

March 13, 2007

The Honorable Michael O. Leavitt

Chairman

American Health Information Community

200 Independence Avenue, S.W.

Washington, D.C. 20201

Dear Mr. Chairman:

The American Health Information Community has identified and prioritized several health information technology applications, or “breakthroughs,” that could produce a specific tangible value to health care consumers. To address one of these breakthrough areas, the Quality Workgroup was formed and given the following broad and specific charges:

Broad Charge for the Workgroup: Make recommendations to the American Health Information Community so that breakthroughs in HIT can provide the data needed for the development of quality measures that are useful to patients and others in the health care industry, automate the measurement and reporting of a comprehensive current and future set of quality measures, and accelerate the use of clinical decision support that can improve performance on those quality measures. Also, make recommendations for how performance measures should align with the capabilities and limitations of HIT.

Specific Charge for the Workgroup: Make recommendations to the American Health Information Community that specify how certified health information technology should support the capture, aggregation, and reporting of data for a core set of ambulatory and inpatient quality measures.

This Workgroup is one of many efforts focused on improving the quality of health care and plays an important role within the context of broader efforts. As the Workgroup strives to meet both its broad and specific charges, it has undertaken an iterative approach to integrating quality and health information technology which leverages the collective wisdom of industry experts in the public and private sectors and supports integrated and aligned efforts across the national quality enterprise. The Workgroup values and supports the development of a common framework aligned with a variety of organizations, to ensure that scalable approaches to quality measurement, reporting, and improvement are adopted. To the extent possible, this Workgroup will consider common data needs that may overlap with other Workgroups, as data needs for quality are not entirely separate from data needs for other secondary uses of data. Given advances in technology coupled with increased pressure for quality improvement and growing demand for relevant and

accurate health care information, there is both urgency and an opportunity today to meet the broad charge of the Workgroup.

Success of the Workgroup will be measured by how health information technology enables both informing consumers' health care decisions as well as improving the quality of care delivery. Examples of success might include consumer engagement through information based on a nationally accepted set of quality metrics that informs their decisions about what treatments they want and who they want to provide them, and clinicians who routinely use clinical decision support and electronic health records to bring all needed patient data and medical knowledge into shared decision-making with patients to achieve optimal outcomes.

Our Approach to Date

Consensus on quality metrics is a fundamental precursor to realizing the Workgroup's high-level vision presented to the Community on January 23, 2007. Therefore, it was important for the Workgroup to first define what "core set" of inpatient and ambulatory measures should be addressed first. The Workgroup agreed that the consensus process is critical to convergence on a core set and that the measures selected by AQA and Hospital Quality Alliance (HQA) represent the current national consensus. Both AQA and HQA are multi-stakeholder alliances that prioritize the implementation of measures endorsed by the National Quality Forum (NQF).

Through testimony and the development of the vision, the Workgroup has identified critical barriers and enablers for its near-term priorities that also impact long term priorities.

1. Security and privacy concerns must be addressed.
2. The provider business case for automating quality measurement must be developed in concert with the incentives for EHR adoption and the sharing of clinical data. The business model for value-driven health care will be dependent on the use of a robust set of quality and efficiency measures.
3. In order to produce data for quality metrics, multiple sources must be accessed and aggregated. Therefore, data aggregation strategies are needed to support public reporting of clinical care at a regional, state, and/or national level.
4. Business process and workflow changes will likely be required to ensure optimized capture of data.
5. Consensus is required on the ways in which patients will be uniquely identified through data, both within a subset as well as across institutions that will support quality measurement and reporting while protecting confidentiality.

6. Translating quality measurement and reporting into improved results for patients requires much greater use of effective clinical decision support, as well as rapid development and evolution of market competition and collaboration across multiple stakeholder groups.

The Workgroup's deliberations to date have highlighted a number of key needs that must be addressed in the near-term to meet the group's specific charge, including the following:

1. Automate data capture and reporting to support core sets of AQA clinician-focused and HQA inpatient quality measures.
2. Create a common framework of workflow activities that underpin performance measurement, and improvement with clinical decision support, so that these inter-related activities can occur seamlessly within care delivery.
3. Enable data aggregation to allow public reporting of quality measures based on comprehensive clinical data that is pooled across providers and merged, as appropriate, with other data sources.
4. Align performance measurement with the capabilities and limitations of health information technology.

This letter provides both context and recommendations for how these issues can be addressed so that health information technology can enable and accelerate the consistent delivery of high-quality, safe, and efficient care.

Relevant Organizations and Projects

The following organizations and projects can provide leadership and examples for efforts to encourage quality measurement to improve health care quality and patient safety.

The AQA was formed to improve health care quality and patient safety through a collaborative process in which key stakeholders agree on a strategy for measuring performance at the physician or group level; collecting and aggregating data in the least burdensome way; and reporting meaningful information to consumers, physicians, and other stakeholders to inform choices and improve outcomes. www.aqaalliance.org; George Isham, *American Journal of Managed Care* The AQA has developed a consensus around a starter set of 26 measures of physician quality and has recently adopted an additional 83 measures. However, the AQA measures are not widely deployed due to adaptive challenges related to collecting data and technical challenges related to aggregating physician data from multiple sources to allow for meaningful comparisons.

The HQA is a public-private collaboration to improve the quality of care provided by the nation's hospitals by measuring and publicly reporting on that care. The ultimate goal of the HQA is to identify a set of quality measures that would be reported by all hospitals,

and accepted by all purchasers, oversight and accrediting entities, payers, and providers. The twenty-one measures currently reported on www.hospitalcompare.hhs.gov reflect recommended treatments for heart attack, heart failure, pneumonia, and surgical care improvement/surgical infection prevention. Under Section 5001 (a) of the Deficit Reduction Act (DRA) of 2005 (P.L. 109-171), hospitals who choose not to voluntarily report data to CMS for display on Hospital Compare lose 2% of their market basket adjustment for Fiscal Year 2007. Furthermore, the DRA lays the foundation for a nationwide Medicare hospital value based purchasing (VBP) program. Section 5001(b) of the DRA mandates that CMS propose a plan for a VBP-program for Medicare hospital services that could commence in FY 2009. The HQA measures are expected to be strongly considered for that program. The vast majority of the data required to support HQA measures is collected manually, even among hospitals with electronic medical records. A major barrier to electronic collection of the data required to measure quality, and therefore a barrier to the rapid expansion of measurement requirements, is the lack of standards for documentation, storage, and transmission of such data.

The Quality Alliance Steering Committee is a collaboration between the AQA and the HQA. The goal of the committee is to better coordinate the promotion of quality measurement, transparency, and improvement in care by considering how best to expand the scope, speed, and adoption of the work of AQA and HQA.

The National Quality Forum is a voluntary consensus organization which reviews and endorses quality measures and is a critical actor in helping to identify a set of common data elements across measure sets. Through their work with the Quality Alliance Steering Committee, the NQF has led efforts to harmonize measure definitions across settings and developers. Through its endorsement process, NQF also can apply criteria that reinforce the use of standardized data elements in measures to allow quality measures to be embedded in EHRs.

Value Exchanges are an expansion of current AQA pilot sites focused on facilitating use of quality data and promoting local quality improvement efforts.

The Better Quality Information to Improve Care for Medicare Beneficiaries (BQI) Project is part of HHS' Value-driven Health Care Initiative which is based on the following four cornerstones announced in President Bush's Executive Order issued in August 2006: interoperable health information technology (health IT); transparency of price information; transparency of quality information; and the use of incentives to promote high-quality and cost-efficient health care. The Executive Order directs federal agencies, to the extent permitted by law, to share information with beneficiaries on the quality of services provided by doctors, hospitals, and other health care providers.

Recommendations

The Workgroup identified the following actionable recommendations to meet the specific charge.

- 1. Automate data capture and reporting from electronic health records to support a core set of AQA clinician-focused and HQA quality measures.**

The Quality Workgroup sees opportunities to advance the use of the AQA and HQA measures and to lower the burden associated with manual data collection by accelerating the use of electronic health records to capture and transmit the data required to support the measures and by standardizing the claims data that can be used as a proxy for electronic health records data.

Recommendation 1.1: The Quality Alliance Steering Committee, with support from HHS and other relevant federal agencies, should convene an expert panel that would accelerate the current efforts to identify a set of common data elements to be standardized in order to enable automation of a prioritized set of AQA and HQA measures through electronic health records and health information exchange. The Quality Alliance Steering Committee, with support from HHS and other relevant federal agencies, should establish the priority order for the measures. This panel will build on work already done by NQF and others. The first group of recommendations from the expert panel should be shared with the Community by June 5, 2007.

Recommendation 1.2: The Health Information Technology Standards Panel (HITSP) should use the work of the Quality Workgroup's expert panel recommended in 1.1 to identify the data standards to fill identified gaps for data elements required for automation of core sets of AQA and HQA quality measures.

Recommendation 1.3: The Certification Commission for Health Information Technology (CCHIT) should develop appropriate criteria necessary to support the reporting of core sets of AQA and HQA measures in the next round of criteria development.

- 2. Establish a unified framework and enhanced collaborations around gathering key data from care processes and delivering key information to providers to help drive improved care outcomes.**

Clinical decision support (CDS) and quality measurement are fundamentally interconnected and draw from the same evidence base. The former is a systematic process for ensuring that the right information gets to the right persons in the right manner to support optimal decisions and outcomes, and the latter is an assessment of the extent to which those outcomes are achieved. Today's clinical decision support tools are hampered by similar challenges as quality measurement; for example, the lack of standardized approaches for delivering key information into, and abstracting it from, the clinical workflows through which patient care is delivered.

The Quality Workgroup recognizes opportunities to approach performance measurement and improvement in a more integrated and effective fashion. For example, work is beginning in several initiatives to identify specific opportunities for delivering CDS into specific provider workflows to support improved performance in areas such as those targeted by AQA and HQA measures. These efforts could be accelerated, expanded, and

coordinated to produce frameworks for determining how best to gather the data needed to determine which patients are eligible for specific care targeted by quality metrics.

These same frameworks could simultaneously be used to identify optimal strategies for helping providers know precisely what they need to do (and for whom) to ensure the highest quality care. Furthermore, shared models of clinical workflows underpinning concurrent performance measurement and CDS can help accelerate collaboration and results across a variety of performance measurement and improvement initiatives focused on targets such as AQA/HQA measures.

Recommendation 2.1: The expert panel convened by the Quality Alliance Steering Committee in Recommendation 1 should gather, synthesize and refine clinical workflow maps, focusing on care processes related to the care underlying the conditions targeted by the prioritized set of AQA and HQA measures. The Quality Alliance Steering Committee, with support from HHS and other relevant federal agencies, should establish the priority order for the measures. The panel should determine mechanisms and opportunities within these workflows for identifying patients who are eligible for inclusion in the AQA and HQA measure populations, for gathering performance measurement data, and for providing clinical decision support to optimize performance in targeted areas. In addition to a generic framework that could be used across many clinical conditions, the deliverable should include at least one scenario for how the workflows operate for AQA/HQA targeted conditions. Measure inclusion mechanisms must protect privacy and confidentiality. The results of this analysis should be reported to the Community by September 18, 2007.

- 3. Enable data aggregation as needed to allow public reporting of quality measures based on comprehensive health care data that are pooled across payers and providers and merged, as appropriate, with other data sources while protecting privacy.**

Many measures require that data be collected from multiple sources to provide an accurate picture of performance. Data aggregation would support the measurement of care across episodes, and would help reduce the burden of reporting by capitalizing on comprehensive reporting of data one time, to then be used for multiple purposes. Data aggregation is required to support the uniform measure of quality across providers, and to provide consumers with useful information with which to make decisions.

Recommendation 3.1: HHS, working with relevant public and private sector leaders and the BQI projects, should identify and articulate the key challenges associated with linking claims data from multiple sources (e.g., physician IDs, claims adjudication processes, data storage/purge policies), and the benefits and challenges of linking clinical data to other data sources, including claims. A report should be submitted to the Quality Workgroup by June 30, 2007.

Recommendation 3.2: HHS should enable, through the NHIN contracting process and Value Exchanges, efforts to combine clinical and non-clinical electronic data for quality measurement and timely reporting of results.

4. Align quality measurement with the capabilities and limitations of health information technology.

Development of quality measures and health information technology development are currently pursued independently of each other, yet the efficient and effective implementation of quality measurement and reporting systems is reliant upon the effective use of health information technology. The Quality Workgroup recognizes an opportunity to reduce the future burden of data collection for quality measurement purposes through increased collaboration and communication between developers of quality measures and health information technology vendors. The communication channels outlined in the following recommendations should be leveraged to ensure that HIT vendors are attuned to the data requirements of emerging quality measures, so that these data needs can be considered in subsequent systems development.

Recommendation 4.1: HHS, through the Centers for Medicare & Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ), along with major measure developers, should identify opportunities to enhance measure development by considering the data needs at the time a measure is developed, especially for measures targeted for public reporting. This effort should also include clinical practice guideline developers and should coordinate their role in developing performance measures.

Recommendation 4.2: The National Quality Forum, through its endorsement process, should apply criteria that reinforce the use of standardized data elements in measures to allow quality measures to be embedded in EHRs. The NQF may do so by incorporating such criteria into its endorsement criteria for new measures.

These recommendations are supported by information obtained through research and testimony to the Quality Workgroup, which is contained in the supporting documents available at <http://www.hhs.gov/healthit/>.

Thank you for giving us the opportunity to submit these recommendations. We look forward to discussing these recommendations with you and the members of the American Health Information Community.

Sincerely yours,

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