

Office of the National Coordinator for Health IT (ONC)
Clinical Quality Public Hearing
June 7, 2012

Written Testimony of Connie Moser
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Thank you for the opportunity to provide testimony today. We commend this panel, the Office of the National Coordinator (ONC) and the Centers for Medicare and Medicaid Services (CMS) for their continued efforts to seek comments on how the industry, ONC and CMS can collaborate to improve the support of electronic clinical quality measurement.

I am Connie Moser, Vice President of Enterprise Intelligence, McKesson Provider Technologies, a division of McKesson Corporation. My team is responsible for developing, implementing, and supporting data analytics and quality measurement solutions for our provider customers. I am testifying today on behalf of McKesson Corporation, a Fortune 14 company with decades of experience leading the health IT industry. McKesson supports the largest and most diverse provider customer base in the health IT industry, including 50 percent of all health systems with 77 percent of those with more than 200 beds, 20 percent of all physician practices and 25 percent of home care agencies, representing more than 50,000 home care visits annually. We also process billions of financial healthcare transactions between physicians, hospitals, insurers and financial institutions, and provide care and claims management solutions to most of America's health insurance companies. RelayHealth, McKesson's clinical connectivity business, is a participant in community and regional health information exchanges and connects patients online with their physicians, hospitals and health plans.

McKesson's perspective on quality measurement is based on more than 40 years of experience in the development and implementation of healthcare analytics. Our enterprise intelligence suite of products

support analytics for the enterprise healthcare organization by leveraging patient data, transforming it and making it useful to every constituent in the healthcare system so that they can change their behavior to improve the quality, safety and efficiency of care.

We believe McKesson's approach to eMeasurement aligns well with the vision that emerged out of the work of the ONC federal advisory committees and was introduced in the NPRM for Health Information Technology: Proposed 2014 Edition EHR Certification Criteria:

- For Stage 1, we created an inpatient clinical quality measure (CQM) platform that is vendor neutral and 100% reliant on data captured as a byproduct of patient care.
- For Stage 2, we are developing the next generation of that platform and expanding it to the ambulatory care setting.

We remain confident that electronic quality measurement (eMeasurement) can successfully enhance the process of care and patient outcomes. We are encouraged by ONC's commitment to understanding and addressing the challenges for the success of eMeasurement.

Current Limitations

Today, health IT has limited ability to support clinical quality optimization for several reasons:

1. With the admirable interest of moving electronic quality measurement forward, ONC has adopted the standards available, even where these standards may not be well suited to the goal. For example, the quality data model (QDM) is a useful information model for organizing the elements of measure content, but it has low utility as a certification tool. The mere fact that an EHR can represent a QDM category and state, e.g., "problem active" does not ensure it effectively represents all the relevant problem values for quality measurement in appropriate workflows. Likewise, the XML-based HQMF standard provides flexibility to measure

developers, but is not well adapted to ensuring that the content of a measure can be automatically computed by a CQM platform.

2. The requisite standards and infrastructure remain immature. While progress has been made, we are still several years away from having measure specifications and implementation guidelines that are consistently computable. Until the eMeasure specifications (eSpecs) designed by measure developers and generated by the measure authoring tool (MAT) can be accurately parsed and interpreted without human intervention, electronic health record (EHR) vendors will have to continue some form of hard coding.
3. In some cases, standards and formats for quality measurement add little value to the healthcare system as a whole. QRDA1 is a prime example of this. Its only purpose is to support measure calculations. QRDA1 requires both the EHR and the CQM platform to support measure logic; it needs to be updated every time new measures are added and provides an inconsistent data set for analytics related to measurement. It would be more effective to standardize and enhance the data requirements for the summary of care record within the framework of the Consolidated Clinical Document Architecture (CCDA) so that it can also support requisite data for quality measurement. Reliance on the summary of care record may limit the types of measures that can be adopted in the short run, such as those that rely on observables that are not currently part of the standard record; however, this approach would be less burdensome to providers and more flexible for measurement purposes.

The ONC has invested heavily in the Standards and Interoperability (S&I) framework, and the Query Health initiative for distributed population queries shows tremendous promise. For those who are not close to the project, it may be easy to believe that Query Health addresses all the technical challenges of quality measurement. It should be noted that while both CQM and Query Health make use of HQMF, the

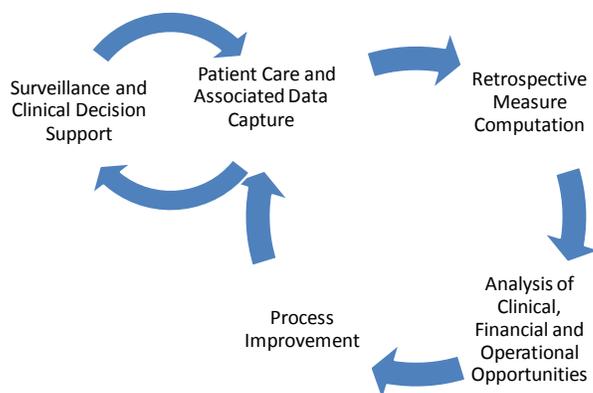
use cases for the two purposes are not the same. HQMF++ as defined by Query Health is inadequate at this time for the kinds of complex measures proposed for Stage 2 of Meaningful Use.

How can health IT and clinical decision support better support quality measurement/improvement?

The great promise of health IT to better support quality measurement and improvement is its capability to create what the policy committee has characterized as a “learning health system.” McKesson refers to this learning health system as a “closed loop quality management process.” As stated earlier, this process supports the ability to leverage patient data, transform it into useful information and deliver it to a constituent in a meaningful way so they can change their behavior to improve the quality, safety and efficiency of care.

In this process, data capture within the clinical workflow must not only support retrospective measure submission and calculation, but also comprehensive analytics that allow providers to assess and compare the care of patients who qualify for a given measure population as well as those patients who do not. Because providers need to understand the care process for the entire population, we recommend considering export formats other than the QRDA1, which only includes patients who qualify for a given measure population.

Process improvements, derived from complete analysis, need to then change the EHR workflow. These improvements also inform the specific clinical decision support that will enhance the patient care process. Visual surveillance and clinical decision support tools within the patient care setting drive proactive compliance and support best practice. The resulting improvements in care and reductions in variability should ultimately be reflected in the retrospective measures.



The value of this closed loop process is illustrated most effectively by an integrated delivery network (IDN) in the Midwest. This IDN has been so successful in using real time visual surveillance, which we refer to as Visibility, that they have virtually eliminated ventilator acquired pneumonia. While this condition is not among the Stage 1 Meaningful Use eMeasures, we will be working with this IDN and other providers to expand the same kind of surveillance to the Stage 2 Meaningful Use measures as we implement them.

How can the quality lifecycle be accelerated?

Accelerating the quality lifecycle is not, fundamentally, a technical challenge. While establishing standards and infrastructure may reduce the technical task of computing measures, the real lead time required is for standards-setting work, including establishing measurement priorities, awarding contracts for measure development, evaluating evidence, reaching consensus, and testing validity. We cannot short-cut the rigor of this development process which is critical to the measurement of quality and outcomes in healthcare as we move toward new payment models.

Both controlled testing and field testing need to be part of the eMeasure development, specification, and endorsement process. Controlled testing should ensure the feasibility, validity and accuracy of each eMeasure when implemented in an EHR. The eMeasure testing process should also include a testing site

with a set of sample data, testing examples and an Implementation Guide that can be used by vendors. The Mitre Cypress project, while a good start, does not support inpatient measure testing.

It is important to note that the measures of Meaningful Use objectives such as medication reconciliation at transitions of care are, in fact, structure or process measures. They should be specified as such, using the same format as that used for clinical eMeasures. Not only would this enable us to better evaluate the impact of EHRs on care, but it would reduce the number of different measurement formats and mechanisms that EHR developers must support.

The Role of HIT Vendors in Advancing the eMeasure Agenda

Health IT vendors already play an active role in relevant standards development efforts, including the S&I framework and the HL7 Structured Documents workgroup. We believe we can also provide essential education and support to measure developers. We have found that measure developers are not always knowledgeable about technical aspects and practical workflow of EHRs, which hinders effective insight into measure development. For example, some of the measure developers participating in the NQF eMeasure Learning Collaborative have indicated they have little knowledge of the relevant taxonomies and code sets required for use in an EHR or how to use them effectively in measures. Our discussions with measure developers reveal a need for more education and understanding on their part about the development and use of EHRs.

We also need to educate measure developers on EHR certification standards so that they can reference these standards rather than over specifying measures. For example, NQF measure 0647: Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) details the contents of a summary of care as well as expectations for its use. Measures like this should rely on the EHR certification program to specify content

and focus entirely on expected behaviors. Although cited for illustrative purposes, this particular quality measure is largely duplicative of a similar Meaningful Use measure.

The quality measurement community in general is still in the early stages of transforming from manual to eMeasurement. We are still retooling measures designed for manual data capture. Each measure developer designs data models independently and debate is ongoing as it relates to competing approaches such as whether to use an exception or an exclusion model for measure specifications. As a result, measures are not yet optimized for automation.

Conclusion

In closing, we commend the tremendous investment made by ONC and CMS in measure alignment, infrastructure and standards. We recommend that ONC, CMS, and the MU program consider the following suggestions to optimize and support clinical quality efforts:

- Ensure we have optimal, robust, detailed and mature standards that support consistently computable quality measurement with adequate lead time prior to adoption;
- Resist the temptation to treat a successful proof of concept, such as Query Health, as a production-ready concept for adoption by the entire industry;
- Align EHR certification and measurement qualification processes, so that, for example, certified EHR technology can be used by providers in the PRQI program without requiring a separate qualification process.
- Encourage a common vision for a health IT eMeasurement environment that fosters innovation by technology developers.

On behalf of McKesson, thank you for the opportunity to testify. We welcome further dialogue on these issues and look forward to working with you as you consider the recommendations presented today.

I would be pleased to answer any questions.