The Future is Now

*Why strategic thinking requires a move away from consent and towards an accountability posture*

Kimberly Gray, J.D., CIPP/US
Global Chief Privacy Officer - IQVIA
Discussion points

+ HIPAA’s treatment-payment-healthcare operations (TPO) and public policy purposes
  • express authorization being reserved for specific circumstances

+ GDPR’s concept of legal bases for processing (e.g., legitimate interest, legal requirement, etc.) as preferred basis
  • consent only in limited situations (sensitive personal information)

+ Accountability as a core privacy principle for corporations and other organizations
  • safeguarding information and shifting burden away from consumer
HIPAA’s creators were forward thinking

Robust privacy protections while enhancing data sharing for the public good

- Improved outcomes through enhanced use of healthcare data
- Consent is presumed for delineated uses and disclosures of personal information consistent with consumer expectations
- Allows for the “normal” operations of the health care industry
- These activities are encouraged for the benefit of all healthcare stakeholders and effective operations of the health care system
- Disclosures for certain “public policy purposes” that benefit all
- Other uses and disclosures are permitted only with explicit patient permission
HIPAA as a model – consent is presumed for normal expectations

TPO, public interest and other purposes

- Permitted Uses and Disclosures (without an individual's authorization)
  - To the Individual
  - Treatment, Payment, and Health Care Operations
  - Opportunity to Agree or Object
  - Incident to an otherwise permitted use and disclosure
  - Public Interest and Benefit Activities
  - Limited Data Set for the purposes of research, public health or health care operations

- Professional ethics may enter into decision making when considering permitted uses and disclosures
EU GDPR – reconciling privacy and innovation

Legal Bases for processing (other than consent)

- Legal basis for processing data (e.g., legitimate interest, legal requirement, protect vital interests, performance of contract, public interest)

- Balancing test—legitimate interest
  - Consumer would reasonably expect processing
  - Not likely to negatively impact rights
  - Not likely to result in unwarranted harm or distress
  - Processing in interest of individual
  - Notice provided

- Consent (sensitive personal information): freely given, clear, affirmative, ambiguous, verifiable audit trail
Accountability as a model to replace most consent

Consent limited to specific situations

- Accountability is NOT self-regulation but is a layer on top of legal requirements
- Responsible data stewardship and ethical processing
- Removes burden from individuals (data subjects, consumers) and places it on organizations to protect privacy
- Consent used only where truly meaningful (e.g., context of sharing sensitive data for purpose unrelated original collection)
- Accountability core elements:
  - leadership and oversight;
  - risk assessment;
  - policies and procedures;
  - transparency;
  - training and awareness;
  - monitoring and verification; and
  - response and enforcement.
APPENDIX
**HIPAA - Treatment/Payment/Healthcare Operations (TPO)**

- Treatment is the provision, coordination, or management of health care and related services for an individual by one or more health care providers, including consultation between providers regarding a patient and referral of a patient by one provider to another.

- Payment encompasses activities of a health plan to obtain premiums, determine or fulfill responsibilities for coverage and provision of benefits, and furnish or obtain reimbursement for health care delivered to an individual and activities of a health care provider to obtain payment or be reimbursed for the provision of health care to an individual.

- Health care operations are any of the following activities: (a) quality assessment and improvement activities, including case management and care coordination; (b) competency assurance activities, including provider or health plan performance evaluation, credentialing, and accreditation; (c) conducting or arranging for medical reviews, audits, or legal services, including fraud and abuse detection and compliance programs; (d) specified insurance functions, such as underwriting, risk rating, and reinsuring risk; (e) business planning, development, management, and administration; and (f) business management and general administrative activities of the entity, including but not limited to: de-identifying protected health information, creating a limited data set, and certain fundraising for the benefit of the covered entity.
HIPAA Public Interest

• Public Interest and Benefit Activities. The Privacy Rule permits use and disclosure of protected health information, without an individual’s authorization or permission, for 12 national priority purposes. These disclosures are permitted, although not required, by the Rule in recognition of the important uses made of health information outside of the health care context. Specific conditions or limitations apply to each public interest purpose, striking the balance between the individual privacy interest and the public interest need for this information.

- Required by law
- Public health activities
- Victims of abuse, neglect or domestic violence
- Health oversight activities
- Judicial and administrative proceedings
- Law enforcement purposes
- Decedents
- Cadaveric organ, eye or tissue donation
- Research (conditional)
- Serious threat to health or safety
- Essential government functions
- Workers compensation

**HIPAA – other permissive uses without authorization**

- **Uses and Disclosures with Opportunity to Agree or Object.** Informal permission may be obtained by asking the individual outright, or by circumstances that clearly give the individual the opportunity to agree, acquiesce, or object. Where the individual is incapacitated, in an emergency situation, or not available, covered entities generally may make such uses and disclosures, if in the exercise of their professional judgment, the use or disclosure is determined to be in the best interests of the individual.

- **Incidental Use and Disclosure.** The Privacy Rule does not require that every risk of an incidental use or disclosure of protected health information be eliminated. A use or disclosure of this information that occurs as a result of, or as “incident to,” an otherwise permitted use or disclosure is permitted as long as the covered entity has adopted reasonable safeguards as required by the Privacy Rule, and the information being shared was limited to the “minimum necessary,” as required by the Privacy Rule.

- **A limited data set is protected health information from which certain specified direct identifiers of individuals and their relatives, household members, and employers have been removed.** A limited data set may be used and disclosed for research, health care operations, and public health purposes, provided the recipient enters into a data use agreement promising specified safeguards for the protected health information within the limited data set.

- **To the Individual.** A covered entity may disclose protected health information to the individual who is the subject of the information.

Keys to Using Data to Drive Performance

David Levine, MD, FACEP
Group SVP, Advanced Analytics & Product Management
# Clinical Data Base: Unique Features

<table>
<thead>
<tr>
<th>Clinical Data Base</th>
<th>Custom comparators</th>
<th>Transparency</th>
<th>Drill-down capability</th>
<th>Networking and collaboration</th>
<th>Expert analytics and support</th>
</tr>
</thead>
<tbody>
<tr>
<td>All but one <em>U.S. News &amp; World Report</em> Honor Roll hospitals</td>
<td>View performance by hospital name</td>
<td>More than 80,000 drill-down reports written per month</td>
<td>Connect easily with other hospitals</td>
<td>Analytic, advisory and insight support included</td>
<td></td>
</tr>
<tr>
<td>97% of all academic medical centers</td>
<td>Select fully customizable comparison</td>
<td>Ability to download enriched and benchmarked data sets</td>
<td>Leverage power of member networks to facilitate performance improvement</td>
<td>Insight into comparative performance with Quality and Accountability ranking</td>
<td></td>
</tr>
<tr>
<td>More than 275 community hospitals</td>
<td>View logic behind proprietary methodologies to understand performance</td>
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<td></td>
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</tbody>
</table>

| Competitive databases | | | | | |
|-----------------------|--------------|------------------------|---------------------------|-----------------------------|
| Very few academic medical centers | Benchmark via aggregate groups without names | Fewer drill-down options | Connect either through agreements or at additional cost | Analytic, advisory and insight support for an additional cost |
Hospitals in the Data Base

More than...

<table>
<thead>
<tr>
<th>50+ health care systems</th>
<th>97% academic medical centers</th>
<th>400+ community hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Mayo Clinic Health System</td>
<td>• Stanford School of Medicine</td>
<td>• Duke Regional Hospital</td>
</tr>
<tr>
<td>• BJC HealthCare</td>
<td>• NYU Langone Medical Center</td>
<td>• South Pointe Hospital</td>
</tr>
<tr>
<td>• Partners Healthcare</td>
<td>• University of Arkansas for Medical Sciences</td>
<td>• Houston Methodist Sugar Land Hospital</td>
</tr>
<tr>
<td>• Beaumont Health</td>
<td>• Medical College of Wisconsin</td>
<td>• Sanford Worthington Medical Center</td>
</tr>
<tr>
<td>• Intermountain Healthcare</td>
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Develop Custom Comparators With Ease
Vizient as a Leading Indicator & Quality & Accountability
Vizient Quality & Accountability

### 2019 Comprehensive Academic Medical Center Quality and Accountability
Great State Medical Center Performance Scorecard

<table>
<thead>
<tr>
<th>Star rating</th>
<th>Overall rank</th>
<th>Overall score</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 stars</td>
<td>38</td>
<td>52.91%</td>
</tr>
</tbody>
</table>

#### Domain performance

- **Mortality**: 11.51% of 26.3%
- **Efficiency**: 4.66% of 10.5%
- **Patient centeredness**: 9.76% of 15.8%
- **Safety**: 14.70% of 26.3%
- **Effectiveness**: 12.08% of 21.1%

#### Top performers

<table>
<thead>
<tr>
<th>Institution</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>RUSH</td>
<td>76.66%</td>
</tr>
<tr>
<td>NYU</td>
<td>71.82%</td>
</tr>
<tr>
<td>MAYOCLINIC,MN</td>
<td>70.23%</td>
</tr>
<tr>
<td>UTAH</td>
<td>68.23%</td>
</tr>
<tr>
<td>LIPHS-HEP</td>
<td>65.96%</td>
</tr>
<tr>
<td>UCSD</td>
<td>65.75%</td>
</tr>
<tr>
<td>HERMANN</td>
<td>65.75%</td>
</tr>
<tr>
<td>STANFORD</td>
<td>65.18%</td>
</tr>
<tr>
<td>UTMB-HEALTH</td>
<td>64.22%</td>
</tr>
<tr>
<td>METHODIST_HOUSTON</td>
<td>63.54%</td>
</tr>
</tbody>
</table>

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Over Time: A Lot Can Change

So, what has changed over this time?

- CMS transitioned from ICD-9 to ICD-10
- AHRQ PSI software has been upgraded 3 times
- ‘Selfie’ wasn’t a word
Timing, transparency and drill down are everything: a complication rate comparison across ratings.
## The Difference

<table>
<thead>
<tr>
<th>Vizient Q&amp;A Study</th>
<th>External Ranking Organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Designed to inform hospital staff and leaders about their institution</td>
<td>Designed to inform public or healthcare consumers</td>
</tr>
<tr>
<td>Offers transparent access to the data at the patient level with detailed risk model information down to the specific factors considered, significance level, and expected values for individual encounters</td>
<td>Offers only aggregate data without detailed explanation of how values were derived, often risk adjustment is done at an aggregate level or for very broad groups</td>
</tr>
<tr>
<td>Obtains complete data from hospital members covering all patients</td>
<td>Often only considers Medicare or CMS reported cases</td>
</tr>
<tr>
<td>Examines the most recent data available, with quarterly calculators showing trends over time</td>
<td>At least one, often several years behind current state</td>
</tr>
<tr>
<td>Able to link patient level outcomes data to procedures, drugs, and cost data</td>
<td>Does not consider patient level data or non-outcome related data</td>
</tr>
</tbody>
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Concerns with CMS Hospital Star Rating

- **Concerning statistical approach**
  - Weighting of component measures changes with each re-running of data-hospitals unable to use as improvement tool
  - Poorer outcomes can be REWARDED
  - Shifts of 2-3 stars for some hospitals every 6 months due to methodology
- **One size fits all for all hospitals**
  - All hospitals regardless of patient acuity and case mix considered the same
  - Specialty hospitals and smaller hospitals can be advantaged as many metrics can not be applied due to low volume
- **Does not correlate to penalties**
  - May be ranked high and still receive penalty in Pay for Performance
Work on Revising CMS Stars

• Announced it plans to change methodology in 2021
  • Specifics not announced
  • Will go through rule making with public comment
• Had extensive call for public input in 2019-48 pages
  • Over 800 comments
• Convened a Technical Advisory Panel (TEP) in fall 2019
• Listening session on September 19, 2019
• Released latest rankings in 2020 using old methodology
Best Practices: Improving or Maintaining Scores

• Track key drivers regularly - ideally monthly

• Share scores and regular progress broadly across institution
  • Unit level
  • Institution level

• Educate staff why these metrics and/or scores are important and what their role is
  • Example: Environmental service can impact Patient Satisfaction and Hospital Acquired Infections
Best Practices: Improving or Maintaining Scores (Continued)

- Celebrate success frequently but not for long
- Put a story to the metrics - there is a patient who had the central line infection not just a rate
- Learn from successful units and cascade
- Align incentives at as many levels as possible
- Encourage innovation
“Each year, we use Vizient data to identify our annual strategic quality goals. We then go find the highest performers through Vizient and go talk to them.”

Danny Sama, Northwestern Medicine
Vice President, Analytics and Chief Data Executive
University of Kentucky Case Study 2017-2019

Improvement on Vizient Ranking set as strategic goal. Improve from median of Academic Medical Centers to Rising Star (Improve ranking by at least 20 places and be in top quartile)

• Leadership: Improvement driven by the CEO and CQO
• Accountability: Used Vizient Clinical Data Base (CDB) results and benchmarks to populate much of the scorecards that cascade from the board down to service lines
• Goal-setting: set CDB / Quality and Accountability Ranking as single source of truth to drive improvement
• Realistic: thoughtful use of resources to focus on improving Q&A performance
• Data-driven: Analytic FTEs were deployed to drill down and understand the metrics
Ideal characteristics in ratings

- Timely data reflecting current care
- Inclusive of all patients regardless of payer
- Risk adjusted to control for patient acuity
- Comparisons with other hospitals that deliver same type of services
- Metrics that are easily understandable
- Ability for provider to improve care using the rankings
  - Drill down to patient or clinician level
- Stability in weighting
- Transparency in methodology
A decade of study: Understanding the unique characteristics of top performing organizations

2005: Characteristics of top performers

2010: Characteristics of rapid improvers

2012: Structures to support quality and safety

2013: Good governance

2014: Driving accountability and results

- Ambulatory care
- Community hospitals
- Impactful technology

2015: The role of the modern era CQO

2018: Vizient Presentation │ 2020 │ Confidential Information

2019: Sustainers Study
Questions?