Consumer-Purchaser
DISCLOSURE PROJECT
Better information. Better decisions. Better health.

Submitted electronically

Office of the National Coordinator for Health Information Technology
HIT Policy Committee
Department of Health and Human Services
Patriots Plaza II, 355 E Street, SW
Washington, D.C. 20201

RE: Request for comments by the HIT Policy Committee regarding the Stage 3 definition of Meaningful Use of EHRs.

Dear HIT Policy Committee:

Through the Affordable Care Act (ACA), CMS is implementing new and better ways to improve health and control costs through ACOs, medical homes, and other new models of care. Whether they deliver coordinated, accountable, and patient- and family-centered care will depend heavily on the Meaningful Use (MU) program establishing a strong national health IT infrastructure, and getting clinicians, hospitals, patients, and others to use it for these purposes. The 25 undersigned organizations – from a collaboration of leading consumer, labor, and employer organizations committed to improving quality and affordability of health care – believe the Health IT Policy Committee (HITPC) needs to work with ONC and CMS to accelerate the trajectory of MU, with a focus on the kinds of rigorous requirements that drive true transformation.

Meaningful Use Stage 3 is an important opportunity for ensuring electronic health records are capable of helping realize the triple aim of better care, better population health, and better patient and family experience. To do so, health IT must enable the interoperable exchange of high value personal health data across settings of care and among patients and caregivers. Concurrently, the safety of health IT itself is paramount and there must be ongoing monitoring to assure systems work as intended over time. We are therefore pleased the ONC recently released a proposed plan for monitoring the safety of health IT. We look forward to reviewing the plan.

As consumers and purchasers, we are glad that emerging federal health care programs—such as the Medicare Shared Savings Program—will address the six domains of the national quality

strategy,[1] particularly care coordination, patient engagement, and efficient resource use. We believe focusing the next stage of the MU Program to support these activities should be a high priority.

In particular, we would like the MU Program to drive significant improvements in:

- Information sharing, because it is essential to overcoming the fragmentation, tracking longitudinal outcomes, improving chronic care management and reducing costs.
- Patient and family engagement, because patients and their caregivers need better information and tools to manage their health and care.
- Quality measurement, so providers are capable of generating the data that will improve care in efficient ways, and that also enables better decisions by consumers, purchasers, and policymakers.

We elaborate further on these three priorities and offer recommendations below. An appendix is included with more specific comments on both the functional criteria and the questions posed in the RFC.

1. Information Sharing Is Essential to Improving Care

Information sharing is paramount for achieving better care. As we drive toward the third stage of the program, we are concerned that the national investment in health IT will be wasted if EHRs cannot effectively and efficiently serve as tools for care coordination, patient and family engagement, care transition management, improved patient safety, and clinical decision support. Information sharing is an essential component of each. Patient health outcomes and provider satisfaction are positively impacted by efficient care coordination and smooth transitions between providers. **The HITPC must raise expectations for that exchange of information.**

Conceptually, we support the use of the summary of care as a means of advancing electronic information exchange, as well as the introduction of the concept of closing the information loop (SGRP 303 and 305). We also support the requirement to ensure communication to key members of the care team in a significant health care event (SGRP 308).

Although we strongly support these concepts, this RFC does not take an ambitious enough stance on accelerating exchange of information. CMS data shows that, as of November 2012,

[1] The six domains are: patient and family engagement, patient safety, care coordination, population and public health, efficient use of health care resources, and clinical processes/effectiveness.

84% of all Eligible Hospitals (EHs) were registered and 68% were paid for successful Meaningful Use, while 63% of all Eligible Professionals (EPs) were registered and fully one out of three were paid. Further, CMS expected December 2012 to be the biggest pay out month to date, by threefold[2]. Given the rapidly increasing pace of EHR adoption, and the time remaining between now and the advent of Stage 3, **it is more than reasonable to require more widespread information exchange in Stage 3**. Setting such low expectations for care coordination and data exchange by Stage 3 is simply not sensible. The HITPC should focus on setting higher expectations for improvement of outcomes through information sharing across multiple sources; for example:

- Summaries of care for transitions and referrals are very important. The goals set in this RFC—that summaries are created for just 50% of referrals and transitions, with only 10% being exchanged electronically—is far too low. These targets must be raised. At a minimum, we recommend setting the bar at 80% and 65% for electronic exchange.

However, more work must be done to explore alternative requirements that would accelerate information exchange on a widespread basis instead of an incremental approach. *As consumers and purchasers, we are rapidly approaching the point at which this is a matter of patient safety and skyrocketing costs that will no longer be tolerated.*

- Rather than increase the number of clinical decision support (CDS) rules, ensure the value of using CDS for clinicians, the patients they serve, and the communities in which they practice. Require the use of CDS rules that incorporate data from multiple data sources, including the patient and their caregivers. This step would be a significant advancement in tracking orders, referrals and follow-up, avoiding duplicative tests, and managing population health.[3,4]
- Require providers—both EPs and EHs—to enable patients and their designated caregivers to use automated Blue Button to receive and share basic information without having to request that information repeatedly (SGRP 204A). This addresses a nearly-universal patient frustration with the process of maintaining and sharing up-to-date health information.
- Advance beyond Stage 2 the capability of querying various data sources for purposes of reconciliation of medications, problems, allergies, and patient goals by requiring *all*

[2] Rob Anthony, HITPC Meeting January 8, 2013.
[3] http://www.openclinical.org/dss.html#perreault
[4] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2655879/.

providers (EPs and EHs) to conduct these queries for at least 10% of referrals and transitions.

2. Patient and Family Engagement is Essential to Meeting the Triple Aim

Patients who have online access to their own health information understand their health conditions better, more effectively manage their medications, and are more engaged in the management and improvement of their health.[5] We are pleased with, and fully support, the HITPC's proposal to advance patient and family engagement by advancing patients' access to health records online, enabling them to contribute to those records and facilitating better communication between patients and the care team. We offer the following suggestions for strengthening this priority area:

- The ability of patients and their family caregivers to provide specific high-value information to their electronic health records is essential, (SGRP 204B) both for supporting their engagement in care and for increasing provider awareness of factors affecting their ability to manage their health effectively at home. This information is so critical that we advise making this criterion Core in Stage 3 and calling out additional information types that providers could collect. Information patients and families find to be high-value includes:
    - Goals for care.
    - Medication allergies and non-tolerated medications (e.g.: those which in the past have caused negative side effects for the individual).
    - Caregiver (using DECAF[5]) and additional professional care team member name(s), contact information and role(s).
    - Family history.
    - Functional limitations.
    - Supports and services necessary for independent living.
    - Patient values and preferences for care (e.g.: advance directives, no blood products, etc.).
    - Patient experience

5 National Partnership for Women & Families, Making IT Meaningful: How Consumers Value and Trust Health IT, February 2012. http://www.nationalpartnership.org/site/DocServer/HIT_Making_IT_Meaningful_National_Partnership_February_2.pdf; The Robert Wood Johnson Foundation, OpenNotes: Results, 2012. http://www.rwjf.org/content/dam/farm/communication_and_promotion/promotion_or_communication/2012/rwjf401616

- Behavioral and mental health history.
- Identification of problems or concerns from the patient's perspective.
- Psycho-social information, such as family support, caregiver limitations, financial constraints, living situation, independent living skills, and activation level.
- Data recorded by patient for monitoring of progress toward patient goals.
- Risk factors indicated by structured surveys

- We strongly advocate for a requirement that providers make immediately available to patients everything in their EHR, including electronic progress notes (SGRP 204A).
- In addition, we encourage the HITPC to reduce the amount of time allowed for making available labs and other types of information not generated within the course of a visit to two business days after the results are made available to the provider.
- Require measurement and reporting of providers' timeliness in responding to secure messages from patients (SGRP 207).
- We strongly support the HITPC's intent to further advance patient and family engagement by raising the threshold in Stage 3 both for providers offering patients online access to their health information and patients actually using the VDT capability (SGRP 204A). We also support the requirement that providers are accountable for a threshold amount of use by patients and families.
- Given that automated Blue Button is an advancement of a capability providers are building into their processes in Stage 2, we advise making the automated Blue Button criterion Core for Stage 3.

See the Appendix for more commentary on measures, objectives, and functionality requirements pertaining to patient and family engagement.

3. Using HIT to Improve Quality and Reduce Costs

The EHR Incentive Program is a unique opportunity to advance the capabilities and uses of health IT in quality improvement. However, to date, health IT-enabled quality measurement has not produced the results expected, in part because time and money were expended on developing low-value measures.[6] The MU Program must create a functional health IT *system* for

[6] For example, efforts to build measures of patient-reported outcomes for orthopedic care resulted in check-the-box measures of whether the clinician "assessed" the patient's functional status before and after hip and knee replacement. It failed to take

managing and improving health care, rather than a constellation of separate health IT programs working in parallel but not in concert with each other. We advise doing this through targeted use of the best measures available and developing measures to fill gaps.

At a minimum the HITPC should push to implement a limited set of already-existing high-value measures that leverage functionalities that are only possible in an electronic environment and that support new payment and delivery models. By focusing on high-value measures already applicable to electronic use —such as biometrics data to support risk adjustment, increasing the capacity for patient-reported outcomes (PROs), and measures that identify overuse of tests and procedures—and discarding low-value measures, it will target key areas for improvement. The current program has too many clinical quality measures that will not make a big difference in improving care (e.g., reflect basic competencies, mask outcomes, allow providers to simply check-the-box, etc.). This may be a function of trying to align MU with other programs like PQRS, but MU represents a different program with more potential for measurement that is meaningful to providers, as well as consumers and purchasers.

Although we advocate for adopting already-existing high-value measures, measure development is also necessary to fill certain gaps and demonstrate value of HIT in measuring and improving quality. The MU program is uniquely positioned to play an important role in advancing the creation of more robust quality measures. Please see the Appendix for a more detailed proposal on using MU to fill measure gaps.

Importantly, for quality improvement programs to achieve their greatest potential, results must be fed directly to clinicians, as well as the necessary reporting entities, to drive the *use* of data for quality improvement. Furthermore, in line with nurturing a robust HIT *system* rather than parallel programs, attention should be paid toward facilitating collaboration on quality improvement with providers not eligible to participate in the MU Incentive Program[7]. Our input on the specific questions asked by the HITPC on this topic—in particular, questions QMWG07 and QMWG18—are included in the Appendix.

---

advantage of more valuable measures and tools (e.g., Minnesota Community Measurement's patient-reported outcome measure for total knee replacement, NIH PROMIS).

[7] Such as community and mental health providers, nursing homes, and home health providers.

Conclusion

The HITPC must stand squarely behind the MU Program and accelerate its trajectory toward being capable of supporting the changes in health care we so desperately need—that is, more coordinated, affordable, and patient- and family-centered care.

The Appendix provides more detailed comments on the remaining objectives and measures, and detailed responses to the questions contained in the RFC.

If you have any questions, please contact either of the Consumer-Purchaser Disclosure Project's co-chairs, Bill Kramer, Executive Director for National Health Policy for the Pacific Business Group on Health or Debra Ness, President of the National Partnership for Women & Families.

Sincerely,

AARP
American Benefits Council
American Hospice Foundation
Business Healthcare Group of Southeast Wisconsin
Childbirth Connection
Employers' Coalition on Health
The Empowered Patient Coalition
Health Care Incentives Improvement Institute
Health Policy Corporation of Iowa
Iowa Health Buyer's Alliance
Lamaze International
The Leapfrog Group
Maine Health Management Coalition
Mid-Atlantic Business Group on Health
Minnesota Health Action Group
National Business Coalition on Health
National Family Caregivers Association
National Partnership for Women & Families
New Jersey Health Care Quality Institute
Northeast Business Group on Health
Pacific Business Group on Health
PULSE of America
Silicon Valley Employers Forum
South Carolina Business Coalition on Health
St. Louis Area Business Health Coalition

APPENDIX: Comments on Remaining Objectives, Measures, and Questions

Functionality Requirements We Support Without Additional Changes

We strongly support the following functionality requirements suggested by the HITPC. These measures support care coordination and data exchange, patient and family engagement, and using HIT to improve quality and reduce costs.

1. Computerized provider order entry (SGRP 101).
2. Formulary/E-prescribing (SGRP 103).
3. Patient-oriented dashboards incorporated into the EHR's clinical workflow for the care coordinator or the provider (SGRP 115).
4. Family Health History (SGRP 119)
5. Notification of Significant Healthcare Event (SGRP 308).
6. Ability for patients to offer corrections to their medical records (SGRP 204D).
7. Care coordination (SGRP 305, IEWG 101).

Functionality Requirements and Suggested Changes

Below, we outline further changes we recommend. Although we would argue for higher thresholds in the case of some requirements, we recognize that small incremental increases likely do not accomplish transformational change. Thus, our comments below focus mainly on advancing functionality in more effective ways.

Retiring Demographics Measure (SGRP 104)

In general, what is important is using data to drive improvement, not simply data collection. We therefore support retiring this measure **but only** if it is replaced with other criteria requiring stratification of patient lists and reporting a select number of quality measures by demographic variables. Otherwise, there is a real risk of adverse effects on health disparities.

Advanced Directives (SGRP 112)

Advanced Directives are a powerful tool for engaging patients. We encourage the HITPC to include the contents of such directive as part of Stage 3 criteria. Patients and providers would benefit significantly from this information being available at the point of care; there are technological solutions that make this possible. We also suggest revising the age limit to include all patients. For certification, EHRs should be able to collect this information.

Include Electronic Progress Notes in Patient Records (SGRP 120)

We support requiring that providers make available electronic progress notes in patients' EHRs. However, we urge the HITPC to reduce the amount of time allowed for providers to make information available from four days in Stage 2 to one day in Stage 3.

High Value Patient-Generated Health Data (SGRP 204B)

We fully support the new Stage 3 criterion offering patients the ability to contribute information to their medical record that is specific and material to their care. This is a pivotal opportunity to improve performance on high priority health conditions, address unnecessary readmissions, and enhance patient and family engagement in care.

We recognize HITPC's desire to establish a modest threshold for these new criteria. However, we urge the Committee to increase the threshold for this criterion and to specify a list of optional categories of high-value information that have the potential to significantly improve safety and quality, including but not limited to:

- Goals for care.
- Medication allergies and non-tolerated medications (e.g.: those which in the past have caused negative side effects for the individual).
- Caregiver (using DECAF[5]) and additional professional care team member name(s), contact information and role(s).
- Family history.
- Functional limitations.
- Supports and services necessary for independent living.
- Patient values and preferences for care (e.g.: advance directives, no blood products, etc.).

- Patient experience
- Behavioral and mental health history.
- Identification of problems or concerns from the patient's perspective.
- Psycho-social information, such as family support, caregiver limitations, financial constraints, living situation, independent living skills, and activation level.
- Data recorded by patient for monitoring of progress toward patient goals.
- Risk factors indicated by structured surveys

As efforts to measure and improve health outcomes continue, it will be critical to link patient-generated data to clinical decision support (CDS) technologies to generate alerts based on the needs of patients (clinical and non-clinical), including their preferences for care.

After Visit Summary (SGRP 205)

Information should be included in the after-visit summary that facilitates the goal of patients having concise and clear access to information about their most recent health and care, and understand what they can do next, as well as when to call a doctor if certain symptoms/events arise. That information includes:

- Visit-specific information (date, purpose, etc.).
- Updated list of medications and problems.
- Potential side effects, symptoms and complications to look out for and what to do if these occur.
- Action steps for patients and family caregivers.
- Current care team primary contact.

Furthermore, clinical summaries should be written in clear, plain language, be formatted for ease of use by patients and families, and be accompanied by graphic explanations where possible.

New requirements for providing educational materials to non-English speaking patients in their preferred language (SGRP 206)

We fully support using data collected about a patient's preferred language to determine in what languages to make educational materials available. To clarify and simplify this measure,

we recommend the denominator specify that 80% of all patients whose preferred language is one of the top five non-English languages spoken nationally receive educational materials in their preferred language. In addition, educational materials should leverage visual icons and pictorial instructions wherever possible.

Secure Electronic Messaging Between Patients and Providers (SGRP 207)

Secure messaging is a critical step towards improving patient workflow by advancing access, care coordination, and information exchange with the patient and their caregivers. Furthermore, secure messaging is an important source of patient-generated data, which is critical to a comprehensive view of individual health. The timeliness of providers' responses is also important. Finally, in recognition of family/other caregivers as part of the care team, we support allowing secure messages sent and received by a family or other caregivers approved by or for the patient to count towards the increased threshold.

Reconciliation of Information Upon Transfer of Care (SGRP 302)

It is feasible to add additional fields for reconciliation. We suggest the following high-value categories for reconciliation.

- Caregiver name, contact information, and role.
- Medications being taken, including over-the-counter medications and supplements.
- Problems/complaints.
- Advanced directive status and content.
- Sources of treatment (i.e. primary care, specialists, ER, retail clinics, etc.).

Summary of Care Records Upon Transfer or Referral of Care (SGRP 303)

We support clarifying the requirements regarding a summary of care record to stipulate the kinds of information that must be included. In particular, we applaud the addition of a list of care team members, including their role and contact information, using the structured format offered by the DECAF classification system. We also suggest that ONC require the inclusion of both patient-defined and clinical goals as part of the summary of care record. Recording both kinds of goals will be an important facilitator of shared decision-making. As discussed in the main body of this letter, though, the requirement that only 10% of transitions of care and

referrals be done electronically in Stage 2 is unacceptable, particularly in light of the number of doctors and hospitals expected to be operating EHRs in the future.

We appreciate the opportunity to comment on the data patients think is most important to share electronically with their providers. In addition to the data already prepared, consumers and purchasers would also value the inclusion of:

- Caregiver name, contact information (including e-mail) and role (using DECAF). There should also be a way to record assessment of caregiver limitations.
- Family health history.
- Psycho-social information, including:
    - Living situation.
    - Independent living skills and needs.
    - Activity level.

Care Plan Information in Future MU Stage (SGRP 304)

The HITPC should not delay advancement of the concept of a longitudinal, electronic, shared care plan to non-incentive stages. As we recognize that the full functionality, infrastructure, and widespread use of health IT necessary for bringing this vision to fruition will be achieved some time after the implementation of Stage 3, at the very least, the HITPC needs to make clear that we are all working toward an electronic platform for collaboration, not just another document. A critical step for Stage 3 will be requiring documentation of a cross-setting care team member list, comprehensive patient goals, and psycho-social assessment information, such as an individual's living situation, community based resources currently being received, and mental/behavioral health needs, which are not yet incorporated routinely in EHRs. It will also be critical to identify ways to update the plan (its goals, progress, care team members, etc.) and focal methods of bi-directional collaboration between patients, families, and providers.

Answers to RFC Questions

QMWG02: *When considering the finite resources available to technology developers, what measures, types of measures or attributes of measures should be a high priority?*

In 2010, the Office of the National Coordinator (ONC), with the help of external experts, identified a list of critical areas for measure development (i.e., patient-reported outcomes, quality of shared decision-making, appropriate invasive testing, patient activation and self-management, adverse drug events, health care acquired conditions, adverse events and sub-optimal outcomes from chronic conditions, etc.). CMS and ONC should develop and publish a plan to fill these gaps in Stage 3. Also, a higher priority should be placed on measures that address the six domains of the national quality strategy,[8] particularly care coordination, patient engagement, and efficient resource use. In addition to what is measured, how it is measured in very important. For attributes of meaningful measures, please refer to the *Ten Criteria for Meaningful and Usable Measures of Performance*.[9] See also our response to question QMWG19, specifically section 4 on page 19.

QMWG07: *Please comment with guidance on how consumer-reported data can be incorporated into CQMs. What examples are there of EHR-enabled quality measures that use data directly entered by patients?*

Nationally and internationally, consumer-reported data measures, (or, patient-reported outcomes measures, "PROMs"), are incorporated into CQMs. There are two basic models today for how information is entered by the patient, which are not necessarily mutually exclusive: (1) the patient is invited via e-mail to input data from his/her home computer through the provider's patient portal, and (2) the patient is asked to input data at point of care using a provider-owned tablet or kiosk computer. It is possible that additional models will develop, including those that utilize PHRs.

Some examples of EHR-enabled quality measures that use data directly entered by patients are as follows.

- The Dartmouth Institute (TDI) is tracking PROMs over time to determine the impact of treatments on outcomes and the experience with care. The PROMs they are tracking include four clinical populations: (1) annual wellness visit, (2) heart failure, (3) hip

[8] The six domains are: patient and family engagement, patient safety, care coordination, population and public health, efficient use of health care resources, and clinical processes/effectiveness.

[9] Consumer-Purchaser Disclosure Project, *Ten Criteria for Meaningful and Usable Measures of Performance*, September 2011, http://www.healthcaredisclosure.org/docs/files/CPDP_10_Measure_Criteria.pdf.

replacement, and (4) knee replacement.[10] They believe PROMs will improve patient engagement and the quality of patients' decisions about health and health care. To promote widespread use of PROMs, TDI has made available a data collection platform and benchmarking capability, and facilitated training and sharing of best practices.

- Geisinger Medical Center collects PROs in a variety of areas. In one of these areas—orthopedics—PROs questionnaires are administered to patients with osteoarthritis (OA) via touch-screen monitors located in the orthopedic clinics. Physicians used results from the questionnaires to track outcomes. Geisinger described this capability as "critical [to] developing evidence-based protocols in OA management."[11]
- Partners Healthcare is in the second phase of a two-phase PROMs pilot for CABG procedures and diabetes care. During the pilot, they are collecting PRO data through a multi-modal approach[12], reporting PRO measures to providers and patients, and using PRO data as quality metrics on a physician, clinic, hospital, and system level.[13]
- Consultants at Royal Cornwall used PROMs data to monitor via a website post-surgical patient health following hip and knee replacements. The intent of the initiative was to improve patient health, encourage better compliance with post-surgical therapy, and reduce the need for face-to-face post-op outpatient appointments. This model of having patients report health outcomes via website could be adopted by other providers to collect information in a streamlined way that is straightforward and accessible to most patients.
- The Patient Reported Outcomes Measurement Information System (PROMIS) is a system of measures of patient-reported health status for physical, mental, and social well-being. PROMIS tools measure what patients are able to do and how they feel by asking questions. The developers of this measure believe theirs will create a common language around self-reported health status and enable improved assessment of unique patient information, thereby improving quality of care and quality of clinical research.

---

[10] For details on the condition specific and general health measures being used, see The Dartmouth Institute's Survey Administration Tool (SAT): http://tdiprm.dartmouth.edu/overview.php.

[11] Geisinger Researchers Awarded Funds for Personalized Healthcare Project, 22 January 2010. http://www.newswise.com/articles/geisinger-researchers-awarded-funds-for-personalized-healthcare-project

[12] Modes include interactive voice response (IVR) combined with human phone operators, electronic tablets in the health care facility, and an internet patient portal.

[13] For more on this pilot, see *Patient Reported Outcomes: Measuring Patient-Centered Healthcare Value Across the Continuum of Care at Partners Healthcare System*, Eyal Zimlichman MD, MSc, 22 October 2012. http://www.isqua.org/docs/geneva-presentations/a5-eyal-zimlichman.pdf?sfvrsn=2

QMWG18: *Please comment on the desirability and feasibility of such an innovation track as a voluntary, optional component of the MU CQM requirement.*

The EHR Incentive program is a unique opportunity to address measurement gaps, since it is not a quality measure performance or accountability program. CMS could promote rapid-cycle measure development by encouraging eligible providers and others to create, test, and report on measures that meet robust criteria in each of the six domains identified by the HITPC and its Quality Measures (QM) work group.[14] This sort of real-world testing is a critical part of the NQF endorsement process. In addition, developing and testing new measures as a byproduct of practice encourages the use of real-time, clinical data. Finally, an essential benefit of developing measures as part of the MU process is that it would be done in the electronic environment in which these new measures will be implemented, rather than re-tooling a measure designed for the paper world. Creating such an option would result in shared learning and testing of new measures that advance ability of EHRs to help measure outcomes.

If this approach is pursued, the HITPC should provide specific guidance about which measure gaps to address and which EHR capabilities to leverage, as well as specific criteria measures to meet in order to qualify. In general, the Consumer-Purchaser Disclosure Project's *Ten Criteria for Meaningful and Usable Measures of Performance,*[15] which has been used by the NQF MAP, serves as guidance for creating meaningful and usable measures. The NQF's importance criteria may also provide valuable guideposts. We also elaborate further on QM development in question QMWG19, below.

QMWG19: *The QMWG has considered two approaches to institution-initiated eCQMs. A conservative approach might allow "Certified CQM Development Organizations", such as professional societies and IDNs to design, develop, release and report proprietary CQMs for MU. An alternate approach might open the process to any EP/EH but constrain allowable eCQMs with certain design standards. There are advantages and disadvantages to both. Please submit comments on either, both or unique approaches.*

We support a development and testing option for CQM open to providers with measure development and testing expertise or those without such expertise, who are working in close

[14] The six domains are: patient and family engagement, patient safety, care coordination, population and public health, efficient use of health care resources, and clinical processes/effectiveness.

[15] Consumer-Purchaser Disclosure Project, *Ten Criteria for Meaningful and Usable Measures of Performance*, September 2011, http://www.healthcaredisclosure.org/docs/files/CPDP_10_Measure_Criteria.pdf.

collaboration with those with such expertise (such as specialty societies or community reporting initiatives). We suggest, as a starting point for consideration:

Providers must meet their CQM submission requirement by either:

A. Picking from among a parsimonious set of high value measures selected by CMS and ONC and submitting to CMS (similar to Stage 2)

OR

B. Submitting test measures according to a set of criteria developed to ensure value to the larger quality measurement enterprise.

For those choosing option B:

1. For quality assurance, only measurement development entities, providers with measure development and testing expertise, or providers working in close collaboration with other entities with measure development and testing expertise (e.g.: specialty society, community reporting initiative) would be eligible to participate.
2. Providers choosing the measure development and testing option would seek rapid approval of their measures through ONC, working in collaboration with NQF. Approved measures/concepts would then enter the testing phase as part of the Meaningful Use quality data submission requirements. Providers testing these measures could make adjustments to the measure, until the measure is mature enough to be submitted for full endorsement. The standardization and parsimony necessary for meaningful, sustainable reporting will be achieved through the current endorsement process, which evaluates and prioritizes competing measures.
3. EPs and EHs would submit not just the measures/calculations themselves, but also specific information related to testing, feasibility and usability, so that the EHR Incentive Program becomes a direct pipeline for measures into the endorsement process, as well as improved support for analytics by health IT products.
4. Suggested criteria for measures being developed and tested include (all criteria must be met):
    a. Mapped to the NQF Quality Data Model (QDM) and uses standardized value sets/NQF Measure Authoring Tool,[16] or specifies new value sets that need to be added to the QDM.

[16] The Quality Data Model (QDM)The QDM is an "information model" that clearly defines concepts used in quality measures and clinical care, and is intended to enable automation of structured data capture in EHRs, PHRs, and other clinical applications. It provides a way to describe clinical concepts in a standardized format so individuals (i.e., providers, researchers, measure

b. Value sets for measures include billing codes for mapping to claims data.

c. Includes location of data elements populating measure in the EHR.

d. Measures are outcomes focused, or if a process measure is developed and tested, it must be proven to have a strong link to outcomes.

e. Addresses one or more of the key gap areas identified by the QM workgroup, with an emphasis on outcomes, as described above:

   i. Efficiency;

   ii. Equity;

   iii. Prevention;

   iv. Health risk/status assessment;

   v. Care planning and need to coordinate.

5. Certification criteria would be developed to ensure that certain data fields in EHRs can be used in conjunction with a simplified version of the NQF Measure Authoring Tool. This will enable continuous learning and improvement.

6. In addition, measures being tested by EPs and EHs must meet at least 1 of the following criteria:

   1) Uses data across multiple data sources (i.e.: across settings of care, between patient and provider, with registries, etc.)

   2) Evaluates patient health/functional status over time,

   3) Uses data contributed by the patient to the EHR

---

developers) monitoring clinical performance and outcomes can clearly and concisely communicate necessary information. The QDM describes information so that EHR and other clinical electronic system vendors can uniformly express, consistently interpret, and easily locate the data required.

The QDM provides the potential for more precisely defined, universally adopted electronic quality measures to automate measurement and compare and improve quality using electronic health information. Use of the QDM will enable more standardized, less burdensome quality measurement and reporting and more consistent use and communication of EHRs for direct patient care. In addition to enabling comparisons across performance measures, the QDM can promote delivery of more appropriate, consistent, and evidence-based care through clinical decision support applications.

Measure Authoring Tool (MAT)

The MAT is a standardized tool that allows measure developers to more easily create eMeasures. Built upon the language created with the QDM, the MAT acts as a usable graphic interface, allowing measure developers to more efficiently and consistently create standardized eMeasures that are compatible with or readable by EHR systems and other clinical IT systems. The MAT should significantly reduce the time required to create new quality eMeasures and convert existing paper based measures to EHR-readable format.

For further information or to address any questions, please contact either of the Consumer-Purchaser Disclosure Project's co-chairs, Bill Kramer, Executive Director for National Health Policy for the Pacific Business Group on Health or Debra Ness, President of the National Partnership for Women & Families.