

# Characteristics of Optimal Clinical Quality Measures for Health IT Tiger Team

Karen Kmetik, Chair

April 19, 2012 - 3:30p-4:30p/Eastern

# Tiger Team Membership

## **CHAIR**

Karen Kmetik

American Medical Association

## **MEMBERS**

Ann Castro

John Derr

Bob Dolin

Rosemary Kennedy

David Lansky

Robert C. McClure

Eva Powell

Eric Rose

Danny Rosenthal

Randy Woodward

BlueCross BlueShield of SC

Golden Living

HL7

Thomas Jefferson University

Pacific Business Group on Health

Apelon, Inc.

National Partnership

Intelligent Medical Objects

Inova Health System

Healthbridge

## **Federal Ex Officio**

Patrice Holtz, CMS, HHS

P. Jon White MD, AHRQ

## **Staff**

Amy Gleason, ONC

Jacob Reider, ONC

- April 2<sup>nd</sup> Review purpose, perspectives, and attributes
- April 5<sup>th</sup> Define and use optimal characteristics for evaluation of quality measures
- April 19<sup>th</sup> Vet examples, finalize recommendations

The Characteristics of Optimal Clinical Quality Measures for Health IT Tiger Team will focus on identifying the attributes of optimal clinical quality measures that are created or “re-tooled” for use in Health IT.

The characteristics of optimal clinical quality measures evaluated by this Tiger Team are from a technical lens, not from the perspective of the importance of the quality measure per se.

We are interested in applying this technical lens to measures we have and those we seek (eg, longitudinal, patient-reported, clinical outcomes).

# What Makes an Optimal Quality Measure?

## Usability

Availability of data

Reduces re-entry of data by reusing data where possible

## Feasibility

EHR feasible

EHR Enabled

## Accuracy

Data reported is captured and queried correctly

Process has few errors

Data is known to be accurate

Assumptions are not made on method of capture

## Standard Terminology

Reduces variations in interpretation

Reduces workarounds and hard-coding of choices

- Availability of data – The data is captured in traditional workflow (may include data coming from other source into the practice site EHR). The data may be available now or could be available with reasonable workflow changes. If data are not realistically captured in the workflow, they are not available.
  - An example may be a data element “lack of particular symptoms.”
  - Another example is “blood drawn before antibiotics are given,” requiring time stamps.
- Redundancy – The data capture should reduce re-entry unless entering it again provides value, such as in clinical decision support, care coordination, or verification process.

- EHR Feasibility – Functionality to support the quality measure exist (expected) in most EHRs and could exist within reason for stretch quality measures (data accessible).
- EHR Enabled – The quality measure is enabled due to data being in electronic format. These items are difficult to measure on paper or non-electronic formats.
- ~~• EHR Sensitive – Performance on the measure is improved by the meaningful use of EHRs and can be measured by improved outcomes and clinical performance~~

- Accuracy – For clinical quality measures to be optimal, they need to be accurate, and accuracy has four parts:
  - Data are captured correctly and queried correctly (clear, detailed specifications)
  - Process of collection has few errors and does not require re-entry of data unless it provides value (e.g verification, care coordination, clinical decision support)
  - Knowledge that the data itself are accurate irrespective of capture mechanism
    - An example is when ICD-9 is captured without error, the process had no error, but the data are captured using a vague ICD code that doesn't provide accuracy.
    - Another example is when the patient gives the time of his last meal but isn't sure of the time and doesn't say that he isn't sure
  - Assumptions are not made about how the collection happens, but instead guidance is provided

- Standard Terminology Usage (shared meaning) - Data needed for quality measures should be captured using standard terminology to reduce variations in interpretation and to reduce hard-coding of choices and workarounds.
  - We want confidence that practice A/EHR A and practice B/EHR B are using the same terminology for data elements
  - The data should be easily aggregated because the data are using common standards as dictionaries. For example, everyone uses the same value set to identify the population of patients with diabetes for a particular measure.

- For purpose of discussion,
  - Excel Matrix
  - Make recommendations

# Discussion