HITPC Accountable Care Clinical Quality Measures Subgroup

Recommendations for ACO Measurement Domains and Data Needs

Instructions: Please review the table and questions below and provide your feedback to Lauren Wu ([lauren.wu@hhs.gov](mailto:lauren.wu@hhs.gov)) by **COB Tuesday, January 7, 2014**. Please provide your changes in track changes or a different color font.

ACO Measure Domains, Proposed Data Elements, and Infrastructure

The Subgroup has identified six key domains for ACO measurement, along with a seventh cross-cutting domain for health equity/disparities reduction, which align with the National Quality Strategy priorities. The columns in the table below, from left to right, capture the specific improvement concepts for ACOs, example metrics, data elements and sources required for those metrics, and identifies health IT infrastructure that could help operationalize the desired measurement goal. Please pay special attention to the blank cells and feel free to identify additional example metrics for consideration. The Subgroup’s goal is to present two example metrics per domain area that represent different perspectives within each domain.

| **ACO**  **Domain[[1]](#footnote-2)** | **National Quality Strategy Priorities[[2]](#endnote-2)** | **Specific Improvement Concepts for ACOs** | **Concept Metric (Num/Den) Examples** | **Data Elements Required for Metric** | **Data Source(s) for Concept Metrics** | **Potential HIT Infrastructure to Operationalize** |
| --- | --- | --- | --- | --- | --- | --- |
| Care Coordination | 3 | Improve care transitions after acute hospital discharge | % Patients with contact with outpatient services within 7 days of discharge | Hospital discharge event | EHR  Claims  ADT | Case management registry for all discharged patients including discharge diagnosis and disposition |
| Contact with outpatient services | EHR  Claims |
| % Patients with medication reconciliation within 7 days of discharge | Hospital discharge event | EHR  Claims  ADT |
| Medical reconciliation documentation | EHR |
| Functional Status/Well-Being | 3 | Optimize wellness and functional status of patients and communities | Healthy Days | Data field for healthy days | Patient-reported | Patient portals linked to EHR |
| PROMIS 10 | Mobility, anxiety, anger, depression, fatigue, sleep, pain behavior, pain interference, satisfaction with discretionary social activities, satisfaction with social roles, sexual function, overall health | Patient-reported |
| Shared Decision Making | 2, 3 | 1. 2. Improving quality of medical decision-making  3. Improve patient involvement in decision-making on his/her health care  Improve health care provider awareness of importance of shared-decision making | Included in/collaborated shared decision making | Patient goals for care; alignment of patient goals and clinical goals for care | Patient-reported  EHR | Patient portal; mobile devices; electronic, shared care plan |
| Improvement in Activation | Activation score - pre | Patient-reported  EHR |
| Activation score - post | Patient-reported  EHR |
| Efficiency | 6 | Reduce costs,  Appropriate utilization of health care resources | Total cost of care (PMPM) | Medical and pharmacy costs | Claims  EHR  Pharmacy data |  |
| Monthly membership roster | Claims  EHR |
| Avoidable ED visits per 1000  What about duplicate tests? Seems like that would be easier to measure and more EHR sensitive than avoidable ED visits. But maybe distinguishing valid repeat tests from duplicates isn’t so simple. | Ambulatory ED visits | ADT  EHR  Claims |
| Discharge diagnosis | EHR  Claims |
| Safety | 1 | Reduce medical errors | * Avoidable hospital readmission rate * Drug/drug interaction rates (lower rate better) * Falls rates (lower rate better) | Hospital readmissions  Interaction alerts ignored/# prescriptions  # falls/# of admissions or visits | Claims  EHR  ADT | Need to ‘turn on’ eRx drug/drug interaction functions and calculate monthly rates over time  Need to have falls documented consistently and in a standard way in EHR, with reporting on monthly rates over time. |
| Historical readmission rates | Claims  EHR  ADT |
| Prevention | 4, 5 |  | % Patients with MI with optimal blood pressure control | Blood pressure readings | EHR  Patient-reported |  |
| Patients with diagnosis of MI | EHR |
| % adult patients with BMI >=30 who progress to diabetes in 12 months  Beta blockers after MI  Control of LDL  Mammograms  Colorectal cancer screening  Flu vax | BMI | EHR |
| Glucose readings | EHR  Patient-reported |

Additional Questions

1. Are there other data sets/standards that need to be identified or developed?
2. Informatics infrastructure to operationalize six domains

* Can ACOs report eCQMS one time?
* Would individual providers continue to report?

I would think there would be some way to have providers report individually to ACO level, and that report should also count for CMS on the individual provider level, while ACOs have to report on the ACO level to CMS.

* How does the “roll-up” of individual and group provider data to the ACO level occur using certified EHR technology? EHR technology to be certified must be capable of capturing individual data elements, which can then be transmitted through certified EHR technology to the ACO, which aggregates and computes individual and ACO measures. Isn’t it in the ACO’s interest to know not only how they are doing as an ACO, but also which providers are contributing positively and which are contributing negatively to that overall score?
* Data interoperability needs
* Does group reporting become an option?

1. What types of data standards exist? What data standards are still needed?

1. Seventh cross-cutting domain: health equity/disparities. Be able to stratify measures in each of the six domains by variables of importance for the particular population (e.g., age, gender, language). [↑](#footnote-ref-2)
2. National Quality Strategy Priorities

   1. Making care safer by reducing harm caused in the delivery of care.
   2. Ensuring that each person and family is engaged as partners in their care.
   3. Promoting effective communication and coordination of care.
   4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
   5. Working with communities to promote wide use of best practices to enable healthy living.
   6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

   [↑](#endnote-ref-2)