Is it Time to Re-Focus on the Practice? Strategies and Support for Reliable Quality Measurement

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Patrick Gordon – Rocky Mountain Health Plan
Context

• **Value based payment models** are driving traditionally segregated provider groups to enter into new business arrangements, where they work together to improve coordination and quality of services, and health outcomes.

• **Growing need to evaluate variation and comparative performance** across settings, a process that depends on aggregation of reliable data (e.g. claims, clinical).

• **Aggregating reliable clinical data from EHRs has proven challenging**, particularly for independent practices that don’t have substantial administrative and technical support.

• **These challenges have stimulated interest and innovation** around how to support practices in order to assist with changes in workflow, and to improve the ability to evaluate outcomes while reducing measurement burden.
ONC Support of the State Innovation Models Initiative

- ONC is providing technical assistance to CMS and State Innovation Model States.
- This involves one-on-one subject matter expertise as well as the creation of tools and resources that can be leveraged to support health IT innovation in care delivery and payment systems.

- Materials Cover:
  - Privacy and Security
  - Alerting
  - ID Management
  - Behavioral Health
  - Provider Directories

- Materials are published at: https://www.healthit.gov/providers-professionals/state-innovation-model-health-it-resource-center
### Health IT Modular Functions

<table>
<thead>
<tr>
<th>Reporting Services</th>
<th>Analytics Services</th>
<th>Consumer Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification Services</td>
<td>Exchange Services</td>
<td>Provider Tools</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient Attribution</td>
</tr>
</tbody>
</table>

#### Additional Tools Being Developed

- Strategic planning and implementation guide for health IT enabled quality measurement in support of alternative payment models
- Decision guide to assist with selection of data extraction and measurement strategies
- Content enhanced based on recent HITeQM in-person meeting with SIM States

**Foundation for a ‘healthy’ Health IT Stack**
Statewide Network for Comparative Learning

- 31 Community Health Team Leaders
- 19 Blueprint Practice Facilitators
- 14 Blueprint Project Managers
- 4 ACO Clinical Quality Leaders
- 6 ACO Clinical Consultants
Practice Profiles Evaluate Care Delivery
Commercial, Medicaid, & Medicare
Data Use for a Learning Health System

Measurement
- Utilization
- Expenditures
- Unit Costs
- Quality
- Patient Experience
- Social, Economic, Behavioral
- Variation & Associations

Products
- Practice Profiles
- HSA Profiles
- Learning System Support
- Performance Payments
- Program Impact & Publications
  - PCMH + CHT
  - Opioid Program
- Predictive Models
Use of Federal & State Funding Streams

- State HIT Fund
- 1115 Waiver
- IAPD
- SIM

- HIE Infrastructure
- Clinical Registry
- Provider Registry
- All Payer Claims Database
- Patient Experience Survey
- Data Processing
- Analytics
- Reporting
Collecting Reliable EHR Data for Quality Measurement

Core Measure Set Defines Priority Data Elements

- Capture elements in EHR system
- Extract elements from EHR system
- Transmit to intermediary systems
- Aggregate priority data elements
- Establish patient level records

Dedicated Team for Data Quality
‘EHR Capture to Aggregation to Assessment to Improvement’
Is it Time to Re-Focus on the Practice? Strategies and Support for Reliable Quality Measurement

Vermont Blueprint
Data Quality Initiative

SPRINT Program

Capitol Health Associates LLC
Hans C. Kastensmith
Managing Partner
Introduction

• **Clean Reliable End to End Data**
  » The goal of the Blueprint Sprint is to establish end to end data extraction, transmission, and registry reporting in support of health services

• **Results Oriented Team Approach**
  » The Sprint Program utilizes a results oriented approach where all participants engage in ownership and responsibility for achieving the stated measure of success.
  » The individuals work together as a complete team, with regular direct communication, until the goal is achieved.

• **Intensive Interaction to Completion**
  » A focus and intensity is maintained by all partners so that this process is accelerated and completed at each site as soon as possible.

• **Completion and Verification**
  » Data is verified and accepted by the lead clinicians
  » Analysis can be run and HSA Profiles Produced
High Level Sprint Process

• Blueprint Community Evaluation
• Build Team
• Initial Site Evaluation
• Action Plan
• First Sprint Meeting Reviews Goals and Defines Roles
• Weekly Progress Meetings on Continuing Work
• Final Data Continuity and Validation
• Ongoing Maintenance
Sprint Team

- **Multi-Disciplinary Teams**
  - Representatives from the community and practices are selected and dedicated to the process from beginning to end.

- **Lead Clinicians**
  - A lead clinician from each practice

- **Lead Site IT Representatives**
  - An individual or group that have access and insight to the sources of data

- **Vermont Information Technology Leaders (VITL)**
  - HIE interface team and eHealth Specialist members

- **BPCR Team**
  - Program and Project management team
  - Onboarding and support team members

- **Blueprint**
  - BP Director, Sprint Program Team, BP Assistant Directors, Project Managers, others

- **Bi-State representative (where applicable)**
Initial Site Evaluation

- An initial evaluation is conducted with the site(s) on Demographic and Clinical data collected.
  - Review of EMR data transmission and format capabilities
  - Review of connectivity issues and capabilities
  - Review workflows and procedures around data entry
  - Assess the quality and consistency of data at the source
  - Compare the data transmitted to the V-HIE/BPCR (where applicable.)
  - Generate exception report to identify issues in the feed
Initial Data Verification

• An exception list is generated that gives the team a detailed view of data related issues
  » Shows % of good and bad data elements
  » Permits identification of mapping issues
  » Allows for translation and missing elements to be addressed
  » Identifies data entry issues
• Promotes situational awareness
• Sets up the basis for Action Plan
<table>
<thead>
<tr>
<th>MeasureID</th>
<th>MeasureName</th>
<th>TotalMeasures</th>
<th>TotalValid</th>
<th>PctlValid</th>
<th>ReqMap/Trans</th>
<th>ReqMap/Trans</th>
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<tbody>
<tr>
<td>594</td>
<td>Foot Exam - Visual Inspection</td>
<td>2</td>
<td>2</td>
<td>100.00%</td>
<td>-</td>
<td>0.00%</td>
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<tr>
<td>635</td>
<td>Height (inch)</td>
<td>16,120</td>
<td>16,097</td>
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<td>23</td>
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<td>Weight (lb)</td>
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<td>99.93%</td>
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<td>0.07%</td>
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<td>678</td>
<td>BP SBP</td>
<td>19,223</td>
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<td>1</td>
<td>0.01%</td>
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<td>19,221</td>
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<td>-</td>
<td>0.00%</td>
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<td>800</td>
<td>Lipids-fasting</td>
<td>1</td>
<td>1</td>
<td>100.00%</td>
<td>-</td>
<td>0.00%</td>
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<tr>
<td>1855</td>
<td>HDL - Female</td>
<td>4,658</td>
<td>4,651</td>
<td>99.85%</td>
<td>7</td>
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<td>2144</td>
<td>Asthma Classification (at diagnosis and between treatment)</td>
<td>118</td>
<td>112</td>
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<td>2310</td>
<td>What, if anything have you done about these feelings?</td>
<td>2</td>
<td>2</td>
<td>100.00%</td>
<td>-</td>
<td>0.00%</td>
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<tr>
<td>2367</td>
<td>PHQ.9 Total Score</td>
<td>80</td>
<td>79</td>
<td>98.75%</td>
<td>1</td>
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<tr>
<td>2552</td>
<td>Exercise Duration (minutes per day)</td>
<td>198</td>
<td>1</td>
<td>0.51%</td>
<td>197</td>
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<tr>
<td>2588</td>
<td>Total Cholesterol</td>
<td>9,753</td>
<td>9,704</td>
<td>99.50%</td>
<td>49</td>
<td>0.50%</td>
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<tr>
<td>2763</td>
<td>Exercise (# days/week)</td>
<td>9,076</td>
<td>3,696</td>
<td>40.72%</td>
<td>5,380</td>
<td>59.28%</td>
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<tr>
<td>3138</td>
<td>Hep A</td>
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<td>0.00%</td>
<td>40</td>
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<tr>
<td>3506</td>
<td>Triglycerides</td>
<td>9,073</td>
<td>9,050</td>
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<td>23</td>
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<tr>
<td>3517</td>
<td>LDL</td>
<td>9,347</td>
<td>9,222</td>
<td>98.66%</td>
<td>125</td>
<td>1.34%</td>
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<tr>
<td>3620</td>
<td>Tetanus</td>
<td>9,326</td>
<td>68</td>
<td>0.73%</td>
<td>9,258</td>
<td>99.27%</td>
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<tr>
<td>3983</td>
<td>a. little interest or pleasure in doing anything?</td>
<td>2</td>
<td>2</td>
<td>100.00%</td>
<td>-</td>
<td>0.00%</td>
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<tr>
<td>3984</td>
<td>b. feeling down, depressed or hopeless?</td>
<td>2</td>
<td>2</td>
<td>100.00%</td>
<td>-</td>
<td>0.00%</td>
</tr>
<tr>
<td>4339</td>
<td>Do you still have these feelings</td>
<td>2</td>
<td>-</td>
<td>0.00%</td>
<td>2</td>
<td>100.00%</td>
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<tr>
<td>4412</td>
<td>Today's Visit Type</td>
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<td>536</td>
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<td>3,937</td>
<td>88.02%</td>
</tr>
<tr>
<td>4463</td>
<td>Are they as strong as they were when you were diagnosed with depression</td>
<td>2</td>
<td>-</td>
<td>0.00%</td>
<td>2</td>
<td>100.00%</td>
</tr>
<tr>
<td>4525</td>
<td>Foot Exam Monofil / Visual / Pulse</td>
<td>424</td>
<td>342</td>
<td>80.66%</td>
<td>82</td>
<td>19.34%</td>
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<tr>
<td>4575</td>
<td>HDL - Male</td>
<td>4,640</td>
<td>4,637</td>
<td>99.94%</td>
<td>3</td>
<td>0.06%</td>
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<tr>
<td>4903</td>
<td>Pneumovax</td>
<td>3,868</td>
<td>421</td>
<td>10.88%</td>
<td>3,447</td>
<td>89.12%</td>
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<tr>
<td>5009</td>
<td>Influenza vaccine</td>
<td>10,699</td>
<td>446</td>
<td>4.17%</td>
<td>10,253</td>
<td>95.83%</td>
</tr>
<tr>
<td>5138</td>
<td>IPV</td>
<td>63</td>
<td>-</td>
<td>0.00%</td>
<td>63</td>
<td>100.00%</td>
</tr>
<tr>
<td>5140</td>
<td>MMR (min age 12 months)</td>
<td>80</td>
<td>-</td>
<td>0.00%</td>
<td>80</td>
<td>100.00%</td>
</tr>
<tr>
<td>5142</td>
<td>Varicella (min age 12m)</td>
<td>33</td>
<td>-</td>
<td>0.00%</td>
<td>33</td>
<td>100.00%</td>
</tr>
<tr>
<td>5147</td>
<td>Pneumococcal (PCV) (min age 6 weeks)</td>
<td>9</td>
<td>-</td>
<td>0.00%</td>
<td>9</td>
<td>100.00%</td>
</tr>
<tr>
<td>5391</td>
<td>Rotavirus</td>
<td>1</td>
<td>-</td>
<td>0.00%</td>
<td>1</td>
<td>100.00%</td>
</tr>
</tbody>
</table>
Action Plan

• Based on the findings of the previous steps an action plan is generated

  » Details of issues that require action on data quality and mapping
    - ADT – Provider/Patient Attribution – Active/Inactive – Dups – Field Integrity
    - CCD – Coded Measures – Style Sheets for Message Processing
    - Flat File Feeds – Expanded Measure Capture – Extraction Issues
    - Establish Translation Requirements
    - Death Registry – Consistent Source of Reliable Information

  » Engage upstream data systems representatives if necessary

  » Establish changes in work flow and data entry at the practice level

  » Integrate ongoing known issues and items from other Sprints that are in process for global continuity

  » Establishes the definitive path to completion of the Sprint
### Weekly Progress Reports

<table>
<thead>
<tr>
<th>PCP Assignment</th>
<th>Details</th>
<th>Additional Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP Assignments improving. 60% of patients at CHCRR are missing a PCP in the Registry.</td>
<td>Track improvements as other fixes are applied</td>
<td>On hold until data clean up and reload occurs.</td>
</tr>
<tr>
<td>MedFusion Portal Creating Duplicate Patients - ISSUE HAS BEEN SOLVED Registry Remediation Required</td>
<td>Remediate bad data in Registry</td>
<td>Rick - update on resolution</td>
</tr>
<tr>
<td>Run Duplicates Report in Registry</td>
<td>Rick - update on resolution after MPI reload</td>
<td></td>
</tr>
<tr>
<td>Building PCP De-Activation List - Problem with PM/EMR interface cause</td>
<td>Remediate Bad Data on PCPs in Allscripts EMR</td>
<td>This may be resolved</td>
</tr>
<tr>
<td>Doctor on Call being Investigated to ensure we have proper assignment of urgent care patients and a clean Active patient panel, Issue related to Provider/Patient Attribution</td>
<td>HOLD UNTIL POPULATION VERIFICATION Rutland will send two patient records that are known urgent care - will add a TEST provider and track through the system to determine effects - &quot;Fake NPI&quot;</td>
<td>Hans - update on work underway</td>
</tr>
</tbody>
</table>
## Bennington ADT Values

<table>
<thead>
<tr>
<th>ADT value</th>
<th>Description</th>
<th>Centricity</th>
<th>Meditech</th>
<th>Allscripts Pro</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSH Segment</td>
<td>message header values</td>
<td>y</td>
<td>y</td>
<td>y</td>
</tr>
<tr>
<td>PID segment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PID-3</td>
<td>Patient ID</td>
<td>y</td>
<td>y</td>
<td>y</td>
</tr>
<tr>
<td>PID-5</td>
<td>Name</td>
<td>y</td>
<td>y</td>
<td>y</td>
</tr>
<tr>
<td>PID-7</td>
<td>DoB</td>
<td>y</td>
<td>y</td>
<td>y</td>
</tr>
<tr>
<td>PID-8</td>
<td>Sex</td>
<td>not processed in DocSite</td>
<td>not processed in DocSite</td>
<td>y</td>
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<td>PID-10</td>
<td>Race</td>
<td>y</td>
<td>y</td>
<td>y</td>
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<td>PID-11</td>
<td>Address</td>
<td>y</td>
<td>y</td>
<td>y</td>
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<td>PID-13</td>
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<td>y</td>
</tr>
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<td>PID-15</td>
<td>Language</td>
<td>y</td>
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<td>not required</td>
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<td>PID-18</td>
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<td>y</td>
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<td>PID 19</td>
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<td>not processed in DocSite</td>
<td>n</td>
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<tr>
<td>PID-22</td>
<td>Ethnic Group</td>
<td>y</td>
<td>most not entered</td>
<td>y</td>
</tr>
<tr>
<td>PID-29</td>
<td>Death Date/Time</td>
<td>y</td>
<td>not generally entered</td>
<td>y</td>
</tr>
<tr>
<td>PID-30</td>
<td>Death Indicator</td>
<td>y</td>
<td>not generally entered</td>
<td>y</td>
</tr>
<tr>
<td>PV1 Segment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PV1-3</td>
<td>Assigned Location</td>
<td>y</td>
<td>y</td>
<td>y</td>
</tr>
<tr>
<td>PV1-7</td>
<td>Attending Doc (NPI)</td>
<td>y</td>
<td>y</td>
<td>y</td>
</tr>
<tr>
<td>IN1</td>
<td>mapped to table</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Measures of Success

• The site has optimized data quality for all purposes including health services, quality, evaluation

• The site has high quality data transmission into the HIE network and clinical registry

• The site can produce results of key metrics (ACO, UDS, NCQA, CQM meaningful use)
Types of Sprints

• **Remediation**
  » Sites currently sending data to VHIE/DocSite

• **Onboarding**
  » Sites that are about to send data to VHIE/DocSite

• **Field Team**
  » New Initiative
  » Sites that are earlier in the process of EHR deployment
Data Quality: People, Process and Performance Outcomes

ONC Learning Webinar | September 27, 2016
Independent, network model health plan, with provider and HIE partners;

Serving ~350,000 people;

Extensive participation in ONC and CMMI technology and transformation initiatives;

Focused on Western Colorado; and,

Committed to health equity.
Data Quality Drivers

- Practice Facilitation
- Clinical HIT Advisor ("CHITA")
- Leadership

- Benchmarking
- Gaps in Care
- Stratification
- Predictive Modeling

- Workforce
- Measurement
- Applications
- Data Sharing

- Focused eCQMs
- Aligned HEDIS
- Total Cost & Utilization
- Patient Activation

- EHR
- Community / HIE
- (Multi) Payer
- Patient Reported
The "CHITA"

• **Clinical Health Information Technology Advisor (CHITA)** An expert in data capture and data reporting

• The CHITA becomes familiar with the electronic health record (EHR) platform in each practice to understand how best to report clinical data that document measures that matter to the practice

• The CHITA supports practice workflow as it relates to effective data capture in the EHR, provides oversight and analysis of consistent data entry across practices to enhance the ability to accurately measure and report on key metrics

• The CHITA and the practice facilitator/coach work together closely to optimize their respective skills for the benefit of the practice
Data Quality Steering - Key players

- **People**
  - Leaders / sponsors
  - Measurement / application experts
  - IT/Technology
  - Practice Facilitators

- **Process**
  - Regular
  - Feedback driven
  - Continuous
Data quality: creating a virtuous cycle

**Give**
- Time & Attention
- Leadership
- Process Change

**Get**
- Better Tools
- Better Measures
- Better Results
Data quality: Continuous Feedback

NQF 0418: Preventive Care and Screening Screening for Clinical Depression and Follow-up Plan

<table>
<thead>
<tr>
<th>Practice ID</th>
<th>Practice Name</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Rate</th>
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</thead>
<tbody>
<tr>
<td>30</td>
<td>Foresight Family Physicians</td>
<td>437</td>
<td>1823</td>
<td>23.97%</td>
</tr>
<tr>
<td>46</td>
<td>Peach Valley Family Medical Center</td>
<td>228</td>
<td>2477</td>
<td>9.20%</td>
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<tr>
<td>49</td>
<td>Roaring Fork Family Physicians</td>
<td>474</td>
<td>1902</td>
<td>24.92%</td>
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<tr>
<td>57</td>
<td>Western Colorado Pediatric Associates/PCP (GJ)</td>
<td>0</td>
<td>1349</td>
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<tr>
<td>158</td>
<td>Uncompahgre Medical Center</td>
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<td>456</td>
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<tr>
<td>171</td>
<td>Mountain Medical Center</td>
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Data Quality: Continuous Validation

### NQF-0059: Diabetes Hemoglobin A1c Poor Control

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<tr>
<th>Cohort</th>
<th>Practice ID</th>
<th>Practice Name</th>
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<th>Rate</th>
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<td>1</td>
<td>75</td>
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<td>5</td>
<td>728</td>
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<tr>
<td>30</td>
<td>Foresight Family Physicians</td>
<td>83</td>
<td>185</td>
<td>44.86%</td>
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<tr>
<td>40</td>
<td>MidValley Family Practice</td>
<td>20</td>
<td>36</td>
<td>55.56%</td>
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</tr>
<tr>
<td>46</td>
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<td>144</td>
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<tr>
<td>49</td>
<td>Roaring Fork Family Physicians</td>
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<td>67</td>
<td>16.42%</td>
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<tr>
<td>65</td>
<td>Western Colorado Physician Group/PCP</td>
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<td>386</td>
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Data quality: Trajectory matters

NQF 0421: Preventive Care and Screening Body Mass Index Screening and Follow-up Plan

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<td>1623</td>
<td>4521</td>
<td>35.90%</td>
</tr>
<tr>
<td></td>
<td>Ages 18 - 64</td>
<td>1461</td>
<td>2378</td>
<td>61.44%</td>
</tr>
<tr>
<td></td>
<td>Ages 65+</td>
<td>517</td>
<td>999</td>
<td>51.75%</td>
</tr>
<tr>
<td></td>
<td>Foresight Family Physicians</td>
<td>370</td>
<td>594</td>
<td>62.29%</td>
</tr>
<tr>
<td></td>
<td>Ages 18 - 64</td>
<td>79</td>
<td>132</td>
<td>59.85%</td>
</tr>
<tr>
<td></td>
<td>Ages 65+</td>
<td>149</td>
<td>382</td>
<td>39.01%</td>
</tr>
</tbody>
</table>
Data quality: Continuous learning

Figure 5. Inpatient, ER and PAM Data - Members with More than One PAM Score

- Utilization PMPQ
- Average PAM Score

Graph shows trends from 2012 Q3 to 2015 Q4 for Inpatient, ER, and PAM with different lines representing each category.
Data Quality: Clear Value Proposition

<table>
<thead>
<tr>
<th>Averted events by current treatment</th>
<th>356 (August 353)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Averted events over 50% guideline threshold (356 – 0.5 x 537):</td>
<td>87.4 (August: 85)</td>
</tr>
<tr>
<td>Quarterly Incentive payment (Averted over threshold x $1000)</td>
<td>$87,418</td>
</tr>
</tbody>
</table>

Averted events and contribution by provider:
Each provider contributed some amount to the total calculated as his averted events minus his threshold (50% of guideline for is population). The bar graph and table below show each provider’s threshold, averted events above threshold and their percent of the total events above threshold.
Data quality: creating a virtuous cycle
Data Quality: Steering Process

Do we understand the measure?

Is it the Technology?

Is it the Data?

Is it our process?
Interoperability from the ground up

- **Value sets & specs:** Development of community and statewide data specifications that reflect the elements required to support defined value sets

- **Use & re-use:** Can be repurposed for a wide variety of measurement, analytic and clinical use cases

- **Policy & scale:** This is the essence of the ONC's Common Clinical Data Set concept
Is it Time to Re-Focus on the Practice? Strategies and Support for Reliable Quality Measurement

- Craig Jones - ONC Resource Center
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802 881 1710

- Hans Kastensmith – Capitol Health Associates
hck@capitolhealthdc.com
703 622 6896

- Patrick Gordon - Rocky Mountain Health Plans
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720 515 4129
Follow-Up Listening Event Information

Date: Wednesday, September 28

Time: 4-5 pm EDT

Link: [https://global.gotomeeting.com/join/691653741](https://global.gotomeeting.com/join/691653741)

You can also dial in using your phone.

United States (Toll-free) 1 877 309 2070
United States +1 (312) 757-3119

Access Code: 691-653-741