

Health IT Policy Committee

A Public Advisory Body on Health Information Technology to the National Coordinator for Health IT



Advanced Health Models and Meaningful Use Workgroup

Stage 3 NPRM Group 1: Overall Approach

May 12, 2015

Advanced Health Models and MU Workgroup Members



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- **Paul Tang**, Palo Alto Medical Foundation (Chair)
 - **Joe Kimura**, Atrius Health (co-chair)
 - **Shaun Alfreds**, HealthInfoNet
 - **Cheryl Damberg**, Rand Corp.
 - **Arthur Davidson**, Denver Public Health Department
 - **Marty Fattig**, Nemaha County Hospital (NCHNET)
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 - **Norma Lang**, University of Wisconsin
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 - **Mark Savage**, National Partnership
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- **Jessica Kahn**, Centers for Medicare and Medicaid Services
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- **Samantha Meklir**, Office of Policy
 - **Alex Baker**, Office of Care Transformation



- NPRM respondent process
 - Divide 8 objectives and key questions amongst 4 WGs
 - Advanced Health Models and Meaningful Use WG
 - Interoperability and HIE WG
 - Privacy and Security WG
 - Consumer WG
 - Reconcile responses
 - Presentation to HITPC



- Small Group Assignments
 - Group 1: Assess overall approach
 - Group 2: CDS+ (eRx, CDS, CPOE)
 - Review objectives 2, 3, 4
 - Group 3: Population and Public Health
 - Review objective 8
 - Group 4: Quality Measures



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Subgroup 1: Overall Approach

Group 1: Assess overall approach



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- *Paul Tang, Lead*
- Mark Savage
- Charlene Underwood
- Shaun Alfreds
- Frederick Isasi



- Assessment of CMS Approach to Stage 3 Meaningful Use NPRM
 - Simplify the programs
 - Reduce burden
 - Provide more flexibility

Overarching Approach

Simplification - Comments



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- Unify stages to single stage (stage 3) by 2018 **(AGREE)**
 - Single stage easier to understand
 - Synchronizes internal compliance activity
 - Synchronizes capabilities with trading partners for interoperability
- Align reporting periods **(AGREE)**
 - Easier to understand
 - Synchronizes internal and partner reporting activities
 - Does create peaks of activity with uniform reporting deadlines

Overarching Approach

Burden Reduction - Comments



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- Reduced number of objectives emphasizing advanced functionality (**AGREE**)
- Remove duplicate and topped out measures (**AGREE**)
- Remove paper-counting measures; focus on electronic only (**AGREE**)



- Allow providers to attest to MU3 in 2017; require all providers to attest to MU3 in 2018 (**AGREE, with modification**)
 - Providers appreciate the flexibility
 - Allowing MU3 as optional in 2017 does make it mandatory for vendors
 - 3 options that affect timelines:
 - Optional 2017, mandatory 2018, full 2015 Certification
 - Mandatory 2018 (no optional 2017), full 2015 Certification
 - Optional 2017, mandatory 2018; partial 2015, partial 2014 Certification
- One year reporting period (**AGREE**)
 - **But**, if a shorter reporting period becomes considered, the WG recommends keeping the (shortened) reporting period synchronized (vs. any 90 days) among providers to facilitate electronic HIE

Overarching Approach

Flexibility – Comments (continued)



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- Flexibility related to the following measures:
(AGREE)
 - Health information exchange (report on 3, but meet threshold on 2)
 - Consumer engagement (report on 3, but meet threshold on 2)
 - Public health reporting (EPs report on 3 and EHs report on 4)



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Group 2: CDS+ (eRx, CDS, CPOE)

Group 2: CDS+ (eRx, CDS, CPOE)



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- *Michael Zaroukian, Lead*
- Devin Mann
- Lisa Marsch
- Marty Fattig



Objective 2 (e-Prescribing) is comprised of two measures:

- **EP Measure:** More than **80%** of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.
- **EH Measure:** More than **25%** of hospital discharge medication orders for permissible prescriptions (for new and changed prescriptions) are queried for a drug formulary and transmitted electronically using CEHRT.

Exclusion:

- **EP:** Any EP who: (1) writes fewer than 100 permissible prescriptions during the EHR reporting period; or (2) does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his or her EHR reporting period.
- **EH:** Any eligible hospital or CAH that does not have an internal pharmacy that can accept electronic prescriptions and there are no pharmacies that accept electronic prescriptions within 10 miles at the start of their EHR reporting period.

Objective 2 Description



Stage 3 NPRM Measures	Proposal	Recommendations
<p>EP Measure: More than 80% of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.</p> <p>EH Measure: More than 25% of hospital discharge medication orders for permissible prescriptions (for new and changed prescriptions) are queried for a drug formulary and transmitted electronically using CEHRT.</p>	1. Overall Objective/increase thresholds	1. AGREE: See additional considerations.
	2. Allow for inclusion of scheduled drugs where such drugs are permissible to be electronically prescribed?	2. AGREE: See additional considerations.
	3. Continue to exclude OTC medicines in this objective for Stage 3?	2. REC CHANGE: Do not exclude OTC medicines in this objective for Stage 3 but make optional.
	4. Limit measure to only new and changed prescriptions (exclude refills previously included in Stage 2)?	2. REC CHANGE: Do not limit measure to only new and changed prescriptions.

Objective 2 Annotated Discussion (I)



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1. **AGREE:** Overall objective/threshold increase.
 - We note that 25% may be reasonable for EH but CMS should recognize frequent uncertainty by patient of what pharmacy they would like to use, or transmittal to SNF, or assisted living facility that is not connected to eRx.
 - We also note that it is hard to justify requiring querying for a formulary when one is likely not to be present for the patient's insurance, and lack of transparency and helpful CDS in formularies (including cost, e-preauthorization, etc.). This requirement adds little value.

2. **AGREE:** Allow for inclusion of scheduled drugs where such drugs are permissible to be electronically prescribed.
 - Consider allowing providers to include controlled substance Rxs effective a specified implementation date, even if it falls within the reporting period.

Objective 2 Annotated Discussion (II)



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3. **REC CHANGE:** Do not exclude OTC medicines in this objective for Stage 3 but make optional.
 - Allowing (but not requiring) OTC medications to be ePrescribed and to count would enhance providers' ability to ensure that patients are "prescribed" the right meds (including OTCs) and potentially get fill histories on whether they do so, check for drug interactions, etc.

4. **REC CHANGE:** Do not limit measure to only new and changed prescriptions.
 - Disagree with removal of "refill" prescriptions. Important to encourage patient-centered practice to "renew" medication at discharge for a patient who needs one and a prescriber who is comfortable providing one.



Objective 3 (Clinical Decision Support) is comprised of two measures:

- **Measure 1:** The EP, eligible hospital and CAH must implement five clinical decision support interventions related to four or more CQMs at a relevant point in patient care for the entire EHR reporting period. Absent four CQMs related to an EP, eligible hospital, or CAH's scope of practice or patient population, the clinical decision support interventions must be related to high priority health conditions. CDS encouraged in the following areas:
 - Preventive care;
 - Chronic condition management;
 - Heart disease and hypertension;
 - Appropriateness of diagnostic orders or procedures such as labs, diagnostic imaging, genetic testing, pharmacogenetic and pharmacogenomic test result support or other diagnostic testing;²
 - Advanced medication-related decision support, to include pharmacogenetic and pharmacogenomic test result support.
- **Measure 2:** The EP, eligible hospital, or CAH has enabled and implemented the functionality for drug and drug allergy interaction checks for the entire EHR reporting period.

Objective 3 Description



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Stage 3 NPRM Measure	Proposal	Recommendations
<p>Measure 1: The EP, eligible hospital and CAH must implement five clinical decision support interventions related to four or more CQMs at a relevant point in patient care for the entire EHR reporting period.</p> <p>Measure 2: The EP, eligible hospital, or CAH has enabled and implemented the functionality for drug and drug allergy interaction checks for the entire EHR reporting period.</p>	<p>1. Overall measures/objective.</p>	<p>1. AGREE: See additional considerations.</p>



1. **AGREE:** Overall measures/objectives.
 - For Measure 1, CMS should provide more guidance about the definition of "high priority health conditions." (not clearly synonymous with "CMS Encouraged" areas.
 - For Measure 2, CMS should provide more guidance about how providers may calibrate/filter drug-drug interaction alerts, e.g. to optimize usability by focusing on high priority alerts, while still meeting measure.
 - Consider behavioral health as an additional priority area.
 - CMS should reiterate current policy that "licensed health professionals" includes credentialed medical assistants, akin to policy for CPOE.



Objective 4 (CPOE) is comprised of two measures:

- **Measure 1.** More than **80%** of **medication orders** created are recorded using computerized provider order entry.
- **Measure 2:** More than **60%** of **laboratory orders** created are recorded using computerized provider order entry.
- **Measure 3:** More than **60%** of **diagnostic imaging orders** created are recorded using computerized provider order entry.
- **Exclusion:** Eligible Professional can be excluded out of each respective measure if they write fewer than 100 diagnostic imaging, lab, or imaging orders during the EHR reporting period.

Objective 4 Description



Stage 3 NPRM Measures	Proposal	Recommendations
<p>Measure 1: More than 80% of medication orders created are recorded using computerized provider order entry.</p>	<p>Expand the objective to include diagnostic imaging, which is a broader category including other imaging tests such as ultrasound, magnetic resonance, and computed tomography in addition to traditional radiology?</p>	<p>1. AGREE: See additional considerations.</p>
<p>Measure 2: More than 60% of laboratory orders created are recorded using computerized provider order entry.</p>	<p>Continue to allow, but not require, providers to limit the measure of this objective to those patients whose records are maintained using CEHRT?</p>	<p>2. AGREE: See additional considerations.</p>
<p>Measure 3: More than 60% of diagnostic imaging orders created are recorded using computerized provider order entry.</p>	<p>Are there circumstances which might warrant an additional exclusion for an EP such as a situation representing a barrier to successfully implementing the technology required to meet the objective?</p>	<p>3. AGREE: See additional considerations.</p>
<p>Measure 3: More than 60% of diagnostic imaging orders created are recorded using computerized provider order entry.</p>	<p>Are there circumstances where an eligible hospital or CAH which focuses on a particular patient population or specialty may have an EHR reporting period where the calculation results in a zero denominator for one of the measures?</p>	<p>4. DISAGREE</p>

Objective 4 Annotated Discussion



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1. **AGREE:** Expand the objective to include diagnostic imaging.
 - Consider more guidance about whether providers have flexibility to define diagnostic imaging broadly, e.g. is an order for dermatology images (e.g., wound) a diagnostic image if it is accompanied by a report? How about an ECG? EEG?
2. **AGREE:** Allow, but not require, providers to limit measure to patients whose records are maintained using CEHRT.
 - Consider larger concern with this measure. Trying to count the orders never entered into the CEHRT is 1) far too burdensome and 2) invites people to under-report because it is virtually impossible to count accurately.
3. **AGREE:** Need for additional exclusion due to technology barriers.
 - There are likely many groups that will face barriers to implementation given technology barriers, resource requirements, and weak usability provided by vendors (certified but poorly usable for implementation and maintenance).
4. **DISAGREE:** Likelihood of certain EHs or CAHs having a zero denominator.
 - This will be an unlikely circumstance. If so, EH or CAH may use the proposed exclusion for less than 100 orders.



Advanced Health Models and Meaningful Use Work Group

Group 3: Population and Public Health

Group 3: Population and Public Health

Objective 8



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- *Joe Kimura, Lead*
- Amy Zimmerman
- Arthur Davidson
- Neal Patterson
- Terry O'Malley
- Jim Daniel, ONC Staff Lead

Objective 8 Overview



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- Objective 8 (Public Health and Clinical Data Registry (CDR) Reporting): The EP, EH, or CAH is in active engagement with a Public Health Agency (PHA) or CDR to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice.
- Objective contains 6 measures:
 - EP must meet 3 of 5
 - EH/CAH must meet 4 of 6
- Comments:
 - Measure 3 is brand new
 - Measures 4 & 5 are closely related
 - 5 of 6 measures with new standards

MEASURE SUMMARY	
Measure 1	Immunization Registry Reporting
Measure 2	Syndromic Surveillance Reporting
Measure 3	Case Reporting
Measure 4	Public Health Registry Reporting
Measure 5	Clinical Data Registry Reporting
Measure 6	Electronic Reportable Lab Reporting

(Source: CMS Stage 3 NPRM)

Summary of Stage 2 Experience



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Stage 2 Experiences	
Measure 1 Immunization Registry Reporting	<ul style="list-style-type: none">• 93.75% of State Public Health Agencies (PHA's) are currently accepting data for both Eligible Providers (EPs) and Eligible Hospitals (EHs).
Measure 2 Syndromic Surveillance Reporting	<ul style="list-style-type: none">• 81.25% of PHA's are currently accepting data for EHs• 37.50% of PHA's are currently accepting data for EPs
Measure 3 Case Reporting	Not Applicable
Measure 4 Public Health Registry Reporting	<ul style="list-style-type: none">• 75.00% of PHA's are currently accepting data for Cancer Registries• 12.50% of PHA's are currently accepting data for Specialized Registries
Measure 5 Clinical Data Registry Reporting	Not Applicable
Measure 6 Electronic Reportable Lab Reporting	<ul style="list-style-type: none">• 93.75% of PHA's are currently accepting data



In general, the AHM & MU workgroup agrees with the direction and goals of the Objective 8 measures

- Important to expand the use of data between delivery systems and public health agencies to improve the care of patients & communities
- Consistent with Interoperability Roadmap
- Begins to set information exchange foundation for population health activities that extend beyond traditional providers

Our major concerns in this objective center around:

- The need for more clarity around timing & what qualifies as eligible
- Focus on unidirectional reporting to PHA when bi-direction exchange may be required for timely tangible benefits to patients and communities



Measure 1 (Immunization Registry Reporting):

- The EP, EH, or CAH is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).

Exclusion:

- Any EP, EH, or CAH meeting one or more of the following may be excluded if the EP, EH, or CAH:
 1. Does not administer any immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR reporting period;
 2. Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or
 3. Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data at the start of the EHR reporting period.



We recommend the following on Measure 1:

1. Since more clinically relevant forecasting may be from either IIS or EHR, need to clarify CMS rule that says forecast and history need to be received but is silent on what is done with the information. ONC cert rule certifies display, but CMS rule does not require.
2. If state /IIS is not ready to do bi-directional exchange, clarify in the exclusion that providers could take an exclusion.



Measure 2 (Syndromic Surveillance Reporting):

- The EP, eligible hospital, or CAH is in active engagement with a public health agency to submit syndromic surveillance data from a non-urgent care ambulatory setting for EPs, or an emergency or urgent care department for eligible hospitals and CAHs (POS 23).



We recommend the following on Measure 2:

1. Keep EH and Urgent care as noted;
2. Syndromic surveillance for public health issues (infections, violence, trauma) is distinct in both content and required timing from syndromic surveillance for chronic conditions (diabetes, hypertension, obesity). If chronic condition surveillance required, consider new measure.
3. To support benefit to patients/communities, should consider support of iterative loop between providers and PHA around “suspected” and “established”.
4. Ambulatory chronic condition syndromic surveillance appears to have more Population Health (Measure 4) meaning and may combine ambulatory + hospital data.



Measure 3 (Case Reporting):

- The EP, eligible hospital, or CAH is in active engagement with a public health agency to submit case reporting of reportable conditions.

(*NEW reporting option that was not part of Stage 2)

Exclusion:

- Any EP, EH, or CAH meeting one or more of the following may be excluded if the EP, EH, or CAH:
 1. Does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction's reportable disease system during the EHR reporting period;
 2. Operates in a jurisdiction for which no public health agency is capable of receiving electronic case reporting data in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or
 3. Operates in a jurisdiction where no public health agency has declared readiness to receive electronic case reporting data at the start of the EHR reporting period.



We recommend the following on Measure 3:

1. Consider bi-directional component (e.g., use of knowledge management systems for triggers) in the measure definition to drive value to both parties.
2. With differences in data collected, need to ensure that jurisdictions have the capacity to receive the data. (CDC/ASTHO Public Health Community Platform)
3. Consider bi-directional component (e.g., use of knowledge management systems for triggers) in the measure definition to drive value to both parties. If no bi-directional exchange capability from PHA, potential exclusion.



Measures 4 and 5 (Public Health and Clinical Data Registry Reporting):

- The EP, eligible hospital, or CAH is in active engagement to submit data to a public health/clinical data registry reporting.

Exclusion:

- Any EP, EH, or CAH meeting at least one of the following criteria may be excluded if the EP, EH, or CAH:
 1. Does not diagnose or directly treat any disease or condition associated with a clinical data registry in their jurisdiction during the EHR reporting period;
 2. Operates in a jurisdiction for which no clinical data registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the HER reporting period; or
 3. Operates in a jurisdiction where no clinical data registry for which the EP, eligible hospital, or CAH is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period.



We recommend the following on Measures 4 and 5:

1. Regulation of what registries would “count” needs to be expanded. Only registries with standards called out are specific to Measure 4 and not Measure 5. Currently, many Stage 2 specialized registries appear not to count. Examples: FDA (Mini-sentinel), PCORI (PCORnet)
2. No bi-directionality component to registries discussed.
3. PHR and CDR distinction needs better definition.
4. Exclusions for both need to acknowledge existence of national registries independent of jurisdiction.



Measure 6 (Electronic Reportable Laboratory Result Reporting):

- The eligible hospital or CAH is in active engagement with a public health agency to submit electronic reportable laboratory results.

We recommend the following on Measure 6:

General Comment:

Syndromic surveillance measure now includes some lab data, so need to better define difference between ELR & Syndromic Surveillance.

1. Regulatory goal is for public health to receive all laboratory reports consistent with local regulations.
2. To support benefit to patients/communities, should consider support of iterative loop between providers and PHA around “suspected” cases and laboratory “confirmed” cases.

Recommendations on NPRM Questions



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Proposal	Comments
Active Engagement Option 1: Completed Registration to Submit Data	Agree
Active Engagement Option 2: Testing and Validation	Recommend Change: Define “response” for validation phase. Propose to allow for acknowledgement and intent to fix within 30 days and not a code change and fix within 30 days of request. (Example: "Providers must respond to PHA or, where applicable, the CDR within 30 days of request through acknowledgement of request and process for investigation.")
Active Engagement Option 3: Production	Recommend Change: Address requirements if active production engagement is disrupted on either PHA/CDR or EP/EH/CAH side. (Example: "Providers must respond to PHA or, where applicable, the CDR within 30 days of request through acknowledgement of request and process for investigation.")

Recommendations on NPRM Questions, continued



Proposal	Comments
<p>Provide support to providers seeking to meet the requirements of this objective by creating a repository of national, state, and local PHA and CDR readiness.</p> <p>Additionally, comment on the use and structure of the centralized repository</p>	<p>Recommend Change:</p> <ul style="list-style-type: none"> • National, state, and local PHA and CDRs must register readiness of ability to accept each measure or intent to accept future registry data within 12 months prior to reporting period. • Registration must include type of settings currently accepting or intent to accept, including any exclusion or specialties they are not accepting from. • If a separate required implementation guide if other than CEHRT guide is required by the registries or through state flexibility, a link to the required implementation guide must be included. • To ensure registries options, a minimum of three PHA and three CDR registries must be available as currently accepting or intend to accept in the future. Registry hosts would need to commit to development once system is on the list. Providers could meet measure by registration of intent if registry is not ready in time. <p>Change allows:</p> <ol style="list-style-type: none"> 1) Providers to appropriately plan, purchase, implement and develop based on available measures, 2) States time to develop readiness for current and new development of systems, and 3) Vendors to develop systems for meeting applicable implementation guides. 4) Requires CMS repository to be ready by January 2017

Recommendations on NPRM Questions, continued



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Proposal	Comments
<p><u>EP Measure:</u> EPs would be required to choose from measures 1 through 5, and would be required to successfully attest to any combination of three measures.</p> <p><u>EH and CAHs Measure:</u> required to choose from measures one through six, and would be required to successfully attest to any combination of four measures.</p>	<p>Recommend Change:</p> <ul style="list-style-type: none">• An EP/EH/CAH sending the same data to multiple unique registries should get credit for active engagement in each registry as long as the data sent to each registry satisfies the data criteria & purpose of each specific registry.• It should not matter that an EP/EH/CAH has used the same data



Advanced Health Models and Meaningful Use Work Group

Group 4: Quality Measures

Group 4: Quality Measures



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- *Cherly Damberg, Lead*
- Norma Lang
- Ginny Meadows
- Sumit Nagpal

Overview of Quality Measure Questions in NPRM (1 of 2)



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- **# of CQMs vendors must certify to:** CMS believes EHRs should be certified to more than the minimum number of CQMs required by one or more CMS quality reporting reports. Three options were proposed for comment.
 - Option 1- EP vendors certify to all CQMS
 - Option 2- Phased approach
 - Option 3- EHRs certified to more than the minimum of CQMs
- **Alignment with CMS Quality Measurement Programs:** The Stage 3 NPRM further supports efforts to align the EHR Incentive Programs with CMS quality reporting programs that use certified EHR technology (e.g., the Hospital Inpatient Quality Reporting (IQR) and Physician Quality Reporting System (PQRS) programs), as well as continue alignment across care settings for providers demonstrating meaningful use.

Overview of Quality Measure Questions in NPRM (2 of 2)



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- **Filtering Criterion to Measure and Reduce Disparities:**
Relevant to Stage 3 CQM Review- ONC propose to adopt a new 2015 Edition certification criterion that would require health IT to be able to record structured data for the purposes of being able to filter CQM results to create different patient population groupings.

Summary of Stage 2 Experience



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- Many EHR vendors eventually implemented and certified to all CQMs to meet the varied quality measurement needs of their provider clients
- Delays in release of fully tested and accurate measure specifications and certification tools created challenges for vendors and providers
 - Vendors experienced difficulties meeting Stage 2 certification deadlines when only being given a 6-9 month window to create the CQMs within EHRs
 - Providers experienced problems when measure specifications were inaccurate (loss of confidence in the tools) and didn't have sufficient time to change workflows
- Not all CQMs were relevant to all providers or practice settings, given the different quality measurement and improvement needs of different clinical specialists
- EPs and hospitals were innovating, creating locally-developed eCQMs to address priority quality improvement opportunities within their health systems



- **Option 1—Vendors certify EHRs to all CQMs**
 - **Recommendation is conditional on:**
 - **Innovative Measure Development:** Recommend HITPC promote pathways to test, share, and implement new and innovative measures in order to address, in part, time constraints involved with vendor implementation cited as part of conditional support for option 1 above
 - Adequate implementation time (18 months) to allow for EHR vendor implementation, certification and roll-out, and provider implementation
- **Improved Alignment:** We recommend the HITPC support efforts to align the EHR Incentive Programs with CMS quality reporting programs that use certified EHR technology regarding measures, measure specifications, and reporting requirements (i.e., reporting formats, standards utilized and reporting periods and data submission timelines)
- **Including clinical quality measure filtering criterion (Certification NPRM):** We recommend the HITPC support proposed criteria included in the ONC 2015 Edition Health IT Certification NPRM



- A phased approach to increasing the number of CQMs vendors must certify to does not reduce vendor burden
 - Many EHR vendors eventually implemented all CQMs to meet the varied quality measurement needs of their provider clients
- CQM specification and certification tools must be accurate, complete, and fully tested prior to release
 - A period of 18 months should be allowed for EHR vendor implementation, certification and roll-out to providers, as well as provider implementation
 - Cypress testing tool, test procedures and test data must also be available within the same time frame



- There should be flexibility to allow EHR vendors to certify specialty EHRs to those measures that are relevant to the particular specialty because not all CQMs are relevant to all providers or practice settings.
 - The role of the specialists and their measurement needs should be a key consideration in weighing CQM requirements
- To more rapidly increase the development and implementation of CQMs that are meaningful to providers, the AHM supports a previous recommendation for ONC and CMS to consider an optional “innovation pathway”
 - The innovation pathway would allow MU participants (EPs and hospitals) to waive one or more objectives by demonstrating that they are collecting data for innovative or locally-developed eCQMs (See July 21, 2014 HITPC Transmittal Letter)



- Support efforts to align quality measurement and requirements across CMS quality measurement and reporting programs.
- Additionally, support, where feasible, greater alignment of quality measurement across private and public payer initiatives to reduce the burden on providers.
- Alignment should include using the same measure specifications and data collection requirements for measures that address the same concept, and alignment of reporting formats, standards, and reporting periods and data submission timelines.
- Alignment efforts should include data elements across ONC and CMS programs
 - Current CMS IPPS NPRM, ONC Certification 2015 NPRM and ONC Common Clinical Data Set lack alignment among age (birthdate, age at admission), gender (sex), vital signs as examples.
 - Alignment of data elements is essential both to furthering interoperability and to streamlining the implementation of new measures and their specifications



- We support the proposed clinical quality measure filter criterion in the ONC 2015 Edition Health IT Certification NPRM especially as it furthers health disparity measurement:

“Health IT should support an organization’s ability to filter patient-level and aggregate-level eCQM results by data that would support administrative reporting as well as identification of health disparities and gaps in care for patients.”

- The collection of disparities-sensitive data elements in a structured data format using standardized variable definitions in Health IT systems could support efforts to reduce disparities through measurement and improved targeting of quality improvement interventions.



- CMS annual updates should be limited to changes that do not have a significant impact on clinician workflow or provider implementation time, or require extensive software code changes or recertification of the EHR software due to the compressed time between the release of annual eCQM updates and required use of the measures in an EHR.
 - If an eCQM requires more extensive modification, and for any NEW CQMs introduced to any program, then the scheduling of such changes should provide ample time to accommodate these activities
- We appreciate CMS' efforts to work with stakeholders regarding the 2015 annual measures updates in order to obtain feedback on changes that may be considered, and hope this process will be continued as measures evolve.
- We note and support the provision in the 2016 IPPS NPRM, where CMS acknowledges the need to determine a predictable cycle for the introduction and certification of new measures, as well as the testing of updated measures and submission capabilities; CMS will publish an RFI to gain better insights and recommendations on this.



The following overarching comments related to advancing the ability of EHRs to support quality measurement are provided as context for framing focused recommendations specific to the NPRM:

- It is essential to improve the availability of standards to further interoperability, as it pertains to the ability to measure the quality of care across settings and time for a patient. Pilots for new standards being worked on via the Clinical Quality Framework focus on CDS and do not yet pilot the effectiveness of the standards to advance quality measurement.
 - Interoperability must advance to support patient-centered measurement and improvement of patient outcomes and move beyond quality measurement that focuses primarily on assessing care processes delivered by individual providers.



- Currently, most electronic quality measures are retooled clinical process measures constructed using data from manual chart abstractions or claims and focus on individual provider processes.
- Electronic quality measurement should look across longer periods of time, utilize more data sources, and consider care in other settings beyond hospitals and ambulatory care such as long-term post acute care, behavioral health, and palliative care.
 - These capabilities are needed to support new value-based payment models
 - A change in the existing paradigm is necessary in order to support care delivery while moving toward the use and development of longitudinal “lifespan” measurement.
 - It is important to broaden the focus of measurement and reporting/use of data beyond EPs and EHs and recognize other providers, individuals and family as contributing to (“input”) and accessing information systems (“throughput” and “output”).