



STATEMENT FOR THE RECORD

SUBMITTED TO THE

Quality Measures Workgroup

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AARP

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AARP is a consumer organization representing millions of members age 50 and older. Our mission is to enhance the quality of life for all as we age and we do this through advocacy and information. We have been an ardent and long-standing advocate for reforming the nation's delivery of health care services to assure our members and the public-at-large access to affordable, high quality care. We supported the quality provisions in the Patient Protection and Affordable Care Act of 2010 (ACA) as well as the HITECH provisions of the American Recovery and Reinvestment Act (ARRA). In our view, the combined impact of these statutes will permit significant advancements in quality improvement and help achieve better care, affordable care, and better health and wellness within communities. This statement focuses on quality measurement and why we believe performance assessment and evaluation are a necessary (although not sufficient) part of a quality improvement agenda for the nation.

Measure clinical quality *and* patient experience

From a patient's perspective, the health care system should offer everyone high quality, affordable care. It should be designed around the needs of patients; make the most efficient use of resources—financial and personnel; employ technology to support patient and clinical decisions by facilitating access to timely, useful information, facilitate clinician/patient partnerships and patient/caregiver engagement; ensure coordinated, integrated services; promote community-wide health and wellness by collaborating with partners beyond the health care sector; and pursue continuous, rapid cycle improvement through regular assessment and correction of detected problems. Importantly, the system should eliminate disparities in care, be attentive to the needs of vulnerable populations, and responsive to individuals' personal preferences and circumstances. Finally, the system should be accountable for results.

Sadly, this vision is far from the current reality for most people. The considerable evidence attesting to quality deficits, failure to place a patient's needs and desires front and center, coupled with increasing costs for individuals, payers, and society underscore the urgent imperative to address these problems if we are to achieve the health care system patients need and want. They compel

AARP to advocate for a different way for people to experience health care. We know that measuring performance, especially when results are publicly reported, produces results. Therefore, we believe comprehensive measurement is an important part of an improvement strategy.

By “comprehensive,” we mean measurement that addresses each of the Institute of Medicine’s six domains of quality: safety, timeliness of care, effectiveness, efficiency, patient-centeredness, and equity. Using these domains as the organizing framework for measure development will ensure that measures are relevant and meaningful to consumers and family caregivers.

We believe, measurement activities should extend beyond clinical quality to capture patient experience, patient activation, shared decision making, decision quality, and patient-reported outcomes like functional status and quality of life. To be most salient to patients, measurement should assess episodes of care, because this is how people experience service delivery. This means we need measures that can assess performance across the continuum of care and across settings, including how well care is coordinated. This requires interoperable electronic health records (EHRs) so that information can be shared among the multiple participants in an episode of care, including providers, patients, and family caregivers. The lack of widespread availability of EHRs with this capability is a serious concern. Assessment results should be stratified according to age, sex, race, ethnicity, primary language, as well as sexual orientation and gender identity.

Strengthen and improve traditional measure process as rapidly as possible to meet pressing public policy goals for improvement

Current measurement emphasizes discrete, condition-specific process measures that are typically not HIT-enabled, and sometimes have a weak relationship to outcomes. To mitigate data collection burden, they rely on administrative claims data, which typically lack clinical information from laboratories and pharmacies. The opportunity for more relevant and robust tools generated from

electronic medical records will correct many of the drawbacks in the current system. In addition, we are encouraged by increasing agreement among stakeholders about the need to move to measures that focus on outcomes and patient-reported results.

The ability to measure relies on the existence of “good” measures, the attributes of which have been identified in the NQF’s measure evaluation criteria and which should apply to “e-measures” as well. Measures should be: important to measure and report (i.e., they should assess areas that have potential to drive improvement and are supported by evidence); methodologically sound to permit valid conclusions about quality, and include risk adjustment as appropriate; useable in clinical and patient decision making; and feasible with respect to data collection, and implementation as determined by field testing.

Inclusion of resources for both measure development in the ACA and meaningful use in HITECH will help to drive value for patients by improving the measures used to assess performance. The new measures must be designed to maximize the functionality of EHRs and capture data on the elements of care that are most meaningful to consumers, purchasers, and providers. They should track to the priorities established by the National Priorities Partnership, including patient and family engagement, population and public health, patient safety, care coordination, efficiency, and palliative care and life-limiting illness—priority areas that multiple stakeholders have already endorsed. (These can be linked to the IOM quality domains.)

Opportunities to advance measure development

Meaningful use provides an unprecedented incentive to accelerate HIT adoption and for providers to collect and report e-measures. To consumers, the Stage 1 meaningful use requirements signaled that change is underway and included tangible advancements to support quality, patient engagement, and value. The initial requirements strike a reasonable balance between what is now

achievable for most practices and the more ambitious agenda shared by consumers and purchasers. However, going forward to stages 2 and 3, consumers and purchasers will be impatient to see more focus on the types of patient-centered measures we have described.

We see great opportunity to better engage individuals in their care through the use of technology which will, in turn, improve health outcomes. Information on patient activation should be embedded in the electronic record as should information on an individual's preferences and circumstances. Information on the quality of patient decision making (assessment of knowledge and preferences) would inform clinicians how well they are preparing and helping patients arrive at decisions that reflect their preferences. Further, not only should HIT facilitate the delivery of care, but it should enhance the care experience for patients as well. The functionality of EHRs should connect patients to community resources and supports, provide information that permits them to participate in shared decision making with their clinicians, support home monitoring to permit self-reported symptoms and vital signs, and other symptoms related to a number of chronic conditions with the goal of preventing unnecessary hospitalization; include electronic real-time supports for caregivers, peer support, e-alerts, and online coaching.

It will be important to assess patient engagement with electronic services and to evaluate the level of engagement with on-line services by stratifying responses to detect any disparities among racial, ethnic, and other groups of interest.¹ Secure messaging must be a key feature if patients are to feel comfortable using these tools and the usability of interactive consumer tools should be tested among different population groups. It is noteworthy that the Agency For Healthcare Research and Quality

¹ Ralston, J, Coleman, et al., "Patient Experience Should Be Part of Meaningful-Use Criteria," *Health Affairs*, April 2010, 29.4, pp. 607-613.

reported some evidence that consumers find web-based interactive self-management systems useful.²

Eliminate barriers to creation of better measures

The prospect of being able to have electronic access to clinical and patient-reported information-- information that might otherwise be unobtainable (or very difficult to obtain) in paper records to inform improvement and decisions represents a major advance. But the pathway to a new generation of measures is likely to be challenging. The transition to electronic records is likely inevitable, but, as recently noted by the national coordinator for health information technology, "...inevitability does not mean easy transition."³ Although it makes sense to concentrate resources on developing the next generation of measures, consumers (and purchasers) are not prepared to forgo information in the interim. So, we are going to have to continue to tolerate incomplete information and reliance on measures that depend on data sources that are not ideal. Several new outcome measures and "clinically-enriched" measures have been recently endorsed by the NQF that will have to suffice until we have a full dashboard of "e-measures.

Therefore, the considerable work that must be undertaken to develop and test measures that are HIT-enabled and that adequately address the patient-focused areas identified above must proceed quickly. Failure to fill measures gaps will impede measurement in areas that are important to consumers and that should be important to clinicians and others as well. Development of patient-focused measures needs to be conducted quickly not only for stages 2 and 3 of meaningful use, but also to advance the broader quality improvement agenda.

² Agency for Healthcare Research and Quality, "Barriers and Drivers of Health Information Technology Use for the Elderly, Chronically Ill, and Underserved," Evidence Report/Technology Assessment, Number 175, November 2008.

³ David Blumenthal, and M. Tavenner, "The 'Meaningful Use' Regulation for Electronic Health Records,' *New England Journal of Medicine*, July `3, 2010,

Several barriers need to be addressed, many of which confront traditional measure development as well. For example, the need to produce outcome measures brings with it methodological challenges of risk adjustment, and provider resistance to “less than perfect” measures, and the like. We agree great care should be taken to ensure that measures are statistically reliable and valid and support the Patient Charter that gives providers the opportunity to review performance results and to propose corrections.

Agreement on prioritization is essential if we are to make the best use of resources for measure development, ensure consistent measurement across settings, address agreed-upon high impact areas, and achieve rapid expansion of a library of e-measures. We expect this issue will be addressed by the National Health Care Strategy and Goals soon to be announced by the Department of Health and Human Services (HHS). AARP urged HHS to ensure that care improvement priorities address patient, family and caregiver engagement by emphasizing patient self-management, patient preferences, values, and circumstances. We hope these priorities will be supported. Given the transition from traditional measures to e-measures that will span several years, it would be desirable to crosswalk measures specifications and to flag areas that are not comparable so that results from each will not be misconstrued. In addition, it will important to ensure that EHRs that are certified have the capacity to analyze data in addition to performing other functions.⁴ Access to data across an episode means data need to be linked and aggregated while preserving the confidentiality of personal health information.

In addition, reconciling information reported by patients in personal health records and web portals (medication use, pain assessment, and other experiences) and integrating such information into to EHRs remain issues to be resolved. Obtaining this type of information from vulnerable patients with

⁴ Fernadopulle, R., Patel, N., “How the Electronic Health Record Did Not Measure Up to the Demands of Our Medical Home Practice,” *Health Affairs*, April 2010, 29.4, pp. 622-628.

severe illness, cognitive impairment, and poor health literacy skills who do not use these tools and for whom no caregivers are available to offer proxy information also must be addressed. As noted earlier, interoperability of EHRs is necessary for measures that assess episodes of care

Conclusion

AARP appreciates the opportunity to present our views on steps to improve health care quality and affordability for all Americans. We believe it is essential to ensure that the meaningful use provisions achieve their stated goals. The 2013 and 2015 requirements should focus on outcome measures – including patient experience, patient-reported outcomes as well as clinical outcome or process measures that have a known relationship to an outcome, such as mortality, morbidity, healthcare-acquired conditions, readmissions, functional status, and quality of life. We must address gaps in measurement, including an evaluation of the appropriateness of services delivered, patient-reported outcomes, and efficiency, and resource use in order to incorporate such measures into stages 2 and 3 of meaningful use requirements.