

Draft Criteria for QWG to Evaluate CQM

Criteria Ideas from March 2, 2012 QMWG meeting

1. Quality adjusted life years- which measures impact this most
2. Practical burden of measurement – e.g. depression screening
3. NQF endorsement
4. Developmental measures- measures that would not be audited or used in determination of payment.

Criteria from email discussion:

David Lansky's "Uber criterion"

Demonstrating the capability of certified EHR technology to produce a wide range of measure types - involving local clinical processes, multiple data types, multiple or linked data sources, longitudinal and repeat measures, PROMs, etc. "I hope, when we're done, the US has in place a clinical data infrastructure that can support more reliable measurement of all six domains for a wide variety of purposes."

Paul Tang's recommendations

1. Addresses a high national health priority (e.g., national quality strategy, million hearts)
2. Consistent with efficient clinical workflow (generalizable across the greatest number of clinical specialties)
3. Harmonized with QMs in other national programs
4. Yet, still be parsimonious

Jim Walker proposed set version 1

1. Addresses a healthcare need (e.g., condition) with a high, remedial burden of illness (expressed as population QALY increases achievable with optimal care).
2. Evidence-based (e.g., not HbA1c < 7)
3. Necessary to managing (including evaluating) a high-value care process
4. Statistically valid for the size of the patient population of the clinical unit to which it is applied (e.g., to a single physician's panel, to a clinic or hospital's population, to an ACO's population, to the U.S. population)
5. Sensitive to the actions of the care team
6. Includes an appropriate spectrum of leading and lagging measures, that is, performance of enabling processes (checking INR at least every 4 weeks), performance of processes proven to improve patient outcomes (INR in range) patient outcomes, such as stroke and hemorrhage.
7. Usability
8. Time by which widespread implementation (85% of practices or hospitals?) in health IT is feasible

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Jim Walker proposed set version 2

1. In the aggregate, use all of the 12 categories of data in the consolidation of the Quality Data Model that Floyd has in his possession.
2. Require input from many members of the patient's care team--at least patients, their lay caregivers, physicians, nurses, pharmacists, and insurers; but eventually including therapists, desk clerks, etc.
3. Enable patient input of personal capabilities (e.g., health literacy), preferences (e.g., locus of control), symptoms, and assessments of care.
4. Require substantial decision-engine analytics and provision of analyzed information in actionable form in the workflows of appropriate members of the care team.

MAP Criteria:

Measures within the set meet NQF endorsement criteria

Measure set adequately addresses each of the National Quality Strategy priorities

Measure set adequately addresses high-impact conditions relevant to the program's intended population

Measure set promotes alignment with specific program attributes

Measure set includes an appropriate mix of measure types

Measure set enables measurement across the patient-focused episode of care

Measure set includes considerations for disparities

Measure set promotes parsimony

Mark Overhage recommended criteria

1. Requires data capture from in office devices
2. Requires data captured directly from the patient in a setting outside of an office visit
3. Requires data from external sources (HIE)
4. Requires data captures across a span of encounters
5. Uses physical exam, PMH, SH, FH, ROS, laboratory, clinical observations, medications (both current and historical), problems (both current and historical), radiology results, and allergy data (at least a couple each)
6. Certification criteria require ability to add an "arbitrary" measure definition in emeasure format and create all necessary data capture and calculations needed (this might have to happen in steps with 2014 criteria doing part of it) -- there could be test measures to load but the one actually used for testing would be a surprise ability to use multiple data elements in creating denominator stratification of population by criteria that uses multiple data elements
Etc

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Peter Bacsh's Measure guiding principles

- I. Measures Must Be Important, Understandable and Transparent to Patients and Providers
- II. Measures Must Reflect Current Evidence-Based Medicine
- III. Measures Should Use Consistent Terminology and Definitions
- IV. Measure Denominators Must Consist of Patients Seen By the Provider During the Measure Period
- V. Measures that are Meant to Have Broad Applicability (such as Core Measures) Must Include Numerators That Reflect Reasonable Actions Taken By Providers in All Applicable Specialties
- VI. Wherever Possible, Measures Should be Chosen or Constructed Based On All of the Above AND Their Relevance to Key Health and Healthcare Aims
- VII. Measures Should Be Chosen in the Context of Other Measures
- VIII. Measures Should Not Introduce Competing Requirements to Other Measures
- IX. Specified Data Elements Necessary to Determine a Measure Denominator, Numerator, and/or Exclusion must be "EHR Capable"
- X. Measures Should Be "EHR Enabled"
- XI. Measures Should Be Considered as Organic and Part of a Continuous Learning Process

Paul Tang's suggestions

1. Preventive health exemplar:
 - a. Using discrete clinical and administrative data to filter for patients eligible for a specific preventive health service or procedure
 - b. Tailor the recommendation for clinical risk of an individual patient (e.g., high risk for breast ca or cervical cancer or colon cancer, history of abnormal result)
 - c. Create patient-specific reminders
 - d. Notify patients automatically
 - e. Create a clinical decision support rule to alert provider during visit
 - f. Create patient lists for outreach
2. Clinical guideline on therapy exemplars:
 - a. Detect a patient falling under the scope of a clinical guideline
 - b. Ascertain whether the patient's treatment plan meets the guideline
 - c. Provide a mechanism to remind or alert the provider
 - d. Report on patients not meeting guideline
 - e. Automatically reach out to patients not meeting guideline
3. Honoring patient preferences
 - a. Record patient preferences for communication
 - b. Automatically route and track responses to reminders to patients
4. Flexibility (a new requirement being developed as part of stage 3). Proposing that EHRs can be configured to:
 - a. Incorporate CQMs with standard data definitions using standard terminology and value sets
 - b. Configure which data elements (still complying with standard definitions) in the local EHR (depends on local workflow) are used in the computation of the CQM
 - c. Use the same reporting capability to design and configure other reports for use in local activities (e.g., QI, P4P, other initiatives such as ACO)
 - d. Maintain an auditable report of how queries for a report were structured
5. Incorporating patient-generated data and outcomes (a new requirement being developed as part of stage 3)
 - a. Able to query patients and incorporate their responses in the EHR

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- b. Protect group responses (anonymous part of aggregate response)
 - c. Allow specific identifiable responses to be viewed by provider (e.g., pain score, peak flow, BP)
6. Care coordination (a new requirement being developed as part of stage 3)
- a. Use of longitudinal data crossing organizational barriers
 - b. Create a shared care plan across disciplines
 - c. Reconcile problem list across settings

Functional status criteria from letter to Dr. Mostashari and Dr. Conway

1. Identify a set of instruments or scales that are acceptable for that condition or procedure
2. Identify a simple and broad data collection protocol for those instruments
3. Require the user to record a pre-treatment and post-treatment score within their EHR (regardless of how captured)
4. Require the user to report out a record containing the pre- and post-treatment scores along with a set of risk adjustment variables recommended for interpretation of those scale scores
5. Require the user to report out a computed "quality measure" defined as:
 1. Total number of cases with completed pre- and post-treatment score pairs
 2. Mean pre-treatment scores
 3. Mean post-treatment scores
 4. Number of improved outcome scores (post-score minus pre-score > 0)
 5. Number of same outcome scores
 6. Number of reduced outcome scores