HIMSS Electronic Health Record Association

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January 20, 2012

Dr. George Isham, Dr. Elizabeth McGlynn and the MAP Coordinating Committee
Measure Applications Partnership (MAP)
National Quality Forum
1030 15th St, NW
Suite 800
Washington, D.C. 20005

Dear Drs. Isham, McGlynn, and MAP Coordinating Committee Members:

On behalf of the Electronic Health Record (EHR) Association, we are pleased to offer comments on the MAP pre-rulemaking draft report on measures under consideration for 2012 federal rulemaking for public reporting and performance-based payment programs. The EHR Association is encouraged by the progress we have witnessed in the development of electronic Clinical Quality Measures (eMeasures), and we want to contribute our experience developing and implementing the software and reporting tools required for eMeasures. In this letter, we have identified specific areas of agreement and several suggestions for improvement:

- Develop e-specifications and test them thoroughly
- Require NQF endorsement
- Balance complexity and quantity
- Align metrics and logic

Many of our suggestions are focused on measures reviewed for inclusion in the Meaningful Use EHR incentive program.

Develop e-Specifications and Test Them Thoroughly

We agree with the MAP's assessment that measures without electronic specifications must be retooled as eMeasures prior to inclusion in the EHR incentive program, but we question whether measures currently without eMeasure specifications can be realistically retooled and tested in time for inclusion in the next cycle of rulemaking (Stage 2 proposed rules are expected in February 2012). Given the regulatory schedule for Stage 2, the length of time needed to integrate quality measures into EHRs for data capture, and then implementation and testing in healthcare facilities, we recommend that Stage 2 quality measures be constrained to those that have already been developed and retooled as eMeasures.

Going forward, we suggest that measures be developed from the beginning as eMeasures rather than being retooled, which will improve the quality and usability of eMeasures. We believe this approach has been adopted by NQF. Retooled measures were often created based on the data available in retrospective review of paper records or claims. Retooled measures often contain errors of logic that would not be present in measures developed from the start to be "e-ready."

We agree with the recent recommendations made by the Board of Directors and members of HIMSS to Secretary Sebelius to improve the eMeasure development and implementation process, and encourage MAP to reference that letter as well:
http://www.himss.org/content/files/20120112_HIMSS_FINAL_HHS.pdf

Specifically, we recommend requiring the controlled testing, along with pilot/field testing of all eMeasure specifications, for these reasons:

- An aggressive and thorough quality measures testing program would ensure that measures have been adequately specified and tested before requiring them for Meaningful Use.
- Piloting/field testing of the eMeasure specifications would provide validation of the following:
    - The eMeasure specifications are accurate, consistent, complete, and technologically sound.
    - The eMeasures are tested for validity and reliability against the measures' intent.
    - Required data elements can be efficiently and accurately gathered in the healthcare provider's workflow, if at all possible using data elements that are already collected and stored in the EHR.
    - CQM reports based on eMeasures accurately reflect the care given by the applicable healthcare providers.

Require NQF Endorsement

The MAP report indicates that there are 25 measures being considered for the EHR incentive program for eligible professionals (EPs) which are not yet NQF-endorsed, and the MAP suggests that these measures be submitted for endorsement. We assume that this proposal means that the MAP supports including these measures in the next regulatory cycle for the Meaningful Use program (Stage 2) only if the measures are NQF-endorsed when that rulemaking is issued. We strongly recommend that any measures included in Stage 2 should be NQF-endorsed. We do not think final rulemaking should include any measures that have not yet received endorsement.

Balance Complexity and Quantity

The MAP supports 71 measures for inclusion in the EHR incentive program for EPs and 27 measures for eligible hospitals and CAHs (EHs). We are concerned about both the quantity and complexity of these new measures.

The process of implementing a quality measure can be a complicated one for measure developers, healthcare delivery organizations, and clinicians. The time required to implement a quality measure is a function of such factors as the extent to which the measure utilizes data that is already contained in the EHR and the potential need to support new clinical workflows to capture previously unrecorded information. Complex quality measures can reference data elements that may not yet be captured discretely by clinical systems; data elements that cross care settings and would be difficult to harmonize without more advanced interoperability in place; and data elements that require increased mapping to standard nomenclatures not yet defined by the Health IT Standards Committee.

We suggest that measures be scored for complexity based on the quantity and type of data elements required to be captured in clinical workflows. This transparency would facilitate implementation prioritization among the measures based not only on their anticipated clinical benefit, but the number and complexity of measures that can safely be implemented within the time limits imposed by the Meaningful Use program. We suggest an implementation timeline that reflects the tradeoff between the quantity of new clinical quality measures and the complexity of these measures.

Align Metrics and Logic

The EHR Association commends MAP's support of better performance measurement alignment across programs and settings of care, including all parts of the healthcare delivery system. We also ask you to consider the following components of technical alignment of performance measures:

- **Use of common EHR data elements to address similar clinical concepts. Develop a library of standardized, endorsed "value sets" to be used by measure developers when creating/retooling endorsed measures.**
  - As the number of measures increases, duplicative and even contradictory data collection workflows can reduce efficiency. Today, each measure developer creates custom lists of clinical vocabulary codes to identify clinical concepts, conditions, and data for applicable measures. For example, the concept "asthma" can be described or inferred by a variety of ICD-9 or -10, SNOMED, and CPT codes, which compose the "value set" for that concept. Each measure developer may create a different set of codes for that same concept of "asthma".
  - The resulting inconsistency among measures and value sets can result in inaccuracies and the inability to compare similar measure reports, along with increasing the implementation burden for developers, and the data collection burden for the clinician users.
- **Standard calculations and definitions to ensure measure integrity and comparability.**
  - Consistent logic is essential to support the comparison of outcomes across populations. For example, while the Stage 1 ambulatory quality measures calculate a patient's age prior to the start of the measure period, the Stage 1 hospital quality measures calculate patient age at admission. In addition, "age" is also considered in the measurement of some of the Meaningful Use Stage 1 objectives such as "vital signs" and "smoking status," although the CMS Meaningful Use specifications provide no guidance whether to consider patient age at the start of the measurement period, at the time of the encounter or admission, or at the close of the measurement period. These different approaches to computation require unique age calculations for each individual measure, rather than one common method to calculate age across all measures. A common method would simplify the work involved in implementing these measures and reduce confusion and inaccuracies.

Conclusion

In summary, the Association appreciates the opportunity to provide public comment to the MAP pre-rulemaking draft report on measures under consideration for 2012 federal rulemaking. We offer the following recommendations, and hope they provide constructive insights to NQF and the MAP committee:

- Develop e-specifications and test them thoroughly
- Require NQF endorsement

- Balance complexity and quantity
- Align metrics and logic

We would like to recognize the work of our Meaningful Use Workgroup, the Public Policy Leadership Workgroup, and the Quality and Clinician Experience Workgroup in developing these comments. Among them, they represent health IT industry leadership and expertise that brings important insights to this dialog. We look forward to working closely with MAP and other stakeholders to ensure that eMeasures support our shared objectives to understand and improve the quality of healthcare delivery in the US.

Sincerely,

Carl Dvorak
Chair, EHR Association
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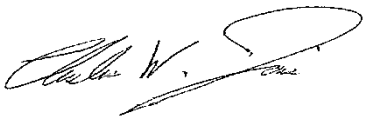
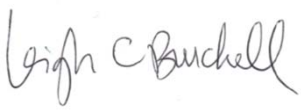


Charles Jarvis
Vice Chair, EHR Association
NextGen Healthcare

HIMSS EHR Association Executive Committee



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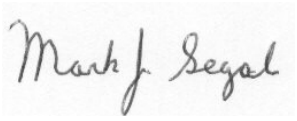

Mark Segal
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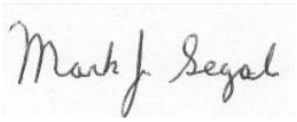

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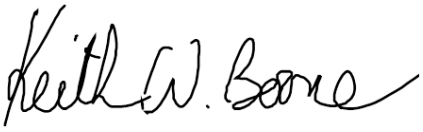

Keith Boone, Vice Chair, GE Healthcare IT

cc: Steve Lieber, HIMSS
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About HIMSS EHR Association

HIMSS EHR Association is a trade association of Electronic Health Record (EHR) companies that join together to lead the health information technology industry in the accelerated adoption of EHRs in hospital and ambulatory care settings in the US. Representing a substantial portion of the installed EHR systems in the US, the association provides a forum for the EHR community to speak with a unified voice relative to standards development, the EHR certification process, interoperability, performance and quality measures, and other EHR issues as they become subject to increasing government, insurance and provider driven initiatives and requests. Membership is open to HIMSS corporate members with legally formed companies designing, developing and marketing their own commercially available EHRs with installations in the US. The association, comprised of more than 40 member companies, is a partner of the Healthcare Information and Management Systems Society (HIMSS) and operates as an organizational unit within HIMSS. For more information, visit http://www.himssehra.org.