**Summary of HITPC QMWG Comments in Response to RFC for Stage 3**

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Q5-8 Patient **Centeredness** p. 4-6

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| **ID #** | **Question** |
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| **QMWG01** | As we propose to expand the features of the eCQM measure set, how can it be done in ways to minimize health care costs and reduces burden on health care providers? |

Summary statement: While few commenters recommended specific measures to the HITPC, **suggestions focused on care coordination (5 comments), preventive care (2) and behavioral health (3).**

* Key Points
  + Include the ADA Dental Quality Alliance's Pediatric Oral Healthcare measures
  + Add Tuberculosis measures
  + Fostering greater cooperation and coordination around the transitions of care is critical, we recommend that ONC focus on one or two person-centered quality measures – such as falls – that can be measured across the spectrum of care.
  + Expand behavioral health measures beyond depression

High priority measure summary statement: The majority of commenters encouraged HITPC to focus on and continue to refine established measures. **New measures should target the greatest impact on patient/population health**. Commenters request the inclusion of patient-entered data as well as consideration of measures **which support patient care transitions**. There continues to be concern about **physician specialty and sub-specialties as it relates to measures of care quality**.

* Key Points

Focus on measures already endorsed by the National Quality Forum and mandated by CMS (PQRS, Hospital IQR)

* + Develop eMeasures that have the greatest impact on quality of care, those that can be fully captured electronically in the common workflow, and that are currently defined in standard nomenclatures
  + Consider measures that support **care transitions**
  + Capture and use **patient entered data**
  + **Align measures to provider specialty and scope of practice** rather than require universal reporting

| **ID #** | **Question** |
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| **QMWG02** | When considering the finite resources available to technology developers, what measures, types of measures or attributes of measures should be a high priority? |

* Types of measures
  + Defer to the National Quality Strategy and the Measure Applications Partnership (MAP)
  + The AAP suggests that evidence based measures that relate to the health and safety of vulnerable populations be of high priority.
  + Development of eMeasures that have the greatest impact on quality of care, those that can be fully captured electronically in the common workflow, and that are currently defined in standard nomenclatures
  + Concerns about physician specialties and sub specialties
    - **Re-evaluate the value and purpose of exclusions** in the measure design. These effectively constitute hidden EMR requirements. Few organizations can accurately, consistently, and automatically apply these exclusions
    - The current eCQM requirements pose unique challenges for specialists, who much choose from a limited number of applicable measures within the six quality domains.
* Attributes
  + The AADA **: advance cautiously, spend time building the technical infrastructure** and prospectively addressing standards for data transport and patient identification
    - Testing of these specifications should be completed in a test system environment using test data to assess the measure logic
  + Ensure that technology developers create and enable the functions and capabilities necessary for capturing information required to populate measures of **patient engagement, care coordination, functional status, longitudinal (delta) measures, wellness and health promotion, and population-based measures include health information exchange, calculation of measures using multiple data sources, and integration of patient-generated data**.
  + Reuse **components of existing** i2b2 processor
  + We also encourage **early publication of new requirements for the Data Element Catalog, individual measure specifications and related value sets and value set information**.
  + “As EHR developers, we prioritize development of measures based on the **suitability of the data elements required to capture in our EHR** and on feedback from our EHR users”.
* Frameworks and approach:
  + We suggest three guiding principles in prioritizing measures, types of measures or attributes of measures.
    - The focus should be on measures that have **direct impact on increased quality** of care, dependent upon specialty (i.e., the populations seen by the eligible providers and eligible hospitals).
    - To move toward meaningful use of EHR, **measures that are uniquely captured by EHR** (vs. administrative) data **should be prioritized** in Stage 3.
      * use data that are already captured: vital signs, medications, etc.
* There are several additional input channels we suggest, along with measures to success:
  + - Data Community Assembly: “Listen and Learn” Open Assembly including all stakeholders.
      * Number of participants attending the “Listen and Learn” Assembly
      * Number of suggestions presented to the HITPC for consideration
    - Open Input Portals to industry that are developing the latest technologies and strategies to improve patient care quality, cost, and patient satisfaction. This is a valuable resource if utilized to its greatest potential.
      * Adaption of resource enhancing combined outcomes of quality, cost, and patient satisfaction
    - Public Data Sub-committee with a wide variety of providers, patients, organizations and societies to solicit input. Build collaboration between stakeholders through data intelligence.
      * Number of industry concepts submitted to HITPC for a continuous consumer advocacy offering

| **ID #** | **Question** |
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| **QMWG03** | Are there innovations or technological capabilities for measure development or specification that the HITPC could support that would reduce the burden on technology developers? |

* **Summary statement: The greatest number of comments suggested alignment of measure specification components (12), collaboration among stakeholders early in development (7), field testing of data elements and data-driven selection of logic and value sets (5). Finally, multiple commenters request inclusion of patient entered data and suggested data elements which may be suitable.**
* Key Points
  + **Measure specification**: Use the **same specifications for PQRS & MU**. Consider standardized tools – such as the PROMIS Patient Reported Outcome Metrics.
    - **ACP**: Open-source measure authoring environment
    - **Greenway**: Specifications to all e-measures released with NPRM, not FR
  + **Certification/Feasibility**: Make Stage 2 Data Elements the ceiling for Stage 3
  + **Technology capabilities**: Comments supported query and reporting capabilities developed through “Query Health”; Measure Authoring Tool (MAT); natural language processing (NLP); application program interfaces (APIs); industry standard clinical code sets, QDM as data model.
    - **Support development of mechanisms for sharing and re-using code specifications from other measure developers**
    - Download all value sets at once (i.e. excel file), support standardized reporting across CMS programs; provide template ID for data mapping
  + **Development process should facilitate collaboration across stakeholders**. Provide an opportunity to **field test measures to determine both the clinical workflow feasibility** as well as EHR feasibility of measures.
    - “We suggest CMS consider a pilot program or provisional use stipulation for **PQRS or Hospital IQR that would permit a new e-measure to be introduced**…prior to its inclusion in certification for meaningful use.”-Cerner
    - Further, EHRs must provide evidence of successful testing (and accuracy) of embedded measures. The NQFs report on development principles is due February 2013 and may prove useful to ONC.
  + Patient entered data might discrete data collected by patient care devices such as weight, blood glucose, blood pressure, behavioral observations, etc.

| **ID #** | **Question** |
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| **QMWG04** | The Meaningful Use program has used menu objectives and menu CQMs to provide flexibility for providers. Should there be core CQMs for high priority health conditions, such as controlling hypertension? |

**Summary: Generally comments suggested retaining the core versus menu approach to CQMs (6) or allowing providers to flexibly choose which measures are higher priorities for their individual practice (8). Comments also suggested that HHS programs align their core measures / harmonize their core set of eCQMs across the department.**

Comments regarding flexibility

* The HITPC could recommend that CMS allow EPs to choose any subset of relevant CQMs.
* Flexibility for providers must be maintained so that they can choose measures most meaningful to their patient population. Measures that are of high value to the majority of providers should be prioritized, with allowance for specialty groups to choose appropriate measures for their population.
* If there were core CQMs, exemptions or alternative CQMs would be needed to accommodate specialists for whom the core CQMs were not applicable.
* Given different mission foci across organizations and different states of maturity for many ancillary and administrative systems, there should be a high degree of choice in the selection of CQMs in the next 3-5 years. Therefore, we support the option of being able to choose from a menu of options for quality measures. Along with these options should be clear direction on how providers can claim exclusions from certain measures absolutely do not collect data on that particular issue because of their specialty.
* There is value in the menu approach. It provides flexibility for providers and organization and allows better alignment with strategic goals or quality gaps as opposed to forcing participation in areas where measure performance may be topped out. With this approach, it is important that the number of menu choices stay within reasonable boundaries.
* Development of an approach that would enable a more flexible definition of the health condition, including what desired controlling mechanisms are to be sought, might enable greater innovation to create measures that enable choices or substitutions for reporting on relevant provider populations and conditions.
* Allow exceptions for providers for whom a measure may be outside of their scope of practice. Including exemptions would reduce administrative burden and enable specialty providers, such as behavioral healthcare providers, to focus on measures relevant to their clinical work.
* Specialists like oncologists should have the opportunity to benefit from quality improvement activities related to quality reporting, rather than have reporting become an administrative exercise.

| **ID #** | **Question** |
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| **QMWG05** | How can the HITPC and QMWG capture input from a wide variety of providers, patients, organizations and societies? |

* + **Stakeholder Engagement-**Nearly all commenters encouraged the HITPC and QMWG to actively seek input from stakeholders. They suggested:
    - **Professional societies**- including nursing, pharmacy, specialty societies
    - **Patient/consumer groups**- including Special Interest Groups for those with disabilities, advocates for the ageing, survivors of violence, breast feeding advocates
    - **Employers**
    - **Public Health**

| **ID #** | **Questions** |
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| **QMWG06** | What additional channels for input should we consider? |

* The majority of the responders agreed that increased patient input is necessary to improve quality measurement
  + **Active Outreach Strategies for Stakeholder Engagement** – many felt the RFC and open meetings are a great start to active outreach, but encouraged the committee and workgroup to go farther utilizing strategies such as:
    - **Social media**
    - Webinars, open forum
    - **Outreach to professional societies and patient advocacy groups**
    - Establishing an “emeasure steering committee” (federation of American Hospitals)

| **ID #** | **Questions** |
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| **QMWG07** | Please comment with guidance on how consumer-reported data can be incorporated into CQMs. What examples are there of EHR-enabled quality measures that use data directly entered by patients? |

* + **Support consumer reported data**- most of the commenters support consumer reported data being used for quality measurement. Many provided examples, such as PROMIS10, CAHPS, functional status and PHQ-9. Many also suggested incorporation of biometric data from consumer devices, such as glucose meters, scales, pedometers and home blood pressure cuffs. A few recommended patient entry of data on past history including immunization and cancer screening status.
  + **Do not support consumer reported data for MU3**- a few commenters expressed concerns that the data standards and EHRs are not yet ready for consumer reported data. They suggested further work be done on meta data standards, provider review/accept tools and software- both EHR and PHR, before consumer generated data become routine in quality measurement.

| **ID #** | **Questions** |
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| **QMWG08** | Please provide examples of how patient-directed data is informing shared decision making. How does the public view the integration of EHR derived data with patient generated data for quality measurement? How important is it to keep this data separate? Should it be separate? |

* **Summary statement: This question asked for public comment on creating measures that combine clinical and patient-generated data for quality measurement. The majority of comments discussed the use of patient-generated data within the EHR. Responses were fairly balanced between pros and cons.**
* Key Points
* Clear recommendation against using generated and physician generated data in quality measures 5 responders
* Clear recommendation to combine or join patient and physician data: 5 responders.
* Caution toward patient-generated information in the electronic record: 10
* Support for patient-generated information in the electronic record:8

| **ID #** | **Questions** |
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| **QMWG09** | Please provide comment on how the HITPC should proceed with our focus on clinical outcomes. Should the HITPC focus its efforts on building point-of-care process measures or value-centered outcome measures? |

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| --- | --- | --- | --- | --- | --- | --- |
|  | Both Supported | Value-Based Outcome | Process Only | HITPC Should Not Build Measures | Different Question Answered | N/A |
| Count | 20 | 16 | 3 | 3 | 5 | 5 |

| **ID #** | **Questions** |
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| **QMWG10** | Is this a false or unnecessary dichotomy? Should we instead consider a third approach, to promote process-outcome measure “suites”, combinations of end outcome measures that are potentially associated with process measures? For example, Stage 2 eCQM set will include three HIV measures. The outcome of viral load suppression is accompanied by two related process measures for an HIV medical visit and for Pneumocystis Pneumonia prophylaxis. |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Supports Suite | Provides Suite Example | Research for Suite | Outcome Only | Process  Only | Does NOT Support Suite | Other Comment | Different Question Answered | N/A |
| Count | 20 | 7 | 2 | 4 | 1 | 1 | 12 | 6 | 1 |

| **ID #** | **Questions** |
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| **QMWG11** | Please comment on challenges and ambiguities in retooling legacy paper abstracted and claims based eCQMs. |

* **Summary statement: There is general consensus that retooling paper-based quality measures is challenging and often results in unintended consequences. Of comments that directly answered this question, 19 commenters prefer de novo eCQM development over retooling of existing paper-based measures. 1 commenters prefers retooling and 2 commenters prefer a system that includes both retooling and de novo development. Specific challenges noted include:**
  + Patient-provider attribution
  + Claims based exceptions & exclusion not routinely documented in current workflows
  + Claims based visit definitions limit the longitudinal benefits of EHR data
  + Lack of consistent data field inclusion/exclusion criteria
  + Need for dual data entry
  + Mismatched reimbursement models drive data collection for payment vs. quality improvement
  + Unknown or unknowable denominator or numerator components

| **ID #** | **Questions** |
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| **QMWG12** | Is this a shift away from retooling legacy paper-based CQMs in exchange for designing CQMs de novo a reasonable course of action? |

* **Summary statement: A shift from retooling of existing paper-based CQMs to de novo development is supported by the commenters (41 comments: 58.5% yes, 14.6% no, 7.3% both, 14.6% NA). Removing the comments that either provided only guidance or did not comment results in 68.5 % support for de novo CQM measure development. Many comments included deep insight into this issue of measure development.**
* Key Points
  + HIMSS notes that it is not the CQM that requires de novo development; it is the CQM specification that must be developed de novo.
  + Boston Medical Center – “While we believe that the existing legacy CQMs have significant clinical validity, the specifications for them need to be reviewed and validated thoroughly.”
  + The Joint Commission - The answer to these issues may lie not on the dichotomist view of retooled vs. de novo measures, but a fundamental change in the approach to retooling should involve: 1. Making careful assessments of the measure feasibility given a specific set of EHR functionality (feasibility) and selecting measures for inclusion in the meaningful use program based on their level of feasibility against a certain level of EHR functionality 2. Simplifying measures to enable their EHR-based implementation and incrementally increasing the complexity of the measures in tandem with EHR functionality.
  + ACOG - EMRs are capable of doing much more in real-time reporting and clinical decision support, and patient monitoring and management. In some emergent or acute situations, real-time reporting might be helpful for medication orders and medication safety. In general, real-time reporting of quality measurement may be synonymous with clinical decision support in non-emergent, non-acute situations at point-of-care or in patient management through tracking and reminder systems.

| **ID #** | **Questions** |
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| **QMWG13** | Please comment on the provider/payer/patient experience with using retooled measures as opposed to experience with de novo measures designed and intended for EHR-based measurement. |

* **Summary statement: In general comments reflect a poor experience with retooled measures and a relative lack of experience with measures developed de novo. Providers have experienced increased burden, attribution problems, significant clinical issues/errors, inefficient workflow modifications, uncertain reporting results, confusion and lack of value add (patients and providers) with retooled measures. According to commenters it is not possible to access patient experience with either retooled or de novo measure because there is currently a relative lack of patient-centric CQMs. However if provider assessments are accurate regarding clinical issues/errors one would ascertain a negative experience for patients with retooled measures. The comment pool did not contain sufficient input from the payer space to comment regarding experience.**
* Key Points
  + Children’s Hospital Association - CQMs for meaningful use have been largely an exercise to report rather than provide value to patients and providers.
  + HIMSS continues to call attention to the increased burden on the provider to collect data for both manually abstracted measures and eMeasures, and we continue to urge the HIT Policy Committee to reduce this burden.
  + The use of retooled measures creates confusion among providers and payers.
  + Boston Medical Center - In contrast to legacy paper measures we have found that the de novo measures, if well designed, are easier to complete.
  + Kaiser Permanente - There are too few de novo measures designed and intended for EHR-based measurement to provide an informed comment.
  + American College of Physicians - There are almost no measures developed de novo so this question cannot be answered.
  + MN Department of Health - Workflows often must be modified to meet the measure instead of the patient need.
  + Oregon Health & Science University (OHSU) - One of the major issues we have had with using retooled measures is that of attribution.
  + S&I LCC Workgroup - There are currently no patient-centered CQMs that reflect what patients value most.
  + Intermountain Healthcare - An increased burden has been added to the providers and health care organizations to report paper-based and electronic CQMs.

| **ID #** | **Questions** |
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| **QMWG14** | Please comment on aligning CQMs with MU Objectives. Would eCQM-MU Objective alignment be clinically valuable to providers or might this be a redundant exercise in shifting resources? |

* **Summary statement: The vast majority of commenters encourage HITPC to push for a single set of national measurement standards for reporting across various quality programs as well as standardized measure definition, calculation and logic. However, there is concern that alignment maybe redundant if reporting remains separate. A number of commenters encourage HITPC to develop a process whereby organizations could submit new measures for consideration. Finally, new measures were proposed, focusing on perinatal health, medication management, care transitions and long term care.**
* Key Points
  + Aligning the objectives will certainly reduce administrative burdens, time management and resources however, do not eliminate opportunities for measures that may be more valuable to providers as it shifts the focus from functional use to quality use of EHRs.
  + HITPC is encouraged to go beyond alignment of eCQMs and MU to a single set of national standards instead of having to answer to various payer, Leapfrog Group, Joint Commission, the National Quality Forum, Physician Quality Reporting System, and Healthcare Effectiveness Data and Information Set (HEDIS), etc. standards and reporting requirements, designed to determine opportunities for quality of care improvement.
  + Standardize calculations and definitions to ensure measure integrity and comparability. Standard logic is essential to support the comparison of outcomes across populations
  + Do not just retool measures for the sake of aligning, but assure that the e-clinical measures make sense.
  + Allow submission of new objectives that would then go through a review process prior to adoption for national use.

| **ID #** | **Questions** |
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| **QMWG15** | Which measures and objectives, in particular, have the greatest potential to maximize meaningful alignment? Please recommend eCQM/Objective alignment opportunities. |

* **Summary statement: Commenters provided examples of existing measures and data elements which should be considered for alignment. Commenters encourage ONC to also consider alignment of reporting requirements not only across quality programs but also for payer requirements. There are several suggests for new measures as well as methods of developing new measures.**
* Key Points
* Align around feasible componenents of existing measures and priorities:
  + vital signs; weight assessment; counseling; medication reconciliation & safety;
  + transitions of care; and CMS eMeasure 26/NQF 0338 with EH core objectives 6 and 10.
* Suggest measures include those focused on congestive heart failure, medication management, population health, and long term care
* Methods for development: invite testimony from organizations that are aligning measures; accept submission from across the healthcare industry, not just professional organizations; standardize submission process; fund pilot tests to determine feasibility and cost benefit; and involve measure developers in the process.

| **ID #** | **Questions** |
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| **QMWG16** | Which, if any, high priority domains should receive prioritized attention in Stage 3? What measure concepts, addressing these domains, should be considered for development? What EHR capabilities should be leveraged to realize these concepts? |

* **The comments roughly were divided between those that identified NQS domains that should received additional attention in Stage 3, those that name clinical areas that should receive attention in Stage 3 and those that either explicitly rejected the NQS domains and/or suggested that clinicians should decide for themselves and their patient populations what their priorities are.**
  + Care Coordination (6)
  + Safety(5)
  + Care Effectiveness/Complex Management (6)
  + Patient Engagement /Shared Decision Making (7)
  + Population and Public Health (5)
  + Care Efficiency (2)
  + Allow Practitioners to choose priority (5) (VA, Siemens, etc)\*not an anticipated response
* FACA efforts should focus on creating infrastructure for health conditions identified as high priority by payers.
* “The [Children’s Hospital] Association recommends that care coordination, medication safety and managing complex patients should receive prioritized attention in Stage 3.”
* Prioritize NQS. Prioritize AMA PCPI developed that emerge from measures (ACOG).
* **Patient and Family Engagement:**
* We suggest this be expanded and perhaps start with something related to a **Health Status/Functional Status assessment for all patients**. (Partners HC System)
* Opposition:
  + CHIME assumes that the concept of high priority domains infers that those domains would supersede a more flexible approach for the EPs and EHSs. This response is similar to the discussion on OMWG04; we encourage regulators not do not narrowly define high priority domains, because not all specific conditions are priority for all EHs and EPs.
  + **UC Davis: allow submission of locally home-grown generated CQM’s and standardize the submission of fields and logic to ensure replication of CQM’s across organizations.**
* “HITPC should look at research initiatives that are funded by the federal government which would support CQMs rather than just putting out measures for the sake of measures and not leveraging the existing research.” Telligen (p17) and AHIMA .
* Noteworthy
  + MU rules should include strongly stated requirements … regarding the design and usability -AAPM&R

| **ID #** | **Questions** |
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| **QMWG17** | Are there EHR based exemplar measures that exist, or that are being conceptualized or developed, that address these domains and theses concepts? What scientific evidence, if any, supports these concepts and exemplars? |

* Summary statement: Wide variety of responses, those that pointed to measures or groups of exemplar measures are below:
  + Consider Centers of Excellence Measures (CHA)
  + AMA PCPI Maternity Health Measures (ACOG)
  + Support for clinical Society involvement (Greenway)
  + “Increased Flexibility” (AMA)
  + Communicate with non-physician providers
* There really was not consensus but there was **consistent comments from EHR vendors suggesting that HHS defer to specialty societies**.

| **ID #** | **Questions** |
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| **QMWG18** | Please comment on the desirability and feasibility of such an innovation track as a voluntary, optional component of the MU CQM requirement. |

* Summary statement: There was strong support for an some form of a flexible innovation track to be added
* Support Innovation Track: 28
  + **Finally, an essential benefit of developing measures as part of the MU process is that it would be done in the electronic environment in which these new measures will be implemented, rather than re-tooling a measure designed for the paper world-Consumer Purchaser Disclosure Project**
  + **“We fully support this concept,** as it fosters provider level innovation and rewards them for their efforts. It also would likely serve as a means of spreading their innovation to other providers who may not have been exposed to it otherwise. **We have found that QI departments want to continue their work and use MU as a stepping stone**.” Boston Medical Center
  + “ASCO **strongly supports changes in Stage 3 of Meaningful Use that would allow the use of quality measures that have not gone through NQF or rulemaking.”**
* Support…with reservations: 5
  + Typical Statement:” Telligen REC is concerned that could be subjective. It also does not allow the comparison on a national level for the self submission. However, **we believe these types of measures will provide the innovation, and engage providers/EHs for bottom up development. We recommend that the EPs and EHs still report on all measures, but substitute one menu item with a local measure**.”
  + Partners Health: “Regarding the notion of encouraging the adoption of locally developed measures in meaningful use, **Partners supports the idea of CMS supported opportunities for learning forums but not incorporating locally developed measures into meaningful use requirements until measures go through an endorsement process, such as NQF**.”
  + Geisinger: We would find this to be a very challenging way to develop CQMs. However, we do believe organizations should be recognized for their innovative work and be paid additional dollars for that work if it is broadly applicable.
  + NextGen. **There is also the concern of the intellectual property (IP) concerning eCQMs. Will there be any protection or will reported and defined eCQMs be considered public domain?**
* Do not Support: 6
  + AHA: “Experimentation is not appropriate within this [regulatory] construct.”
  + CHIME: “CHIME recommends the MU Stage 3 not engage in the development of new quality measures but instead relay on quality standards organizations for the development of new measures.”
  + Intermountain Healthcare: “Intermountain would not like to add this innovation track as an additional requirement. Intermountain requests efforts to simplify and diminish the burden of the meaningful use regulation.

| **ID #** | **Questions** |
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| **QMWG19** | The QMWG has considered two approaches to institution-initiated eCQMs. A **conservative approach might allow “Certified CQM Development Organizations”, such as professional societies** and IDNs to design, develop, release and report proprietary CQMs for MU. **An alternate approach might open the process to any EP/EH but constrain allowable eCQMs with certain design standards**. There are advantages and disadvantages to both. Please submit comments on either, both or unique approaches. |

* **Summary statement: This question asks if only large experienced “Certified” organizations should be allowed to build innovation measures or should the process be open to any EP/EH. Also, responses to 19, 20, and 21 tended to overlap. Answers roughly are split between those that recommend centralized (e.g. NQF) validation of an innovation track or decentralized/local validation with a constrained development environment**
* Key Points
  + Conservative approach(22)
    - **“We encourage HITPC/ONC to consider the more conservative approach,** which would **encourage adoption and use of EHRs among professionals by ensuring more relevant and feasible CQMs developed directly by professional societies** while also **ensuring a minimum level of consistency** among members of the same specialty so that the data could be analyzed over time for trends and patterns related to performance.” American Osteopathic Association
    - **“HIMSS notes that Meaningful Use Stage 3 may not be the appropriate vehicle for creating a nationalized quality measure development process for HHS**.”
    - “The Joint Commission is concerned that **opening measure development to every organization seeking meaningful use attestation may pose an insurmountable burden on CMS** to evaluate each proposed measure and needed standardization …”
  + Alternative approach: (33)
    - “…**there needs to be a mechanism in place to ensure that the measure makes an impact.** Consider requiring those who do this locally, to work with others in their area….QMWG20 measures should be submitted to NQF”
    - **“Flexibility needs to be given for the organization itself to determine its own high priority conditions** and report on CQMs relating to those conditions, preferably using a national measure if one exists already but if not, using its own proprietary measure. “ -VA
    - **“The innovation of eCQMs should be open to all stakeholders who wish to improve the quality of healthcare outcomes**. However, the design standards should include oversight to ensure the consistent creation of eMeasure specifications.” **-Federation of American Hospitals**
  + `Many commenters supported/recommended a combination of the two approaches.
  + Some commenters rejected the idea of the innovation track altogether.
    - “Institution-initiated eCQMs should remain internal goals and not affect what is required by meaningful use”

| **ID #** | **Questions** |
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| **QMWG20** | What information should be **submitted with a locally developed CQM to help CMS and other healthcare providers assess the innovative measure**? For example**, should the submission form include a brief description of: 1) importance/rationale of the measure domain**; 2) **evidence basis for the specific measure; 3) feasibility, and 4) usefulness of the measure?** |

* **Summary statement: Comments roughly answered in three ways: recommending full NQF endorsement (4 commenters), some process managed by HHS that was similar too but not as extensive as NQF endorsement (11), a submission of basic measurement information (12):**
  + **Full NQF Endorsement: 4**
    - AHIMA recommend that those local measures that are substituted for a menu item be submitted with the measure, results and the application to NQF.
    - Health System Assoc of PA: NQF should decide if automated capture/calculation is feasible.
      * **Endorsement** should include independent testing for validity and reliability
      * Certification should assure vendor precision/accuracy.
      * There should be a structured feedback loop w CMS.
  + **Process similar to but not necessarily identical to NQF endorsement: 11**
    - Hearth Rhythm Society: “A brief description of the listed elements would help to ensure a minimum quality standard, but we would not necessarily recommend applying the rigorous testing requirements of the National Quality Forum (NQF) process, which requires heavy investments of time and resources”
    - ANA: Submissions of locally developed CQMs should be accompanied with at least a one-page abstract of the concept, purpose, and each criterion that would be required if presented for endorsement consideration.
  + **Minimal content similar to information proposed:12**
    - Boston Medical Center: We agree with all the proposed pieces of information that would be included in the form, and have one additional suggestion to add **a “lessons learned” item.**

| **ID #** | **Questions** |
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| **QMWG21** | What constraints should be in place? Should individual providers have an option to choose and/or design their own measures outside of the established CQM EHR Incentive Program set? Should these “practice-level” measures be required to conform to the Quality Data Model data elements and/or entered into the Measure Authoring Tool or conform to a simplified HQMF XML? |

* **Summary statement: The comments to this question primarily split into two groups: those that recommend standards be created to conform to a consistent e-measures data model and those that suggested innovation or usability will be limited by imposing such constraints.**
* Constrain to existing Standards and tools for eCQM development: (20)
  + **Children’s Hospital Association**: Some reasonable constraints, such as conforming to the Quality Data Model, would seem appropriate. Again, the balance between fostering innovation and measurement that is meaningful with allowing comparability across providers and hospitals is one that needs to be carefully thought through. It would be helpful to think through a trajectory for how locally developed measures could become more widely used and disseminated. Ensuring that current measurement development efforts, such as the PQMP, are adequately resourced and supported to support EHR generated measures should be part of the strategy.
  + Greenway; “If the end goal as stated is to assess innovation, the next logical goal would be to leverage any findings back into the program**. In order to easily allow for reuse and assure for initial operation in a certified quality system, constraining the measure logic and capturing the value sets as close to the current CQM constraints would allow for plug and play ability if desired.** … **A simple HQMF would be the minimum level of detail needed to allow for decomposition and ensure reuse in the future. We encourage the use of the Measure Authoring Tool (MAT) to ensure consistent use of Values sets and QDM elements...”**
  + The Joint Commission: **the use of standardized quality measures, ensures, at least to some extent, comparability of the data across healthcare providers and supports measure alignment across settings**
  + **At least on commenter noted that the MAT is not yet ready for broad use.**
* Have no constraints, maximize innovation in measures that fit clinician need (5)
  + ANA: “The ONC should not become an impediment to innovation. If a provider chooses to measure quality above and beyond the Incentive Program set, the experience might benefit all providers if shared through publication or testimony. Forcing a provider to comply with an established standard would potentially limit innovation and also step beyond the scope of the ONC’s mission.”
  + MN Department of Health: ““100% of the measures should not be constrained. That may stifle innovation. Instead, allow a very limited number with the understanding that the measure logic would be submitted along with the measure result. “

| **ID #** | **Questions** |
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| **QMWG22** | What precautions might be necessary to mitigate fraud, waste and abuse and to avoid submission of trivial new measures that are unlikely to advance the field? |

* **Summary statement: The recommendations varied broadly but coalesced around using the submission process to ensure measures were useful and impactful.**
* **Require impact on outcomes: 4**
  + **VHA**: Require documentary evidence of the impact of the measure in terms of clinical outcome over time, with a minimum time for observation (e.g., must be in use for at least 6-12 months
* **Use process of oversight or measure development in place already (e.g.,NQF, HQMF, specialty societies, etc): 8**
  + Kaiser Permanente; “For the first year or two, in order to minimize the submission of “trivial new measures,” it **might be reasonable to review only proposed measures that meet the three priorities of the National Quality Strategy**, as noted in our response above”
  + AHIMA: ‘**If the NQF submission and the data model and data authoring tool are utilized this will most likely prevent abuse of measures**. An alternative may be to submit to medical society for refinement and consideration by a larger group in the same specialty, then submitting the documentation required by NQF.“
  + ACP: “**Trusted measure authorities are required to determine the importance, feasibility, reliability and validity of all measures used in government programs…Specialty societies and boards might present good models for the types of organizations that could perform this work, much as is cone with Maintenance of Certification** measures today.
  + Telligen: “If the NQF submission and the data model and data authoring tool are utilized this will most likely prevent abuse of measures. An alternative may be to submit to medical society for refinement and consideration by a larger group in the same specialty, then submitting the documentation required by NQF. Recommend using groups that apply through ONC for approval for the measure. This may provide a pipeline for smaller specialty group to get measures shared, but still need to have the standards and interoperability (want to be sure to ultimately follow the NQF process).”
* **Limit the number of custom measures or features of the measures: 3**
  + Greenway: Disallow zero denominators
  + Kleeberg: Limit the number of custom measures to which any single provider can attest
  + MN Dept of Health: “**Limit the number of custom measures …”**

| **ID #** | **Questions** |
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| **QMWG23** | For the existing and/or in the proposed expanded institution-initiated CQMs, how can federal agencies better support consistent implementation of measures for vendors and local practices (e.g., test case patients, template workflow diagrams, defined intent of measure and value set)? |

* **Summary statement: There is strong support for a measure-level toolkit to support consistent implementation. Commenters described both a federal convening organization and/or a web-portal with open-source tools. Many comments described features of the learning health system. The comments overlapped in describing the above and don’t lend themselves to a useful quantitative account. Several commenters noted that every measure should have intent, HQMF xml, workflows, and test-patients that are exhaustive of logic permutations. No commenter dissented or disagreed with the need for a more robust toolkit. Multiple commenters noted the inadequate current state of tools to support implementation. Statements typical of commenters are below**

* Tools
  + Workflow diagrams 9 comments
  + Test cases/test patients 9 comments
  + Measure Intent: 11 comments
* Also noteworthy:
  + Medicaid needs single set of measures, noted by two commenters (MN and Children’s Hospital Association).
  + ACC and others: “current tools are inadequate”
  + ASCO: Post measures for public comment
    - “To promote meaningful measures likely to advance the field, Certified CQM Development Organizations should be required to post Meaningful Use CQMs for public comment, to review public comments and modify measures accordingly, and to post a summary of public comment results / actions taken.”
* ANA: The ONC might benefit from supporting a **learning health system (LHS)** approach in which providers share their best evidence from their own quality measures with other providers in facilitated interaction among interested providers. The IOM and Kanter Family Foundation are proposing methods to initiate LHSs for overall sharing of evidence. The use of such methods as test cases and value sets would assist in this process, but presenters might express concerns about sharing intellectual property too openly. The proposed LHSs are beginning to address these concerns.
* ACP: **Value set standardization** is essential and the NLM VSAC provides an excellent mechanism to manage the value sets. Moving forward, **data elements need to be evaluated for feasibility based on all of the expected metadata** about the elements, not only the value sets. Such a process also needs a sponsor which should be a **public-private partnership** with federal input.
* Greenway: “For any existing or planned eCQMs the following items are needed:
  + - 1) Intent of measure/ human readable definition,
    - 2) HQMF version of measure,
    - 3) value sets for measure,
    - **4) workflow diagrams with examples of all patient permutations outlined, and**
    - **5) a set of test patients that allow for all permutations along with** the key to the correct output for the measure calculation. **A formal measure maintenance process should also be initiated to provide ongoing technical support and updates to the measure specifications as needed**
* ACC: “The current tools for the CDA implementation guides, the open source Model Driven Health Tools, are inadequate to support the definition and clinical review of large sets of discrete data elements necessary for some quality-related purposes. For instance, an effort to translate the ACC-led consensus document on Key Data Elements for Cardiac Imaging[[1]](#footnote-1) and its 100 discrete data elements into a CDA implementation guide was unsuccessful because of the ineffectiveness of the tools**. Focused investment in tools for developing CDA-based discrete data for coordinated clinical and quality purposes would have significant returns for cardiology and the broader e-clinical quality measure development effort across all care areas. *The ACC urges that HITPC recommend increased funding for the development of tools that support the definition of discrete data sets in CDA-based clinical documentation that will be usable in the e-clinical quality measure development process.”***

| **ID #** | **Questions** |
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| **QMWG24** | Stage 3 may increase the number of measures EPs and EHs calculate and report. Considering provider burden, is there a limit to the number of measures that a provider should be expected to calculate? Is there evidence to support a limit? |

* **Summary statement: Comments urge HITPC to ensure that current measures are being collected effectively, are useful to EPs/EHs, and are positively impacting patient care and outcomes. Further, comments stress a strong need for alignment and standardization of measures across federal programs as well as payer organizations. New measures should be weighed for their impact on patient outcomes balanced by their burden on EP/EH. Commenters suggested taking a population management approach to measure development. Several commenters urged the HITPC to defer to MAT or, at a minimum, develop a standardized approach to development which would actively engage a broad stakeholder group. Commenters caution HITPC in regard to over burdening EP/EH with new measures, as this may shift focus from using quality data meaningfully to a focus on simply attaining reporting goals. Finally, commenters urge the HITPC to support policies which would rapidly advance technology capabilities for seamless and less burdensome reporting.**
* Key Points
  + Validate current measures as effective, useful to care processes and positively impactful to patient outcomes
  + New measures should be useful and matter to EP/EH, and allow more flexibility in reporting (care population centric), as opposed to forcing providers to report in specific domains.
  + Align and standardize measure and reporting across federal programs and payer organizations
  + Consider those measures that would yield the most helpful data for improving quality and support the overall goals of the National Quality Strategy
  + Support policy which encourages population management approach and platform use developed by a number of vendors
  + Convene a stakeholder group (ONC, vendors, providers (EP and EH), and consumers) to discuss the current state of the industry, the barriers to achieving e-Measurement, including any additional burden thresholds for numbers of required clinical quality measurement. This body can effectively research the impact of eCQM requirements.
  + Defer to the MAP that makes recommendations for quality measures for federal health care programs in accordance with the ACA.
  + There is no specific number, though by requiring too many, it is much more likely that the exercise will lose its value in actually promoting quality improvement. We would suggest that a practice can and should only focus on a limited number (1- ‐5) of goals at one time. Concern that increasing the number of measures detracts from care rather than improve quality.
  + Advanced technology capabilities seems to be the best route to expanding on the ability to report on increasing number of measures as it decreases administrative burden. However commenters caution that care process change takes time and that providers most likely cannot focus on an increasing number of measures.

| **ID #** | **Questions** |
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| **QMWG25** | Please comment on the value and feasibility of the eCQM and EHR features listed below: - Ability to accept downloaded specifications for new measures with little tailoring or new coding - Minimal manual data collection or manipulation - Ability to aggregate measure data to varying business units (practice, episode, ACO, medical home, MA plan, etc) - Ability to build measures that incorporate cross-setting records for episodes, medical homes, outcomes (e.g., readmissions) - Ability to build multi-source data records, including claims, patient reported data - Ability to implement machine-readable HQMF that minimizes manual vendor coding  - Ability to drill-down on reported measures for QI analyses |

* **Summary statement: On the whole, commenters overwhelmingly supported all technology features described in this QM. Comments regarding each element are summarized below. Commenters expressed a number of concerns including: a lack of standards; vendors’ ability and time requirement to develop required capabilities; prematurely being prescriptive with data and capability use; accommodating specialty practice settings; and expense. A few commenters note vendors and organizations with experience in these capabilities including Elsevier, population management platform vendors, and Pharmacy e-HIT Collaborative**
* Key Points
  + The listed abilities suggest a path forward for quality measurement that should lead us to a better understanding of the actions and activities that matter most in improving health and health care.
  + Successful implementation of these features will require the continued development of the quality measure frameworks and standards as well as close adherence by all measure developers to specification development principles and practices including the harmonization and leveraging of cross measure value sets where possible.
  + It would be appropriate to revisit the use of the National Quality Forum Quality Data Model as a guide in establishing a more concrete model for quality measurement that all vendors could adhere to.
  + The process should be iterative between HITPC and CMS to align the healthcare initiatives such as ACO, PCMH, MU etc. Currently, health policy is currently driving innovation however it “isn’t a one size fits all” therefore shouldn’t be as prescriptive rather encouraged.
  + While we do not support overly prescriptive rules, we do support articulation of enough detail to ensure vendors fulfill the spirit of the objective when designing such functionality.
  + Most, if not all of these abilities are ones that are technically feasible, however the increased resources needed – specifically the analytical software – is expensive and the availability of competent resources are clear challenges. This is particularly critical as we look to small hospital and small practice settings.
  + Further, policy makers should proceed cautiously and not lose sight of the EHR cost impact; the need for vendor interoperability, standard reusable components, usability testing.
  + Include EHR vendor engineers into the standards development process so that real-world application and experience can be considered in the standards development process.

Ability to accept downloaded specifications for new measures

* Summary statement: Commenters express some doubt that measure will be sufficiently detailed that they will not require manipulation. Thus they encourage a great degree of testing.
* Key points
  + Requires a great degree of measures specificity and accuracy for success
  + Requires testing after each download and update to ensure that downloads are error-free.

Minimal manual data collection/manipulation

* Summary statement: There is great interest in this capability however, commenters point out that data should be captured during the normal course of workflow and that automated abstraction needs to be thoroughly tested in order to gain provider confidence.
* Key points
  + Requires strong feasibility testing
  + Workflow must be efficient; data elements that are captured in the natural course of clinician practice and workflow
  + Providers must trust that automated abstraction is as reliable as manual human-driven abstraction therefore adequate testing is required

Aggregate measure data across units

* Summary statement: Commenters remind HITPC that not all care units have the same level of technical functionality. Security and confidentiality remain a concern.
* Key points
  + Feasibility depends on the presence and maturity of the expected unit as they are not all the same
  + Include the ability to aggregate measure data to the health system level for integrated delivery systems, and to the individual physician.
  + Confidentiality and security remain a concern as this capability requires data exchange across multiple data sources

Ability to build cross-setting measures

* Summary statement: comments remind HITPC that interoperability standards will be needed to achieve this capability. Further, they suggest learning for ACOs and HIEs for best practices as well as considering data warehouse and analytic products as part capability development.
* Key points
  + Interoperability standards are crucial to the success of this capability
  + Develop standards for obtaining, validating and managing external data sources in support of longitudinal records, including data mapping
  + A data warehouse structure may be better able to accept data from multiple EHRs, develop the necessary integrated records of care episodes across multiple settings and provide an effective mechanism for provider QI analysis.
  + analytic products that perform cross cutting analysis may prove useful
  + Examine the practices of hospitals and health systems currently forming accountable care organizations (ACOs) may prove useful. They are developing tools to integrate data across ACO participants.
  + It is important for the healthcare provider to authenticate and attribute patient reported data to assure patient data is correct before pulling into the EMR

Ability to build multi-source data records

* Summary statement: Commenters see this ability as an opportunity to conserve resources by avoiding duplicate data entry. The capability will require patient identification methods, significant standardization of patient-entered data and may warrant analysis of claims data external to EHRs.
* Key points
  + Consideration needs to be given to robust patient identification tools or a national patient identifier. Provider organizations and HIEs spend considerable effort working around this identification gap.
  + No such standard exists for patient reported data as far as we are aware unless the suggestion is that PHRs and portals use QRDA specifications as export formats. This needs a lot more exploration before it can be considered as a criteria for certification.
  + To include claims and EHR-data requires analysis external to the EHR itself.

Ability to implement HQMF

* Summary statement: HQMF is still under development and not yet a turnkey solution
* Key points
  + HQMF-QDM category mapping for all new measures would be valuable
  + HQMF needs to be able to aggregate data
  + A simplified XML based on a standard data model (such as the QDM used appropriately) can provide a template to which vendors can come closer to providing download ability.

Ability to drill down

* Summary statement: In order to take advantage of drill-down capability, commenters note a need to shift from current retrospective practices; assured confidentiality ; dashboard functionality and the ability to provide detail patient level data;
* Key points
  + Capability to provide clinical decision support at the opportune time when the patient is present and available for care
  + Preserve confidentiality
  + Develop certification criteria for dash-board type functions
  + Provide granular detail and the ability to stratify based on provider, location, diagnoses, and other patient characteristics.

| **ID #** | **Questions** |
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| **QMWG26** | What other features, if any, should be considered? Please make suggestions. |

* **Summary statement: Several commenters request the ability to query information in real time, consider additional population health capabilities, and focus on workflow and cross healthcare team collaboration needs. Commenters remind HITPC that there remains a need for well defined standards as much functionality is critically dependent on interoperability. Further HITPC is reminded that the medical record is the legal record of care; therefore managing aggregated data from across disparate systems may be outside of an EHR's intended us. Comments suggest solutions for providing aggregation capability outside of the EHR. Finally, commenters encourage HITPC to set aggressive goals to force the healthcare industry to innovate.**
* Key Points
  + Additional capabilities:
    - Query information in real time
    - electronically aggregate and compare data from rapid response teams and cardiac/respiratory arrests
    - Leverage currently-captured data elements linking reporting more outcome focused to improve the health of the patient
    - The level of training and self-help needed to comply with measures (e.g., reference material at the touch of a button)
    - Focus on the workflow and usability for the provider
    - Visibility of information to the entire healthcare team and not just one provider
    - Data-driven consumer driven education so patients understand the benefit of the additional inquiries regarding the additional questions (e.g., smoking questionnaires, depression screening) to their health outcomes.
  + Recommend adoption of consolidated CDA data standard in addition to all other data standards currently required for the purposes of Population Management and Syndromic Surveillance.
  + We believe encouraging vendors to be more adept at interoperability to provide more cost-effective access to data streams is critical to achieving better population health management.
  + The current model of quality reporting expects the incorporation of data gathered outside this record of care, and puts the onus of collection and reporting upon the eligible provider.
  + Alternate approaches to meet the goal of cross-continuum quality reporting: population management platforms, cloud computing, reusable standard components, High Performance Computing Cluster (HPCC) Platform, and robust server architecture

Suggest prescriptive specifications for EHR functionality that fully automate data collection, data analysis and data reporting/submission would be most beneficial.

| **ID #** | **Questions** |
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| **QMWG27** | What is the role of muliti-source data exchange in achieving these features? |

Commenters agree that multi-source data exchange is essential to many of the features described in QMWG 24-26. Commenters request clear standards and suggest that prescriptive EHRs specifications may be necessary. Further, comments suggest that data aggregation, warehousing and analytic processes belong outside of EHRs in data warehouses or Accountable Care Organizations. Finally Commenters remind ONC and CMS that Clinical EHRs do not have any current practical reason to generate or receive such transactions (e.g., administrative, claims or other clinical data) thus quality data warehouses or analytic products might be better suited for exchange.

* Key Points
  + Multi-source data exchange would provide a more accurate and longitudinal record of the patient, aggregate information across business units and sites, improve access to currently siloed data, improve decision making, as well as aid in determining population health needs
  + Standards are critical to ensuring this can be done efficiently but may be difficult to implement due to the huge variation in current the market. Further one commenter noted that physicians frequently defer measures related to exchange which may be indicative of poor interoperability.
  + Suggest the prescriptive specifications for EHR functionality that fully automate data collection, data analysis and data reporting/submission would be most beneficial.
  + Should take place out side of the EHR used in the day to day care of patients.
  + Be accomplished more effectively through data warehouses, accountable care organizations for HIEs.

| **ID #** | **Questions** |
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| **QMWG28** | Please comment on the value and feasibility of the CQM Population Management Platforms. Is there an evidence basis for clinical population management platform use? Is there a business case? Is this an area that could benefit from HITPC policy guidance or will the market mature and evolve without input? |

There is broad consensus that a business case exists for population management platforms. The majority of commenters, especially the providers, feel there is a role for increased standards and possibly certification for population health platforms or features. A few commenters, especially software companies and some organizations, worry that the market and standards are too immature for certification at this time. They propose a combination of guidance, incentives and grants with continued work on data and interoperability standards rather than certification.

| **ID #** | **Questions** |
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| **QMWG29** | What information or features might be present in a basic clinical CQM population management view (population score, denominator members, patient-level data element drill down, provider comparison, risk adjustment, ad-hoc queries, etc)? |

* Summary statement: There is broad consensus on a number of data elements and features are core to population management tools. The features include provider attribution, benchmarking, population stratification, roll up and drill down. The consensus for core information focuses on risk scores, quality scores, care gaps, diagnosis and procedure status. More advance features include ability to modify cohorts, ad hoc query, stratification and ability to act (e.g. order) from population management tools

| **ID #** | **Questions** |
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| **QMWG30** | What are the technological challenges to widespread release and adoption? Can the HITPC encourage technology in this area without being prohibitively prescriptive? Should the HITPC and HHS pursue avenues outside of regulation to support this technology: e.g. design open source prototypes, challenge grants, demonstration projects, guidance document, etc? |

* Summary statement: There is broad consensus for HITPC and ONC to continue to develop guidance, open source prototypes, demonstrations and challenge grants for population health. There is strong support for creation and enforcement of standards. There is mixed opinion about a role for regulation- some organizations such as Pharmacy e-HIT encouraging a role for regulation while others such as the Alliance of Specialty Medicine encourage a non-regulatory approach
* Key Points
  + Continue work on standards, challenge grants, open source prototypes
  + Consider separation of EHRs transaction system from analytic tools
  + Incorporate clinical decision support integration

1. Hendel RC, Budoff MJ, Cardella JF, et al. ACC/AHA/ACR/ASE/ASNC/HRS/NASCI/RSNA/SAIP/SCAI/SCCT/SCMR/SIR 2008 key data elements

   and definitions for cardiac imaging: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Data Standards (Writing Committee to Develop Clinical Data Standards for Cardiac Imaging). J Am Coll Cardiol. 2009;53:91–124. [↑](#footnote-ref-1)