HIT Policy Committee: Hearing on Meaningful Use Measures Related to Specialists, Smaller Practices and Hospitals, and Providers of Underserved Populations

Questions and Responses from National Quality Forum:
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1. *What is the current state of quality measures that pertain to specialists? Can you provide an inventory of relevant specialty measures? Can the measures be automated through HIT?*

   The current portfolio of NQF measures is quite diverse with over 500 endorsed performance measures. While more than 100 measures would be broadly applicable to a wide range of clinicians, there are numerous specialty areas where a sizable number of measures have been endorsed. There are also measures that reflect shared accountability between clinicians (e.g., congestive heart failure readmission measures), with a clear component of care related to specialty care (e.g., cardiologist care for CHF).

   Among the currently endorsed measures, the majority of specialties have at least 10 measures per specialty with numerous examples of more robust sets of quality measures. For example, there are approximately one hundred measures each related to cardiology and surgery; approximately thirty measures related to pediatric care; approximately twenty measures each related to cardiac surgery, endocrine, infectious diseases, nephrology, neurology, emergency medicine, and psychiatry. There are considerably smaller number of measures related to certain specialty areas, such as gastroenterology, pulmonary, rheumatology, and urology.

   There are an additional 70 measures in the final stages of the endorsement process that are based on clinically enriched administrative data specifications and represent a wide range of specialties. NQF has also recently begun a large project focuses on outcome measures for 20 high impact clinical conditions in which a sizable number of specialty measures are anticipated.

   While it is not known exactly how many of these measures could be automated through HIT, there would likely be a sizeable number that can be effectively retooled for EHRs. The NQF experience to date would suggest that the majority of measures that were selected for retooling can be automated for EHRs without significant burden. The role of clinical registries as the source for a large number of measures, through the Society of Thoracic Surgeons and the American College of Cardiology, would suggest that EHR systems interoperable with clinical registries would significantly increase the number of available specialty measures. In addition, as the EHRs are increasingly designed to meet the data needs of specialists, the systems should be able to support more robust specialty measures.

2. *Who develops quality measures for specialists? What are the impediments to their development?*

   The quality measures for specialists are frequently developed by the specialty societies, often in collaboration with the Physician Consortium for Performance Improvement (PCPI) and the National Committee for Quality Assurance (NCQA). The linkage to specialty societies is likely related in part to the underlying role in guideline development for specialty societies. There is also an emerging

growth of clinical registries as the source for specialty based measures that are also frequently affiliated with specialty societies. There are many broad-based measurement initiatives, such as the Surgical Care Improvement Project (SCIP) and the AHRQ Quality Indicators that have been developed under contract to the federal government. Lastly, health plans and others have a long history of developing physician-level measures that run off of clinically enriched administrative data.

There are several important impediments to development of quality measures for specialists:
1) Lack of financial support for measure development;
2) Lack of available clinical data in most readily available data sources to date; and
3) Limitations of clinical guidelines that can support performance measures

While many specialty societies have invested heavily in guideline development, few specialty societies have had the resources to adequately fund measure development. Measure development has frequently been done in collaboration with PCPI and NCQA. Lack of adequate funds has also limited support for crucial steps in measure development, such as support for field testing to ensure reliability and validity. Measure development has also been driven by the need to rapidly develop measures using readily available data, such as the use of Category II CPT coding rather than primary clinical data. It is hoped that the transition to EHRs will encourage initial measure development for EHRs, rather than retooling measures that were envisioned for a less robust source of clinical data. Finally, measure development has been limited by the clinical guidelines that frequently serve as the basis for performance measures. Clinical guidelines are often not developed with quality measurement in mind and translation is limited by lack of specificity (e.g., periodicity of testing); lack of precise definitions (e.g., "high risk"); and use of imprecise "action" terms (e.g., "may consider"). There has also been a tendency to focus on the "measurable" branch points from guidelines, even if the less measurable branch points could support greater improvements in quality and outcomes.

3. *To what extent are they used in quality improvement and public reporting? What are the impediments to their use?*

Many of the currently available specialty measures are used in quality improvement and public reporting programs. The specialty measures have been extensively used in the PQRI program, as well as the hospital value based purchasing program. Registry based measures have been used for quality improvement and benchmarking purposes, though public reporting has been limited to date. In addition, many of the specialty measures are embedded within maintenance of certification through the specialty boards.

Impediments to wider use of specialty measures include the burden of data collection and methodological challenges. Many specialty measures rely on medical record abstraction or special data collection and coding, such as Category II CPT coding that has had limited adoption beyond the PQRI program. Many of these measures can be retooled for EHRs and it is expected that adoption should increase. NQF efforts to harmonize measures should also reduce the burden on specialists for reporting of multiple measures to different entities. There are also methodological challenges that impede specialty measurement in certain areas, especially when measuring at the level of individual clinician or small practice requires sufficient sample size and adequate risk adjustment.

4. *Are there any possibilities for cross-cutting measures that would apply to all or to a broad cross-section of specialists?*

   An extensive number of cross-cutting measures are broadly applicable to a wide range of specialists and generalists alike. Many of these cross-cutting measures that would be broadly applicable to specialists reflect the priorities and goals of the National Priorities Partnership. Some of these measures are already available, such as smoking cessation counseling and assistance, avoidance of hospital falls, medication reconciliation, and patient experience of care measures. Additional measures that reflect transitions in care and care coordination are expected in the short-term and would be important measures for both generalist and specialists. Hospital mortality and readmission measures for certain conditions are also useful across a wide range of specialists in the hospital and community. With broad specialties such as surgery, there are cross-cutting measures already in use, such as the rate of surgical site infections, post-operative complications, and venous thromboembolism prophylaxis. Additional cross-cutting surgical measures could include unexpected return to the operating room, admit to hospital after ambulatory surgery, composite measure associated with processes to prevent surgical site infections, timely transmission of an operative note shared with referring provider. NQFs current work in the area of cross-cutting and condition-specific outcomes should provide additional measures appropriate for specialists.

5. *In the context of the meaningful use care goals and objectives, what do you see as the most effective, efficient process for arriving at a set of measures that would apply to all or most specialties?*

   An efficient and effective process for arriving at a set of measures that would broadly applicable to most specialties would be to focus on the cross-cutting priority areas identified by the National Priorities Partnership. These six national priorities present important opportunities for measures that could be widely applicable across specialists and generalists alike. The priorities of population health, care coordination, overuse, patient safety, and patient and family engagement are excellent opportunities for shared accountability across specialties. While many measures should work well across specialties, NQF is also open to endorsement of specialty-specific measures within these priority areas, such as the current development of a Surgical CAHPS instrument. Greater emphasis on measures that reflect shared accountability for outcomes of the health care system should lead to a right-sized set of endorsed NQF measures that would be broadly applicable to a wide range of specialties.

   Measure development across a range of specialties should also benefit from a recently initiated NQF effort that will build an agenda for measure development and endorsement to ensure strategic development of the measures needed for a variety of purposes, including measures needed for meaningful use. This work will begin with efforts to identify high priority conditions and associated measures under contract to HHS. Through this effort to strategically identify measurement gaps, NQF will work with a broad group of stakeholders, including measure developers, to ensure that the measure development pipeline is more closely related to identified gaps. A multistakeholder meeting in January 2010 will launch this work with additional work through 2010 to develop the action plan for gap filling.

Another important opportunity for effective and efficient measure development is the development of measures from clinical registries integrated with EHRs. While many specialties require information unique to the specific conditions/procedures, the capacity to integrate specialty-specific data from clinical registries into electronic health records should provide important opportunities for rapid measure development of most interest to specialists.