

Comments submitted by:

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UnitedHealth Group submits the following comments on the quality measures for Stages 2 and 3 of Meaningful Use laid out by Quality Measures Workgroup. UnitedHealth Group is dedicated to making our nation's health care system work better.

Recognized as America's most innovative health care company by *Fortune* magazine, our highly diversified and comprehensive array of health and well-being products and services empowers individuals, expands consumer choice, and strengthens patient-provider relationships.

Our 80,000 employees serve the health care needs of more than 75 million individuals, develop and advance new health technologies and enhance financial and operational connectivity across the health care system. Our role as a national leader in the quality arena through our benefit and services products in both private and public health benefits programs enables us to foster innovative health solutions aimed at creating a modern health care system.

We applaud the Workgroup's initial measure concepts and measure sets as progress in fostering a higher quality structure for the meaningful use program that, if leveraged well, will help improve the quality of care delivered by participating providers. We are especially appreciative of the efficiency measures as they hold the potential to foster appropriate cost containment while at the same time improving care quality.

We support the approach of working down from conceptual and outcomes based domains, as opposed to building up from percentages of specific measures based on processes. We do not believe the two are incompatible, however. It is important to patients that we identify and fill gaps in areas delineated by the Workgroup. We believe the top down approach will be most fruitful in the long term.

While we appreciate this initial progress, we urge the Policy Committee to adopt a more robust set of quality measures to help improve the care patients receive. If adopted along with the proposed efficiency measures, we believe the measure sets will also promote cost reduction by promoting care coordination, reducing hospital readmissions and enhancing patient safety efforts.

Finally, we believe our recommendations fit into at least one of the categories outlined by the Policy Committee (HIT sensitive, parsimonious, demonstrates preventable burden, assesses health risk status and outcomes, and longitudinal).

Where available we cite as examples NQF Endorsed® measures applicable to our recommendations and not already adopted under Stage 1 meaningful use. In many areas there are limited or no applicable NQF Endorsed measures, indicating a gap that should be filled in order to address the measure concept. Important areas include, but are not limited to, emergency room utilization and a broader array of iatrogenic complications and infections occurring in hospital or other settings. We have drawn attention to a number of those areas in our comments below, and further work will be required to develop the many important measures delineated.

Domain: Patient and Family Engagement

- Self-Management/Activation - support
- Honoring patient preferences and Shared Decision making - support
- Effective care planning - support
- Patient Health Outcomes: These are important and we agree that they should address physical, mental and social domains. The key will be to operationalize the measures and develop appropriate action items. The personal health record could be expanded to take these domains into account, and the EHR could be expanded to collect the necessary data during visits.
- Community Resources Coordination/Connection: this measure set should be viewed as an extension of the prior item in the sense of addressing gaps identified by patient health outcome measures. Resource and provider directories could be coupled with measures of their use, and the outcomes of that use, for example.
- Applicable NQF measures:
 - NQF 310, Low Back Pain: Shared Decision Making
 - NQF 326, Advance Care Plan

Domain: Clinical Appropriateness

- Appropriate/Efficient use of facilities: We strongly support an all condition all cause re-admissions measure, as well as the adjusted length of stay measure (for example the ones currently in use developed and maintained by UnitedHealth Group, NQF #0329 and #0328), and believe that these should be coupled together for use in tandem. They form a conceptual and practical balanced pair of measures that, together, calibrate appropriate utilization and quality of care.
- Appropriate/Efficient use of facilities: We urge adding back the recommended measure of emergency room to inpatient/observation escalation rate, which supports appropriate use of facilities as well as decreasing patient exposure to hospital acquired conditions and infections
- Appropriate/Efficient use of diagnostic tests: We recommend adding diagnostic procedures performed by physicians, as well as diagnostic imaging. Overuse of diagnostic testing procedures exposes patients to safety issues as well as unnecessary costs. In all cases efficient use of diagnostic tests includes measures

of interoperability such that one EHR user has knowledge of other users' tests and their results.

- Appropriate/Efficient use of treatments: We strongly urge retaining the general concept of efficient use of invasive treatments, as well as including the two specific concepts of other measures into this domain (see comments in “Other” below).
- Appropriate/Efficient use of medications: We suggest adding measures related to polypharmacy, an important patient safety issue. These should include measures that reflect careful documentation and communication about all medications (all medications prescribed, all OTC, vitamins, etc.). Measures of related to medication safety should be included as well, either under this concept or the patient safety concept
- Applicable NQF measures:
 - NQF 021, Therapeutic monitoring: Annual monitoring for patients on persistent medications
 - NQF 051, Osteoarthritis: assessment for use of anti-inflammatory or analgesic over-the-counter (OTC) medications
 - NQF 097, Medication Reconciliation [at outpatient follow up]
 - NQF 293, Medication Information [transfers from one acute care hospital to another]
 - NQF 309, Low Back Pain: Appropriate Use of Epidural Steroid Injections
 - NQF 312, Low Back Pain: Repeat Imaging Studies
 - NQF 315, Low Back Pain: Appropriate Imaging for Acute Back Pain
 - NQF 328, Inpatient Hospital Average Length of Stay (risk adjusted)
 - NQF 329, All Cause Readmission Index (risk adjusted)
 - NQF 514, MRI Lumbar Spine for Low Back Pain
 - NQF 548, Suboptimal Asthma Control (SAC) and Absence of Controller Therapy (ACT)
 - NQF 552, HBIPS-4: Patients discharged on multiple antipsychotic medications.
 - NQF 553, Care for Older Adults: Medication Review (COA)
 - NQF 554, Medication Reconciliation Post Discharge (MRP)
 - NQF 567, Appropriate Work-up Prior to Endometrial Ablation Procedure
 - NQF 555, 556, 586, and 612 regarding warfarin monitoring
 - NQF 595, 596, and 609 regarding lithium monitoring
 - NQF 597, 598, and 599 regarding methotrexate monitoring
 - NQF 614, Steroid Use – Osteoporosis Screening

Domain: Care Coordination:

- We support these measures and suggest that these measures should be used as a foundation for the standard or model for primary care medical homes and ACO care coordination measures and vice versa.
- Applicable NQF measures:

- NQF 488/490 regarding use of health information technology to perform care management at the point of care.
- NQF 491 regarding tracking clinical results between visits. This includes: lab results, diagnostic studies (including preventative screenings), as well as patient EHR-generated referrals and reminders.
- NQF 494 regarding medical homes medical home setting.

- In addition we support the AMA PCPI transition of care measures:
 - Reconciled Medication List Received by Discharged Patients
 - Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges)
 - Timely Transmission of Transition Record
 - Transition Record with Specified Elements Received by Discharged Patients

Domain: Patient Safety

- We urge adding measures of hospital acquired conditions in general, of which thromboembolic events and falls are only two examples, and hospital acquired infections
- EHRs should report never events as well. While this will generally be a small number of events, it will promote an understanding that they should never happen.
- Meaningful use of EHR should include never events, HAC and HAI in the ambulatory surgery and outpatient hospital settings, as well as the inpatient hospital settings.
- Applicable NQF measures:
 - NQF 464 , Anesthesiology and Critical Care: Prevention of Catheter-Related Bloodstream Infections (CRBSI), Central Venous Catheter (CVC) Insertion Protocol
 - NQF 345, Accidental Puncture or Laceration (AHRQ PSI 15)
 - NQF 346, Iatrogenic Pneumothorax (AHRQ PSI 6) (risk adjusted)
 - NQF 347, Death in Low Mortality DRGs (AHRQ PSI 2)
 - NQF 349, Transfusion Reaction (AHRQ PSI 16)
 - NQF 351, Death among surgical inpatients with serious, treatable complications (AHRQ PSI 4)
 - NQF 363, Foreign Body Left in During Procedure (AHRQ PSI 5)
 - NQF 368, Post operative Wound Dehiscence (AHRQ PSI 14) (risk adjusted)
 - NQF 474, Birth Trauma Rate: Injury to Neonates (AHRQ PSI #17)
 - NQF 533, Postoperative Respiratory Failure (AHRQ PSI #11)

Domain: Population and Public Health

- We urge consistent inclusion of outcomes as well as screening for the relevant factors. For example, tobacco quit rate is noted as a measure but for alcohol use it is only screening (rather than decreased alcohol use rate).
- We encourage the measures to reflect ongoing (e.g. each visit) screening activities.
- Effective Preventive Services – Mental Health Screening: Depression screening should include populations at high risk for example, post-partum period, adolescents, the elderly, and those with chronic diseases including chronic pain.
- Health Equity: We agree that this is an important area but the measure concept described seems extremely complex and difficult to implement within individual EHRs. The amount of discrepancy requires not only the outcomes but also aggregation and comparison across populations of interest due to small sample sizes within each sub-population. Such work might be supported by data gathered through EHRs, but is larger in scope than a given physician or hospital EHR itself. Therefore we would support more straightforward direct and concrete measures, such as the ability to communicate in the patient’s language of preference.
- Applicable NQF measures:
 - NQF 076, CAD: optimally managed modifiable risk

Domain: Other

- Measures that assess preventable ED visits: we suggest including this in the Appropriate/Efficient use of facilities category.
- Measures that assess adherence to clinical practice standards (appropriate cardiac/cancer treatments): are two specific instances of the concept, efficient use of treatments, and those should be added as examples under the general concept in the domain of clinical appropriateness.
- We support the measures that assess combined quality and cost measures at each level and site of care reflecting potential defects in care and suggest moving this important measure into the care co-ordination domain.
- A measure of “near miss” in medications implies that the potential error could be identified through logic from data supplied. This can be done through clinical decision support. We suggest that tying this concept to CDS and then measuring the number of times the physician overrides the clinical decision support would be more appropriate to measure.

UHG recognizes the excellent work done by the Policy Committee members and the Quality workgroup to advance a higher quality, more efficient health system. We look forward to continuing to work together to ensure all Americans have access to a higher value, quality driven health system.