HIT Policy Committee
Quality Measures Workgroup
March 3rd, 2012

Overview
The meeting of the HIT Policy Committee's Quality Measures Workgroup on the 3rd of March consisted of a discussion of the Meaningful Use Stage 2 (MU2) NPRM and possible workgroup recommendations, and an update from the ONC on the Adverse Drug Event (ADE) measure.

Background
The HITECH Act, part of the American Recovery and Reinvestment Act of 2009, was passed to help promote the adoption of health information technology (HIT) for a better health care system. HITECH established two federal advisory committees to assist the Office of the National Coordinator for health information technology (ONC) in the adoption process, with one of them being the HIT Policy Committee (HITPC). This committee provides recommendations to ONC on major health IT policy issues for consideration. HITPC is itself composed of many workgroups that cover a variety of topics. One of which is the Quality Measures Workgroup, who produce initial recommendations on quality measure prioritization and the quality measure convergence process pertaining to measure gaps and opportunities for future stages of meaningful use (MU).

Summary of Meeting:

Discussion of Meaningful Use NPRM
Note: Page numbers refer to pre-publication version of the EHR Incentive Program NPRM

Overall Policy Expectations of Stage 2 – Clinical Quality Measures (CQMs) Discussion Outline

1) Overall policy expectations of Stage 2
   a. Refresh on Tiger Team and HITPC recommendations (see CMS criteria pp. 169-173)
   b. Workgroup philosophy on role of quality measures in EHR incentive program (will bear upon Option 1a vs. 1b discussion)
   c. Strategic directions regarding "hard wiring", data integration, capture of patient-reported information, shift towards outcomes
   d. High-level reactions to proposed approach for Stage 2

Discussion:
Providers struggling to meet MU1 are overwhelmed by MU2; this is especially true for smaller practices. Vendors will have challenges meeting MU2 quality measures because it will require re-hardwiring their products. Perhaps building a platform or engine that can easily adopt new measures should be supported by the government in some way.
Progress has been made in the alignment of measures across the many government programs, but work still needs to be done. Meeting MU requirements should grant providers some leeway for meeting other requirements. People want more clarity on this issue and maybe the creation of tables or a crosswalks comparing MU to other incentive programs and showing how health care providers can earn the most incentives.
There is confusion about when the reporting for CQMs is due because of the differences between the calendar year, the fiscal year, and quality measure reporting periods.

2) CQM reporting structure for CY2014 – EPs
   a. Option 1a (12 of 125 (Table 8), including 1 from each category) vs. Option 1b (11 from core list (Table 6) plus 1 from Table 8)

   Discussion:
   The flexibility of Option 1a is preferential for most providers, as Option 1b may not apply to all provider types (like pediatricians). Option 1a would also allow for providers to integrate some of their own measures.
   The vendors may prefer the shorter measure list in Option 1b because it would be easier to build and test.

The longer list (Option 1a) gives people more options to find measures that are pertinent to their practice, while the shorter list (Option 1b) allows providers and vendors to focus on a few key measures.
Action: The group believes there are valid arguments for both options and may try to develop an alternative that merges the two.

b. Numbers of measures to be reported
Discussion:
The sheer number of measures in table 8 needs to be reduced. The number of measures to be eliminated and the criteria used to evaluate them needs to be established.
Possible criteria:

- The top criteria should be QALYs, as it makes sense from the provider and patient perspectives.
- The ability of the EHR to measure and calculate the measures should be part of the criteria as it addresses feasibility issues.
- The context of the measures needs to be taken into account, as MU1 left out measures for some provider types.
- Evidence of the CQM being effective should be taken into account.
- The use of the data from measures for other purposes such as public reporting, research, meeting other incentive program requirements etc.
- Eliminate QMs that have not been approved by NQF, because they may not be tested or endorsed by MU2 rollout. However, the new CQMs may be more conducive to EHR use. Probably best to have a mix.
- Some measures may not be able to get the necessary data from an EHR.

Action: Debate will continue in the future.

c. Distribution (categories, etc.)
Discussion:
If we reduce the number of measures do we need to adjust the number of categories (currently six)? Some measures could be placed in multiple categories and perhaps the measures should be labeled that way to provide additional flexibility in meeting the MU2 requirements.
The measures should be fairly generic or general, as making them specific could make them inapplicable to some provider types.

d. Reporting options
1) Group reporting (pp. 214-216)
2) PQRS (p. 184): If you submit and report the PQRS measures you are meeting MU2.

Discussion:
The workgroup believes having the PQRS reporting option encourages alignment between measurements.
The group reporting method is already being used by some MU1 adopters, so encouraging and formalizing it in MU2 would be beneficial.
There are concerns about group reporting, in terms of tracing which provider entered the data.

3) <u>CQM reporting structure for FY 2014 – hospitals (24 of 49 from Table 9, including 1 from each category)</u>
Discussion:
The alignment goals on the hospital side seem to be further along than provider CQMs.
In general, the workgroup accepts the measures, but is concerned with the ability to extract the necessary information to meet them.

4) <u>Comments on specific measures</u>
a. Categorization of measures into categories
b. Adequacy of categories
c. Recommendations on proposed reduction in number of final measures
d. Whether to comment on specific measures

Discussion:
The workgroup believes that it should stay on the criteria level to evaluate the CQMs, instead of dealing with measures on an individual level.
Venders and providers realize that they will have to meet over a hundred measures.

5) Other comments from MU & QM WG that have been discussed over the last few months and how they relate to NPRM

General Comments:
The industry is generally accepting of the measures, but the question is if the NPRM's measure methods are the best methods in existence.

Action: Work offline to develop recommendations in a few areas and meet again on the phone in late March. Recommendations will be presented to the HITPC in early April.

Update on ADE Measure
Jesse Singer, ONC

The goal for the ADE measure is to broadly, over-time, improve safety around adverse drug effects. Booz Allen Hamilton was contracted to perform an environmental scan, gap analysis, and convene an expert panel. The recommendations from these efforts were to:

1) Create a measure around antidote utilization (focused on warfarin)
2) Drug monitoring for labs
3) Adverse drug report monitoring based on physician reporting

Discussion:
Is warfarin the right drug to measure?
A lot of patients on warfarin are able to manage their drug use on their own, making it difficult to consider it a viable measure, unless home monitoring is possible.
Warfarin may be replaced by other drugs in the near future, so it may not be the drug to pick.