Draft Progress Report:

eCQM Design Group

March 16, 2017
For Review by the Health IT Advisory Council

I. Background

The State Innovation Model (SIM) Operational Plan for Connecticut proposes to address the challenges of the current system of fragmented performance measurement by developing a recommended core quality measure set, and work with all payers in Connecticut to voluntarily align around the recommended measures in their value-based payment contracts. Connecticut views such a measure set as a key enabler of the shift to more comprehensive, person-centered, and accountable care and a means to drive continuous quality improvement. This effort is intended to support continuous quality improvement and reduce provider and payer burden, cost, and inefficiency that results from excessive or misaligned measures.

The SIM Operational Plan also provides a vision for boosting aggregation of data across payers and providers through the development of a multi-payer shared utility solution for the extraction, integration, and reporting of eCQMs.

During the February 16th meeting, the Health IT Advisory Council voted to convene an eCQM Design Group that would explore and make recommendations to the Council on the objectives and functional requirements of a shared solution.

II. The Design Group Charter

The eCQM Design Group (DG) was chartered by the Connecticut Health IT Advisory Council to identify and recommend the objectives and the functional requirements of a shared, statewide health IT-enabled electronic quality measurement solution in the context of Alternative Payment Models (APMs). The kick-off meeting afforded the opportunity for all participants to introduce themselves, the stakeholder group(s) they represent, and their interest in supporting a statewide shared solution for quality measurement development and reporting. The meeting also afforded the opportunity for a robust discussion on the need to include measures that are based on data from multiple other sources, which led to amending the purpose statement before approval of the charter.

The restated purpose of the Design Group is now *"to identify the objectives and requirements of an efficient, shared, statewide health IT-enabled electronic clinical quality measure solution that can extract, aggregate, and analyze relevant data from existing clinical sources (e.g. EHRs and registries) in the context of APMs. The design group may consider future requirements related to the integration of*

data from other electronic sources such as claims, patient-generated data, and state-sponsored databases."

III. Value Propositions

Recognizing the first step in development of DG recommendations was to develop value propositions for a defined cohort of stakeholders based on high priority uses, the February 28 meeting identified stakeholders that would find value in a statewide solution. The group recognized that value would not be distributed equitably among all stakeholders; value would accrue earlier to some than others; and that optimal value was dependent on the solution's ability to incorporate data from multiple sources, including claims, patient-generated health data, data on social determinants of health, and data from state sources (e.g. public health registries, the justice system, and social support programs). The discussion also included high level categories of how the output measures from a shared solution could be used by each stakeholder.

Further discussion during the March 6 meeting emphasized the added value of a statewide solution to the clinical quality measurement processes and programs that are already embedded through the state in both the provider and payer sectors. This added value to all stakeholders can be derived from:

- Person-centric measures that reflect the clinical care that has been received from all providers, included those who are outside of the network of providers in a specific APM
- Trusted data and information from a third party with state-of-the-art security infrastructure; a quality assurance program; a data governance system that focuses on data integrity, reliability, timeliness; and an overall governance system that is inclusive of stakeholder needs and priorities
- Decreased administrative burden for providers by enabling a solution that allows for data senders to submit once to a single entity, and allows users of the data and measures to be more efficient by eliminating the need to collate and recalculate data and measures from multiple sources

The DG further characterized a number of activities could be better supported by a core solution as well as how and to whom these advantages could accrue. The following Table groups these high-level users of a solution, organized by key value propositions:

Value in support of Patient Care
• Comprehensive data and measures support quality improvement activities by identifying opportunities
• Comprehensive data and measures improve care coordination activities by identifying gaps in care

• Comprehensive data measures support integration of care between BH and other parts of delivery system by evaluating patient use of services
Value in support of Value-Based Care and Payment Strategies
• Comprehensive data and measures can support payers in adjudicating payments and weighting quality components in various contract
• Comprehensive data and measures support providers by maximizing incentive payments through more accurate health risk assessments; identified care out of contracted system
Value in support of Public Health
• Comprehensive data and measures to support more transparency of healthcare costs to payers and consumers and quality performance
• Comprehensive data and measures to inform community needs assessments and resource planning by evaluation of various subpopulations
• Comprehensive data and measures to assess equity in health care across the delivery system and diverse populations
Value to multiple stakeholders to support diverse needs
• Increased efficiency and decreased administrative burden by streamlining reporting of quality measures to a central source
• Support for research and program evaluation by enhancing ability to identify cohorts and outcomes.

IV. Realizing Value: Use Case Development

'Use case' is a term often used in the field of Health IT to describe activities in support of organizational goals that require data sharing Health IT functionality. Use cases can have a policy or technical focus. Policy-focused use cases support strategic planning, prioritization of resources, and similar high level decisions that affect overall operations and may be implemented differently by different stakeholders.

The value propositions listed in the Table identify a number of policy-focused use cases and can be used to further explore related processes and their applicability to specific stakeholders.

Technical use cases identify and define the technical requirements for implementation of exchange modalities, either internal to an organization or between one entity and others, and are highly specific with respect to every step of a process: who is engaged, what specific data are required, when, and under what circumstances. Technical use cases are out of the scope of this Design Group.

V. Next Steps

The DG work to date has set the stage for outlining and validating the functional requirements of a statewide quality measurement solution. In its remaining sessions, the DG will further develop and prioritize use case categories and discuss current sources of quality data as well as data and measurement flows by users. Recommendations on the functional requirements of a statewide solution and priority use cases will be presented to the Health IT Advisory Council at its April 20 meeting.