

Characteristics of Optimal Clinical Quality Measures for Health IT Tiger Team

Karen Kmetik, Chair

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- April 2nd Review purpose, perspectives, and attributes
- April 5th Define and use optimal characteristics for evaluation of quality measures
- April 19th Vet examples, finalize recommendations

The Characteristics of Optimal Clinical Quality Measures for Health IT Tiger Team will focus on identifying the attributes of optimal clinical quality measures that are created or “re-tooled” for use in Health IT.

The characteristics of optimal clinical quality measures evaluated by this Tiger Team are from a technical lens, not from the perspective of the importance of the quality measure per se.

We are interested in applying this technical lens to measures we have and those we seek (eg, longitudinal, patient-reported, clinical outcomes).

What Makes an Optimal Quality Measure?

Usability

Fits into traditional workflow – does not slow down the provider

Does not require users to capture information

Feasibility

The data to be captured is specific enough to be captured

The information is recorded in the EHR

Accuracy

Data reported is captured correctly

Recording data for reporting has few errors

Standard Terminology

Reduces variations in interpretation

Reduces workarounds and hard-coding of choices

- Availability of data – The data must be captured in traditional workflow (may include data coming from other source into the practice site EHR). The data may be available now or could be available with reasonable workflow changes. If data are not realistically captured in the workflow, they are not available.
 - An example may be a data element “lack of particular symptoms.”
 - Another example is “blood drawn before antibiotics are given,” requiring time stamps.
- Redundancy – The data capture should not be redundant unless perhaps tied to clinical decision support, care coordination (?)

- EHR Feasibility – Functionality and data to support the quality measure exist (expected) in most EHRs and could exist within reason for stretch quality measures (data accessible).
- EHR Enabled – The quality measure is enabled due to data being in electronic format. These items are difficult to measure on paper or non-electronic formats.
- EHR Sensitive – Performance on the measure is improved by the meaningful use of EHRs and can be measured by improved outcomes and clinical performance

- Accuracy – For clinical quality measures to be optimal, they need to be accurate, and accuracy has three parts:
 - Data are captured correctly and queried correctly (clear, detailed specifications)
 - Process of collection has few errors
 - Knowledge that the data itself are accurate irrespective of capture mechanism
 - An example is when ICD-9 is captured without error, the process had no error, but the data are captured using a vague ICD code that doesn't provide accuracy.
 - Another example is when the patient gives the time of his last meal but isn't sure of the time and doesn't say that he isn't sure

- Standard Terminology Usage (shared meaning) - Data needed for quality measures should be captured using standard terminology to avoid variations in interpretation and to reduce hard-coding of choices and workarounds.
 - We want confidence that practice A/EHR A and practice B/EHR B are using the same terminology for data elements
 - The data should be easily aggregated because the data are using common standards as dictionaries. For example, everyone uses the same value set to identify the population of patients with diabetes for a particular measure.

- For purpose of discussion,
 - Assume quality measure is measure we highly value
 - We gather information as to whether measure meets our attributes (multiple practice sites, EHRs)
 - Would we want to bucket results so as to direction action/decision?

For example, thinking about just EHR feasibility

- Feasible today for the majority of EHRs and sites
 - How will we assess this? For example, consensus of a sample of sites and EHRs?
- Feasible with reasonable workflow changes
 - How do you define reasonable? From the perspective of the provider?
- Feasible with reasonable technical change that site can make (add a discrete field)
 - Does it have to be mapped to standardized terminology?
- Technical change needed by EHR provider
 - How do we make sure that it doesn't add unreasonable workflow or non-standard terminology capture?
- Infeasible
 - what are valid reasons?

Discussion