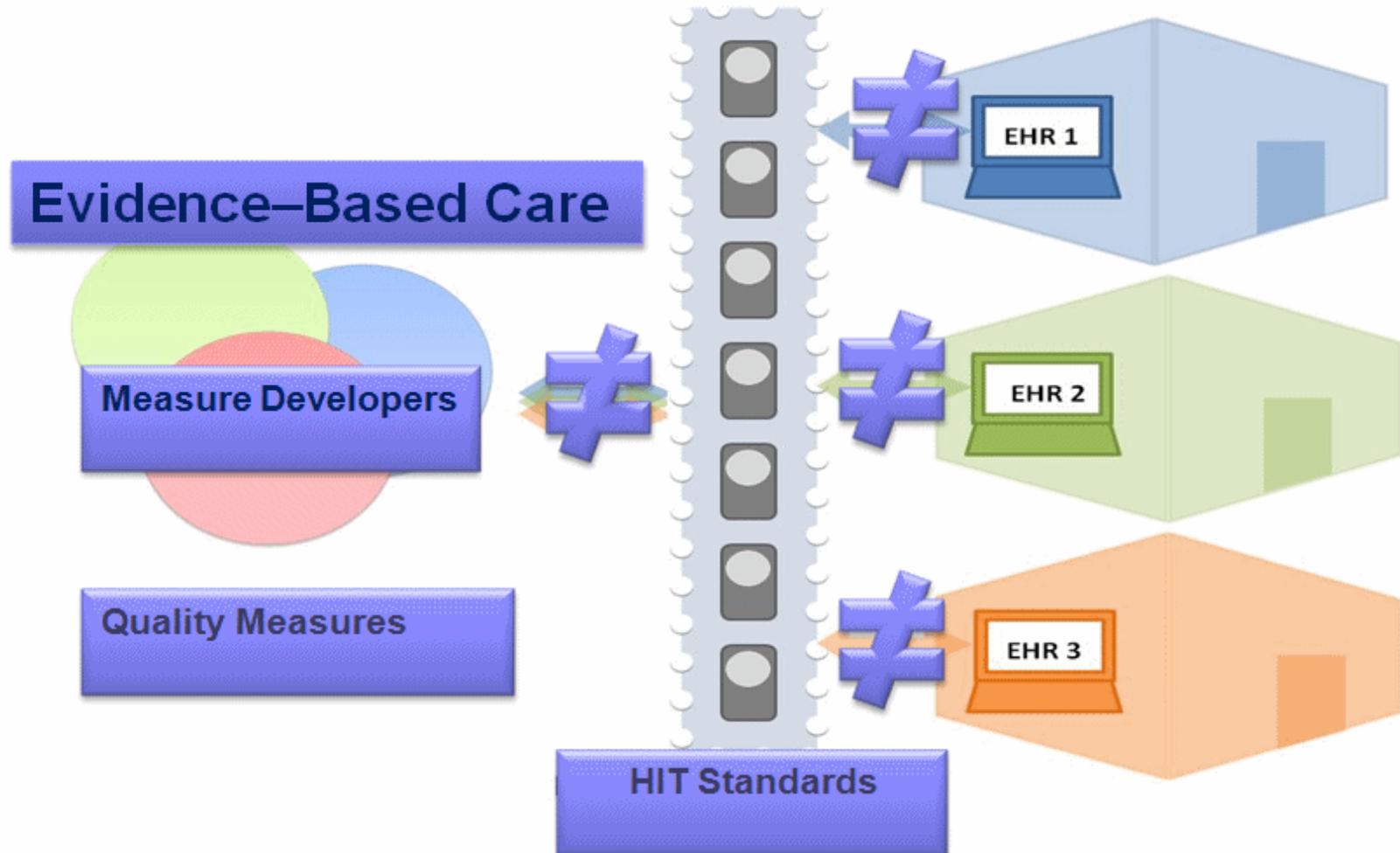


Quality and HIT

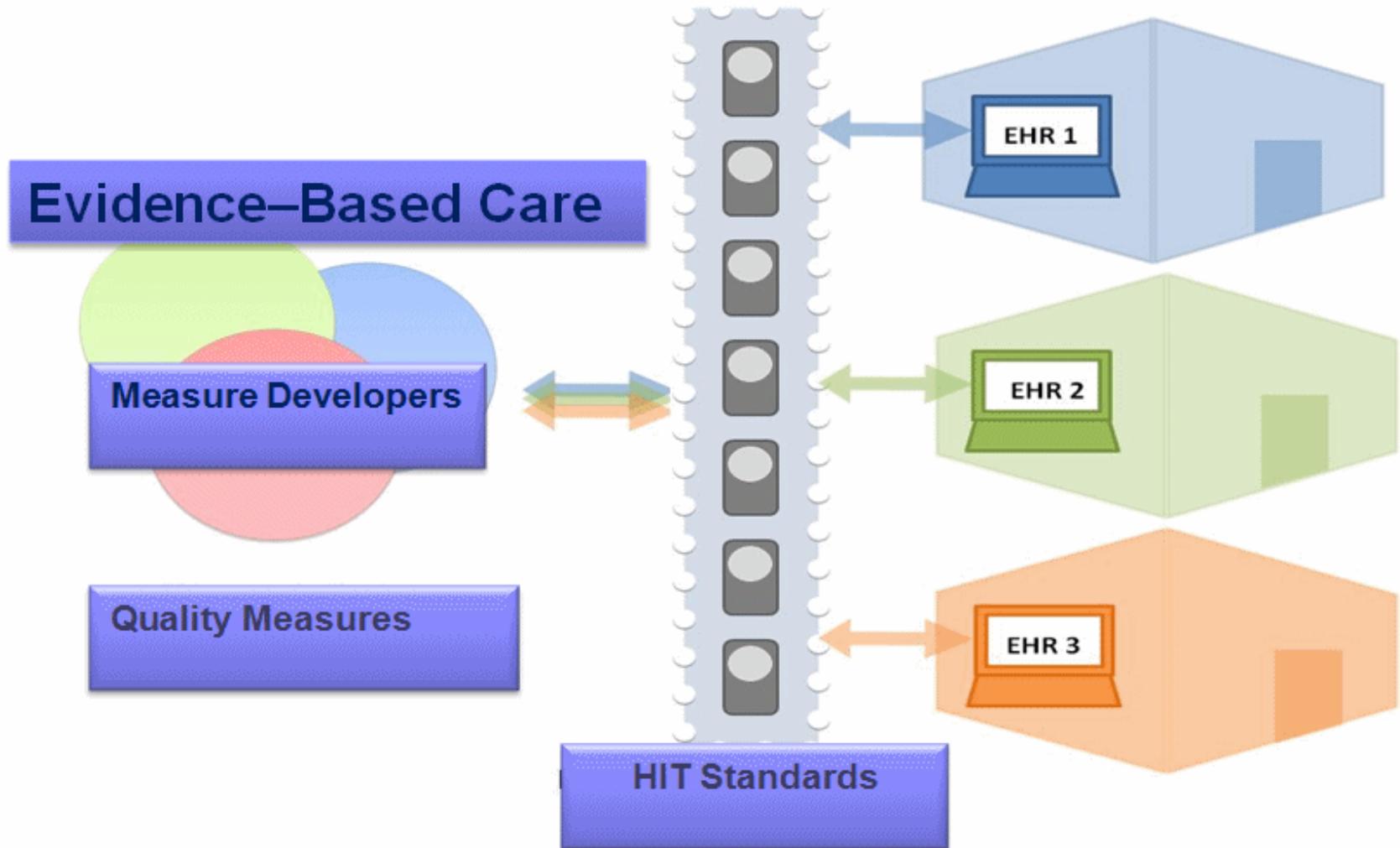
- We need a well-defined definition of a quality measure for HIT.
- Standards should enable quality measurement reporting and sharing.
- A well-defined quality measure is composed of a set of common data elements, encoded using standard taxonomies, structured logically into a standardized expression that can be shared and applied to patient data and reported.

Disconnected World

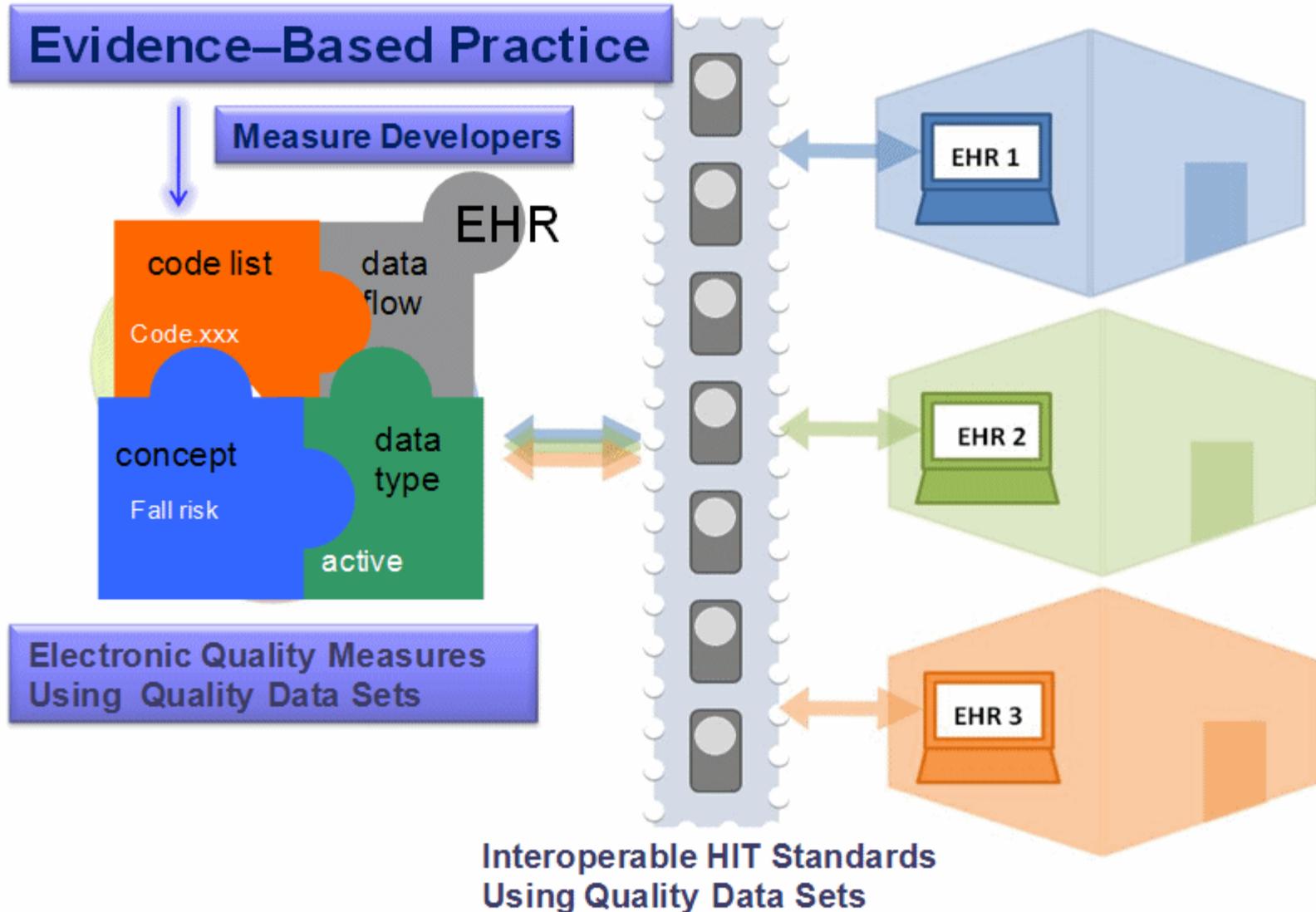
Gaps in Information Flow



The Goal



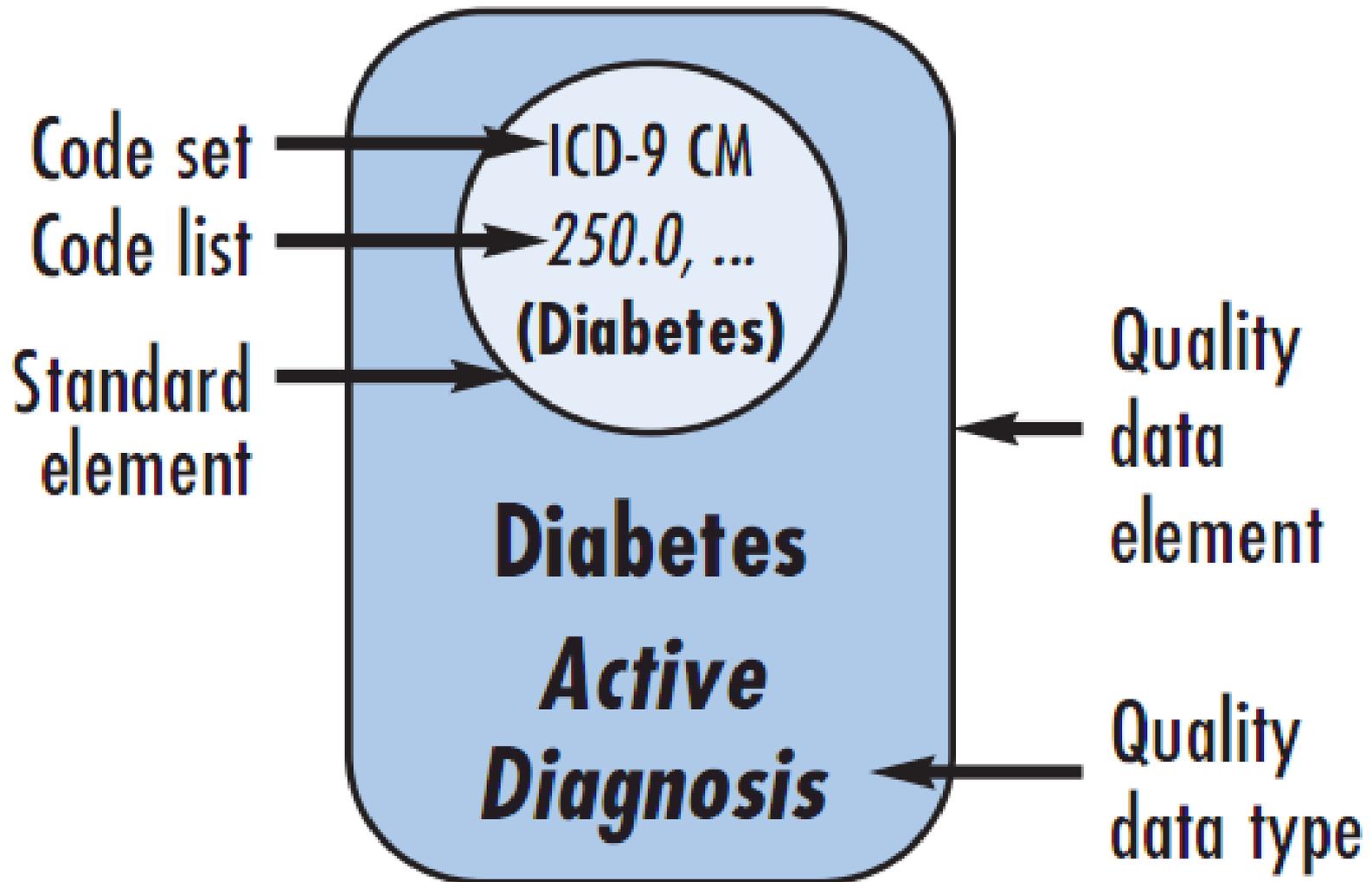
Quality and HIT



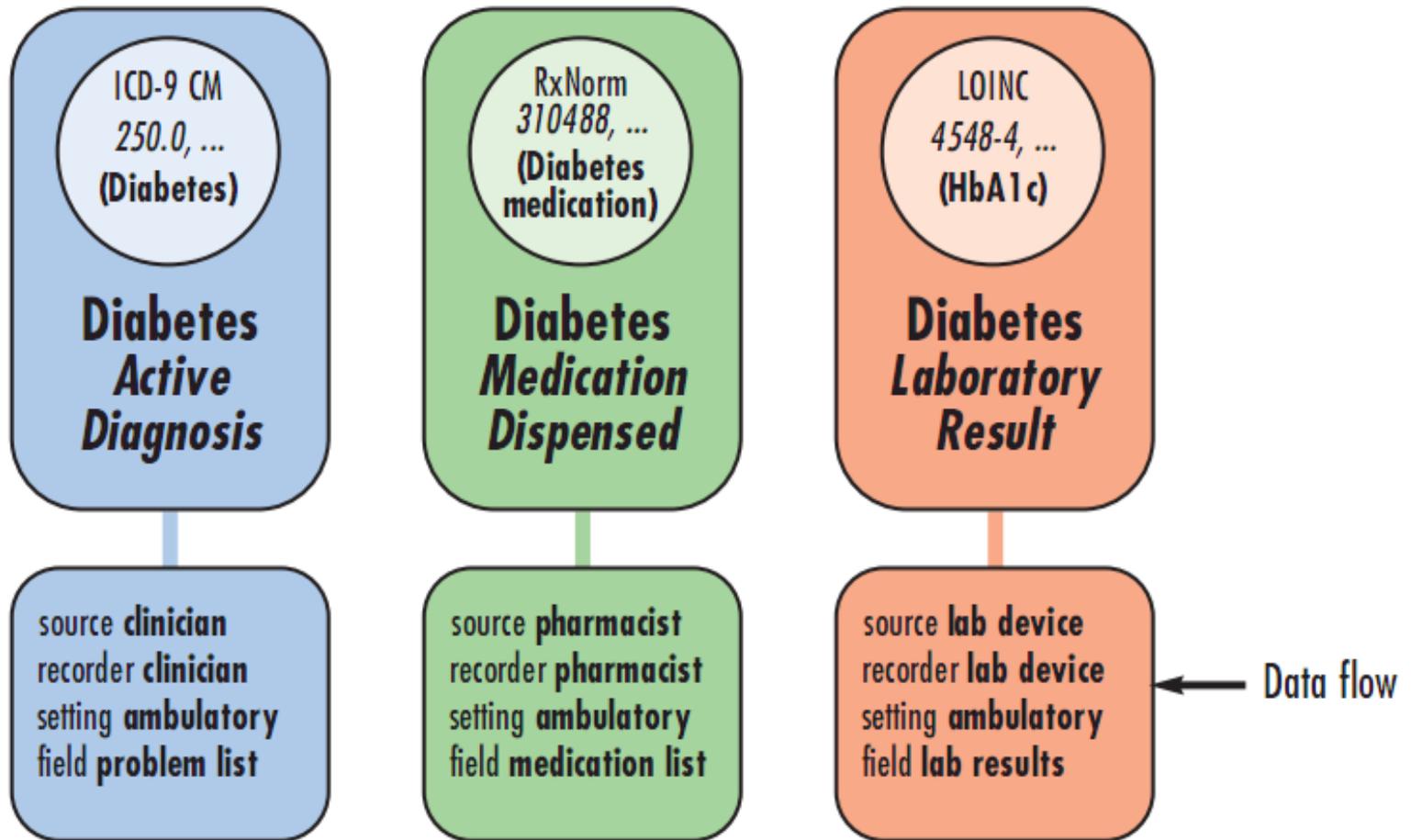
QDS Data Types

STANDARD CATEGORIES	QDS DATA TYPES
Care experience	Patient care experience Provider care experience
Care goal	Care goal Care plan
Communication	Communication provider to provider Communication to patient Communication from patient
Device	Device adverse event Device applied Device intolerance Device ordered Device offered Device declined
Diagnosis/condition/problem	Diagnosis active Diagnosis family history Diagnosis past history Diagnosis, risk of Diagnosis, factored risk
Diagnostic study	Diagnostic study adverse event Diagnostic study intolerance Diagnostic study order Diagnostic study result Diagnostic study offered Diagnostic study declined

QDS Data Element

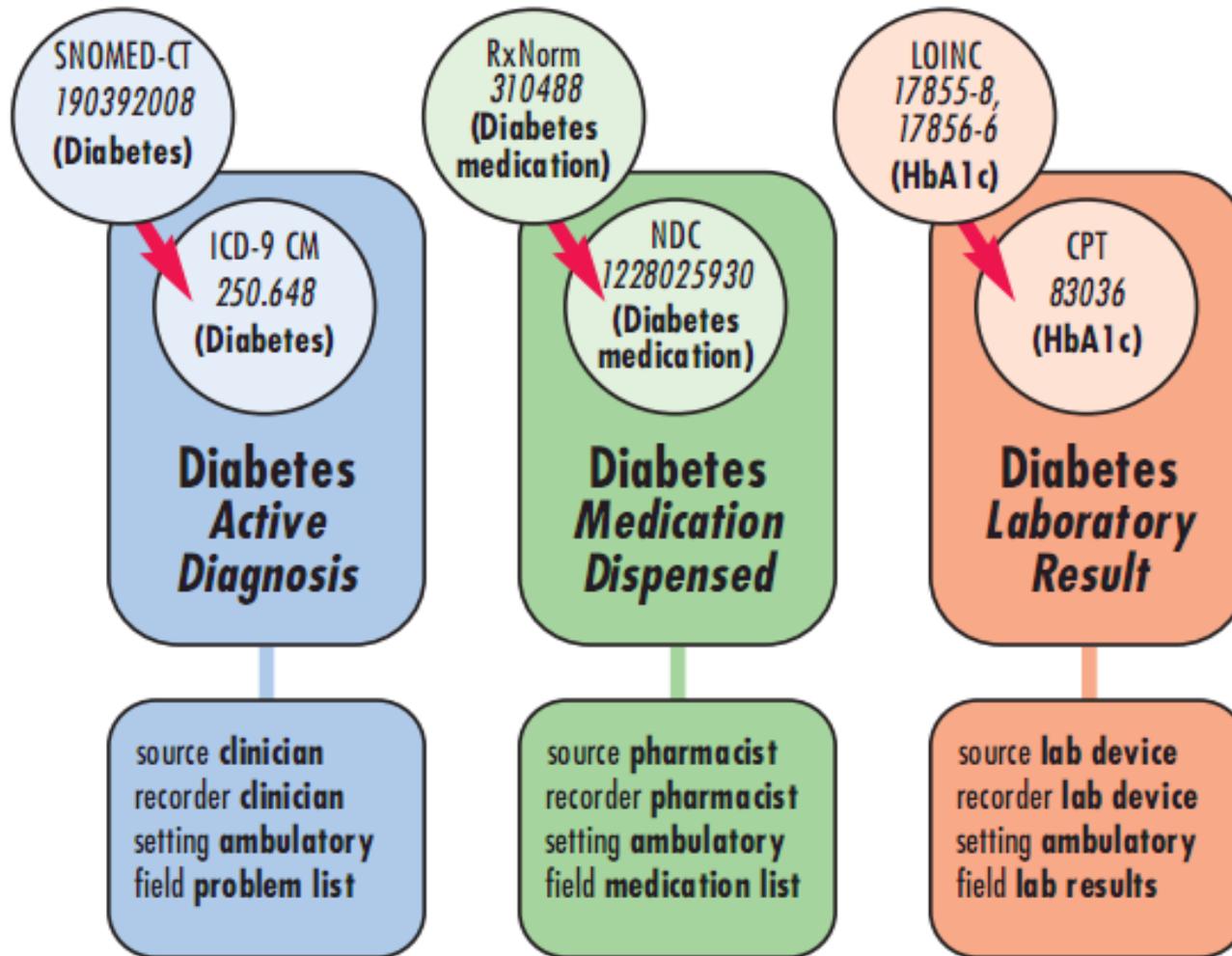


QDS Data Flow



Each quality data element (rounded rectangle) has associated data flow information (bottom rounded rectangles). These data flow attributes describe where to find the quality data element electronically.

Transition to Preferred Code Sets



Using the standard element framework of the QDS, code lists can be migrated to preferred code sets.

QDS and Retooling

Datatype / Context of Use

diagnosis active
 diagnosis family history
 diagnosis past history
 diagnosis, factored risk
 diagnosis, risk of

Relative to other QDS element (optional)

before
 before or simultaneously to
 after
 after or simultaneously to
during

4	aminoglycoside	medication adm
3	cephalosporin	medication adm
1	diabetes	diagnosis activ
2	general surgery	procedure perf
5	measurement enddate	end: today m/d,
6	measurement period	start of measur

optional time constraint

number unit

comparatee attribute for comparison

Datatype Specific Attributes

datetime

What additional information do you need from this element? For example: datetime, dose, route, endtime.

Comments

HINT: double-click for quick add

Dataflow Attributes (optional)

Ctrl-click to select multiple individual choices for each; Shift-click to select a section of choices

source(s)

- [ANY]
- Any Clinician
- Care Manager
- Certified Nurse Assistant (CN)
- Certified Nurse Midwife (CNM)
- Certified Registered Nurse Ar
- Clinical Medical Assistant (CM)
- Clinical Nurse Specialist (CNS)
- Clinical Trial Coordinator
- CPOE

recorder(s)

- [ANY]
- Any Clinician
- Care Manager
- Certified Nurse Assistant (CN)
- Certified Nurse Midwife (CNM)
- Certified Registered Nurse Ar
- Clinical Medical Assistant (CM)
- Clinical Nurse Specialist (CNS)
- Clinical Trial Coordinator
- Dentist

setting(s)

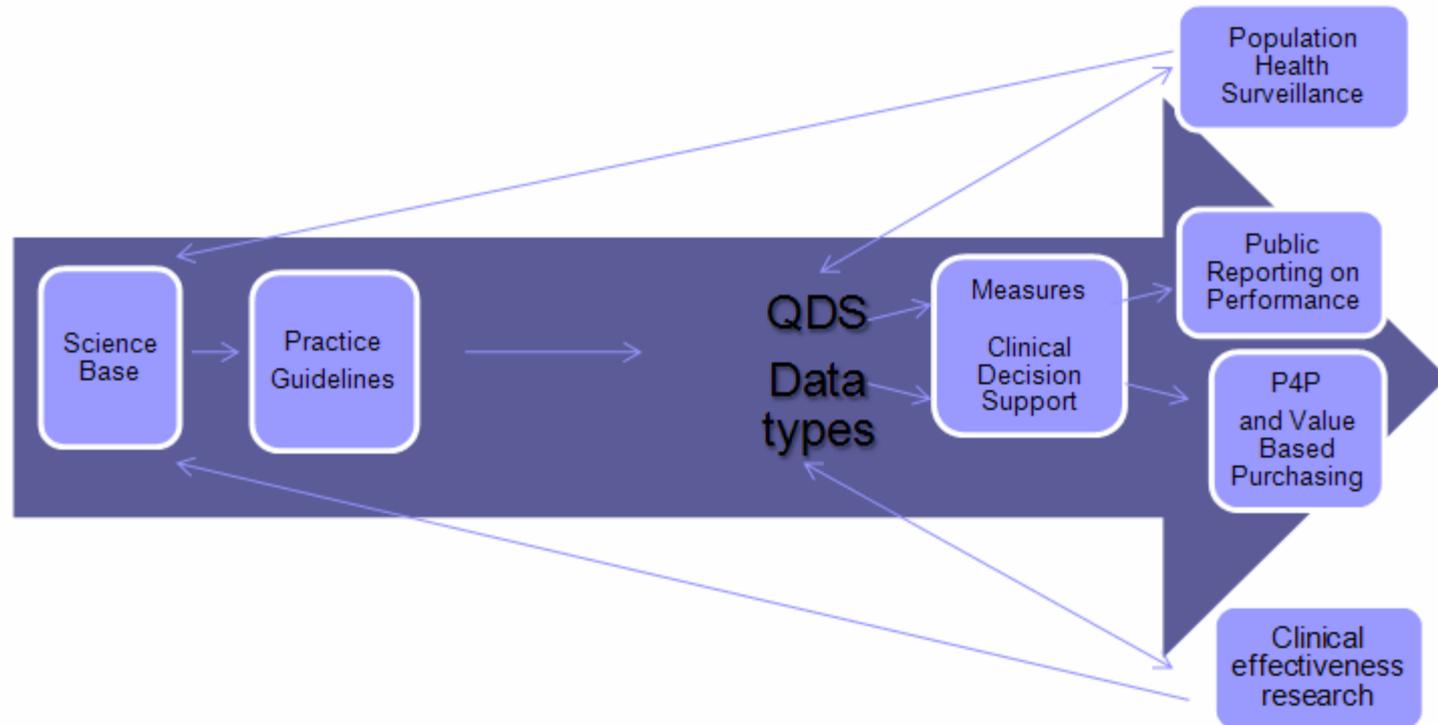
- [ANY]
- Acute Care Facility
- Ambulatory
- Ambulatory Community Base
- Ambulatory Hospital Based
- Ambulatory Surgicenter
- Emergency Department
- EMS Entity
- Home
- Home Care

health record field(s)

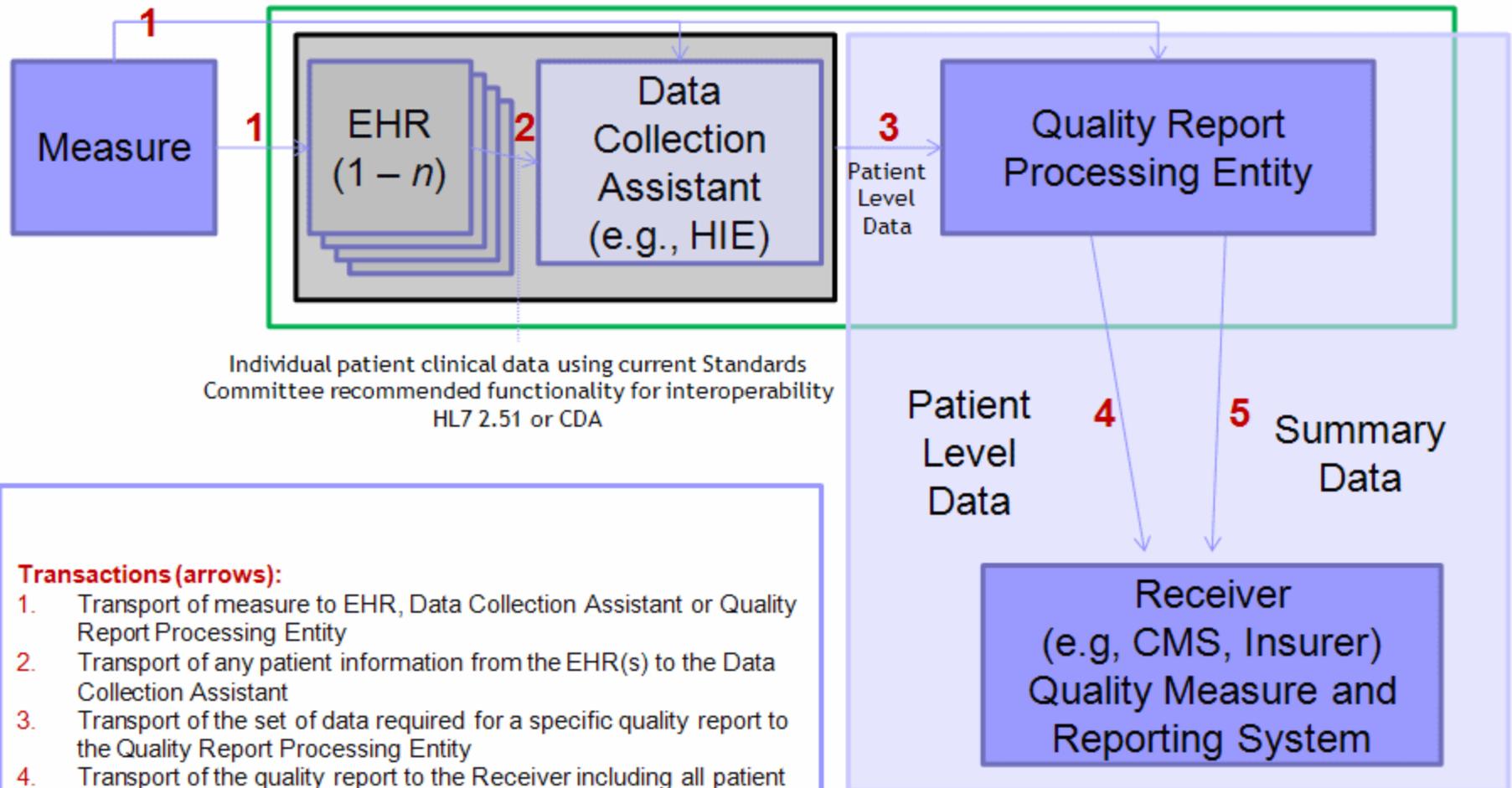
- [ANY]
- Administering Agent/Vendor
- ADT
- Advanced Directives
- Allergy List
- Allergy Repository
- Allergy Service
- Ambulatory e-Pharmacy Mana
- Anesthesia Record
- Autopsy Record

Ok

Other Potential Venues for QDS



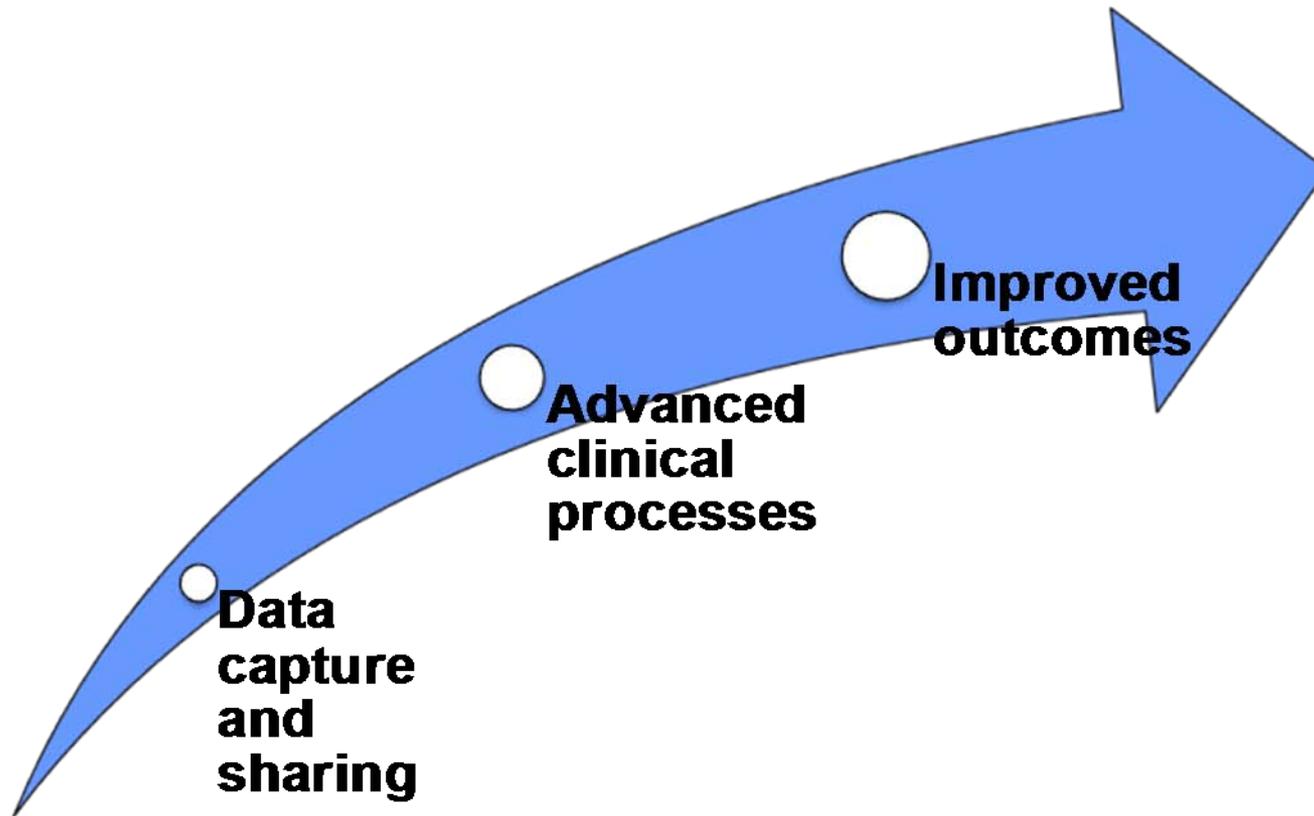
Measure Process Workflow



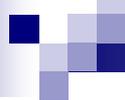
Transactions (arrows):

1. Transport of measure to EHR, Data Collection Assistant or Quality Report Processing Entity
2. Transport of any patient information from the EHR(s) to the Data Collection Assistant
3. Transport of the set of data required for a specific quality report to the Quality Report Processing Entity
4. Transport of the quality report to the Receiver including all patient level data
5. Transport of the quality report to the Receiver of the performance summary

Bending the Curve Toward Transformed Health*



*Source: Office of the National Coordinator



Thank You

Rosemary Kennedy, RN, MBA, FAAN
Senior Director Nursing and Healthcare
Informatics
National Quality Forum



Module 1: Discussion

- Has your agency identified quality measures that would be/are being used in quality reporting or quality improvement initiatives?
- If so:
 - Do providers or managed care organizations report any quality measurement data to you currently?
 - Do you sponsor any financial reward programs to support quality improvement efforts?
- If not, what plans do you have to enhance your agency's capacity to use quality measures to support quality reporting or quality improvement initiatives?

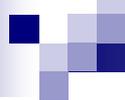


Using HEDIS Measures for Quality Assessment, Improvement, and Reporting

Presented by:

Jay Buechner, PhD

April 26, 2010



Our Mission

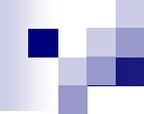
Neighborhood Health Plan of Rhode Island, an innovative health plan in partnership with Community Health Centers, is a catalyst for improved access and better health in Rhode Island, especially for vulnerable populations.

Neighborhood Health Plan of Rhode Island (NHPRI)

- Established in 1994 by Rhode Island's Community Health Centers (CHCs)
- Nonprofit, Medicaid-only managed care plan
- Today: 80,000 members, >60% of Medicaid managed care enrollees in RI
- NCQA accreditation: "Excellent" status since 2001
- Ranked #7 Medicaid plan by *US News & World Report* / NCQA

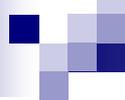
Our Members

- Populations / Lines of Business
 - RItE Care (TANF families), 1994: 66, 700 members
 - SubCare (children in foster care), 2000: 2,200 members
 - CSN (children with special health care needs), 2003: 5,300 members
 - Rhody Health Partners (adults with disabilities), 2008: 6,000 members
- Low-income
 - 74% of RItE Care participants earn at or below the Federal poverty level
- Barriers
 - 25% of our members speak a language other than English as their primary language.
 - 30% of our adult members report not graduating high school.
 - 70% of our Rhody Health Partners members have at least one chronic health condition.



Our Providers

- 42% of Neighborhood's members receive their primary care at one of the 21 CHCs in RI.
- 43% are aligned with private practice sites, 15% with hospital clinics.
- Neighborhood has more than 700 primary care practitioners at 242 primary care sites.
- We have nearly 1,600 specialists.
- We work with all hospitals in the State.



Department of Evaluation and Improvement

Charter Statement

The Department of Evaluation and Improvement will use data to drive improvement at Neighborhood Health Plan of Rhode Island and to demonstrate our value to our members and stakeholders.

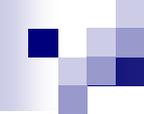
Ongoing Activities

- Organization-wide quality improvement program
- NCQA accreditation
- HEDIS data preparation, submission, and analysis
- Evaluation studies—clinical programs
- Quality of care case review

HEDIS—Description

- Core monitoring indicators for health plans established and maintained by the National Committee for Quality Assurance (NCQA)
- Healthcare Effectiveness Data and Information Set—HEDIS
- Annual benchmarks for Medicare, Medicaid, and commercial plans—Quality Compass
- Combination of administrative measures, hybrid measures, and survey measures
- Collected with a certified HEDIS vendor and auditor and an approved CAHPS* survey organization

*Consumer Assessment of Healthcare Providers and Systems

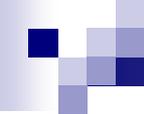


HEDIS—Measures

- Domain A. Effectiveness of Care
- Domain B. Access/Availability of Care
- Domain C. Satisfaction with the Experience of Care
- Domain D. Use of Services
- Domain E. Cost of Care (RRUs)
- Domain F. Health Plan Descriptive Information
- Domain G. Health Plan Stability

HEDIS—Data Sources

- Internal
 - Enrollment files
 - Provider/credentialing databases
 - Utilization review data (prior authorizations)
 - Plan's core claims data
 - Vendors' claims data: behavioral health, pharmacy benefits manager, durable medical equipment vendor, etc.
 - Customer service call volume and disposition
- External
 - Medical records
 - Provider elective medical records (EMRs)
 - Immunization registries
 - Laboratory results

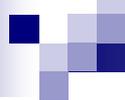


HEDIS—Reports

- Annual
 - All-member trends (3 years) and benchmarks
 - Performance by line of business
 - Disparities (race and ethnicity, language, age, sex)
 - Performance by type of primary care site
 - Performance by individual primary care site
- Ad hoc
 - Clinical program planning and evaluation

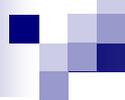
Importance of HEDIS—NCQA

- NCQA accreditation (~1/3 of score)
- Comparison of health plans and establishment of benchmarks in Quality Compass
- Annual NCQA/*US News & World Report* national rankings of health plans



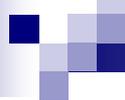
Importance of HEDIS— Local and Internal

- Medicaid Performance Goal Program
- Department of Health certification
- Pay-for-performance for primary care sites
- 2009–2010 corporate objectives
- Identify opportunities for quality improvement



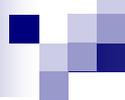
Engaging Providers

- Clinical programs
 - Bright Start (birth outcomes)
 - Diabetes
 - Asthma
 - Coronary artery disease
 - Chronic obstructive pulmonary diseases



Engaging Providers (cont'd)

- Pay-for-performance for primary care sites
 - Annual incentive payments based on selected HEDIS measures
 - Presentations on quality improvement opportunities based on HEDIS measures
 - Provide HEDIS technical specifications to primary care sites
 - Involve primary care sites in HEDIS chart review and abstraction



NHPRI's Major Incentives for CHCs and Other High-Volume Primary Care Sites

- Primary Care Initiative
- HEDIS measures pay-for-performance
- Continuous quality improvement projects
- Health information technology infrastructure
- Unrestricted development fund

Primary Care Initiative— Corporate Goal

Strategic Goal: Promote the continued advancement of a system of high-quality, cost-effective, and community-centered primary care for Rhode Islanders by strengthening the State's Community Health Centers (CHCs).

Measure: 80% of CHCs have adopted the components of the advanced medical home: multidisciplinary care teams, broad systems of access, patient self-management, health information technology, and enhanced performance measurement.

HEDIS Incentives— Through 2008

- All CHCs worked toward same four measures
 - Childhood immunization status, combo 3
 - Diabetes, LDL-C <100
 - Diabetes, HbA1c testing
 - Well-child visits, ages 3–6 years
- Had to achieve Quality Compass 90th percentile for any payment
- Performance measured by NHPRI by chart review ($N \geq 30$) or by self-report from EMR

HEDIS Incentives— Outcomes in 2008

- Comparing Neighborhood's 2008 performance to 2007:
 - **Childhood immunization status, combo 3** improved from 77.3% to 81.1% and from 75th to 90th percentile (11/20 sites achieved goal)
 - **Diabetes, LDL-C <100** declined from 32.1% to 30.2% (7/20 sites achieved goal)
 - **Diabetes, HbA1c testing** improved from 85.9% to 88.3% (12/20 sites achieved goal)
 - **Well-child visits, ages 3–6 years** improved from 77.0% to 80.0% (4/20 sites achieved goal)

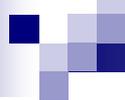
HEDIS Incentives—2009

- CHCs work toward 4 measures selected individually from a list of 11:
 - Adult access to preventive services: ages 45–64
 - Childhood immunization status: combo 3
 - Children's/adolescents' access to primary care: ages 25 months–6 years and ages 12–19 [2 measures]
 - Diabetes: LDL-C < 100; HbA1c < 8; medical attention for nephropathy [3 measures]
 - Frequency of prenatal care (81+%)
 - Postpartum care
 - Timeliness of prenatal care
 - Well-child visits, ages 3–6 years
- Partial payment awarded for improvement short of QC 90th percentile
- CHCs may self-report some measures from EMRs

HEDIS Incentives—2009

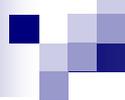
(cont'd)

- CHCs and NHPRI selected these HEDIS measures as targets most often
 - **Well-child visits, ages 3–6 years—7 CHCs**
 - **Diabetes: HbA1c < 8—6 CHCs**
 - **Adult access to preventive services: ages 45–64—5 CHCs**
 - **Childhood immunization status: combo 3—5 CHCs**
 - **Postpartum care—4 CHCs**
 - **Diabetes: LDL-C < 100—4 CHCs**
 - **Children/adolescents access to primary care: ages 12–19—3 CHCs**
 - **Frequency of prenatal care (81+%)—3 CHCs**



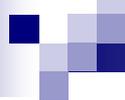
HEDIS Incentives— Changes for 2010

- Reduced chart review burden on plan
- Encouraged self-reporting through EMRs and other data sources (allow incentive to be based on all-payer performance)
- Revise list of priority measures (replaced two measures)



HEDIS and HIT—Opportunities and Challenges

- Input
 - Electronic reporting from EMRs in provider sites
 - Match to childhood immunization registries
 - Electronic reporting of laboratory test values
- Use
 - Quarterly/periodic reporting of “admin” data
 - Care reminders to members and providers
 - Increased analysis of utilization and RRU measures
 - Link to State’s provider HIT survey database



Contact Info

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Module 2: Discussion

- If your agency is currently using your health IT or HIE system to support quality reporting or improvement, please describe the kinds of improvement initiatives you are working on.
- If you are **not** currently doing so, what plans do you have to enhance your agency's capacity to use quality measures to support quality reporting or quality improvement initiatives?
- Is your agency currently using HEDIS data to promote targeted improvements in care quality and delivery? If so, how?

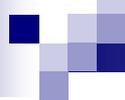


HIT Meaningful Use—Prime Opportunity to Enhance the Measurement of Quality in Medicaid

Presented by:

David K. Kelley, MD, MPA, Chief Medical Officer
Office of Medical Assistance Programs
Pennsylvania Department of Public Welfare

Funded by the Agency for Healthcare Research and Quality



Outline

- Meaningful use
- Current status of measuring quality
 - MCOs
 - PCCM
- Pennsylvania future strategy
- CHIPRA grant
- Possible multistate approach



Meaningful Use Policy Priorities

- Improve quality, safety, and efficiency.
- Reduce disparities.
- Engage providers, patients, and families.
- Improve coordination of care.
- Reduce cycle time between “new” evidence-based care and community practice.
- Improve population and public health.
- Ensure privacy and security of PHI.



Meaningful Use Functions

- Problem list
- Medication list/reconciliation
- Electronic prescribing
- Referral tracking
- Lab results incorporated in EHR
- CPOE—labs, procedures, diagnostic tests
- Transition of care
- Patient access to information

Quality Measures for Eligible Providers

- 90 proposed quality measures
- 16 clinical categories/specialties
- PCPs, pediatrics, ob/gyn, psychiatry
- Pediatrics: 9 measures with considerable overlap with 23 CHIPRA measures
- Medical specialties
- Surgery/radiology

Examples of Clinical Measures

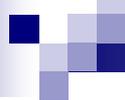
- Diabetes:
 - HgA1c control
 - Hypertension control
- Aspirin use in patients at high risk for cardiovascular event
- Drug therapy for lowering LDL in patients with CAD
- Smoking status/cessation counseling offered
- Obesity: BMI screening and follow-up
- Colorectal, breast, cervical cancer screening
- Pediatric immunizations
- Management and treatment of ADHD

Quality Measures—Hospitals and EDs

- 3 ED measures primarily throughput
- Hospital: 30 measures, 8 specific to Medicaid
- Stroke, VTE, AMI, CHF, infections, readmissions
- Medicaid: pneumonia care, antibiotic use, 3 pediatric measures
- Need to link meaningful use measures to overall Medicaid quality improvement plan

Medicaid Quality—Capitated MCOs

- NCQA accreditation not always required
- Not all plans publicly report
- States may have different populations in managed care (e.g., may exclude or not mandate ABD)
- No reporting on disparities
- EQRO focus on specific State needs
- Data 18 months old: lost opportunity for rapid cycle quality improvement

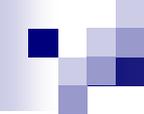


Medicaid Quality—Capitated MCOs

- Claims data/chart review
- Limited population sampling
- Limited ability to look at geographic variation or analyze disparities
- Difficult to report on quality by aid category
- Limited ability to evaluate coordination of care
- Limited ability to evaluate transition of care

Medicaid Quality Measurement PCCM Programs

- Covers large percentage of Medicaid lives
- No NCQA “product” to achieve accreditation
- States do not have consistent method or resources to measure quality
- EQRO focus on specific State needs
- Even if HEDIS-like measurement done, same limitations as discussed with capitated programs



Pennsylvania's Current Strategy

- Currently, all seven MCOs collect HEDIS[®] measures including extra sampling to perform disparity studies.
- PCCM program collects HEDIS measures plus intensive chart review of over 100 PCP offices per year.
- EQRO develops State-specific measures.
- DPW compares quality across all programs.

Pennsylvania's Future Quality Strategy

EQUIPs—Electronic Quality Improvement Projects

- Continue current activities but focus on electronic extraction of quality processes and outcomes in pediatrics, ob/gyn, screening, chronic care coordination, transitions of care.
- Links meaningful use from a provider's qualified electronic health record to Medicaid quality outcomes.
- Connect providers to statewide HIE.
- Integrate HIT to medical home strategy.
- Leverage CHIPRA grant to initiate rapid time quality improvement in high-volume pediatric health systems.

Medical Assistance EQUIPs

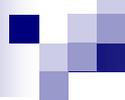
—	Clinical Data (EHR only)	Admin data or EHR
Ob/Gyn	Race/ethnicity OB needs assessment form Depression screening, live birth weight, ACOG recommended lab results	>80% ob visits, 1st trimester access Postpartum visit C-section rate low -risk first birth Hysterectomy rates
Pediatrics	Race/ethnicity Smoking status if >13/referral Ht, Wt, BMI, BMI%/referral Developmental screening/referral	Asthma medication, well child visits, access to care visits, dental access, lead screening, ADHD medication follow-up, Immunizations
Chronic Care	Race/ethnicity Smoking status/referral HgA1C value LDL value for diabetics and cardiovascular Blood pressure for diabetics and hypertension Aspirin use in diabetes and cardiovascular conditions	HgA1C and LDL done Asthma medication Immunizations
Screening	Race/ethnicity, depression, SBIRT, adult BMI referral	Colorectal, breast, cervical cancer screening, Chlamydia screening
ED utilization	Medical home referral Medication reconciliation Diagnostic test results	Name, MAID, DOB, DOS, facility, Dx 1-5, new meds
Hospital Discharge	Medical home referral Medication reconciliation Diagnostic test results 30-day readmissions rate	Name, MAID, DOB, DOS, facility, Dx 1-5, CPT 1-5 attending physician, discharge code,

CHIPRA Grant

- Pennsylvania one of ten grants awarded
- The QUICKSTEPS Program—**QU**ality **I**mprovement and **C**are for **KidS** **T**hrough **E**lectronic **P**rogram**S**
- Three grant categories A, B, and D
- Funded for just under \$10 million over the next 5 years.

The Players

- Pennsylvania Medicaid, CHIP, Dept of Health
- Seven health systems:
 - Children's Hospital of Philadelphia—lead category B
 - Geisinger Health System—lead category A
 - Penn State Hershey Medical Center—category D
 - Pinnacle Health System—category D
 - Pocono Health System—category D
 - St. Christopher's Hospital for Children—lead category D
 - West Penn Allegheny Health System—category D
- Over 250 primary care practices
- Over 1.2 million children across the Commonwealth

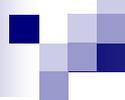


Category A

- CHIPRA core quality measures
 - Extraction from EHR
 - Reporting in common file layout
 - Measuring baseline performance
- Incentives for:
 - Extraction, reporting, baseline of core measures
 - Improving baseline measures
 - Linking to statewide immunization registry
 - Providers to use electronic quality improvement data for board recertification

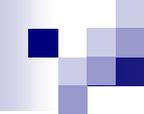
Category B

- Web-based or kiosk pre-visit questionnaire/screening tool linked to EHR
- Focused on developmental delay, behavioral health issues, and children with complex medical conditions
- Allows clinician to focus history and physical exam during visit
- Links referrals to appropriate specialists
- Pelican System links medical providers to care plan system for families and social agencies



Category D

- Five health systems
- Implementation of CMS pediatric EHR
- Linkage to statewide immunization registry
- Extraction, reporting, baseline measurement of pediatric core measures through the pediatric EHR
- Incentives for quality improvement



Strategic Planning

- Leverage existing quality improvement infrastructure.
- Leverage lessons learned from CHIPRA grant.
- Partner with MCOs to push/pull data to providers.
- Facilitate exchange of physical health/behavioral health data in HIPAA and regulatory compliant manner.
- Leverage quality improvement to encourage providers to adopt HIT (P4P).



Future Directions

- Reduction/elimination of paper chart reviews
- Rapid cycle quality improvement
- Common quality measures
- Larger sampling of population
- Enhanced ability to study health disparities
- Multistate quality reporting



Meaningful Use

- Capture necessary clinical data
 - Multistate collaboration
 - Common definitions of quality
 - More consumer input
- Exchange clinical data with other systems
 - Ability to push/pull data from State providers
 - Coordinate behavioral health and physical health data
 - Incorporate consumer portal input
- Produce clinical reports and quality metrics
 - Rapid cycle quality improvement
 - Multistate reporting with regional variation
 - Disparity analysis
 - Real-time consumer feedback



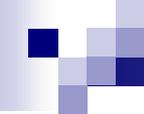
Possible Next Steps

- Agree upon common quality measures:
 - CHIPRA measures,
 - CMS meaningful use priorities, and
 - CMS adult Medicaid quality measures.
- Consider including multistate collaboration in State Medicaid HIT plan.
- Define States that are interested in participating in consistent clinical quality reporting.



Module 3: Discussion

- If your Medicaid/CHIP agency currently reports or obtains quality measures to support quality reporting or quality improvement initiatives through participation in an HIE, what specific clinical areas or care delivery processes are the focus of your quality improvement efforts?
- If you are not currently reporting or obtaining quality measures, but your agency is currently engaging in HIE, how do you plan to leverage this system to facilitate these efforts to improve care quality?



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Comments and Recommendations for Future Sessions

- Please send your comments and recommendations for future sessions to the project's e-mail address:

Medicaid-SCHIP-HIT@ahrq.hhs.gov



Project Information

Please send comments and recommendations to:

Medicaid-SCHIP-HIT@ahrq.hhs.gov

or call toll-free:

1-866-253-1627

<http://healthit.ahrq.gov/Medicaid-SCHIP>

RESOURCES

National Quality Forum Report. *Health Information Technology Automation of Quality Measurement: Quality Data Set and Data Flow*

<http://www.qualityforum.org/projects/hitep2.aspx>

NCQA's HEDIS pages

<http://www.ncqa.org/tabid/59/Default.aspx>

NHPRI's Quality Improvement pages

http://www.nhpri.org/matriarch/MultiPiecePage.asp_Q_PageID_E_372_A_PageName_E_Commitment2Quality

NHPRI's annual HEDIS and CAHPS results, with improvement initiatives

<http://www.nhpri.org/matriarch/documents/HEDIS%202008%20General%20Report-Final%2010%2027%2008.pdf>

Pennsylvania Quality Reports

<http://www.dpw.state.pa.us/PubsFormsReports/MedicalAssistanceDocuments/003674902.htm>

WORKSHOP PRESENTERS AND FACILITATORS

Moderator

Lekisha Daniel-Robinson, MSPH

Ms. Daniel-Robinson has progressive experience working with health care organizations and States to define performance standards to achieve financial, service, and quality goals. Currently a health insurance specialist at the Center for Medicare & Medicaid Services (CMS), Ms. Daniel-Robinson manages projects primarily focused on quality measurement in Medicaid. She is the lead CMS staff member in the collaboration between AHRQ and CMS for implementation of Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) requirements for establishing an initial core set of quality measures for children and the development of new pediatric quality measures. She holds a key role in establishing a measurement program for adult quality measures in Medicaid as a result of health reform. She also manages the CMS Neonatal Outcomes Improvement Project aimed to improve the lives of children and families by reducing morbidity and mortality of newborns.

Prior to joining CMS, Ms. Daniel-Robinson was a health policy analyst for the State of Maryland, where she was involved in public reporting initiatives for the State's health facilities. She has also worked for several years as a consultant, providing analytic support to assist health care organizations to interpret financial and operational statistics to improve process, service, and financial positions. She holds a MSPH degree from Meharry Medical College and completed her undergraduate education at Virginia Tech.

Module 1:

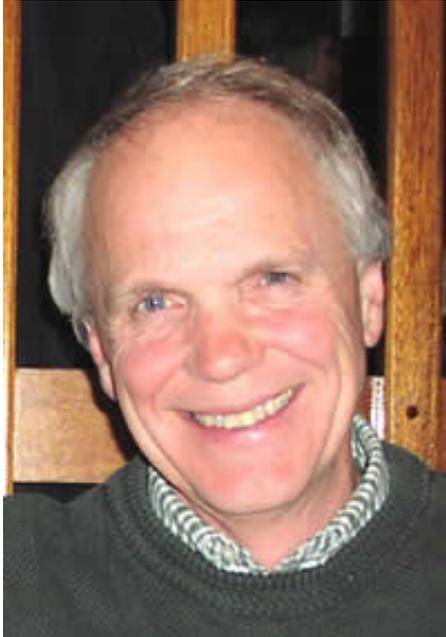
Rosemary Kennedy, RN, MBA, FAAN

Ms. Kennedy is the Senior Director of Nursing and Healthcare Informatics at the National Quality Forum. In addition to being an informatics domain expert, she holds many leadership roles through her work with the Healthcare Information and Management Systems Society's (HIMSS), the American Medical Informatics Association (AMIA), and the International Medical Informatics Association (IMIA). Ms. Kennedy is a delegate to the International Medical Informatics Association Nursing Informatics Special Interest Group and serves as a leader of the nursing informatics communities at AMIA. She is a fellow in the American Academy of Nursing and recently received the HIMSS 2009 Nursing Informatics Award and was also recognized as one of the top 25 women in health care for 2009. Ms. Kennedy has made numerous presentations and is widely published in the field of nursing informatics, clinical documentation, and terminology standards.

Prior to joining NQF, she served as the Chief Nursing Informatics Officer for Siemens Healthcare Solutions where she provided professional practice leadership over the development and deployment of solutions to ensure nursing practice and interdisciplinary

requirements were met. Ms Kennedy is a graduate of Widener University, and is pursuing a doctorate in nursing at Loyola University, Chicago.

Module 2:



Jay Buechner, PhD

Dr. Buechner is the Director of Evaluation and Improvement for Neighborhood Health Plan of Rhode Island, a nonprofit Medicaid managed care organization. In that role he is responsible for developing and supporting an organization-wide quality improvement program encompassing clinical programs, organizational activities, and member and provider services. He also oversees the evaluation of clinical interventions, the investigation of quality of care complaints and concerns, accreditation as a Medicaid MCO by the National Committee on Quality Assurance, and the collection, submission, and dissemination of annual HEDIS data for Neighborhood.

Prior to joining Neighborhood in 2008, Dr. Buechner held several leadership positions involving public health statistics and quality of care measurement at the Rhode Island Department of Health. His primary responsibilities in public health statistics included disease and injury surveillance, analysis and dissemination of health data, population and provider surveys, and health program evaluation. He also directed a program established under legislative mandate to publicly report measures of quality for licensed health care facilities and professionals in the State. During 1994–1997 he served as Director of Research and Evaluation for Rhode Island's Medicaid Managed Care Program, where he designed and implemented the encounter data system and developed an ongoing research and evaluation program. He served for many years as the Chair of the Department's Institutional Review

Board and was its first HIPAA Privacy Officer. In 1986, he was appointed Clinical Assistant Professor in the Department of Community Health in the Warren Alpert School of Medicine at Brown University. He served as a member of the Board of Directors of the National Association of Health Data Organizations, representing public-sector data organizations.

Dr. Buechner received his PhD in physics from Brown University in 1975, concentrating on experimental low-temperature solid-state physics. After leaving Brown, he received a postdoctoral appointment through the United States–France Exchange of Scientists program of the National Science Foundation to continue his research at the École Normale Supérieure in Paris.

Module 3:

David Kelley, MD, MPA

Dr. Kelley is the Chief Medical Officer for Pennsylvania Department of Public Welfare's Office of Medical Assistance Programs. He oversees the clinical and quality aspects of the Medical Assistance Program that provides health benefits to over 2.0 million recipients. The Office includes oversight of seven managed care organizations and Access Plus, a FFS managed care program. In the past 5 years the Office has implemented an Expanded Primary Care Case Management program, participated in a multipayer medical home collaborative, initiated three pay-for-performance programs, implemented a pharmacy preferred drug list, and established a childhood weight management and nutritional counseling program.

Prior to joining the Department, Dr. Kelley worked for Aetna Health, Inc., as the medical director responsible for utilization and quality management in central and northeastern Pennsylvania. Prior to Aetna, he served as Assistant Professor and Director of Clinical Quality Improvement at Penn State University's College of Medicine. As the Director for Clinical Quality Improvement, he oversaw the quality and utilization management at Penn State's Hershey Medical Center.

Dr. Kelley attended medical school at the University of Pittsburgh, completed his residency training at Baylor College of Medicine in Houston, and is board certified in internal medicine. He has clinically practiced in a federally qualified health center, private practice, an academic practice at Penn State University, and a community-based team approach to diabetes care in a Medicaid hospital clinic.