

# **HIT Policy Committee**

## **Meaningful Use Workgroup**

### **Presentation to HIT Policy Committee**

**Paul Tang, Palo Alto Medical Foundation,  
Chair**

**George Hripcsak, Columbia University,  
Co-Chair**

**January 10, 2012**

# Workgroup Membership

## **Co-Chairs:**

Paul Tang

George Hripcsak

Palo Alto Medical Foundation

Columbia University

## **Members:**

- Michael Barr  
American College of Physicians
- David Bates  
Brigham & Women's Hospital
- Christine Bechtel  
National Partnership/Women & Families
- Neil Calman  
Institute for Family Health
- Tim Cromwell  
Dept of Veterans Affairs
- Art Davidson  
Denver Public Health
- Marty Fattig  
Nemaha County Hospital
- Joe Francis  
Veterans Administration
- Leslie Kelly Hall  
Healthwise
- Yael Harris  
HRSA
- David Lansky  
Pacific Business Group/Health
- Deven McGraw  
Center/Democracy & Technology
- Greg Pace  
Social Security Administration
- Latanya Sweeney  
Carnegie Mellon University
- Robert Tagalicod  
CMS/HHS
- Charlene Underwood  
Siemens
- Amy Zimmerman  
Rhode Island Office of Health & Human Services

# Agenda

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- Timeline for development of stage 3 MU objectives and criteria
- Initial recommendations on CQMs related to stage 3 MU (to begin discussion with HITSC)
- Discussion

## Updated Work Plan for Developing Recommendations for Stage 3

- Nov 9: Reported on Oct 5 Hearing; input from HITPC
- Nov 30: Sec announced intent to delay stage 2 to 2014
  - => IF we were to assume stage 3 begins 2 years after stage 2 (await NPRM and Final Rule), HITPC MU recommendations would be needed by mid-2013
- Need lead time for HITSC work if relevant standards need to be adopted or developed
  - 4Q12 for HITSC-sensitive MU recommendations
  - 2Q13 for policy-only MU recommendations
- Today @ HITPC: Initial HITSC recommendations for HITPC review related to quality measure development
  - Planned joint workshop with HITSC/ONC/CMS on Quality Measures

# Initial Recommendations for HITSC

Group 1 for Immediate Action – Could Impact  
Stage 2

# Recommendations for HITSC

## *Recommendation 1: Certification of CQM Reports*

- **Problem:**
  1. Many healthcare organizations use reporting systems (vs. EHRs) to generate quality reports for public reporting and quality improvement
  2. MU certification rules state that the healthcare organizations must use the certified EHR to report the CQM measures to CMS
  3. EHR vendors hardwire CQM calculations without knowing local clinical workflows, causing workflow work arounds
  4. Not all CQMs are relevant to all certified HIT systems
- **Proposed Solution:**
  - HIT vendor products should be certified for all CQMs relevant to the scope of the product
  - Providers should be permitted to use non-certified systems to generate CQM reports, as long as all the data used in the calculation of the measure are derived from certified HIT systems
  - All submitted CQMs are subject to audit
  - CQM reporting systems should be tested (subject to audit) based on a standardized test data set

# **Initial Recommendations for HITSC**

Group 2 – Longer Lead Time Required

# Initial Recommendations for HITSC

## *Recommendation 2: “CQM Platform”*

- **Problem:**
  1. Clinical Quality Measures (CQMs) are being “hard wired” into EHRs, which require upgrades in order to implement or revise
  2. EHR vendors are pre-defining data elements used in calculating CQMs, which impact clinical workflows of clinicians
  3. Healthcare organizations do not have an easy way to report on quality-improvement measures (vs. just CQMs)
- **Proposed Solution:**
  - By stage 3, EHR vendors should develop a “CQM platform” onto which new and evolving CQMs can be added to an EHR without requiring an upgrade to the EHR system.
  - Longer term, such platforms should be capable of incorporating CQM “plug-ins” that can be shared, and that allow organizations to localize data fields that fit local work flow.
  - We recommend that HITSC develop certification criteria to encourage/require this CQM platform as part of MU

# Initial Recommendations for HITSC

## *Recommendation 3: Patient-Reported Data and CQMs*

- Problem:
  1. Most CQMs are written for clinicians, pertinent to diseases
  2. Most CQMs do not incorporate information meaningful for consumers
- Proposed Solution:
  - Some CQMs should incorporate patient-reported data and outcomes
  - HIT vendors should develop secure, patient-friendly systems that allow direct entry of patient-reported data that can be incorporated into CQM reports
  - Patients should be able to access CQM reports

# Initial Recommendations for HITSC

## *Recommendation 4: Delta Measures*

- Problem:
  1. Most CQMs report risk-adjusted population means
  2. Patients seek measures that would apply to “people like me”
- Proposed Solution:
  - Some CQMs should report on percent of patients improving (“delta measures”) vs. only reporting risk-adjusted population means
  - EHR vendors should be able to calculate delta measures

# Follow-Up Actions on New CQM Recommendations

- Form joint HITPC/HITSC work group, including CMS, ONC, CQM stakeholders
- Conduct hearing on longer term CQM actions (CQM platform, new CQM concepts)
  - QM supply chain
  - QM consumer issues (informed by NCVHS February hearing on Measures that Matter to Consumers)
  - HIT vendor considerations
- All-day working session following hearing

# Summary

- Re: Certification Policies: We recommend that clinical quality measures should be based on clinical data from certified EHRs, and reported using standard definitions, subject to audit. CQMs can be reported to CMS from non-certified systems as long as the above is true.
- Re: CQM Reporting: Vendor-neutral CQM platforms that accept “CQM plug-ins” should be developed to support evolving quality measurement
- Re: Patient-centered CQMs: New CQMs that are meaningful to patients should be developed, and patient-reported data should be captured and reported using HIT

# Discussion