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Testimony to the Health IT Policy Committee
Quality Measures Workgroup

Panel 2: Technology and Measure Developers

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On behalf of the American College of Physicians and our 130,000 members, thank you for this opportunity to offer comments pertaining to quality measurement and electronic health records. To be clear, the American College of Physicians does not develop clinical quality measures though our Performance Measurement Committee actively reviews and comments on measures through the National Quality Forum and Physicians' Consortium for Performance Improvement. In 2010, the ACP Performance Measurement Committee reviewed over 340 individual measures, 25 measurement sets, and almost 8,000 pages of material.

My remarks are based on existing ACP policy and precedent. I will comment on guidelines, measures, and the challenges of achieving clinical quality improvement using eMeasures for point-of-care activities as well as external reporting.

Introduction

ACP established its evidence-based clinical practice guidelines program in 1981. The Guidelines Committee and staff of ACP develop the clinical recommendations of which there are 2 different types: 1) clinical practice guidelines, and 2) clinical guidance statements. Guidelines are based on a systematic review of the literature. Guidance statements are based on a review of existing guidelines. The ACP clinical practice guidelines and guidance statements follow a multistep development process that includes a systematic review of the evidence, deliberation of the evidence by the committee, summary recommendations, and evidence and recommendation grading. All ACP clinical practice guidelines and clinical guidance statements, if not updated, are considered automatically withdrawn or invalid 5 years after publication or once an update has been issued.

Translating, with high fidelity, clinical guidelines and statements into validated, tested, and NQF-endorsed EHR-based clinical quality measures for quality improvement and public reporting is essential to achieving meaningful use of health information technology and the attainment of higher quality, more cost-effective health care delivery. As noted above, the ACP spends considerable committee and staff time reviewing and offering comments on new

measures and updates to existing measures. ACP supports the conversion of endorsed performance measures into an electronic format, or eMeasures.

However, clinical processes are complex and current measures generally target what can be measured now rather than what should be measured based on clinical relevance. As Albert Einstein once said, “Not everything that can be counted counts and not everything that counts can be counted.”

Patients move through various health care settings and we tend to measure something in each setting – but not across settings in a patient-centered manner. While an outcome may be attributed to a particular clinician or setting, that result is a consequence of the patient’s trek through the health care system, affected by multiple different factors along the way. How can we improve care without measures that assess the adequacy, efficiency, and effectiveness of that road traveled? In our current schema, measures predominantly rely on activities that generate claims or orders and depend on coding systems (e.g., ICD-9/ICD-10, CPT, and NDC) that are not clinician-friendly or specific enough to assess particular elements of the care delivery process. One of the biggest quality of care issues currently not addressed adequately relates to patients who are not seen. For example, a truly valuable function would be for EHRs to supply physicians with a list of patients who are not receiving appropriate care. The associated measure might assess what the practice or physician did in response to that information. Further, few, if any measures, assess the accuracy of diagnosis, clinical judgment, or engagement of patients/family in decision-making.

To be effective, measures need to provide timely, understandable, comprehensive, clinically valid, and meaningful feedback to health care professionals and their practice teams. Quality measures should provide context-appropriate guidance and assistance wherever and whenever the patient needs care.

It is also crucial to clearly distinguish between measurement to guide quality improvement from performance measurement for accountability, and public reporting potentially tied to reimbursement. Quality measures and reporting are common to both approaches. The difference is between use of the information generated for internal quality initiatives and use for public reporting. Ideally, well-implemented quality measures should provide valuable guidance and assistance for quality improvement activities occurring throughout the care-delivery process and at the point of care. External reporting on the performance of quality measures is, however, a separate activity that may lead to improvements in care delivery, but will not affect the patient rapidly or directly. Optimally the same measures of quality, efficiency, care coordination, and outcomes should both guide improvements to care-delivery processes internally and provide evidence of the extent of those improvements externally as part of a well-designed public reporting process.

With these points as background, let me provide ten recommendations for your consideration.

Recommendations:

1. ACP encourages full transparency in the conversion of NQF-endorsed measures to eMeasures. Such transparency should include:
 - The names of individuals/entities involved in the coding process, so that it is clear how much clinical expertise is available during the conversion process;
 - The criteria used during the review process to determine measure fidelity with the original clinical practice guidelines upon which the eMeasure is based;
 - An ongoing testing and evaluation service through which converted measures are analyzed prior to implementation and subsequent attestation to the reliability and fidelity of the eMeasures to the foundational clinical practice guidelines.
2. ACP recommends field testing of each eMeasures through simulation with a known data set to identify any possible misclassifications or miscalculations prior to implementation. Field testing prior to implementation will reduce potential eMeasure conversion errors and help protect the safety of clinical care.
3. ACP recommends the development of an online reference implementation – an actual working demonstration of how eMeasures and automated measure reporting could work. This system would help facilitate and speed vendor implementation.
4. ACP suggests that vendors be urged to adopt the needed functionality to support eMeasures as rapidly as possible, but that additional ONC-ATCB certification criteria should not be instituted until the vendors have had sufficient time to field test and implement new eMeasures.
5. Data to support EHR-based quality measurement and reporting should rely upon information routinely collected during the course of providing clinical care and measure developers should consider whether required data for measures are routinely captured in order to minimize unwarranted complexity and additional work at the point of care.
6. Future measures should include relevant data supplied by patients.

Current measures do not incorporate patient reporting in anything close to real time for guiding practice change. Debra Ness and I co-chair the Quality Alliance Steering Committee workgroup on patient-reported measures. We look forward to coming forth with a set of recommendations on this important progression of clinical quality improvement through measures that include patient-generated information.

7. EHR-based quality measurement should begin with the goal of facilitating the real-time collection of data that support the effective use of point-of-care clinical decision support algorithms.

The same evidence-based clinical guidelines upon which EHR-based quality measurement are based can in turn inform the development of robust clinical decision support systems (CDSSs). CDSSs could provide real-time, patient-specific recommendations based on information collected as a consequence of routine clinical

documentation at the point of care, including stated patient preferences and unique characteristics (such as the preferred method of learning and known barriers to adherence with care plans). This type of information has the potential to significantly improve care processes and patient outcomes. Actions of physicians and the clinical team in response to recommendations provided by CDSSs could form the basis of future assessments of quality delivered and potentially become part of ongoing maintenance of certification and achievement of continuous life-long learning objectives.

8. Data elements that comprise quality measure data sets should be defined in a standard way to enable health IT developers to implement them effectively.

Quality measure developers should provide standard definitions for the data elements necessary to construct proposed measures and end-users must agree to use these elements consistently. All measure developers must strive harder for consistency and re-use data element definitions, reporting periods, patient populations, etc. across all measures. In addition, they should provide data sources as well as clear and comprehensive implementation guidance for all participants.

The proposed measure specifications must also be clear with regard to the context of each data element. For reports to be generated automatically from EHRs, quality measures must specify the definitions and appropriate codes for each data element required for the measure. For example, an active problem in the patient's problem list clearly does not have the same meaning as the same problem if it is found in the family history. Not only must measure developers specify exactly what recorded data elements they want to use to represent a specific measure attribute, they must also agree to define and use the data elements consistently across different measures.

9. Measurement developers should recognize that other information systems (i.e., other than EHRs in practices/hospitals such as CMS, other payers, Surescripts, labs, public health entities, other providers) have important data that could either pre-populate reports or be reported directly on behalf of physicians and institutions. This could dramatically reduce the reporting burden for clinical teams. For some measures, physicians could simply document exceptions.
10. Certification criteria should recognize that data required for reporting is scattered across multiple systems and multiple organizational entities. EHRs may not have to – and perhaps should not - collect, aggregate, analyze and report quality data to multiple target agencies. Other systems are much more appropriate for this work. EHRs should more appropriately focus on delivering important clinical information at the point of care, quality dashboards, and clinical decision support – all features that are aimed providing valuable guidance and assistance for quality improvement activities throughout the care-delivery process.

Conclusion

As quality measures are developed in a standardized way that specifies EHR data elements and calculation logic, they will provide a new and powerful building block of CDSS tools designed to improve patient outcomes. The linkage between CDSS, evidence-based guidelines, and quality improvements integrated with improved workflows for the clinical teams will provide them with more relevant, timely, and useful information. Further, if EHR-based collection of standardized quality measures produces data that are consistent from practice to practice and from setting to

setting, the quality of care that patients receive as they move through the health care system can be meaningfully assessed and appropriately attributed and can provide the ability for relevant comparisons. For example, measures related to the adequacy of transition planning and care coordination could help identify system failures and best practices to inform quality improvement efforts. These comparative data could then be used to identify the types of care-quality failures identified with specific transitions of care and inform quality improvement efforts at those transitions.

It is critical that future quality measures be specified so that required data elements can be easily and reliably identified within the variety of EHR systems in use and within the many settings in which they are used. Until and unless we have far more standardization of capturing, organizing, and reporting information from EHRs as well as exchanging information between health care systems, it will be challenging to generate robust indicators of meaningful use of health IT or to provide accurate, relevant, and trusted clinical guidance to inform health care delivery and patient care. Stage 1 of meaningful use did not specify a standard for quality measures. We are hopeful that the work of the Measure Application Partnership to identify relevant measures, the NQF Quality Data Set framework to specify measures, and the recommendations of the Health IT Policy Committee Work Group Quality Measures Workgroup will help accelerate this essential element of meaningful use of health information technology.

References

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