When Does It Make Sense to Outsource Quality Measure Reporting?

January 23, 2014 by David Raths

Beth Israel Deaconess Care Organization CIO turns to Massachusetts eHealth Collaborative’s Quality Data Center

Physician networks face an alphabet soup of acronyms in the array of quality measure reporting programs they participate in: MU, PQRS and ACO, just to name a few. Even organizations that are relatively sophisticated in terms of technology deployment may still lack the capacity to handle their clinical quality measure reporting needs internally.

About two years ago, Bill Gillis, the chief information officer for Beth Israel Deaconess Care Organization (BIDCO), made the decision to outsource the quality reporting data center function to the Massachusetts eHealth Collaborative (MAeHC), and he’s glad he did.

BIDCO, an independent physician network and accountable care organization, has approximately 1,700 participating providers. The network is affiliated with the Beth Israel Deaconess Medical Center (BIDMC) in Boston. For the most part, physicians on the BIDMC campus use the homegrown WebOMR as their EHR. About a third of community-based physicians use eClinicalWorks, and another third use a variety of other ambulatory EHRs.

I recently had the opportunity to talk to Gillis about why he chose to turn to MAeHC’s Quality Data Center (QDC) for meaningful use and ACO quality measure reporting. The QDC is certified to support both Stage 1 and Stage 2 meaningful use measures. More than 2,500 providers are currently contributing data to the QDC, covering more than 600,000 patients, according to MAeHC.

The biggest concern for BIDCO is that it has a variety of health IT systems, Gillis says. “How do we combine the data from those in a structured way?” he asked, noting that BIDCO is resource-constrained in terms of the staff with the skill set to build something internally. “It made sense to us to go to someone with the expertise and who already understands how this works.” It takes a combination of both IT and clinical expertise, he adds. A software engineer might develop a way to pull a numerator and denominator out of the system in a literal reading of the measure, but a clinician would not interpret it in the same way.

BIDMC is an academic medical center and would be able to develop something, but Gillis says he was concerned that it would be “medical center-centric” — that is, it would work well in that setting but two-thirds of BIDCO’s constituency is made up of community physicians and it might not work as well for them. The decision to outsource was made easier by the comfort level BIDCO had developed in working with MAeHC on EHR deployment over the past few years.
Starting in 2012 MAeHC’s QDC helped BIDCO with meaningful use Stage 1 reporting and followed up with ACO reporting using the CMS GPRO (Group Practice Reporting Option) tool. Now BIDCO is working on getting the data from the myriad EHRs into the QDC as it gets ready for Stage 2 of MU.

Gillis says one challenge is to make sure the quality of the data is uniformly good. “We can build the plumbing to the Quality Data Center, but if the water we put in isn’t any good, we have a problem,” he says. “We have just done a study to qualify the data, to ensure that the way the physicians enter the data is the way it appears in the Quality Data Center and we are finding some interesting gaps.” One problem is that the “envelope” the EHR vendors use to deliver the Continuity of Care Document (CCD) could restrict how much data appears in the data center. With one vendor, BIDCO is looking at doing direct query extractions to get more data into the QDC. “When we do the digging, we see that important pieces of data are not coming through,” he says. “This may be a problem with more than one vendor system as we begin to connect them to the QDC.”

Gillis says outsourcing offers BIDCO the flexibility to make changes fairly quickly. “When we first started on ACO measures, we initially ran into errors because the CMS specifications were complicated. MAeHC staff was helpful in making adjustments,” he says. “In a larger enterprise, trying to do that internally could be challenging for an IT organization that is already working at capacity. They tend not to have the ability to respond as quickly as we would need for something like this. In working with MAeHC, I always feel that they know a lot more about this than I do.”

For other provider organizations considering outsourcing, Gillis says he would recommend looking for a company with a track record in healthcare quality measure reporting, not just big data. “Or if not, go into it with your eyes open that you are learning together,” he says. “Of course, we are still figuring things out. There are new measures all the time and we have to work together to figure out how to report on them.”