

# Comments for the ONC HIT Policy Committee

December 15, 2009

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It is a pleasure to have the opportunity to share my thoughts with you this afternoon on meaningful uses of health data for performance measurement. Before I start, let me introduce myself and share the context from which I will make my comments. I am Catherine MacLean. I am currently the Staff Vice-President of Clinical Quality Interventions at WellPoint where I lead the Center for Quality Measures and Improvement. My responsibilities include facilitating the development of quality metrics and programs and serving as a liaison between national medical specialty societies, national quality organizations and WellPoint. Prior to joining WellPoint in 2006, I spent 15 years in academic medicine at UCLA, RAND and the Greater Los Angeles Veterans Administration (VA) Health Care System as a rheumatologist and health services researcher where the focus of my research was on the development, evaluation and implementation of quality measures including the assessment of the feasibility and validity of different types of data in measuring quality. I retain appointments at each of these institutions and remain active in patient care at the VA.

My comments will focus on the interface between health plans and health providers; between data that are produced in the course of providing health benefits and those produced in the course of delivering health care. I posit that the administrative and clinical data sets that are developed by health plans and health providers are complimentary and that when linked or otherwise combined, provide significantly more useful information to providers and health plans than either dataset alone. The utility of the combined data stems from the filling in of gaps that are inherent in each data set. To be sure, the size of the gaps, and hence the added utility of a combined data set, varies greatly depending on the particular administrative or clinical dataset. It is my view, however, that there is added value even when combining robust datasets. This value stems from increasing data completeness and accuracy as well as from reducing burdens of data collection and organization for different parties.

Health care quality can be defined and measured by the structures, processes and outcomes of care delivered. The last five years have witnessed an explosion in the development and endorsement of performance metrics to assess health care quality. My area tracks publically available performance metrics including those developed by NCQA, TJC, medical specialty societies, medical boards, academic institutions and vendors. There are currently well over 2,000 measures in our database, including 545 which have been endorsed by NQF. Despite these seemingly large numbers, there are still significant gaps in the areas for which performance metrics exist and the depth of measurement within specific clinical areas. However, even with these gaps in available measures, the largest challenge we face in performance measurement is in obtaining the data elements that are specified in many performance measures.

In the US today, the collective administrative data of health plans represents the single largest and likely the most commonly used source of data to assess health care quality. The main advantages of administrative data are that they are readily available, include large amounts of data across large numbers of patients and providers, and pose no collection burden for health care providers. However, these data do not contain the detailed clinical information that is specified in many performance measures. We estimate that only about 600 of the 2000-plus measures that we have identified in the public domain could be reasonably applied to administrative data, including around 100 that are NQF endorsed. Further, there is at times a level of skepticism among physicians regarding the results of the measures applied to administrative data, which can hamper meaningful discussions around quality improvement.

More important than the total number of measures that can be obtained from a given dataset, however, is the number of important measures for which the required data elements are available. Many of the most meaningful measures of health care quality require specific, detailed clinical data. Broadly speaking these ‘most meaningful’ measures include outcome measures such as mortality and the occurrence of specific morbidities but also include process measures that require clinical parameters to have meaning. For example, the AMA-PCPI’s NQF-endorsed measure for the use of angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy in coronary artery disease (CAD) specifies that patients with CAD who also have diabetes and/or left ventricular systolic dysfunction (LVSD) (left ventricular ejection fraction [LVEF] < 40% or moderately or severely depressed left ventricular systolic function) should be treated with an ACE inhibitor or an ARB.

For the most part, the most meaningful measures currently cannot be applied to administrative data. In fact, there are few existing dataset to which these measures can be applied in such a way as to provide uniform measurement across large numbers of patients or providers. Barriers to measurement include irregular reporting of some data elements at the point of service and the absence of a mechanism or infrastructure to capture, organize, pool and analyze the clinical data elements. Organizations that have overcome these barriers include some integrated health systems such as the Veterans Administration and a few medical specialty societies including the Society for Thoracic Surgery and the American College of Cardiology, each of which maintain detailed clinical registries for cardiovascular disease.

The goals of any efforts to measure health care quality should be to improve quality for the individual patient at the point of service, to provide feedback on performance to individual physicians and groups in order to facilitate population management and quality improvement, and to make available to the public meaningful assessments of health care quality by provider or group as appropriate. I am unaware of any organization in the US that accomplishes all three of these goals well. In my view the reason for this is that performance measurement is hard, resource-intensive work that few individual organizations are equipped to handle. Collectively, however, I think that the US health care community has the skills and resources to overcome these limitations.

Boiled down to a basic level, the challenge we face in measuring quality is one of ‘missing’ data and datasets that are not organized appropriately to measure quality. In some instances the data elements are truly missing and methods to collect them need to be developed. In many other cases, however, the data exist somewhere, though not in the data set being used to measure quality. Collaborations between health plans and health care providers could facilitate the development of ‘complete’ and appropriately organized datasets while reducing the administrative burden of either party going it alone.

Over the next few minutes I will explain how. In so doing I will address the committee’s interest in understanding how health plans can provide physicians with "real-time" information that can be used by providers for clinical decision support about an individual patient, in addition to population management and quality improvement (QI) by the practice.

For the purposes of this discussion I will define ‘real time’ information as information that is available at the point of service, recognizing that there are lag times associated with both clinical and claims data and that period of the lag impacts the usefulness of the data to varying degrees for different scenarios.

Further, I will point out that certain data elements, which have a long lag time, may provide value in the long run even though they may have little immediate value. Hence, these elements may provide ‘real time’ value.

Data for an individual patient can be characterized by length, or the longitudinal aspect of the data; depth, or the degree of detail included in the data; and breadth, or the completeness of the data across providers or care settings. Data for a population can additionally be characterized by inclusiveness, or the degree to which all members of the population are represented in the dataset.

Data length, depth, breadth and inclusiveness are each critical for some aspects of patient and population management and irrelevant for others. Additionally, each of these characteristics is associated with acquisition costs, which can be substantial. Consequently, data sets are typically built so that they can facilitate the specific management tasks relevant to the dataset owner with the lowest possible acquisition costs. This approach has led to the development of a myriad of different data sets within the US which may fulfill their intended individual functions, but collectively fail to serve the overall management needs of individuals and populations in the US because they were not designed to do so.

The data included in the health records maintained by clinicians, clinical registries and health plan administrative data differ in their length, depth, breadth and inclusiveness. While clinical records generally provide length and depth, the records of virtually all health care providers will contain gaps regarding the care provided by other health care providers. This problem exists even in relatively self-contained systems with robust data sets. For example, CPRS (Computerized Patient Record System), the electronic health record used in the Veterans Administration (VA) Healthcare System, is very complete in terms of length, depth and breadth for Veterans who obtain all health care within the VA system, but lacks important clinical data for the significant number of Veterans who obtain care obtained outside the VA system. For these veterans, the dataset lacks breadth. Data included in clinical registries are generally focused on the care rendered by a single provider at a single facility, and often for a single episode of care. Hence these datasets are generally very deep, but lack either length or breadth. Health plan administrative data lack clinical depth and length depends on the enrollment period

of individual beneficiaries. These data, however, have great breadth, capturing encounters across all health providers over a given time period and have the potential to serve as the link to bring together data from different providers and hence develop a linked dataset with the length, depth and breadth to measure healthcare quality well.

To this end, WellPoint is collaborating with The Society of Thoracic Surgeons on a project that is linking data from the STS registry with WellPoint's administrative data. This project is being done in collaboration with the Brookings Institute through the Robert Wood Johnson Foundation's high value health care initiative. Our hypothesis is that the quality than either dataset alone. In this project we are assessing the nuts and bolts of making the first linkage. Should this prove successful we will explore linking in additional datasets.

Beyond assessing whether we can achieve a successful link, we will also explore the utility of the link both in terms of quality output and administrative simplification. One area where linkage could provide simplification is in the pre-population of registry data fields with data from the health plan, for example using pharmacy claims.

We have also done a fair amount of work developing the concept of leveraging the breadth our claims data to serve as the glue that would bring together data from all providers who care for an individual patient through a 'trusted intermediary.' This concept was inspired by work done by Wellmark, about which you will hear from Dr. Miller in a few minutes. It builds on the Wellmark concept to include all healthcare providers who care for an individual patient and to utilize plan data to prepopulate data fields both as a means of increasing data capture and as a means of reducing data entry burden for providers.

In summary, although access to the data elements that are required to measure health care quality in the most meaningful way is currently difficult in most health settings in the US, many of the required elements exist. Data linking between different health care providers within an organized structure would go long way toward facilitating this measurement. As a result of its breadth, health plan administrative data could facilitate this link while providing administrative simplification by pre-populating a number of the data fields.