



The Office of the National Coordinator for  
Health Information Technology



# Clinical Quality Hearing June 7, 2012

Putting the **I** in Health **IT**   
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- High Performing Healthcare Improvement Organizations and Analytics Systems to Support Them
- Clinical Decision Support, The “Improvement” Arm of Quality Improvement
- E-measures
- EHR Vendor Perspectives of Necessary Components of Quality Improvement

- Meaningful use has unleashed tremendous energy across providers and vendors
- Significant learnings, even from first months of MU 1
- Opportunity to leverage the “common substrate” to support quality improvement across EHR implementations
- Emergence of a growing set of tools to populate and manipulate the “common substrate”

- Inadequate standards – especially “value sets”
- No clear link between requirements for decision support (CDS) and quality measures
- Insufficient payment incentives to drive deep adoption
- Even the most advanced sites have substantial unstructured data, and difficulty identifying “source of truth”
- Concern about new fields and requirements – users want to better leverage the data already captured
- Most effective quality improvement occurs across “communities” and through mutual education but systems are silo’d

- Some view QMs as defining targets for improvement activity, so should be at process level
- Some prefer few measures linked to major care processes (6-7 metrics per process), with drill-down done locally; perhaps federal identification of “top 10 conditions”
- Need standard, downloadable e-measure specifications
- Need same data model for QM as for drill-down that supports quality improvement
- Attribution to provider level constant challenge
- QM development should include collaboration with CDS community

- Local institutions are now building their own tools for drill-down analysis
- Data integration to support analysis remains difficult (such as from claims or remote sites): unstructured data, localized coding, incomplete longitudinal records, etc.
- Current eCQMs do not leverage new data elements in EHRs effectively
- Need to migrate to “app-like” architecture to allow specialized vendors to solve some problems, rather than having EHR vendor do it all

- Facilities are building their own CDS alerts based on guidelines – is this realistic (or efficient) for all MU sites?
- Need plug and play mechanism to bring national “knowledge assets” into the EHR decision support functions (some experimental models now exist)
- Need standard, downloadable CDS specifications
- Organizations want real time visibility into care goals that are measured- this key strategy for improvement and likely CDS intervention

- What is the HITECH role in quality measurement and clinical decision support?
  - Adopt and ‘enforce’ standards?
  - Develop infrastructure for transmission of quality measures and CDS rules?
  - Identify content of quality measures and CDS rules (exemplar only?)
  - Assure certified EHRs capable of capturing information for policy-relevant purposes (e.g., Medicare value-based payment programs)?
  - Assure certified EHRs capable of supporting local quality improvement analysis and monitoring?
- Should CDS and QM be linked – or are they intentionally different (i.e., CDS represents prescriptive process guidance; QMs measure whether outcomes are improved)

- Standardize measure components?- attribution, value sets, denominator definitions
- Vendors need value sets, need to know what's coming over time
- How to include the patient as an actor in the design process
- Governance – especially if we are prescriptive on clinical processes through CDS rules or through process-oriented quality measures