HITPC Accountable Care Clinical Quality Measures Subgroup

Recommendations for ACO Measurement Domains and Data Needs

ACO Measure Domains, Proposed Data Elements, and Infrastructure

The Subgroup has identified six key domains for general 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 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.

| **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[[3]](#footnote-3)** | **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 | EHRClaimsADT | Case management registry for all discharged patients including discharge diagnosis and disposition |
| Contact with outpatient services | EHRClaims |
| % Patients with medication reconciliation within 7 days of discharge | Hospital discharge event | EHRClaimsADT |
| 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 | Infrastructure to collection patient-generated health data (e.g., 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. Improve the quality of medical decision-making2. Improve patient involvement in decision-making on his/her health care3. 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-reportedEHR | Infrastructure to collect patient-generated health data (e.g., patient portal, mobile devices, electronic, shared care plan) |
| % DM patients at Level 4 for 13-item PAM score[[4]](#footnote-4) or Improvement in Activation | Patients diagnosed with DM or Activation score - pre | Patient-reportedEHR |
| PAM score as a PROM or Activation score - post | Patient-reportedEHR |
| Efficiency | 6 | Reduce costs, Appropriate utilization of health care resources  | Total cost of care (PMPM) | Medical and pharmacy costs | ClaimsEHRPharmacy data | Need consistent collection of claims data (agreed-upon data format and common data element definitions) across payers and claims warehouses |
| Monthly membership roster | ClaimsEHR |
| Reduction of duplicate tests | Tests (historical and current) | ADTEHRClaims |
| Tests (historical and current) – algorithms to determine whether tests were needed | ADTEHRClaims |
| Safety | 1 | Reduce medical errors | Drug/drug interaction rates (lower rate better) | Interaction alerts ignored/# prescriptions | ClaimsEHRADT | Need to ‘turn on’ eRx drug/drug interaction functions and calculate monthly rates over time |
| Number of drugs prescribed/prescriptions | ClaimsEHRADT |
| Prevention | 4, 5 | Prevent onset of disease and control disease for patients and communities | % Patients with MI with optimal blood pressure control | Blood pressure readings | EHRPatient-reported | Electronic, shared care plan |
| Patients with diagnosis of MI | EHR |
| % adult patients with BMI >=30 who progress to diabetes in 12 months | BMI | EHR |
| Glucose readings | EHRPatient-reported |
| Beta blockers after MI | Prescriptions | EHRPharmacyClaims |
| Diagnosis of MI | EHRClaims |
| Control of LDL | LDL readings/change in LDL readings | EHRLab |
| LDL readings | EHRLab |
| Screenings (e.g., mammograms, colorectal cancer screening) | Screenings given/offered | EHRClaims  |
| Eligible patient population | EHRClaims |

These recommendations complement the table of measure domains, data sources, and HIT infrastructure.

Policy

**Should ACOs be required to report ACO metrics at the individual physician level?**

**Should ACOs be given the option to only report ACO metrics at the group level?**

ACO metrics should to be reported at group level; additionally some, but not all metrics may be appropriate to report at physician level. Patients make decisions about providers at the individual provider level, so they should be able to view individual provider performance. Metrics reported at the ACO level should be transparent, so a patient could see which providers were part of and contributing to the group. However, the details down to the level of the financial breakdown by physicians would not be needed (e.g., PMPM). Additionally, ACO measures should be structured so that individual physicians would maintain individual accountability for performance. For example, ACOs may internally use performance information on individual providers to see how they are performing and contributing to the group level for quality improvement. There is a need to design ACO measures that reduce reporting burden but also factor in systemic shared accountability.

**Should ACOs report eCQMs once to qualify for multiple programs? What policy and program changes need to be considered to allow reporting once across programs?**

The WG advocates for reporting once to qualify for multiple ACO programs to reduce burden, and programs would need to require the same measures consistently. In the case where an organization may participate in multiple ACOs, we propose reporting once “all patients, all payers” to count for reporting for multiple programs. This mechanism requires specifying some minimum threshold proportion of a common population in the denominator to assure that the population being measured is truly representative and the measures are accurate. Exclusion criteria for not being counted in the denominators of measures also need to be defined.

Technical

**How does “roll-up” to the ACO level occur?**

**What data interfaces are needed based on our list of metrics?**

**Are there other data sets/standards that need to be identified or developed?**

Apply the same principles for ACO “all payer, all patients” report once as proposed above. If an individual physician accounts for a minimum threshold of the total patient population, their data could be eligible to roll up to the next level (e.g., group level or business/service unit).

The key data pieces are EHR, ADT, and claims, and the WG recommends that clinical and claims data need to be integrated and that a data architecture is put in place. There may be a logical way to prioritize which interfaces should be developed first based on data that are clean and robust. The WG recommends work to develop a common data format and data definitions for commercial health plan claims data. Currently, claims data are structured closely enough that it would not be a heavy lift to develop a common set of fields and specifications for each field with common data definitions. This would go a long way in allowing integration of claims with clinical data.

The WG also recognizes a need for patient matching in order to link data from multiple sources together. Many states, HIEs, and regional groups have developed their own way of patient matching, and it would be helpful to hold a forum where groups can share their successes and lessons learned toward a more national unified strategy.

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)
3. For the “Data Sources for Concept Metrics” and “Potential HIT Infrastructure to Operationalize” columns, data could come from the individual provider and/or at the group/ACO level. These specifics depend on the measure construct/specifications and the method used to calculate the measure itself. [↑](#footnote-ref-3)
4. The PAM score is provided as an illustration of the type of measure that could be considered for the shared decision-making domain. Measures that may be become required would need to be publicly available to all entities. [↑](#footnote-ref-4)