

HIT Policy Committee

Meaningful Use Workgroup

Presentation to HIT Policy Committee

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

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

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Workgroup Membership

Co-Chairs:

Paul Tang

Palo Alto Medical Foundation

George Hripcsak

Columbia University

Members:

- David Bates
Brigham & Women's Hospital
- Michael Barr
American College of Physicians
- Christine Bechtel
National Partnership/Women & Families
- Neil Calman
Institute for Family Health
- Art Davidson
Denver Public Health
- Marty Fattig
Nemaha County Hospital
- James Figge
NY State Dept. of Health
- Joe Francis
Veterans Administration
- David Lansky
Pacific Business Group/Health
- Deven McGraw
Center/Democracy & Technology
- Judy Murphy
Aurora Health Care
- Latanya Sweeney
Carnegie Mellon University
- Karen Trudel
CMS
- Charlene Underwood
Siemens

Agenda

- Summary of Oct 5, 2011 Hearing on Meaningful Use Experience and Input to Stage 3
 - Topics and participants
 - Summary findings
- Initial work-in-progress on focus areas for stage 3
- Work plan for developing stage 3 recommendations
- Discussion

Panel 1: Meaningful Use – Supporting the Goals of Health Reform

- CMS, state, and private payer's experience with MU
 - Adoption rates
 - Challenges
 - Recommendations for supporting accountable care
 - Alignment

Rob Tagalicod, CMS, eHealth Standards & Services

Patrick Conway, CMS, Clinical Standards & Quality

Julie Boughn, CMS Deputy Center Director

David Kelley, MD, Pennsylvania State Medicaid Rep

Charles Kennedy, Aetna

Panel 2: Providers – Working Toward Meaningful Use Stage 3

- EP and EH experience with MU
 - Experience with MU objectives, QMs, and certification
 - Cost and challenges
 - Care team
 - Value and types of QMs
 - Patient's response to MU
 - Effect on other activities and on achieving accountable care

Paul Kleeberg, MD, REACH,
Minnesota

Denni McColm, CIO, Citizens
Memorial Healthcare, MO

Thomas W. Smith, CIO, NorthShore
University Health System, IL

Jennifer Bolduc, MD, CMIO, Walla
Walla Clinic, Washington

Carol Steltenkamp, MD, CMIO,
University of Kentucky Healthcare

Chantal Worzala, American
Hospital Association

Kelley Bridges, RN, East Alabama
Medical Center

Eileen Fuller, MD, Vermont

Panel 3: Vendors – Developing Systems to Meet MU3

- Vendor's experience with MU
 - Which objectives most challenging
 - Development and implementation time
 - What approach customers are taking
 - HIE
 - Sharing data with patients
 - Images
 - Effect on other initiatives

Sasha TerMaat, Epic
Lauren Fifield and Jeremy Delinsky,
Athenahealth
Michelle Freed, McKesson
Lawrence McKnight, MD, Siemens
Healthcare
Michael Stearns, MD, e-MDs

Panel 4: Finding Solutions & Creating Outcomes

- Key data challenges to improving America's health system
 - Quality measure development, certification of healthcare professionals, consumer use of comparison data, coordination of care, payer
- Solutions to make the acquisition, analysis, and use of health data more effective and efficient
 - Standards, architectural approaches, workflow changes, policy changes

Karen Kmetik, American Medical Association

Judith Hibbard, University of Oregon

Maureen Dailey, American Nurses Association

Kevin Weiss, MD, American Board of Medical Specialists

Sarah Woolsey, MD, Beacon, Utah

Reid Coleman, MD, Lifespan, RI

Richard Elmore, ONC

Summary Findings from Oct 5 Hearing

Clinical Quality Measures (CQM)

1. Measuring quality and performance is a good thing, but current CQMs and process of extracting them requires considerable effort (e.g., up to 75% of cost of meeting MU) and time
 - a. Lack of clarity of CQM definition; unclear owner/maintainer of retooled measures
 - b. Need standard case definitions (e.g., diabetes)
 - c. Errors in CQM definitions (when retooled); measures not field tested
 - d. Exclusions often require chart review
 - e. Requirement to use vendor-supplied, certified method → redesign workflow to implement vendor's view on how data elements should be captured and where stored
 - f. Alternatives to vendor method requires certification of local reporting methods
 - g. Certification of vendor for CQM neither required testing of a complete set (only 9/44) nor assessed accuracy of result
 - h. Concern over volume of CQMs (growing with stages) vs. parsimonious exemplars

Summary Findings from Oct 5 Hearing

Clinical Quality Measures, II

2. Lack of alignment or harmonization of CQM with other CMS and private payer QMs, P4P, accreditors, public reporting, professional boards (e.g., MOC)
 - a. May not be as relevant locally
 - b. Would like to be more outcome-focused and less process-measurement focused
3. Would like CQM to provide realtime benefits to clinicians (e.g., dashboard vs. only retrospective reporting)
4. Would like capabilities for improvement measures, not just reporting (ie. CQMs are hardwired)
5. Effort required is more challenging for smaller providers

Summary Findings from Oct 5 Hearing

Patient Engagement

Patient engagement challenges

- a. Clinical summaries sometimes "forced" on patients (to meet 50% threshold) → privacy risk and waste of paper
- b. Need more engagement from the public on benefits of access (through public education)
- c. Need more flexibility (vs. prescriptive objectives e.g., "give" clinical summaries, "download")

Summary Findings from Oct 5 Hearing

Lack of HIE

Lack of HIE

- Business model for HIE still a problem
- Connectivity with clinical trading partners makes more business sense for provider than connecting with HIE
- Payers now owning HIE technology partners
- "Testing" public health connectivity is costly; few ready to receive

Summary Findings from Oct 5 Hearing

Other Sources for Feedback

Beacon communities

Other challenges from organizations who are not able to attest yet

Crowd sourcing

Would like timely feedback to questions

- Timely updates to FAQ

Follow Up Small Group Activities

Clinical Quality Measures

Attributes of “ideal” Clinical Quality Measures

- Strategic attributes of CQM
 - Meaningful measures (to patients and providers)
 - Follow exemplar philosophy; parsimony
 - Aligned with future payment models
 - Outcomes-oriented
 - Include flexibility for local relevance
 - EHRs capable of reporting both QI and reporting QMs
 - Minimize data capture burden (assess ‘value’ of QM)
 - Simplicity is much preferred over complex QMs; e.g., fewer exclusions
 - Include act of exchanging health information

Follow Up Small Group Activities

Clinical Quality Measures

Attributes of “ideal” Clinical Quality Measures

- Technical attributes of CQM
 - Clear, well specified definitions
 - Field-tested
 - ONC-specified testbed of exemplars
 - Data capture fits workflow, and is consistent among providers
 - Method of providing feedback to measure stewards for QM QI
 - Easily updated in EHRs (~”plugin”) vs. hard-wired
 - Reporting options besides tethering to specific EHR

Follow Up Small Group Activity – Work in Pro *Specialties*

- Reviewing past hearing and testimony
- Reviewing AMA matrix of responses from specialty societies
- Prefer not to have separate MU track for specialists
- Want to focus broadly on all types of specialists
- Specialists should contribute to EHR content, not just access
- May seek more feedback on options

Developing Focus Areas for Stage 3

Principles

- Goals of Meaningful Use still appropriate, and is consistent with National Quality Strategy
- Principles for Stage 3 focus areas:
 - Align with emerging payment policies and NQS
 - Consider harmonized qualifications among CMS programs (e.g., cross-credit ACO, MU?)
 - Support population health data analysis
 - Support innovative approaches to using HIT to improve health and health care
 - Flexible, adaptive platforms
 - Not penalize success (e.g., not take a step back to prove capability for success)

Initial Draft Focal Areas for Stage 3 *Leveraging Tools to Support Health*

1. Real-time impact of information at point of care (i.e., ongoing, timely, patient-specific impact to clinicians): Examples
 - a. Clinical performance dashboard
 - b. Adverse event prevention, detection, mitigation, reporting
 - c. Continuous learning health system
2. Reinforce and empower patient partnership
 - a. Access to information
 - b. Contribute to record
 - c. Support of caregivers
 - d. Measures that matter to patients
3. Emerging sources of data (including patient-reported outcomes)
4. CDS domains
 - a. Prevention
 - b. Disease management
 - c. Safety
5. Use of population health assessment, analysis, and surveillance to drive policy making

Work Plan for Developing Recommendations for Stage 3

- Oct 5: Hearing on Stage 1 experience and input for Stage 3
- Meaningful Use WG meetings
- Small group task forces gathering more information
 - Clinical quality measures
 - Specialists
- **Nov 9: Input from HITPC**
- Nov-Jan: MU WG meetings
- Feb: Initial recommendations for HITPC review
- Spring, 2012: Public RFC
- Spring, 2012: Revised recommendations for HITPC review
- Mid-2012: Final recommendations to ONC/CMS

Summary

- Goals of Meaningful Use reconfirmed and do support National Quality Strategy
- Major challenges to address
 - Clinical Quality Measures
 - Patient engagement
 - Exchange of health information
 - Specialists
- Developing focus areas for stage 3
- Plan
 - Additional deliberations and feedback
 - RFC
 - Recommendations

Discussion