AQA Measures and Improvement Workgroup Conference Call Notes
June 18, 2013

Participants
Bruce Bagley, TransforMed (American Academy of Family Physicians), Co-Chair
Andy Amster, Kaiser Permanente
Joel Brill, American Gastroenterological Association
Kirstin Dawson, America’s Health Insurance Plans
Tom James, AmeriHealth Caritas
Norman Kahn, Council of Medical Specialty Societies
Sarah Mahmood, American College of Physicians
Sharon McGill, American Osteopathic Association
Scott McKenzie, Johnson and Johnson
Amy Miller, American College of Rheumatology
Jason Murray, American Academy of Orthopedic Surgeons
Peter Robertson, American Academy of Ophthalmology
Heather Smith, American Physical Therapy Association
Colleen Tallant, American College of Radiology
Cynthia Wark, Healthcare Information Consulting, LLC
Nancy Wilson, Agency for Healthcare Research and Quality

Invited Guest Speakers
Ernest Moy, MD, MPH, Medical Officer, The Center for Quality Improvement And Patient Safety, AHRQ
Samuel Walters, MD, Director of Quality Measurement and Informatics, The American Gastroenterological Association (AGA)
Heather Smith PT, MPH, Associate Director of Quality Initiatives, The American Physical Therapy Association (APTA)

Introduction
Dr. Bruce Bagley, Co-Chair, welcomed workgroup members to the conference call and reviewed the agenda:

- Review/Approval of April 24 20, 2013 Call Notes
- Review of findings from the latest AHRQ National Healthcare Quality Report
- Innovations Profiles – two example profiles from AGA and APTA

Review/Approval of Previous Call Minutes
The April 24, 2013 call notes were approved as written with no corrections or additions.

AHRQ report
Dr. Bruce Bagley welcomed Dr. Ernest Moy to the meeting from the Agency for Healthcare Research and Quality. Dr. Moy has been closely involved with the content and production of the National Healthcare Quality and Disparities reports for the last ten years.
Dr. Moy began by discussing the history of the reports. They are produced on an annual basis and provided to Congress from the Secretary of Health and Human Services since 2003. The reports are developed as companion reports, one covering quality and one focused on disparities. The quality report provides a snapshot and trends in quality of health care in America, focusing on effectiveness, safety, timeliness, patient centeredness, care coordination, efficiency, health system infrastructure, and access. The report looks at variation across states. The disparities report provides a snapshot and trends in disparities in health care, focusing on differences across race, ethnicity, and socioeconomic status. The report looks at variation in populations.

The reports track 250 measures from approximately 40 databases. The philosophy behind the reports is to provide as broad a picture of quality as possible encompassing as many settings as possible including physician offices, hospitals, nursing homes, home health etc. The intent is to provide a wide variety of quality measures and to look at the magnitude of change over time. Below is a list of data sources used to produce metrics:

- **Survey data collected from populations**
  - AHRQ, Medical Expenditure Panel Survey (MEPS)
  - CDC-NCHS, National Health Interview Survey (NHIS)
  - CMS, Medicare Current Beneficiary Survey (MCBS)
  - SAMHSA, National Survey of Drug Use and Health (NSDUH)

- **Data collected from samples of health care facilities**
  - American Cancer Society-American College of Surgeons, National Cancer Data Base
  - CDC-NCHS, National Ambulatory Medical Care Survey (NAMCS)
  - CMS, End-Stage Renal Disease Clinical Performance Measurement Program

- **Data extracted from data systems of health care organizations**
  - AHRQ, Healthcare Cost and Utilization Project State Inpatient Databases (HCUP SID)
  - CMS, Quality Improvement Organization (QIO) program.
  - Indian Health Service, National Patient Information Reporting System (NPIRS)
  - NIH, United States Renal Data System (USRDS)

- **Data from surveillance and vital statistics systems**
  - CDC-National Center for HIV, STD, and TB Prevention, HIV/AIDS Surveillance System
  - CDC-NCHS, National Vital Statistics System (NVSS)
  - NIH-National Cancer Institute, Surveillance, Epidemiology, and End Results program

AHRQ takes a bundle of measure for the total US population and looks at what is improving, changing, or worsening. Things change slowly over time. Quality is improving slowly for everyone over time but disparities are not changing substantially over time. There is less improvement in prevention and chronic disease management. Disparities related to diabetes & cancer screening worsening. See slides for specific measures where quality is improving and measures where quality is worsening.
Benchmarks are used to set achievable rates of care. The benchmarks are the same for quality and disparities and reflect the top 10% of states (30+ states with reliable estimates, exclude territories). Dr. Moy provided an example of colorectal cancer screening where quality and disparities are both improved.

Quality of healthcare varies across states. There are drill-down tools for states to look within their own geographic region. Income related disparities vary across states.

In conclusion, the National Healthcare Reports tell us where we are, where we are going, and where things are the worst. Quality of care is improving slowly for everyone but lagging for preventive services and chronic disease management. States differ in quality & disparities and the two are often independent.

Dr. Bagley opened the call for comments and questions. He asked what year of data is used in the reports. Dr. Moy clarified that there is approximately a lag of three years in most databases.

Dr. Bagley followed with a question about components of the lag. Dr. Moy explained that there are many reasons for the lag. For example, the 2009 data has to finish being collected and then be transmitted. Data has to flow from the states to AHRQ, therefore the slowest state will determine how long it takes to get all data.

Dr. Bagley asked how the reports are being used. Dr. Moy explained that two key audiences are policy makers and advocacy organizations. States use reports to look at their state compared to others and advocacy groups use the reports to assess needed improvements for specific populations.

Dr. Bagley asked how stable the measures are that are used in the reports. Dr. May explained that they add measures and sometimes retire measures that are topped out. Approximately 95% of the measures are stable over time.

Dr. Bagley thanked Dr. Moy for presenting the information about the AHRQ reports to the workgroup.

Innovations Profiles
Dr. Bagley gave a brief summary of the innovation profiles project and invited guest speakers from AGA and APTA to summarize information in their two example profiles.

Dr. Joel Brill provided an overview of the Digestive Health Outcomes Registry (see below for more detail).

Heather Smith provided an overview of the American Physical Therapy Association’s (APTA) clinician web portal, PTNow (see below for more detail).

Cynthia Wark explained that the two example profiles were produced through a pilot test of the questionnaire used to collect information. Next steps are to expand collection of information to
other AQA organizations. Dr. Bagley asked members to let staff know if they would like to volunteer to participate in development of the next round of profiles.

The call ended at 4:00 pm.
Example Profile: BEST PRACTICES IN QUALITY MEASUREMENT AND IMPROVEMENT

INNOVATIONS PROFILE: THE AMERICAN GASTROENTEROLOGICAL ASSOCIATION

INNOVATIVE ACTIVITY:

The American Gastroenterological Association’s (AGA) Digestive Health Outcomes Registry

PROMOTING IMPROVED OUTCOMES:

The purpose of the registry is focused on colorectal cancer prevention.

LENGTH OF PROGRAM:

The AGA launched the Digestive Health Outcomes Registry in 2010.

TARGET AUDIENCE:

The Digestive Health Outcomes Registry targets gastroenterologists who perform endoscopies.

MAGNITUDE OF PARTICIPATION:

The registry includes data on over 100,000 colonoscopies from 578 clinicians in only three short years.

CORE ELEMENTS:

The three core elements are:

- Integrated naturally within practice environment, enabling focus on improving practice rather than meeting reporting requirements.
- Development of real time data reporting infrastructure.
- Incorporated by payers in reimbursement strategies to reward improving care.

MEASURES:

The Registry is based on six quality and utilization measures:

1. Use of a standardized instrument to identify colorectal cancer risk with documentation of established guidelines (family risk, age, race, etc.)
2. Internal documentation of endoscopic exam (assign appropriate exam interval, post procedure, etc.)
3. Rate of utilization (use of anesthesia professionals, use of certified nurse anesthetists based on American Society of Anesthesiologists’ classification system)
4. Rate of procedure-related complications (bleeding, in-patient hospitalization, etc.)
5. Procedural adequacy (sufficient preparation)
6. Adenoma detection rate (25-30%)

The measures are not endorsed by the National Quality Forum. The colorectal cancer measures are not part of the Physician Quality Reporting System (PQRS). However, AGA has an add-on module that allows participants to report a patient sample using the hepatitis C PQRS measures.

REPORTING ELEMENT:

The registry requires use of electronic health records or endoscopic reporting systems for collection and transmission of data. The registry uses a hands-off feed and data is submitted nightly or weekly. Reports are run on-demand for each provider.

The Registry does not currently report publicly, but does publish a list of participating practices and physicians.

PROGRAM RESULTS:

The American Gastroenterological Association has not conducted conclusive studies but believes that physicians participating in the Registry have improved care. One of the successes of the program is establishing an infrastructure that can be used for improvement.

STAFFING REQUIREMENTS:

Providers contribute a small fee to participate ($200/year) in the Registry. The AGA has invested funds to partner with a data analytics firm and build the infrastructure (approximately $2 million over three years). AGA started with one FTE to develop the Registry and now has several staff who contribute to supporting the operation.

THE FUTURE:

The AGA has already made improvements to the Registry by streamlining data collection and eliminating all non-essential quality improvement elements. As new gastroenterological measures are endorsed (by NQF) the AGA will align the measures accordingly. In addition, AGA is working with other organizations to expand into other areas. For example, the AGA has worked with the Infectious Diseases Society of America to enhance their Hepatitis C quality and practice programs, and has additionally worked with members of other allied associations, including the American Association for the Study of Liver Disease, and the Crohn’s and Colitis Foundation of America.
INNOVATIVE ACTIVITY:

The American Physical Therapy Association’s (APTA) clinician web portal, PTNow, is a collaborative effort designed to become the physical therapist’s “multi-tool”: a translation tool for translating research to knowledge for practice; an implementation tool for implementing evidence in the evaluation and treatment of patients; a collaboration tool for sharing information and strategizing when evidence is lacking; and a search tool for seeking out relevant, vetted sites across the Web and organizing results based on the source of information.

PROMOTING IMPROVED OUTCOMES:

The purpose of PTNow is to help physical therapists improve patient outcomes, reduce unwarranted variation in practice, and demonstrate the value of physical therapist services to the health care system.

LENGTH OF PROGRAM:

PTNow has been in existence since a testing phase in 2011 and went live in January 2013. PTNow is updated on an ongoing basis. To date, a total of 260 clinical practice guidelines have been uploaded to PTNow’s Evidence Based Practice Library; about 95% of these are linked to full text. PTNow clinical summaries cite appropriate test and measures (5-30 per summary) - about 25% of cited measures currently are linked to test summary pages, and about half will be linked to test summary pages by fall 2013.

In response to new reporting requirements for therapy patients billed under Medicare Part B, PTNow is working to integrate functional assessment tools in 2013 that will be searchable at the ICF category level by practice area, diagnosis, and/or functional limitation reporting category.

TARGET AUDIENCE:

PTNow is targeted to all American Physical Therapy Association members in various practice settings. Additionally, PTNow is planning to consider subscription service that is not tied to APTA membership in the future.
MAGNITUDE OF PARTICIPATION:
In 2012, the PTNow beta (test) site had 13,929 unique visits and an overall total of 20,398 visits for the year. The American Physical Therapy Association is anticipating increased traffic this year due to the new Medicare reporting requirements and greater promotion of the site.

CORE ELEMENTS:
Collaboration is a core element of success of the program. The APTA currently has 18 special interest sections that are focused on specific practice areas such as orthopedics or neurology. In order for the project to be successful, each section must share relevant clinical practice guidelines and other information applicable to the general membership with PTNow.

MEASURES:
PTNow is currently participating in a study that looks at the usability of the information on the site. Additionally, there are plans to survey clinicians regarding their behaviors pre- and post-exposure to the PTNow site, as the main goal of the project is to alter clinician behavior. Members currently do not submit functional status information to APTA, however, they are in the process of developing a registry to serve this purpose. Additionally, CMS is collecting functional outcomes data on beneficiaries (new requirement in 2013) who receive therapy services under Medicare part B.

REPORTING ELEMENT:
PTNow does not contain a reporting element at this time. The American Physical Therapy Association, however, is in the process of developing a registry and is considering incorporating practice guidelines and identified functional tools into the registry in the future.

PROGRAM RESULTS:
PTNow will be conducting two types of surveys to determine the usability and impact of the content.

STAFFING REQUIREMENTS:
PTNow is currently free to members and in the future may offer subscription service to others. APTA currently has 3.6 staff dedicated to the ongoing development of the project. PTNow also has an Editorial board of 10 members and is growing. Additionally, there are hundreds of reviewers, authors, and other contributors working on the project.

THE FUTURE:
PTNow is planning to continue to expand through the addition of content in all practice areas. There is a possibility that clinical practice guidelines, tests, and measures may be linked to a future American Physical Therapy Association registry.