

QUALITY MEASURES PANEL: RESPONSE TO QUESTIONS
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Q1. Outcome Sciences works with over twenty medical and surgical professional societies and patient organizations on quality measurement and improvement programs. We work with over 1800 U.S. hospitals and several thousand physician office practices in implementing quality measurement and reporting. These quality registries, both regional and national, collect and confidentially benchmark quality measurement across organizational boundaries. In terms of the Quality Work Group's model, these registries serve in the role of both Data Collection Assistant and Quality Report Processing Entity. As I will describe later, many of these registries have proven to be highly effective in measuring and improving quality of care. In addition to standardization of definitions used in national quality measures, two challenges in broad based quality measurement are the work effort required to collect the data and the ability to do so across multiple care settings so that longitudinal patient outcomes can be collected. We believe that both can eventually be addressed through standards based approaches. To date, we have primarily utilized standards to address the first of these issues—assisting in the collection of data. We have had varying levels of success using different approaches that I will describe later. The group of standards that have shown the greatest promise in our experience for facilitating quality measurement between organizations as it is currently performed are the integration (e.g., HITSP TP-50) and the content (e.g., HITSP C76) profiles.

Q2. First, in all of these programs, implementing quality measurement between organizations is in fact a core component of quality improvement because it is clear that benchmarking is a crucial piece of the QI process. Using this approach, the American Heart Association's Get With the Guidelines® registries in stroke, coronary artery disease and heart failure, for example, have been demonstrated to improve care in multiple studies and publications beyond what has been achieved in institutional programs that do not have rapid presentation of comparison information.

Second, quality measurement between organizations will become more important as we eventually develop next generation quality measures—those that focus on longer term outcomes—because patients move between organizations. In other words, to reduce bias in measurement, outcomes information will need to be collected from different organizations that care for the same patient.

Third, many of our clients are national professional associations that are actively developing and testing future quality measures and these measures need to be tested across multiple organizations to better understand performance characteristics in different settings, disparities in care, and opportunities for improvement. We further believe that standards that enable measure development and testing across organizations is an infrastructure need—as evidence development is an ongoing pursuit.

Q3. Before describing success, let me explain some of the key challenges faced by our clients that have bearing on the use case for quality measurement. The list of currently endorsed, nationally standardized measures is relatively short and most of these measures focus on process. All of the professional association clients we work with, are actively developing, implementing and benchmarking both new and next generation quality measures. The latter measures focus on outcomes, rather than process, and require the collection of condition-focused information on risk factors, treatments and longitudinal outcomes, including patient reported information.

In our experience, only a portion of the data required to generate the measures currently exist (including the appropriately defined data elements), in most EHRs; and, since these clients are testing or actively modifying their measure specifications, the measure definitions are subject to periodic change, as frequently as several times per year.

To date, our efforts at standards implementation have focused on automating the process of data collection, as this is the most expensive and burdensome part of the current paradigm. We have tried several different standards based approaches to this problem, such as webservice transfers of the Continuity of Care Document, and I will be happy to address the success and frustrations with that approach during Q&A, but by far the most promising results, in our experience through multiple implementations, have come from using a standard integration profile (e.g., HITSP TP 50, IHE RFD) and a content profile (e.g. HITSP C76, IHE Clinical Research Data Capture(CRD) and Drug Safety Content(DSC)).

In brief, the standard integration profile opens a circuit to allow an EHR to exchange information with the registry. When an eligible or returning patient is identified, a data collection form is retrieved and surfaced within the EHR, and the content profile then is used to pre-populate that form with data that is contained within the EHR (e.g. the HL7 Continuity of Care Document). But as noted above, there is typically additional data required for the quality measure, or, there are changes in the measure from time to time, and both of these cases can require additional data entry. Using this set of standards, if there is additional data not contained within the EHR, that data can be entered directly by the provider during the same encounter and user session.

This approach has been successfully deployed for several professional society driven quality measurement programs, including for example the American College of Rheumatology Rheumapoint Registry and the American Society of Plastic Surgeons TOPS programs. In users of EHRs that have implemented this standards package, it significantly reduces the burden of data collection for providers. For example, in a rheumatology registry focused on gout, approximately 70% of the data elements can be completed from the CCD and the remaining elements completed by the clinician during the encounter. We have had similar success using this combination of standards in automating data collection from EHRs to the Outcome CMS Physician Quality Reporting Initiative registry as well. We have found that provider user satisfaction with the model is extremely high.

Frankly, the greatest frustration for both our professional association clients and the physicians who participate in their quality measurement programs is that this level of standards-based interoperability is only currently available from one or two EHRs. As a result, these solutions have produced remarkable demonstrations, but will not have practical impact until a majority of EHRs have enabled their systems to use such standards in a provider determined way.

Q4. We strongly support the efforts of the committee in identifying methods for implementing standards based quality measurement across organizational boundaries. To accelerate adoption of health information technology standards for quality measurement, we strongly advocate broader implementation of tested interoperability standards (such as HITSP TP-50, HITSP C76, etc.) that have already shown tremendous promise in assisting data collection in multiple demonstrations, and to do so sooner rather than later. We believe that one of the most important advantages of this approach is the ability to further query the provider through the EHR for additional data elements not contained within the EHR –which is common in national quality measurement programs, where some degree of definitional change is a reality as new measures are being developed or tested. Finally, although not discussed because of time limitations, with the evolution to quality measures based on longitudinal outcomes, it will be critical that the implemented standards enable the collection and aggregation of information for one measure from more than one health IT system for the same patient and at different time points. This will require a standards-based method for confidential patient indexing.

Thank you for the opportunity to present on this important panel and I look forward to your questions.