

HIT Policy Committee, Meaningful Use Workgroup

Meaningful Use Workgroup analysis

Preamble: Below are some recommendations regarding CQMs used in the Meaningful Use Incentive program. These recommendations are based on feedback from a hearing about experience with stage 1 MU qualification and panelists' recommendation regarding stage 3 measures as well as further sub-group discussion.

The recommendations about types of CQMs are consistent with, and reconfirm the recommendations of the Quality Measure WG transmitted in August, 2011. Given the importance of quality measurement and reporting in a wide variety of public programs in addition to Meaningful Use, such as Accountable Care Organizations, Medical Homes and HHS reporting programs, these recommendations focus on areas that are known gaps in the ability of health IT to support more advanced measurement. Our recommendations highlight functional requirements for HIT to support capture of relevant data and their use in specific CQMs.

1. After receiving feedback about stage 1 MU experience with CQMs, we re-confirm the direction of the Quality Measures work group approach of requiring a small number of core measures in addition to a menu selection from each of the following domains:

- 1) Patient and Family Engagement
- 2) Efficiency measures
- 3) Patient Safety
- 4) Population and Public Health
- 5) Care Coordination
- 6) Clinical Processes

We encourage complete alignment with NQF's MAP selection criteria for CQMs. Alignment and parsimony of measures were universally of high priority.

2. We recommend that EHR vendors develop a CQM "platform" to which new and evolving CQMs can be added to an EHR without requiring an upgrade to the EHR system. In the longer run, such platforms should be capable of incorporating CQM "plug-ins" that require little to no user modification. We recommend that HITSC develop certification criteria to encourage/require this CQM platform as part of MU

3. CQMs should include measures that encourage EPs and EOs to incorporate patient reported data and outcomes to evaluate quality. We recommend that vendors develop secure and patient-friendly platforms that will allow direct entry of such patient reported data by patients or their designees.

4. CQMs should include delta measures that report on the percent of patients in a population which improved by some threshold (vs. only reporting on risk-adjusted population means)

5. A small number of CQMs should be reported out, stratified by patient characteristics (e.g., disparity demographics, clinical severity of illness)
6. A small number of CQMs should involve use of information exchange to support longitudinal quality measure reporting (to support ACOs, episode of care, transition of care)
7. 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, and are subject to audit.
8. EHRs certified for CQM reporting, and providers using non-certified systems to generate CQM reports, should be tested for accurately reporting all possible CQMs based on a standardized test data set.