



Health IT Policy Committee

A Public Advisory Body on Health Information Technology to the National Coordinator for Health IT

February 3, 2014

Karen DeSalvo, MD, MPH, MSc
National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. DeSalvo:

The Health IT (HIT) Policy Committee (HITPC) gave the following broad charge to the Quality Measures Working Group (QMWG):

Charge for the Quality Measures Working Group:

The QMWG is charged with developing recommendations for the next generation of e-measure constructs, including those that are patient and population centered, longitudinal, across settings of care where appropriate, and address efficiency of care delivery. The QMWG should focus on the domains, concepts, and infrastructure for these e-measure constructs.

Background and Previous Recommendations

The QMWG formed in 2010 to begin developing recommendations regarding a clinical quality measure (CQM) framework for meaningful use (MU) Stage 2. Clinical quality measures are critical in the evaluation of our delivery system and can assist providers and systems in the improvement of care. The growing adoption of electronic health record (EHR) systems and emerging capabilities for health information exchange will allow our health system to measure clinical performance in clinical areas previously considered infeasible.

The QMWG issued its first set of recommendations¹ for Stages 2 and 3 after the HITPC approved them on August 3, 2011. The recommendations include 1) a reporting framework that builds upon the Stage 1 core plus menu option for eligible providers; 2) a list of menu domains and measures to be developed, and 3) a list of methodological challenges/issues related to implementation of novel measures in the future.

QMWG Deliberations

The QMWG performed a review of current quality measures and measures under development, and identified domains and subdomains with gaps. Within these gaps, the QMWG discussed example measures, the sources of data for these example measures, and HIT infrastructure needs to implement these measures. The QMWG also discussed a measure “innovation pathway,” hybrid measures, data intermediaries, patient-reported outcomes, risk adjustment, and social determinants of health as related to quality measurement.

¹ http://www.healthit.gov/FACAS/sites/faca/files/HITPC_transmitLQMWG_8_5_2011.pdf

In addition to QMWG deliberations on its charge, an Accountable Care Clinical Quality Measure Subgroup (ACQM Subgroup) was formed with members from the QMWG and Accountable Care Working Group to discuss specific e-measure constructs, domains, and HIT infrastructure for accountable care organization settings.

The Vendor Tiger Team provided input from the perspective of the HIT vendor community on development and implementation of systems to support the quality measure domains and measures discussed by the QMWG.

Last, ONC issued a Request for Comment² (RFC) for MU Stage 3 in early 2013 which included a section on quality measures.

The stakeholder feedback on the Stage 3 RFC, ACQM Subgroup's recommendations, and Vendor Tiger Team's recommendations were taken into consideration and helped inform the QMWG's final recommendations.

Measurement Domain Framework

The QMWG developed a framework (Appendix I) that displays a desired move toward health care and public health community support measures that come together for a patient-centered value of health.

Using this framework, the QMWG discussed that in the current system, the majority of quality measures focus on intermediate health care outcomes, and the system needs to move toward inclusion of health outcomes. The domain framework (Appendix II) demonstrates the patient-centered value of health view with the intersection of social, behavioral, and clinical health services across patient subpopulations.

Recommendations approved by the HITPC on January 14, 2014

Key Measure Dependencies

The HITPC recommends a review of the key measure dependencies below to determine what progress has been made in these areas, whether additional dependencies should be added to this list, and what additional work needs to be done to further progress in these areas. The key measure dependencies include:

- Interoperable systems
 - Start with a subset of key data before working on making all data interoperable;
- Data sharing across providers;
- Tools for population health as well as for patient encounters;
- Measures built using multiple data sources (e.g., hybrid measures);
- Measures and data accessible by all providers;
- Consistently capturing variables required for stratification.

² http://www.healthit.gov/sites/default/files/hitpc_stage3_rfc_final.pdf

Measure Domain Recommendations

Domain #1: Safety

The HITPC recommends the development of measures that address falls prevention, health care associated infections, and EHR safety.

ACO sub-recommendation: Develop measures combining claims, EHR, and ADT (admission, discharge, transfer) data that focus on reducing medical errors.

Example measures: Avoidable hospital readmission rate, drug/drug interaction rates, falls rates.

HIT infrastructure needs: EHR decision support tools to prevent errors (e.g., drug-drug interactions), reports to proactively notify clinicians of high risk patients (e.g., re-admission risk, risk of falls, etc.), interoperable systems across settings of care, data across electronic and claims-based systems.

Domain #2: Population Health and Equity

The HITPC recommends development of measures that address population health and health equity.

ACO sub-recommendation: Develop measures combining EHR and patient-reported data that focus on improving the health of communities and populations.

Example measures: Prevention of pre-diabetic progressing to diabetes, mammograms, colorectal cancer screening, influenza vaccination, reduction of disparities.

HIT infrastructure needs: Access to race, ethnicity, and language data for stratification.

Domain #3: Effective Use of Resources

The HITPC recommends development of measures that address appropriateness of care and efficient use of facilities.

Data sources: claims, EHR, and pharmacy data.

Example measures: total cost of care (PMPM), duplicate tests, avoidable ED visits per 1000.

HIT infrastructure needs: Comprehensive and complete medical expense data for aligned accountable population, interoperable systems across settings of care, data across electronic and claims-based systems.

Domain #4: Patient and Family Engagement

The HITPC recommends development of measures that address patient health outcomes, experiences, and self-management/activation; honor patient preferences; and include shared-decision making.

ACO sub-recommendation: Develop measures combining EHR and patient-reported data that focus on 1) improving the quality of medical decision-making, 2) improving patient involvement in his/her health care, and 3) improving health care provider awareness of the importance of shared decision-making.

Example measures: Included in/collaborated decision making, patients with personal goals aligned with clinical goals for care, patients with longitudinal care plan, patient experience.

HIT infrastructure needs: Electronic shared care plan, patient portals, mobile devices, and other ways of capturing patient-generated health data.

Domain #5: Functional Status and Well-Being

The HITPC recommends development of measures that address post-procedure functional status and recovery times.

ACO sub-recommendation: Develop measures combining EHR and patient-reported data that focus on optimizing wellness and functional status of patients and communities.

Example measures: Healthy days, PROMIS 10.

HIT infrastructure needs: Patient portals, mobile devices, and other ways of capturing patient-generated health data.

Domain #6: Care Coordination

The HITPC recommends development of measures that improve longitudinal care coordination and care transitions after acute hospital discharge.

Data sources: EHR, claims, ADT.

Example measures: % patients with contact with outpatient services within 7 days of discharge, % patients with medication reconciliation within 7 days of discharge, effective partnering with community resources, degree to which care plan is shared across providers.

HIT infrastructure needs: Case management registry for all discharged patients including discharge diagnosis and disposition.

Measure Criteria Recommendations

The HITPC recommends that measures are developed using the following set of evaluation criteria:

1. Preference for eQMs or measures that leverage data from HIT systems (e.g., clinical decision support)
 - Includes “HIT sensitivity” – EHR systems that help improve quality of care (e.g., CDS, CPOE for accuracy and content of order, structured referral documentation).
2. Enables patient-focused and patient-centered view of longitudinal care
 - Across eligible providers (EPs) or eligible hospitals (EHs)
 - Across groups of providers
 - With non-eligible providers (e.g., behavioral health)
 - Broadest possible experience of the patient/population is reflected in measurement (e.g., require interoperable systems) – longitudinal view, continuum of care.
3. Supports health risk status assessment and outcomes
 - Supports assessment of patient health risks that can be used for risk adjusting other measures and assessing change in outcomes to drive improvement.
4. Preference for reporting once across programs that aggregate data reporting
 - e.g., PCMH, MSSP, HRRP, CAHPS.

5. Measurement is beneficial and meaningful to multiple stakeholders
 - Benefits of measuring & improving population health outweighs the burden of organizational data collection and implementation
 - Ensure measures are usable and meaningful for consumers and purchasers as well as providers.
6. Promotes shared responsibility
 - Measure as designed requires collaboration and/or interoperability across settings and providers
 - Interoperability – systems need to be able to communicate to receive longitudinal care.
7. Promotes efficiency
 - Reduces high cost and overuse, and promotes proper utilization
8. Measures can be used for population health reporting
 - Use existing measures or build measures where the denominator can be adjusted for population health reporting
 - Group reporting options in all reporting programs (e.g., in CMS reporting programs).

Innovation Pathway Recommendations

ONC and CMS should consider an optional “innovation pathway” whereby MU participants would be able to waive one or more objectives by demonstrating that they are collecting data for innovative or locally-developed CQMs.

ONC and CMS should specify the gaps that an innovation pathway should help close, including identifying measure gaps for specialty providers. For example, these gaps can include the measure domains identified above, which are also appropriate for specialty providers.

Health care organizations choosing this optional track should be required to use a brief submission form that describes some of the evidence that supports their measure and how the measure was used in their organization to improve care. This will allow providers and organizations to disseminate information that others and CMS can consider for future quality measurement.

Two possible approaches for implementing an innovation pathway include:

- A conservative approach might allow “Certified Development Organizations” to develop, release and report proprietary CQMs for MU.
- An alternate approach might open the process to any EP/EH but constrain allowable eCQMs via measure design software (e.g., Measure Authoring Tool).

The Vendor Tiger Team commented that an innovation pathway would be costly to create, maintain, and build into systems. Validating data would also be costly. They recommended that this approach should not be required for certification.

Patient-Reported Outcomes Recommendations

ONC and CMS should include patient-reported outcomes (PROs) as MU objective measures. This supports the development flexible EHR technology to broadly incorporate PROs. It also allows for PROs for many more specialties and conditions than are currently covered. This objective measure could function like the clinical decision support objective from MU Stage 2 by allowing attestation rather than reporting of the use of PROs.

As discussed by other working groups (WGs) and the HITPC, there is a need to develop HIT infrastructure and guidance for supporting PROs and data generated by external providers.

The QM WG supports the recommendations on patient-generated health data (PGHD) from the Consumer Empowerment WG that the HITPC approved on December 4, 2013. The QM WG also supports the ongoing work of the Consumer Technology WG of the HIT Standards Committee on standards for PGHD. The QMWG endorses the extension of standards into additional domains that include the non-traditional determinants of health.

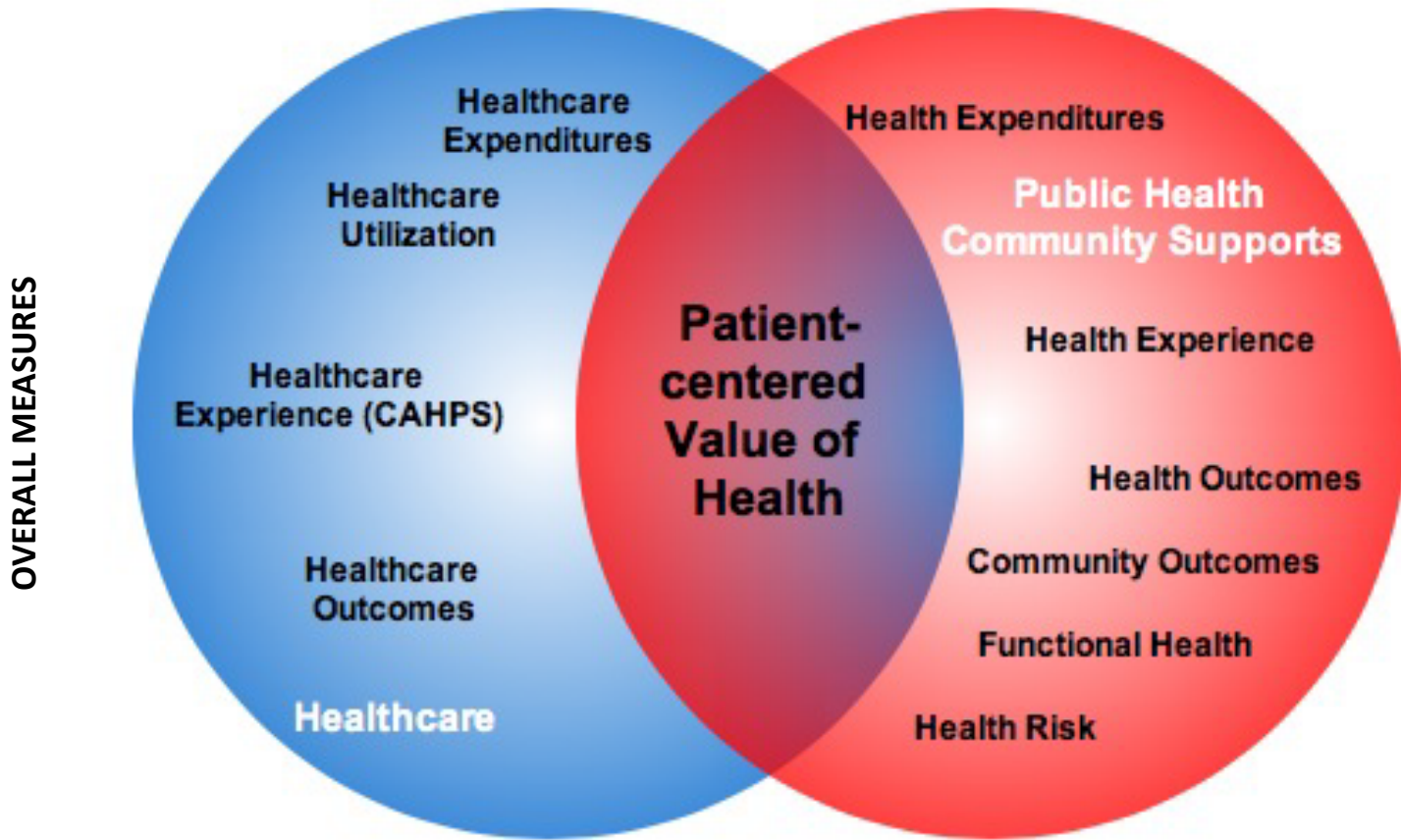
We appreciate the opportunity to provide these recommendations and look forward to discussing next steps.

Sincerely yours,

/s/

Paul Tang
Vice Chair, HIT Policy Committee

Appendix I: Measurement Framework



	Expenditures	Experience	Outcomes
Intermediate Outcomes	Healthcare Expenditures Public Health Expenditures Patient Expenditures Enabling Service Expenditures	Patient Activation Access to Care and Information Communication with Healthcare Shared Decision-making Access to Enabling Service	Functional Health Health Risk Disease/condition Site of Care

Appendix II: Domain Framework

Accountable Care Population (Total Patient Population)

