



**HIT STANDARDS COMMITTEE  
IMPLEMENTATION WORKGROUP  
Hearing on Adoption of Experiences  
October 29, 2009**

**Quality Measure Panel**

**When working with your clients, what business problem (e.g., clinical issue, health outcomes problem, etc) were you helping them solve with implementing standards-based, quality measurement across organizational boundaries? What standards did you use and why? What were they hoping to achieve and did they succeed?**

Chief executives and clinical leaders from five Wisconsin healthcare provider organizations gathered in late 2002 to discuss formation of a group to publicly report healthcare results. Recognizing the importance of performance measurement, the leaders joined together, in partnership with healthcare purchasers, to form the Wisconsin Collaborative for Healthcare Quality (WCHQ). An important strategy to start the Collaborative was to select organizations with minimally overlapping market boundaries. This lessened the fear of potential loss of market share by a lesser performing organization. We now know public reporting at the system level does not perceptibly change market share, but at that time it removed a potential barrier to public reporting.

Agreement to publish comparative performance measures achieved several important business goals;

First, ambulatory clinic systems were working in isolation as far as knowing how well their own system performed compared to others. Although one could find organizations who published their own performance metrics, you did not have the other organizations' specifications to understand what exactly was being measured.

Second, each of the founding organizations understood and believed in the importance of measurement for continuous improvement. Call it altruistic, maybe even naïve, but participating organizations believed a public accounting of performance would focus each organization's leadership team on continuous improvement of care processes. In the end, public reporting and sharing improvement strategies would "raise all boats". Organizations might compete on price and various aspects of service, but none of the organizations believed they should compete on quality of care or patient safety. Consequently, participation in WCHQ specifically excludes the use of publicly reported results for the purpose of marketing.

Third, the burden of healthcare costs to employer and government payers was no less an issue in 2003 than it is today. Hospital and clinic CEO's clearly understood the payers request for accountability by healthcare organizations. A return on investment, so to speak, for the level of care received for the dollars spent. Beyond agreeing to publicly report clinical results, the provider organizations invited employers, healthcare purchasing coalitions and state government to participate in the process. This made it more likely the final product would meet the needs of all stakeholders.

Another goal of the WCHQ members' was to do create reports with minimal additional burden to the reporting organizations. Health plan measures replicated publication of NCQA HEDIS results and hospital measures, except for the efficiency measure, replicated CMS Core Measures. As for ambulatory measures, some used NCQA HEDIS specifications as a starting point, but modified those specifications in order to capture all-patients-all-payers as well as modify some diagnosis and procedure codes. Other measures were developed from input of member organizations, professional societies and other existing measure specifications (e.g., NQF). Development of ambulatory care



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specifications continues to be a fairly resource intensive process. That said, the true success of the ambulatory measures effort is the acceptance of the results by frontline clinicians and leaders who use this information for strategic planning. Additionally, purchasers use WCHQ results to add incentives to provider contracts.

**How did implementing quality measurement between organizations help your clients achieve their goals, or did it inhibit progress toward achieving their goals? What role did the standards play?**

Release and comparison of performance measures resulted in the simple but important question from clinicians and healthcare leaders, "What are they doing to get those results?" Of course, that question only comes when there is confidence in the apples-to-apples comparison of performance results across organizations. Clinician confidence in the public reports came with open and on-going communications between leadership and frontline clinicians. The clinicians know the results are not perfect, but they are good enough to focus on questions related to process change and improvement rather than excuses to deny or ignore the results.

WCHQ membership includes slightly more than 40% of specialists and 50% of primary care physicians practicing in all regions of Wisconsin. The patient volume represented by this percentage of clinicians also suggests the potential impact of improvement for the residents of the State. Aggregated WCHQ population tracking of ambulatory chronic disease management and preventive care shows slow but ever increasing trend lines.

**What is an example of the greatest success and the most frustrating issue from your clients' implementations?**

Greatest successes include;

- Clinician acceptance of the results. This is critical to an organization's ability to affect change.
- All-patient-all-payer reporting. Many physicians were frustrated with the presentation of results for a portion of their patient population (e.g., insurer, Medicare or Medicaid data). Reports of these population subsets often result in small N's and served more to frustrate physicians than enlighten them.
- Stakeholder participation in and acceptance of the results
- Provided a mechanism for non-EMR organizations to participate

Greatest frustrations include:

- Initial development and implementation of a data validation process to assure members of the apples-to-apples comparison of the final performance metrics
- The additional resources (time and people) required for ambulatory care performance measure specification development and data aggregation, by organization, to generate the public report. The best specifications are developed with a team-attitude and representation of clinical and technical experts from member organizations.

**What advice would you give to help others mitigate problems or accelerate adoption of health information technology standards for quality measurement?**

First, make it as easy for clinicians to do the right thing in terms of coding, results entry and care documentation. Information in an EMR is not necessarily easily retrievable because it is in an



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electronic format. Many searchable fields can be scattered across hundreds of behind the scenes tables. Additionally, information from typed and dictated notes as well as 'smart' electronic templates are not easily retrievable.

Provide guidelines for attribution of patients to systems, clinics, specialties and individual providers. This is a challenging problem being addressed by multiple organizations. As with much of performance measurement specification development and reporting, there is significant redundant work for each public reporting body to develop its own processes. Attribution will always be difficult and never perfect, but similar processes across organizations will make the end-product more useful for comparison and learning.

**Other:**

- Detailed documentation of measure specifications. Do not leave room for interpretation. This is a grueling process, but the end-product is worth the effort.
- Participation by all stakeholders. Clinicians and payers have to believe in the process and the results.
- Frequent communication
- Reduce the burden of work for provider organizations related to quality reporting. This is being approached through Repository Based Submission (RBS) at WCHQ. WCHQ's RBS process was initiated to make it easy for member organization to participate in the CMS Physician Quality Reporting Initiative (PQRI). WCHQ is expanding the PQRI capabilities to accept patient level data for WCHQ performance reporting as well as ad hoc reporting to meet the individual needs of member organizations. Additional RBS benefits include:
  - Standard the interpretation of specifications as the data calculations come from a single source,
  - Annual spec changes due to coding revisions are applied through a single source rather than at the organization level, reducing the probability of errors and omissions,
  - Testing of new measures or changes to existing measures can be done through RBS rather than needing to occur at the organization level

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## **WCHQ FACT SHEET**

*A voluntary consortium of organizations learning and working together to improve the quality and cost-effectiveness of healthcare for the people of Wisconsin*

### **What is the Wisconsin Collaborative for Healthcare Quality?**

- WCHQ is a voluntary partnership that brings together key healthcare providers and stakeholders in Wisconsin to develop and report performance measures for assessing the quality of healthcare services.
- WCHQ aspires to be a national leader in the public reporting of healthcare quality measures, one that is respected for its integrity and trust, recognized for its transparency and inclusive governance and willingness to innovate and improve continuously.
- WCHQ has built a set of ambulatory care measures that enable medical groups and / or health systems to collect and report quality of care data using medical group information on **all** patients.
- WCHQ publicly reports measurement results for healthcare providers, purchasers and consumers.
- WCHQ member organizations share their best practices in care that demonstrate high quality and positive clinical outcomes enabling all providers to adopt successful methods.
- WCHQ is a CMS approved registry for submission of the Physician Quality Reporting Initiative (PQRI) measures supporting provider incentive payments.

### **Who is participating?**

- Provider members represent approximately 40% of all Wisconsin physicians (5,200) and 50% of Wisconsin primary care physicians (2,000). Member organizations represent all geographic regions of the state.
- WCHQ's purchaser and strategic partner groups are represented by both individual businesses and business coalitions, state government, payer organizations and other state healthcare quality organizations.

### **What measures have been developed and reported?**

- WCHQ has over 20 ambulatory and an additional number of hospital and health plan measures publicly reported on its website, [www.wchq.org](http://www.wchq.org). The ambulatory measures represent care within the categories of prevention, chronic disease, episodic health needs and overall access to physician providers.
- WCHQ publishes the ambulatory measures annually, half of them in the spring with the remaining measures in the fall. Most hospital measures are reported quarterly and some on an annual basis. Health plan measures are updated annually.



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- Many WCHQ member organizations utilize the measure sets for more frequent internal reporting to their providers either by department or by individual.
- Participation by purchasers, payers and health care providers help ensure that all points of view are considered and that priority areas of measurement are considered with each new development cycle.

***How does the data get collected and reported?***

- WCHQ has deployed a data repository approach to data collection and measurement. This requires secure and confidential transfer of patient level data files to WCHQ's software vendor on a periodic basis. WCHQ's technical staff and software vendor apply the measurement technical specifications required for any given measure and run the resulting reports accordingly.
- WCHQ measures incorporate data from both administrative claims information and medical record documentation. For organizations that have not fully deployed an electronic medical record, the repository data submission process will still allow the opportunity to complete the data requirements through additional manual record review on a random sample basis. The data tool actually calculates the random sample size required based on the denominator volume submitted and will generate a worksheet by individual patient file clarifying the required information needed.
- WCHQ technical staff conducts ongoing validation procedures to assure data accuracy and compliance with the submission processes.
- All publicly reported data is first previewed by the member organizations for a defined period of time. This allows time to review the initial results and provide follow up to remaining data questions prior to reporting.
- The staff time required on the part of member organizations to carry out this process varies from organization to organization based on their existing documentation systems. WCHQ staff work closely with staff from each of the organizations to streamline processes and make this work as efficient as possible.
- The majority of hospital data is accessed by WCHQ staff directly from the Wisconsin Hospital Association Information Center and does not require direct submission by the hospital members to WCHQ.
- WCHQ works directly with the represented health plans to post selected measures from their data sets on our website. Likewise, this does not require any additional data submission from our member organizations.

***What else is expected of member organizations?***

WCHQ members agree to respect these guiding principles:



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- Work in the spirit of improvement.
- Engage members' staff to actively participate in WCHQ workgroups.
- Commit to reporting data for member's affiliated entities within 3 years of joining.
- Comply with WCHQ audit and validation procedures.
- Accept governance by the WCHQ Board of Directors.
- Make annual dues payments in a timely manner.
- Refrain from selectively reporting performance. Members must submit data for all WCHQ measures they are capable of reporting.
- Refrain from submitting false data or manipulating the data submission process to improve performance results.
- Refrain from using WCHQ performance data for competitive differentiation in marketing or advertising materials.