

**Office of the National Coordinator for Health IT (ONC)
HIT Policy Committee Quality Measures Workgroup
HIT Standards Committee Clinical Quality Workgroup
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Thank you for the opportunity to provide testimony today. We commend this panel for exploring how we can work together to improve the quality of healthcare through effective measurement and health information technology (IT).

I am Connie Moser, Vice President of McKesson Provider Technologies, a division of McKesson Corporation. I am testifying today on behalf of McKesson Corporation, a Fortune 15 company with decades of experience leading the health IT industry. In my current role, I am responsible for developing, implementing, and supporting data analytics and quality measurement solutions for our technology customers. 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, which support 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.

Our perspective on quality measurement is based on our extensive experience in the development and implementation of health IT to improve quality, safety and efficiency of care. Most recently, McKesson has ensured that our physician office, hospital and healthcare information exchange products are ready for Meaningful Use Stage 1 certification, and we are assisting our customers in becoming meaningful users of those products.

In response to questions you have raised, we will share with the panel the lessons we have learned in three key areas and our recommendations for you to consider in:

- I. Alignment of Measures
- II. Maturity of Standards
- III. Clarity of Methodology

I. Measure Specification should be Aligned

Statutory mandates, as well as market expectations, have created a sense of urgency to identify and adopt an increasing number of ever more complex specifications for measurement. Within the context of health IT standards and the adoption of electronic health records (EHR), McKesson recommends measure alignment include these components:

a) Common EHR data elements to address similar clinical concepts and facilitate efficient and safe clinical workflows.

As the number of measures increases, duplicative, and even contradictory, data collection workflows could hinder patient care and impact patient safety. For example, multiple Centers for Medicare and Medicaid Services (CMS), Joint Commission, and Meaningful Use measures include information on tobacco use including cigarette use frequency, other tobacco use, and the desire to quit, but each

measure defines the data elements in a slightly different way and with no standardization. This requires a provider to ask a patient multiple questions about smoking and tobacco use in order to capture all of these related concepts, simply to satisfy the measure requirements, instead of focusing on the priorities of patient care.

b) Standard calculations and definitions to ensure measure integrity and comparability.

Standard logic is essential to support the comparison of outcomes across populations. For example, while the Stage 1 ambulatory measures calculate a patient's age prior to the start of the measure period, the Stage 1 hospital measures calculate patient age at admission. In addition, "Age" is also considered in the measurement of some of the Meaningful Use Stage 1 objectives such as "Vital Signs" and "Smoking Status," although the CMS Meaningful Use specifications provide no guidance on how patient age should be computed. These different approaches to computation require unique age calculations for each individual measure, rather than one common method to calculate age across all measures. A common method would simplify the work involved in implementing these measures and alleviate confusion and inaccuracies.

c) Adoption and use of a common National Quality Forum (NQF) format for measure specifications across and between programs.

The National Quality Forum (NQF) is in the process of developing a standard data model and electronic measure (eMeasure) specification format. However, because of the compressed timeline and priority to implement clinical quality measures for Meaningful Use Stage 1, as well as other regulatory programs, CMS has adopted measures from multiple sources that use multiple specification standards. For example, in Meaningful Use Stage 1, we had a mix of NQF and Health Information Technology Standards Panel (HITSP) specifications with different definitions, formats and approaches. The NQF eMeasures specify problems and diagnoses in a way that is largely

consistent with the HIT Standards Committee glide path, using a choice of ICD-9-CM, ICD-10 or SNOMED CT. The HITSP specifications for hospitals rely entirely on SNOMED CT. Further, under the proposed Accountable Care Organization (ACO) rule, the number of different format requirements increases to include not only NQF eMeasure specifications, but CMS specifications, and other measure specifications (manual measures) which are inconsistent with EHR implementation because they rely on manual chart review. We recommend that all health IT-enabled clinical quality measures move to the NQF eMeasure format, including any relevant manual measures. A standard format for all measure specifications will generate efficiencies, promote the incorporation of measures in clinical decision support tools and accelerate the implementation and maintenance of additional quality measures.

II. Maturity of Standards

Before adopting new measures, we ask the panel to consider the maturity of both the measure specifications themselves, and the data standards referenced by those measures. Some standards may need to be enhanced or developed in their entirety. Some quality measures may need to be deferred pending the successful establishment and adoption of supporting standards within the industry. When enhancing or introducing new standards, we recommend the following:

a) Review and validate implementation that supports clinical practice.

For example, RxNorm does not support partial doses, even though it is a common clinical practice to administer only half a tablet. In a CMS audit, the care provider is expected to explain the discrepancy between what was administered and what was used in calculating the measure. While the intent of the measure may be merely to document that a specific drug was administered, the documentation and associated computational logic should be aligned to clinical practice.

b) Provide implementation guidance around handling missing, duplicative or conflicting data.

Such guidance exists today in measure specifications for manual chart review and is even more important with high volume, automated calculations.

c) Develop and deploy standards that support the evolution of eMeasure data capture.

For example, the Meaningful Use Workgroup has proposed a new Stage 2 objective for capturing a longitudinal care plan, and the Quality Workgroup has suggested adding quality measures related to the effectiveness of the care plan, including the patient's adherence to the plan. However, no current standard exists for a longitudinal care plan, the data elements which would be included or even a clinical understanding of how providers would manage the care plan across care settings. Therefore, we urge this panel to evaluate and determine whether the prerequisite data standards are in place before adopting new measures which depend upon this foundation.

III. Measure scope and methodology should be clarified

Many of the Meaningful Use Stage 1 ambulatory measures, the 69 newly released NQF eMeasure specifications and the measures being considered by the HIT Policy Committee Quality Measure Workgroup for Stage 2 require information from multiple settings and providers, potentially using multiple EHRs. Without specific guidance, it is not evident who is responsible for the calculation and submission of these measures or how claims and EHR data should be combined and used in measure calculations. We commend the Policy Committee for establishing a Methodologic Issues Tiger Team, and urge the Team to address the following critical methodological and scope issues before expanding the number of quality measures:

a) Challenge of Longitudinal Data Aggregation across Provider Settings of Care and EHRs, and Patient Encounters:

- For Stage 2, a given provider will have data only for him/herself, plus what little is currently exchanged at a sufficiently granular level. It is difficult, and of questionable value, to attribute outcomes to a specific provider for care which occurs over time across multiple settings and providers.
- The workgroups must consider the burden of connectivity and data aggregation placed on small physician practices by the measures that are selected. For example, the retooled NQF measure 270, Perioperative Care: Timing of Prophylactic Antibiotics - Ordering Physician, includes the guidance:

“For this measure, the source of the clinical data will be located in both the hospital EHR and the physician practice EHR. The denominator is identified by the procedures that are performed by the physician, whereas the clinical data required for the numerator and exceptions will be located in the hospital EHR. In order to calculate the measure, there may be some abstraction required from the inpatient record to the ambulatory physician EHR.”

b) Certification and Data Source Boundaries:

Many of the proposed NQF eMeasures rely on a blend of claims and EHR data, yet this creates questions about EHR product certification boundaries and the appropriate data sources for reporting Meaningful Use. If such measures are adopted, we ask ONC to clearly define the data sources that should be used to report Meaningful Use quality measures through an EHR.

Conclusion

As we move through Stage 1, we are learning that time pressures can lead to substantial challenges and data integrity issues for eMeasure specifications. For Stage 2, we urge the Committee to focus on solidifying the current infrastructure for health IT-enabled measurement before introducing new quality measures. Building this foundation should incorporate time for establishing the necessary data standards, completing adequate field testing and developing implementation guidelines to ensure data quality and consistent, efficient clinical workflows. Without this preparation, the validity of quality measurement will be compromised. It will provide little information to improve care, and may actually threaten, rather than enhance, patient safety by introducing suboptimal workflows. These unintended consequences could become a barrier to the adoption of technology and innovative new models of payment and care delivery. McKesson is confident, however, that if adequate time is given to test the feasibility of implementation and prepare for the subsequent impact on clinical care, we can coordinate our efforts to achieve the successful adoption of automated quality measures through health IT and, ultimately to enhance patient outcomes.

In conclusion, we reiterate McKesson's recommendations to this panel:

- Align measures and focus on common EHR data elements, standard calculations and adoption of NQF formats for measure specification;
- Evaluate the maturity of existing health IT standards and clarify the scope and methodology of measures that need to be established; and
- Solidify the current infrastructure for measurement before new quality measures are introduced.

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.