



Ensuring the Quality of Data Quality Hearing-November 30, 2012 Panel Two: Addressing Barriers to EHR-Generated Data Quality Comments of Alan Silver

Bio-sketch:

Alan Silver, MD, MPH is a medical director at IPRO, a New York-based non-profit health care assessment and quality-improvement company. He received his undergraduate, master's degree and general preventive medicine residency training at the University of Michigan, and his medical degree and internal medicine residency training at Wayne State University. In 1980, Dr. Silver helped found a general internal medicine group practice at Mount Sinai Medical Center in New York and was later a medical director in quality management at the North Shore-Long Island Jewish Health System. As a medical director at IPRO he has been involved with the CMS Quality Improvement Organization Health Care Quality Improvement Program since its inception. Much of his current work centers on the integration of health information technology into primary care practices focusing on clinical performance and patient-centered-medical-home care delivery.

Notes of comments to be given to the work group

- On behalf of IPRO, I want to thank the Quality Measures Work Group for the opportunity to participate in this session. IPRO is a non-profit health care evaluation company whose activities include being the New York State Medicare quality improvement organization (QIO).
- These comments will emphasize my colleagues and my experience on projects related to the implementation and support of clinical performance measures- predominantly in the primary care office setting. I have been involved with quality improvement work since 1993. This includes quality metric development, technical assistance in electronic health record (EHR) implementation under both QIO & ONC REC funding, care coordination and the patient-centered medical home. IPRO also is involved with EHR data quality validation; including our ongoing QIO work, work for the New York State Department of Health and a recently completed effort with the New York City Department of Health and Mental Hygiene Primary Care Information Project.
- The use of EHR-based data for quality-of-care surveillance is a great advance. Clinicians and vendors, however, are still adjusting to their use. We have seen issues related to:
 - Measure specifications
 - Measurement mapping and interfacing
 - Determination of active patient panels (the denominator)
 - Clinical work flow
 - Using the right discrete elements for measure calculation
 - Use of registries
 - Office site policies and procedures to use the data in team-based care
 - Difficulties in adjusting the metrics to match uncertainties related to day-to-day care; for example flexibility in inclusion-exclusion-synonym criteria, mapping codes to the apparent intention of the metric
 - Lack of a uniform source for code or algorithm calculation modification
 - Infrequent measure specification update
 - Examples
 - Measure specifications- Not always reflective of what is going on at the practice. For example, there have not been CPT II evaluation codes included with screening procedures such as mammography (3014F) documenting that the results have documented and reviewed. The codes relate to performing the procedure-which primary care practices don't do. In our work as a QIO and in our role as an EHR



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- evaluator for PCIP- mammography was grossly undercounted. This also occurred with other procedures such as colorectal cancer screening. Practices and vendors compensate for this by creating work-arounds to capture the intent of the metrics.
- Measurement mapping- practice uses atypical or incorrect billing or LOINC codes, labs do not use optimal sets or the practices do not have direct interfaces.
 - Determination of panels- practices are lax in identifying active patients and attributing patients to the appropriate clinicians
 - Clinical work flow
 - Issues of free text or practices being unsure of where to document for tracking (diagnostic image or lab test or consultation). We have seen instances of marked variation within a practice site.
 - Use of registries- still need to create queries and export data to formats for panel management- many practices find it difficult
 - Inability to get clarification on unforeseen situations- For example during an interaction with a vendor last week we encountered the following: for assessing aspirin (ASA) use- can one use general medication reconciliation date as a review date for a specific medication labeled as active, or must the vendor continue to insist a specific date entry for each medication? Whom to ask? Vendors can experience multiple PQRS workgroups within CMS, variable detail in response or no response, staff turnover. Vendors will look at CMS FAQ but also go to newsletters, blog and colleagues to get a sense of what might work. CMS FAQ is helpful, but insufficient and at times difficult to use.
 - Quality-metric use by office teams- a major QI stumbling block, but this mainly an organizational/training issue- not data quality per se.
- One possible way to support the quality of quality-metric data; federal support for a more robust single-source Q&A/ specifications update process for vendors and clinicians. These vendors may be the EHR vendors or external data aggregators.
 - Taken from my experience at NSLIJHS where I worked with a review team on hospital core measures for 15 hospitals.
 - Single, combined CMS-JC specification standards
 - Complete specification updates every six months
 - Questions responded to quickly- written response posted and searchable
 - Allowed me to regularly meet reviewers, clinicians and QI teams both to provide information and allow me to respond to questions from the hospitals
 - Benefit- flexibility and speed to finely adjust the measures and their collection process. This makes the measures more accurate and aids in their acceptance by to medical community; clinicians recognize there is a process to promote veracity and fairness.
 - Thank you again for the opportunity to speak to the work group.