Health IT Policy Committee
Clinical, Technical, Organizational and Financial Barriers to Interoperability Task Force
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I am Dr. Helen Burstin, the Chief Scientific Officer of the National Quality Forum, a non-profit, nonpartisan, membership-based, multistakeholder organization that works to catalyze improvement in healthcare through measurement. I have been asked to focus on how eMeasurement can help facilitate care transformation. My testimony will focus on the three questions posed to me by the committee.

Do the current quality measures depend on an organization's ability to coordinate care and improve the population's health status across organizational boundaries?

Unfortunately, very few quality measures currently depend on an organization's ability to coordinate care and improve population health status across organizational boundaries. Given the lack of interoperability, measures remain very setting-specific and usually do not reflect care coordination. As an example, medication reconciliation would ideally reflect the confirmation of medications from one setting, such as a hospital, to an outpatient setting. However, it is often measured via physician attestation without an actual comparison to an electronic hospital medication list. Similarly, a measure that assesses appropriate screening and a follow-up plan if the screen is positive only assesses whether a follow-up plan was documented on the day of the positive screen, rather than whether follow-up was performed. While measures that demonstrate that follow-up care occurred would be more relevant from a quality measurement perspective, they could more importantly enhance clinical care. Some newer clinical eCQMS are pushing the boundary on these issues. A recent NCQA measure assesses whether referring providers receive a report from the provider to whom the patient was referred.

The Health IT Policy Committee's Quality Measures Workgroup which I was privileged to chair specifically recommended a shift toward measures that enable a more patient-centered view of longitudinal care, as well as measures that require systems to be able to communicate across settings and providers. To date, many of these important measure concepts are not yet possible given the lack of interoperability. In fact, the absence of interoperability was identified as the rate limiting step to move toward more meaningful eCQMs. Without interoperability, the burden of measure workarounds often fall to busy clinicians who need to divert time from direct patient care.

Are there incentives or endorsement criteria that encourage development of "HIE-sensitive" measures?

In order to encourage the development of HIE sensitive measures, it would be helpful to review the intent of HIT sensitivity. We developed the concept of "HIT sensitivity" with Dr. Tang in 2010. In its original conceptualization, HIT sensitive measures built into EHR-systems with implementation of relevant HIT functions, such as clinical decision support would result in improved outcomes and/or clinical performance. The key feature of HIT sensitive measures demonstrated evidence of improvement – not simply that measurement is possible in an electronic environment. HIT sensitivity was linked to key functions of electronic health systems, including order entry, decision support systems, e-prescribing, HIE, and interoperability with an emphasis on point-to-point data sharing. An example of a

measure with high HIT sensitivity was medication reconciliation since it was anticipated that interoperable systems would improve a clinician's ability to reconcile medication lists across hospitals and clinician office. To date, few eCQMs have demonstrated HIT or HIE sensitivity. At the end of the day, measures that matter to patients and clinicians should take advantage of these critical HIT functions and help drive meaningful improvement. If measure development is focused on HIT sensitive measures that can support improvement, clinicians and patients will likely benefit. As mentioned in the earlier panel by Dr. Stack, the goal should be to "exchange useful data that supports care, enhances care coordination, and facilitates consumer engagement." Measures that are required because they are measurable, not because they are important to patient care and engagement are not meeting the bar.

There are multiple potential levers in terms of measure endorsement. NQF's role as a standard setting organization for quality measurement requires a multi-stakeholder process that works toward consensus and provides an opportunity for open dialogue and transparency. Increasingly, the NQF table includes EHR vendors such as Epic that have joined NQF to ensure a seat the table when these important issues are discussed.

NQF utilizes four hierarchical criteria to evaluate performance measures – importance to measure and report, scientific acceptability of the measure properties, feasibility, and usability and use. The first must-pass requirement at the top of the NQF hierarchy is importance to measure and report since it reflects the greatest potential of driving improvement. If a measure is not important, the other criteria are less important. Measures should be used when there is considerable variation or less-than-optimal performance across providers and populations. New eCQMs should demonstrate leverage to improve health and healthcare. We should remember that measurement is a means to an end – not an end in itself.

If a measure is important enough to measure because it can drive improvement, then the focus can shift to the second must-pass of scientific acceptability so that the measure can be used to make valid conclusions about quality. If a measure is not reliable and valid, then there may be risk of misclassification and improper interpretation. Systematic missing or "incorrect" data in EHRs pose a significant threat to the validity of eCQMs. A measure's feasibility is assessed to ensure that data collection for the measure causes as little burden as possible. Under contract to ONC and CMS, NQF developed an eMeasure feasibility assessment that helps to address this critical issue. However, there is no substitute for adequate field testing of new eCQMs to see how they perform "in the real world" prior to use. A current NQF advisory panel has placed greater emphasis on a potential NQF requirement for widespread use. Finally, and perhaps most importantly in this context, measures must be useful and usable. Many of the concerns expressed in the first panel suggest that many eCQMs are not useful to drive improvement and may lead to unintended consequences. Without feedback loops from clinicians and hospitals, we may be missing important clues that measures are not having their desired effect. We must collectively put more emphasis on the critical role that end-users can play in measure implementation and feedback. Measurement should be increasingly agile and adaptable.

NQF has a stated preference for outcome measures, including patient experience and patient-reported outcomes. It is hoped that new eCQMS would emphasize outcome over process. Over-engineering process measures into EHRs limits innovation and overburdens clinicians and systems. New and novel approaches to incorporate the patient voice should be explored. For example, some health systems are feeding PROMIS scores from patients directly into EHRs. Though these PRO-based performance

measures are difficult to develop and test, they ultimately serve the higher purpose of being more meaningful to patients and providers alike. Ensuring access to the right data platforms for PRO development and patient engagement are critical elements to success.

What policies would facilitate development of HIE-sensitive measures or mitigate current barriers to their development?

We need to develop measures that matter -- measures that can demonstrably move the needle on improvement. Measures should be increasingly built into clinical workflow and not require clinicians to interrupt clinical care to enter data that should be readily available if systems were interoperable. If the measures are accompanied by HIT tools that can drive improvements in real time, measurement will be more valued. In a recent Commonwealth Fund survey, half of primary care physicians reported that greater use of quality metrics was having a negative effect on their ability to provide quality care to their patients. We can and should do better. It is hard to get to meaningful patient centered care without a full view of the patient's experience across providers and settings. An advanced infrastructure is needed to support development and testing of these more meaningful measures.

Policies should incentivize the development, testing and use of measures in EHR systems in real world settings. Many measure developers struggle to find EHRs that contain the data they need to effectively test important and innovative measures. As suggested by the Quality Measures Workgroup last year, a potential policy could promote an alternative pathway that would test, share and implement new and innovative eCQMs.

Newly developed measures should take advantage of the best data available for measurement, creating hybrid measures of clinical data from electronic health records, clinical registries, and claims. Linkages are needed between emerging electronic health records and patient-reported data to ensure that measures are built on the best possible data sources. To effectively measure value, clinical data from EHRs will need to be linked to billing data. Further work on data linkages is needed. NQF is entering the proof of concept phase for a measure incubator where those with measure ideas, electronic data, expertise and resources can come together to create new and novel measures.

It is time to take advantage of the advances we have witnessed in some leading health systems. Many health systems have built innovative measurement approaches into their electronic systems. It is time to "prospect" from these leading health systems and avoid recreating de novo measures that lack the experience of health systems who have used, modified and improve their measures. A learning health system would not re-invent the wheel but build upon shared learning.

Finally, given the explicit focus on interoperability, new eCQMs should demonstrate data sharing across providers in a manner meaningful to patient care. Measures that utilize workarounds for the sake of measurement should be minimized and emphasize measures that take advantage of HIT systems that can improve care. Interoperability should not be the rate limiting step to measurement and improvement across the patient-focused continuum. A recent report from NQF, funded by Peterson and Moore Foundations emphasized opportunities to improve data and make it more useful for system improvement. The report identified an opportunity for EHR vendors and HIT policymakers to improve the healthcare delivery system's ability to retrieve and act on data, with an emphasis on the need for interoperability and linkage of disparate data sources. The time is right to consider opportunities that

can meaningfully move the healthcare sector toward the data we need for measurement and improvement.