

**Office of the National Coordinator for Health IT (ONC) Ensuring the Quality of Quality Data:
Public Hearing
November 30, 2012**

Supplementary Written Testimony of Howard S. Bregman, MD, MS, from Epic

These supplementary remarks are meant to address issues that arose during the question and answer session after the first panel testimony on November 30.

During the discussion, we were asked in what form requests for EHR feasibility testing of quality measures should be submitted to us. I responded, "just ask us". I'd like to elaborate on this response.

I don't think that a request for feasibility needs to have any particular structure, other than a description of the measure in as specific form as possible, accompanied by a request to us to evaluate it for feasibility. I think a reasonable time frame for us to respond to requests would be 4-6 weeks, depending on the number of measures. I know that feasibility "testing" is the usual nomenclature for this process, but I think feasibility evaluation is a more accurate term, as the process that we would go through to produce a response really is not a test in any usual sense.

I do think that it would be reasonable to expect a standardized response to such a request, and here are some suggestions of how that response might look. These categories would make the most sense to both the quality community and to vendors.

1. Can be gleaned from an existing workflow without any additional input from the provider or surrogate. (This is the gold standard for any quality measure.)
2. Will require extra documentation by the provider or surrogate that will be seen as consistent with existing workflows.
3. Will require extra documentation by the provider or surrogate that will be seen as intrusive or burdensome.
4. Would require a new workflow or tool.

These categories would not be meaningful without accompanying explanation of why they were chosen and what they mean in the context of the measure in question. I am sure this list can be refined with input from others, but I don't think it would change substantially or include too many more choices. Also, one should expect that a value would be assigned for each data element to be collected in the measure (including any exclusions). One score would likely not suffice for a measure with multiple elements.

My second comment is regarding the statement I made referring to the quality measure that requires the provider to attest that a complete reconciliation was done of all medications at the time of the encounter. The measure I was referring to is CMS68v1 and NQF measure 419. Let me start by saying that none of my comments should be interpreted as impugning the motives of the authors or the sponsors of this measure. There is no question that documenting a full and accurate medication list at each encounter is a laudable goal, especially so given my oral testimony regarding reconciliation.

However, I think that the MU program should choose its quality measures wisely. Beyond the considerations of validity and relevance to an important quality goal, each measure should be evaluated from a cost/benefit perspective. The benefit evaluation should look at the importance of the quality goal of the measure, how many patients would be affected and how much value would accrue to each, and how likely is the measure to significantly improve practice and to collect valid data. The cost evaluation should look at the EHR feasibility mentioned above, the burden on organizations to implement and train its users, and the burden on the individual provider. But it should also look at how the measure would be

perceived by providers, and how it would color their perspective on the Meaningful Use program as a whole.

I believe that this particular measure would score poorly in that analysis in several areas. First, I think it should be clear that measures which only measure attestation will fail to generate reliable data. When faced with a decision to attest or not to attest in a given situation, many people are going to attest by habit, not by an objective evaluation of their own behavior. In other words, the attestation is not likely to be a good proxy for the action of documenting an accurate medication list. Second, most people recognize that this is the case, and they find attestation to be a meaningless, burdensome exercise, and it colors their perspective of the entire Meaningful Use program. Third, in the EHR feasibility evaluation, this measure will score low, as I stated in my testimony.

Now there are two reasonable counterarguments that I can anticipate, one being that just by repetition of a statement that may be seen as intrusive, increased awareness and increased quality are still the result over time. One can make this argument about the safety announcements before every airline flight, or about safety time-outs that are done before surgical procedures. By constantly attesting to doing a certain action, people are reminded to actually do the action when given the opportunity. I think this argument has merit. But a message to the provider on the top of the medication list would have a similar effect, and no extra work on the part of the provider would need to be done.

The second counterargument is that this is just one of many menu measures, and any organization that finds it not meaningful or reasonable can choose not to implement it.

To this argument I would say that the risk of this approach is that an organization may implement this measure primarily because it can apply to physicians of all types, minimizing the total number of measures they must implement. They may not appreciate the burden it places on individual users. In that case, the users may have a negative perspective on the Meaningful Use program as a result, which is to be avoided.

On the balance, I feel that the cost of this measure outweighs the potential benefits, and therefore I think it should not have been incorporated into the Meaningful Use program.