

The National Quality Forum Health Information Technology Expert Panel Report  
Public Comments and Responses

#	Commenter	Comment	Action
1	Craig Law, Delaware Health Net	This seems to be very good work. One area not noticed relates to creation of standardized data sets on successful clinical measure completion. The mechanism of coding diligence in completing recommended tasks. A discussion would be valuable in creating standards relating to both providers and patients success in services that are referred, declined, refused, recommended but not completed and how they become part of the construct of performance.	Future work of tracking actions that as a result of measures (similar to decision support) and "closing the loop."
2	Kevin Scheckelhoff, McKesson Corporation	Re: line 327, item #5 re: medication duration calculation. Manipulation/analysis of pharmacy dispensing data has substantial limitations that should be recognized. Outpatient dispensing data is typically only accurate at the time of dispense: should the prescriber alter the dosage in a manner that does not require a new prescription (i.e. split tablets or double tablets) the dispensing pharmacy is typically not notified and would only become aware of the change if/when presented with a new prescription (unless patient receiving MTM). Same would be true for discontinuation. Use of multiple pharmacies also creates limitation as previous dispensing histories from other pharmacies are not viewable unless part of same organization and medication histories not always complete. There have been some advances in bridging this gap through the use of pharmacy dispensing databases collected when Rx claims are adjudicated online but this also has limitations: many prescriptions do not require adjudication (a trend currently being fueled by \$4 generic Rx offerings paid in cash). All insurers do not allow their electronic claims data to be entered into the common database. The result is information that can be helpful but not comprehensive. Vendors may be able to create means to perform duration calculations but the quality of this output is limited by inputs. Could be problematic if user places too much reliance on med duration calculation that has limited accuracy given the data source.	Modify recommendations to "EHR vendors should develop methods of presenting EHR medication data with external medication data from pharmacies and pharmacy networks to help providers assess patients' adherence with medication treatment plans."
3	William Conway, Henry Ford Health System	The emphasis on use of a common set of data elements across different care settings is an important recommendation of the report. We recommend creation of common data elements based upon the ISO/IEC 11179 standard. This should be tied in with development of the individual data elements using a community driven approach similar to the one NCI's caBIG program has adopted. Several data elements may already be available in the NCI's common data element repository (caDSR). This ISO/IEC 11179 approach will allow anchoring the data elements robustly in semantics from standard vocabularies/ontologies like SNOMED CT. Further, the developers of electronic health record systems should be encouraged to align the semantics of the data elements with HL7 RIM based information models. (provided by Dr. Robert Enberg and Dr. Hemant Shah)	Agree with the need for standards, however determination of standards is deferred to HITSP. No changes to report.
4	William Conway, Henry Ford Health System	Clinical Guidelines and the metrics for clinical performance are inextricably linked. It is notable that the panel took cognizance of this fact and has given it due weight. We advocate taking this approach further to evolve a methodology for developing actionable guidelines. This will ensure that the evaluation of process performance is not restricted to measures based on single data points. Rather, processes are best evaluated by multiple data points describing their characteristics. This will also encourage a movement in the direction of merging of the two apparently dichotomous approaches, those evaluating the outputs of processes and those evaluating the outcomes of patients. (provided by Dr. Robert Enberg and Dr. Hemant Shah)	Agree for the need to develop actionable guidelines. While outside the scope of this report, we hope action to follow closely behind EHR implementation of quality measures -- in the form of Clinical Decision Support. No changes to report.
5	Jesse Singer, New York City Department of Health and Mental Hygiene	Understanding that this may be out of scope of the panel charge, as it is not an area of AQA or HQA approved measures, we feel strongly that, as an IOM priority area, the additional domain of obesity should be considered in the assessment of priority measure status.  The selection criteria for determining priority order for measure selection included impact, improvability and inclusiveness per IOM. Obesity is a current IOM priority area and as such, we feel that obesity should be included as a high priority with the following NQF-endorsed measure:  Body Mass Index (BMI) in adults > 18 years of age: Percentage of adults with BMI documentation in the past 24 months.	Report is scoped to AQA/HQA NQF-endorsed measures related to IOM priority areas as proof-of-concept. Measure prioritization schema was intended to provide initial starting point for further discussion. Future mechanism currently in development to update data types utilized in quality measurement. NQF's current National Priority Partners effort will drive priority and goal setting. No changes to report.
6	Jesse Singer, New York City Department of Health and Mental Hygiene	Understanding that this may be out of scope of the panel charge, as it is not an area of AQA or HQA approved measures, we feel strongly that, as an IOM priority area, the additional domain of care coordination should be considered in the assessment of priority measure status.  The selection criteria for determining priority order for measure selection included impact, improvability and inclusiveness per IOM. Care coordination is a current IOM priority area and as such, we feel that care coordination should be included as a high priority. In an effort to begin to address the concept of care coordination and the patient centered medical home, the corresponding measure should be considered for this purpose:  Patients > 18 years of age seeing assigned PCP:	Four care coordination measures were included by scope (Appendix B). For additional proposed measure for evaluation. (see response #5). NQF's current National Priority Partners effort will drive priority and goal setting. No changes to report.

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		Percentage of adults who have seen their assigned Primary Care Provider at least once in the last 12 months.	
7	Jesse Singer, New York City Department of Health and Mental Hygiene	<p>After reviewing the draft document, we feel the addition of two data types are warranted:</p> <p>Data Category: History should include the Data type: Visit, which may include further subtypes beyond the scope of this draft such as visit type and date of visit. This is critical for all measures when you consider a data model that includes measure driven clinical decision support at the point of care.</p> <p>Data Category: Medication should include the Data type: Patient adherence, which may include further subtypes beyond the charge of this panel. Although a full discussion of patient medication adherence is beyond the scope of this comment, please see the following references for discussion on this domain:</p> <p>N Engl J Med 2005;353:487-97 Arch Intern Med. 2007;167:847-852 Arch Intern Med. 2007;167:540-550 Journal of Asthma, 2006;43:521 526</p>	<p>Visit is included data category "Location." As each location has an associated date and time, these data can be used to calculate unique visits. While improving patient compliance is an important aspect of quality care, it is out of the scope of these 84 measures (<i>see response #5</i>). Future iterations of the data formats will specifically include patient-derived data, including patient adherence and functional status. No changes to report.</p>
8	Jesse Singer, New York City Department of Health and Mental Hygiene	<p>Re: Measure exclusions beginning line 291:</p> <p>Given the relative immaturity of Health Information Exchange implementation, the addition of measure specific exclusion criteria raises the question of data validity, especially in other than closed healthcare systems. The incorporation of electronically operable diagnostic testing results and even procedures (which follow the CPT standard), both distantly historical and those done via external entities creates numerous problems for data capture as applied to quality measurement.</p> <p>For example, in the NQF-endorsed breast cancer measure, using mastectomy as exclusion criteria, we felt that the codification and capture of these exclusion criteria would be problematic as externally performed or historically distant mastectomy would often fail to be captured by the provider in a standardized way for these criteria to electronically operate.</p> <p>Instead, we included provider entered exclusions as part of the clinical decision support system workflow. During an alert for a specific measure, a provider has the ability to suppress the alert either temporarily or permanently, excluding the patient from the measure. These exclusions must be justified and are auditable and accounted for in the aggregate data. We feel this allows providers to deal with these exclusions at the point of care, for all situations, including those unanticipated or for those which information is known, but has not been or is unable to be codified.</p>	<p>Agree with need to classify source of data. This classification of data source would be an extension of the proposed data types in this report – however taxonomy for that data type should not change. No changes to report.</p>
9	Stephen Persell, Northwestern University	<p>I agree that if EHRs data is to be used to accurately measure quality of care for external accountability and provider selection, there is a strong need to ensure that measures obtained from data in one healthcare information system capture the same concepts and speak the same language as those from another. However, the high-priority, standard data elements identified by the panel may not allow for fair comparison of quality across different user groups. The panel is right to prioritize data elements that are readily available from typical work flow. But, the work flows of different kinds of practices differ in important ways that could impact how quality is measured. A multi-specialty practice that includes inpatient and outpatient data within the same information system (e.g., Kaiser Permanente, Veterans Administration) will capture data in a very different way than does a stand-alone single specialty outpatient practice using their own information system. The panel's recommendations should perhaps consider that even with the most important standard data elements (diagnoses, procedures, medications, allergies, adverse drug effects), there might not be a level playing field for quality comparisons across user groups that are so different from each other. For example procedures and diagnosis codes will more likely be present in the multi-specialty system than the single specialty one and this could have</p>	<p>Agree that the availability of data depending on the level of integration across systems has implications for data availability for quality measurement. The data quality/integrity scores represent consensus of HITEP members, taking into consideration different care settings, providers, and overall data sources. However, the criterion focused on "availability in EHRs" had a limited effect on the overall score based on a sensitivity analysis (removal of "In EHR" criterion changed score by 2.5% ; "workflow," 1.0%;</p>

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		important implications for quality measurement.	removal of both, 4.6%.) Future iterations of this work will consider workflow across sites of care to obtain patient data across episodes of care. No changes to report.
10	Stephen Persell, Northwestern University	Cervical cancer screening is a useful example. Procedure codes for pap tests or hysterectomies are more likely to be captured in a large multi-specialty group during standard work flow. A stand alone primary care group does need to track these procedures in order to deliver high quality care. To do this though, it may be preferable to use codes within an EHR that are suited to the quality task at hand. It would not be correct for a practice to insert a procedure code for a specific kind of pap test into their EHR as if the test had happened within that system on a specific date when a patient reports historically that the had the test done elsewhere. There is a need for standard ways to capture data that is relevant to quality measurement but which does not imply a level of certainty that does not exist. In this example, a patient reported pap completed elsewhere on an approximate date is valuable information for quality measurement but users should not be forced to represent this data within their system in an overly specified way in order to not appear to be delivering inadequate care. Flu shots are another good example. If only standard procedure codes are used to measure the quality of flu shot delivery, the care will always appear worse than it is. What is needed is a standard way to capture within the EHR that a patient reports receiving a flu shot this fall or winter. This is a patient reported data element necessary for quality measurement. EHR users should not be forced to represent it as a procedure in order to demonstrate high quality care.	Agree that it is important to identify the source and accuracy of that data source. Further efforts are needed to optimize the workflow of data capture in systems constrained by limited data sources, with a goal of consistency of standard taxonomy with appropriate modifiers, regardless of data source. See #8.
11	Stephen Persell, Northwestern University	There is also a need for standard ways to capture which patients declined a recommended service. This data has a role in performance measurement for accountability or provider selection. Even more importantly, the standardized capture of this form of data will enable EHRs to be used to efficiently identify patients for education outreach at the practice or health plan level.  By establishing standards for documentation of these kinds of exceptions to performance measures, the panel could do a great deal to advance quality measurement so that it could both better serve internal quality improvement and permit more fair comparisons across provider groups working in different settings.	The measures evaluated by HITEP used patient refusal as exclusion criteria and are accounted in the data category_class "Optout/Other_reason." To identify patients for outreach, new measures would need to be developed to specifically address this issue (i.e. included in numerator).
12	Jeffrey Apfelbaum, American Society of Anesthesiologists	The American Society of Anesthesiologists is writing this letter in response to the National Quality Forum's Health Information Technology Expert Panel Report. ASA shares NQF's goal of improving quality of care, and wishes to indicate its support of the recommendations contained in this report.	Thank you.
13	Jeffrey Apfelbaum, American Society of Anesthesiologists	Compliance with quality initiatives is currently measured by collecting healthcare performance data from insurance claims, but these documents contain limited clinical information. The NQF was commissioned by the Agency for Healthcare Research and Quality to convene an expert panel that would accelerate the adoption of standards that allow data from electronic health records (EHRs) to measure healthcare quality. The report generated by NQF recommends that common data types be included as part of an EHR. This would enable the use of specific queries to measure compliance with clinical initiatives such as timely administration of antibiotics for surgical infection prophylaxis. ASA agrees that the use of administrative and billing data limits the information available for later analysis, and agrees with NQF's proposed use of a problem list instead of the current diagnostic coding schema. Fewer than three hundred CPT codes are used to bill for anesthesia services for all surgical, obstetrical, and diagnostic procedures, meaning that in some cases, the same anesthesia CPT code is used to describe the anesthetic technique for more than 100 different surgical procedures. The implication of very broad and non-specific claims data is that the availability of more specific and descriptive clinical information from an EHR is especially critical for quality measurement in perioperative care.	General comment. No changes to report.

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14	Jeffrey Apfelbaum, American Society of Anesthesiologists	<p>ASA is planning a comprehensive clinical outcome registry that will be used to generate data for clinical research and benchmarking. Information gleaned from perioperative electronic records can be of value to many stakeholders, including health care providers, quality organizations such as NQF, healthcare researchers, and third party payers. NQF's goals are a subset of those for ASA's proposed registry in that NQF's health information technology experts propose a system for monitoring compliance with specific guidelines while ASA is interested additionally in monitoring patient outcomes and correlating them to anesthesia techniques and practices. There are, however, several issues that must be addressed in order to achieve both goals: the appropriate questions must be asked, a common language must be developed to facilitate data collection and analysis, and there must be widespread adoption of EHR technology.</p>	General comment. No changes to report.
15	Jeffrey Apfelbaum, American Society of Anesthesiologists	<p>ASA has long supported the Panel's recommendation to develop a data dictionary and standardized terminology through its alliance with the Anesthesia Patient Safety Foundation (APSF), which formed a Data Dictionary Task Force in 2001. This early effort led to the formation of the International Organization for Terminology in Anesthesia (IOTA) that serves as the official source of anesthesia terminology for both SNOMED and also as the Special Interest Group for the Generation of Anesthesia Standards for Health Level Seven (HL7). Several thousand SNOMED terms now constitute a standardized perioperative terminology. IOTA is directing additional efforts to use the Clinical Document Architecture framework of HL7 to model the attributes of the SNOMED/IOTA terms in a fashion that will serve as the framework for a comprehensive perioperative EHR. ASA believes that this serves both the AHRQ initiatives as well as the ASA clinical outcomes registry and related initiatives by other specialties.</p> <p>In summary, ASA fully supports the recommendations of the NQF Health Information Technology Expert Panel. The initiatives contained in this report may have the beneficial effect of encouraging the widespread adoption of EHRs, a common data dictionary, and adoption of standards for data interchange. ASA wishes to indicate its interest in working with these organizations toward the shared goal of improving the quality of healthcare.</p>	Appreciate ASA's comments. In future iterations of this work, NQF will consider a recommendation to HITSP to determine an appropriate code set for procedures. No changes to report.
16	Rachel Groman, American Association of Neurological Surgeons	<p>Recommendation #1 appears to be yet another attempt to replace the CPT system with ICD-10 or SNOMED. While these two classification systems are more exact, the practicality of asking all U.S. physicians to convert to a substantially more complicated diagnosis/treatment coding system while also converting to EMR will only accomplish a more resolute pushback from the medical community. Hospital-based physicians may find this task easier to accomplish due to better access to resources. However, the majority of the measures for which data collection is desired apply to outpatient primary care physicians. Even if as a fallback hospitals were first required to comply with this transition, this would necessitate the government running two systems (CPT and ICD-10), which makes the transition even more complex and virtually impossible. In the text, the authors assume that data would be coming from those most experienced in EMR. The reality is, as the concomitant push for EMR goes forward, physicians will either not code or low code data sets, or completely bypass the measures by putting a text note in the chart. As experience grows, CMS would find skewed data trends as physicians increasingly code measures correctly. Severity would most likely appear to increase, as would claims, creating suspicion among all parties.</p> <p>Recommendation #2 simply appears to be a recommendation for a factual document and seems reasonable within its context.</p>	Change to adopted standards will likely occur in a step-wise fashion. Once implemented into EHRs, coding should be relatively transparent to the clinicians - no longer need to choose a code, rather choose the appropriate clinical concept; the translation to the coding standard will be handled by the EHR. No changes to report.

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17	Rachel Groman, American Association of Neurological Surgeons	<p>AANS strongly agrees that the issues identified in recommendation #3 need to be addressed and incorporated in all measures.</p> <p>Recommendation #4 is complicated since labs and other tests would most likely have a "drop down" menu with very basic choices (e.g. normal, not clinically relevant to current service, abnormal), which limits and/or alters decision making. One immediate problem is that physicians will be leery of classifying a radiologist's lengthy report as "not relevant" because of liability concerns. Standardization of laboratory values and ranges may also be an issue.</p> <p>If we understand recommendation #5 correctly, it sounds like data aggregation by a third party since the prescribing physician with an EMR already has a complete temporal record of medication usage.</p> <p>In terms of recommendation #6, discharge instructions work well for the emergency room physician, whose job it is to fix one diagnosis. In the office setting, with multiple diagnoses, this is not practical. It is also unclear who would be responsible for constructing these functionalities medical professional societies?</p>	<p>Clarification: codified summary impressions are to be initially completed by interpreting specialty consultant (e.g. radiologist) and will be as objective as possible, within the constraints of the diagnostic technology (e.g. lesion size, characteristics, location), as opposed to subjective evaluation of the findings (e.g. "not relevant").</p> <p>Rec #4 does not apply to laboratory results.</p> <p>Rec #5: EHR has temporal record of orders, but not necessarily date of last filled.</p> <p>Rec #6: Specifically referring to measures pertaining to discharge instructions from the hospital. Change to "Quality and information technology stakeholders should define additional EHR functional requirements that support quality measurement" and list discharge instructions as an example</p>
18	Rachel Groman, American Association of Neurological Surgeons	<p>In terms of recommendation #7, the AANS encourages the NQF to continue to rely on measures developed through the physician-led, consensus-based AMA Physician Consortium for Performance Improvement. A formal process should be developed to determine and compare the costs and benefits of exclusion and inclusion criteria. Unfortunately, CMS will not worry about the cost to acquire more data. It will simply require it and doctors will be left with yet another "unfunded mandate."</p>	<p>General comment. No changes to report.</p>
19	Elliot Levine, E & C Medical Intelligence, Inc.	<p>Although there are 84 high-priority quality measures listed, only 2 (2.4%) are directly related to pregnancy care, though such care is included in the Institute of Medicine (IOM) list of healthcare areas for which efforts at quality improvement measures should be directed. Given the inordinate liability litigation occurring in the field of obstetrics, and leading to its spiraling healthcare costs, attention should certainly be paid to the measurement of quality in obstetrics, as this may lead to significant error reduction and improved patient safety and potentially decreased liability costs. Further, given the scope of the population impact, the improvability (or preventability of harm) and the inclusiveness of the pregnancy condition, the quality measure selection criteria established by the IOM are met, when considering quality measures specifically relating to pregnancy care. With this in mind, consideration should be given to having a greater emphasis for quality measures in this high impact area of obstetrics.</p>	<p>Comment appreciated. The prioritization schema for identifying the 84 measures was chosen to narrow the scope of the task of identifying common data types. Future iterations of this work will rely on the NQF National Priority Partners efforts to set priorities and goals for the nation. Additional areas will be considered to advance quality measurement and improvement for all populations. A future mechanism will need to be established to identify additional data types for standards identification.</p>

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20	Elliot Levine, E & C Medical Intelligence, Inc.	<p>It appears that the High Priority Quality Measure item #74 (Screening for HIV), seen in Appendix B, refers to quality measures in the last trimester of pregnancy care until hospital discharge of mother and newborn. However, the CDC recommends HIV screening in the first trimester of pregnancy, which is also consistent with the recommendations of the American College of Obstetricians and Gynecologists (ACOG). Therefore, consistent with published guidelines and current accepted standards, the following recommendations for pregnant women should be considered with regard to HIV:</p> <ul style="list-style-type: none"> <li>- HIV screening should be included in the routine panel of prenatal screening tests for all pregnant women, and typically performed in the first trimester.</li> <li>- HIV screening is recommended after the patient is notified that testing will be performed unless the patient declines (opt-out screening).</li> <li>- Separate written consent for HIV testing should not be required; general consent for medical care should be considered sufficient to encompass consent for HIV testing.</li> <li>- Repeat screening in the third trimester should be considered in certain high prevalence areas and among certain high risk populations.</li> </ul> <p>The last recommendation illustrates the potential vagueness and complexity of the medical issues relating to pregnancy, and therefore, the difficulty inherent in devising quality measures that can be specific enough to effect direct healthcare improvement.</p>	<p>This report does not comment on the soundness of individual measures for the purpose of improving these specific measures, rather it serves to identify data requirements, data standards, and a framework for evaluation the <i>future</i> soundness of measures. NQF is currently engaged in a project focused on perinatal measures.</p> <p>(Of note, measure #74 is for 1st or 2nd trimester)</p> <p>Out of scope. No changes to report.</p>
21	Elliot Levine, E & C Medical Intelligence, Inc.	<p>Regarding Quality Measure Item #75 (Anti-D Immune Globulin), this will likely impact less than 10% of pregnant women, as opposed to the greater impact of the following proposal.</p> <p>As the incidence of Group B Streptococcal (GBS) Neonatal Sepsis has significantly diminished (by 1/3) since the publication of the CDC's Guidelines for the Prevention of Group B Streptococcal Disease in 2002, it appears that Intrapartum Antibiotic Prophylaxis (IAP) should be appropriately provided when indicated, with quality measures prepared to identify provider compliance with this recommendation. Given that the probable incidence of lower genital tract carriage of GBS is 20% of pregnant women, with the incidence of GBS Neonatal Sepsis as 0.15%, prior to the wide-scale adoption of IAP practices, a large number of patients would be impacted.</p> <p>Since there are published and accepted algorithms for directing optimal care in this environment, based on a high level of evidence, reducing complex clinical scenarios to reasonably manageable ones, quality measures can be devised that could monitor compliance with these accepted standards. A compelling argument can therefore be made that quality measurement, with regard to intrapartum GBS prophylaxis, can improve ultimate perinatal outcomes.</p>	See #20.
22	Elliot Levine, E & C Medical Intelligence, Inc.	<p>In terms of the HITEP category types found in Appendix B, one important category type is absent, namely height and weight, which should be considered essential, equal in importance to the other Vital Signs (e.g. BP). Documentation of height and weight are fairly standard measurements that are taken upon a patient's hospital admission or presentation to an ambulatory clinic. With such measurements, a Body-Mass Index (BMI) can be calculated, which in turn has the potential to be linked to a variety of risk factors, for which specific medically related tasks may be indicated. Body weight has further implications for proper dosing of certain medications, which can potentially relate to multiple separate quality measures, perhaps even relating to medication management. Specifically, with regard to pregnancy care, weight gain in pregnancy has been judged as a risk factor for a number of pregnancy complications (low weight with Intrauterine Growth Restriction, and elevated weights with increased rates of Shoulder Dystocia, for example). As obesity is one of the twenty IOM healthcare areas in which national quality improvement efforts should be focused, it is reasonable to include measures that can precisely quantify this particular health factor, namely weight and height. Recognizing obesity, however it is defined, can further indicate the possible need for nutritional counseling, for example. This is not unlike the Joint Commission's standards relating to smoking cessation.</p>	<p>Definitely would like to include Ht/Wt, but it wasn't part of our charge since it wasn't on the list of high priority initial measures. The work of HITEP was to establish an initial prioritization of measures and their associated data types. Work should not stop where we left off, and should grow as additional priorities, measures and their required data types are developed.</p>

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23	Elliot Levine, E & C Medical Intelligence, Inc.	<p>It is indeed true that measuring quality is a first step toward improving American healthcare.</p> <p>As an organization devoted to diminishing the incidence of preventable obstetrical error, thus improving the clinical obstetrical care provided and resulting in better perinatal outcomes, E &amp; C Medical Intelligence has developed numerous practice guidelines for this purpose. Its current primary EMR product, the Intelligent Patient Record for Obstetrics (IPROB), among other things, provides an interdisciplinary clinical problem list, not associated with billing codes. It also maintains protocols that keep current with published accepted specialty guidelines (e.g. ACOG) that drive its clinical decision support. It encourages and provides integrated documentation of nurse-physician and physician-physician communication, in the course of care, that is patient-centered. Physician-patient communication is further promoted, for informed patient/physician shared decision-making, and for episodes of unanticipated outcomes. In addition, the printing of patient discharge instructions, specific to the discharge diagnoses and patient circumstance is integral to its EMR function. These described measures perfectly synchronize with the HIT recommendations included in its draft report. We therefore submit that the comments offered are consistent with the perspective and mission of the National Quality Forum, and respectfully ask that they are considered in that light.</p>	General comment. No changes to report.
24	Crystal Kallem, American Health Information Management Association (AHIMA)	<p>True interoperability will not occur until data definitions and codes are standardized and incorporated into technical standards. AHIMA recommends including additional text describing how the common data types defined in the report should be aligned with similar data elements in other data sets. This exercise will support movement toward collecting data once so it can be repurposed multiple times for quality, population health reporting, research, and administration.</p>	As HITEP identified common content, it shall be the role of HITSP to identify taxonomies for these data types No changes to report.
25	Crystal Kallem, American Health Information Management Association (AHIMA)	<p>AHIMA suggests specifically calling out the role of standard development organizations (SDOs) and the need align the HITEP common data types with new and existing technical standards. Active engagement of SDOs will aid in bridging the gap between the quality and information technology enterprises.</p>	Action: clarify role of HITSP as bridge to SDO.
26	Crystal Kallem, American Health Information Management Association (AHIMA)	<p>Section III. Expert Panel Analysis:</p> <p>Page 15, line 305 The report discusses "the need to influence 'upstream' processes so that measures being submitted for NQF endorsement meet criteria set to increase the comparative value of quality scores and minimize the effort required to acquire and report out the quality scores in an EHR." Following this statement, Figure 3 is displayed representing the "Organizational Relationships in Quality measurement, Health IT and NQF Influence." Does this figure represent current quality measurement, health IT and NQF relationships? If so, how will the organizational relationships change after the 'upstream' processes have been influenced? It may be useful to include an additional figure depicting the envisioned "future state."</p> <p>Page 16, Figure 3 AHIMA recommends incorporating corresponding descriptions for each element of the diagram (similar to the format used in the AHIC Use Cases, with numbers and corresponding detailed descriptions of the entities and processes depicted).</p> <p>Page 15, line 299 The Expert Panel constructed an organizational chart (Figure 4) The figure notation is incorrect. The correct notation should be Figure 3.</p>	<p>No change in organization relationships proposed. Action: clarify "upstream" are specifically MDOs.</p> <p>Action: Organizational chart removed. See #117.</p>
27	Crystal Kallem, American Health Information Management Association (AHIMA)	<p>Section IV. Expert Panel Recommendations:</p> <p>Page 18, Recommendations 5 and 6 AHIMA supports recommendations for developing key EHR system functionality that will support automated collection and reporting of quality measurement information, but functionality should be defined and vetted in a coordinated and transparent manner, such as through the development of a Quality Measurement Functional Profile standard based on the HL7 EHR System Functional Model (EHR-S FM). Development of a Quality Measurement Functional Profile will facilitate a collaborative approach toward defining quality related EHR functionality, further demonstrate the business needs for system vendors, and guide the development of CCHIT certification criteria to support quality.</p>	Future work: defining workflow of quality measurement in EHR. ACTION: all vendor recommendations will be sent to the HL7 EHR technical committee as suggestions for further development of their functional model.

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28	Crystal Kallem, American Health Information Management Association (AHIMA)	AHIMA suggests that the HITEP enhance recommendations 5 and 6, stating "Quality and information technology stakeholders are encouraged to define EHR functional requirements that support quality measurement through the development of a Quality Measurement Functional Profile. This profile should include functionality to automatically capture the issuance of discharge instructions regarding specific conditions and methods of using data from dispensing pharmacies to automatically determine the duration of medication usage." This type of project will further bridge the gap between the quality and information technology enterprises.	Action: Modified recommendation #6 to include "quality and information technology stakeholders" and the need to identify "EHR functional requirements." Added: "EHR vendors should consider data requirements for quality measurement and efficient capture of the data elements within clinical workflow."
29	Crystal Kallem, American Health Information Management Association (AHIMA)	Section IV. Expert Panel Recommendations (cont.):  Page 18, Recommendation 7 Quality measure specifications were are not designed to leverage clinical data from EHR systems, but with the emerging capability of EHRs to capture clinically-relevant information and support quality measurement reporting, AHIMA supports the HITEP's recommendation for NQF to encourage the use of high quality data elements for newly submitted measures and gradually retire endorsed measures that rely on poor quality data elements . However; measure developers must provide explicit logic and algorithms when defining quality measure parameters to allow vendors the ability to easily incorporate measure logic into EHR systems. AHIMA recommends that NQF work with both measure developers and SDOs to define technical standards and validated processes for translating quality measure specifications into standardized computable logic.	Action: clarify role of NQF as final common pathway for MDOs and a potential role of encouraging standards work by SDOs.  NQF is actively working with the measure and standards development communities to define and implement technical standards for representing and distributing quality measure specifications in a computer-readable format.
30	Carmella Bocchino, AHIP	We agree with the report's proposed methodology whereby existing measures are put in a priority order based on the Institute of Medicine's (IOM) priority conditions and common data types are standardized. This roadmap is essential to automate quality reporting. We also strongly support one of the report's main recommendations that the NQF should work with measure developers to limit exclusions, where appropriate to make measures easier to automated reporting from electronic health records (EHRs). Measure developers should also be encouraged to utilize common measure specifications that can utilize multiple complementary data sources such as administrative, claims, medical records and EHR.  AHIP strongly supports the goal of report to automate the reporting of quality measures from EHRs. However, as steps are taken to meet this goal, it is important the transition does not lead to two sets of quality measures one set based on claims and administrative systems and a second set of measures derived from EHRs. It is important that the HITEP recognize that in many provider offices it is premature to move from the current quality reporting based on claims and administrative systems by the health plan on behalf of the provider to a system electronically reported from the provider's EHR.	See #29 . No changes to report.  Measure specification data types are independent of data extraction and reporting methods; although they will be intended for EHR use, they can still be used for manual data abstraction and reporting. No changes to report.  ACTION: added "There will clearly be a transition period with reliance on clinically enriched claims data as a pathway towards quality measurement built on electronic health records. This initial HITEP work focused on envisioning the EHR platform required for performance measurement in the future."
31	Carmella Bocchino, AHIP	We recommend the report includes an additional recommendation focusing on the needed strategy and transition plan to implement the proposed changes to the data types used for quality reporting (e.g. movement from billing codes to standard problem lists). This strategy should include a phased-in approach to revising the criteria used by measure development organizations.	Action: include statement regarding phased-in approach regarding potential multiple data sources.
32	Carmella Bocchino, AHIP	Recommendation One: Use of Clinical Problem Lists in Place of Billing Codes  We support the use of problem lists as the basis to identify patient conditions, however the report should acknowledge that this transition will require significant administrative costs by physicians and will take time to implement, either concurrently or immediately following the adoption of an EHR by physician or provider-group practice. We recommend that there may need to be a hybrid approach whereby either clinical problem-list diagnoses coded using standard terminologies like the Systematized Nomenclature of Medicine (SNOMED) terminology or billing codes are used concurrently for a short period of time.  Given that the recommended clinical data types will serve as the basis for recognized interoperability specifications by the Healthcare Information Technology Standards Panel (HITSP) and thereby required for implementation in federal healthcare programs, it is important that the recommended code sets for the clinical problem list are consistent with existing HITSP recommended standards. Therefore, we agree with the report's recommendation that HITSP should consider nationally and internationally accepted standard terminologies like the SNOMED terminology set for coding	See #31. No changes to report.

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		problem-list diagnoses.	
33	Carmella Bocchino, AHIP	<p>Recommendation Five: EHR Vendors Use of Data from Dispensing Pharmacies</p> <p>We agree with the general premise of this recommendation; we suggest the text of the recommendation should be clarified. It is important that quality reporting systems (with EHRs or administrative) have a mechanism to capture data from pharmacies to determine the duration of medication usage. We recommend the phrase dispensing pharmacy is changed to pharmacy or pharmacy network because the data may be more readily available from the network used by the pharmacy as opposed to directly from the pharmacy that dispensed the medication. For example, through agreements with Pharmacy Benefits Managers health plans can determine whether a prescription has been picked up and/or refilled. The Centers for Medicare &amp; Medicaid Services will soon have access to similar data through Medicare Part D.</p>	Action: change rec to "pharmacy or pharmacy network"
34	Carmella Bocchino, AHIP	<p>Recommendation Seven: Quality of Data Types Used in Measure Specifications</p> <p>We agree that NQF should evaluate the quality of data types used in measure specifications as a criterion in the endorsement of new measures, as well as re-assessment of measures for continued endorsement. However, the report should recognize that these measures will need to be transitioned over time and that the system should be able to continue to support measures based on administrative data in the short term.</p>	See #31. No changes to report.
35	Debra Ness, National Partnership for Women & Families	We applaud HITEP's work to examine the feasibility of using electronic data to enhance performance measurement and reporting. We, along with a number of other consumer organizations, have long advocated for greater use of EMRs to facilitate performance measurement. Currently, data collection and reporting on measures often require medical record extraction or other burdensome and expensive processes. Greater use of health information technology offers hope for reducing that burden and facilitating the collection and analysis of data. It is critical, however, that there is some uniformity among the various EMR systems if that promise is to be realized. We think the recommendations of the panel are an excellent start.	Thank you.
36	Debra Ness, National Partnership for Women & Families	We suggest making a priority of identifying and including common elements (i.e., vital signs) that could support more robust risk-adjustment.	The important issue of data required for risk adjustment will be considered in future iterations of HITEP. The restriction of the current work to the AQA/HQA measures limited the ability of the committee to consider this issue.
37	Debra Ness, National Partnership for Women & Families	We urge that the report include a recommendation that the data types used to assess disparities in care (i.e., patient ethnicity/race, language and payment source) be incorporated into EHRs.	The issue of the disparities measurement will be more prominent in future iterations of this work. At the current time, the data types specifically include race, ethnicity and language. Additional details on data sources will need to be considered.
38	Barb Corn, NAHQ	Page 18: Future work. If a EHR is certified with the current standards, will outside agencies use the certification at face value and not require audit of the coding?	HITEP has no role with auditing and outside scope of the initial HITEP report.

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39	Joel Slackman, BlueCross BlueShield Association	Recommendation #2: The recommendation is somewhat vague as to exactly what the named data dictionary would comprise; BCBSA recommends expanding the dictionary's description in the report to clarify what is being calling for. Regardless, any data dictionary that is developed should be vetted by industry stakeholders to ensure that it is comprehensive and accurate.	Action: change recommendation #2 to "NQF should work with HITSP to develop a "reader's digest" version of a data dictionary for use by measure developers that would contain the HITEP data types and their corresponding HITSP-recommended code-sets"
40	Joel Slackman, BlueCross BlueShield Association	Recommendation #5: Data could come from multiple dispensing pharmacies, mail order pharmacies, and/or PBMs. It should be noted that while the data can serve as a valuable guide in estimating duration of medication usage, it only measures the fill rate and is therefore not an exact indicator.	See #33. No changes to report.
41	Nancy Nielsen, American Medical Association	The American Medical Association (AMA) is pleased to have the opportunity to comment on the National Quality Forum's (NQF) draft Health IT Expert Panel Report: Recommended Common Data Types and Prioritized Performance Measures for Electronic Healthcare Information Systems. We commend the attention and detail that the NQF has given to this topic and agree that it is imperative to maximize the benefits of electronic health record systems (EHRS) and ease their use for deriving performance measures, which will assist in improving the quality of care delivered. In this letter, we discuss overarching issues, outline our comments on each of the recommendations and provide requests for clarification and recommendations for further refinement for the Panel's consideration.	General comment. No changes to report.
42	Nancy Nielsen, American Medical Association	<p>Overarching Suggestions Regarding Data Quality Criteria and Scoring</p> <p>We strongly support the development of criteria to guide the prioritization of measures and related data elements in the context of EHRS. Because of the importance of such criteria, we recommend that the Panel further describe each criterion and consider carefully the implication or message of a low score for each of the criteria.</p> <p>For example, we suggest that the Panel specify that the criterion availability in EHRS not be a rate limiting factor. For example, there may be widespread agreement that a performance measure and related element (eg, ACEI/ARB for HF and ejection fraction) are priorities from a clinical perspective. Yet a data element for ejection fraction is not widely available today in EHRS and would therefore receive a low score on that criterion. If NQF does not place a high priority on this measure, as a result, we may lose the opportunity to advance and maximize EHRS for performance measurement and quality improvement. We believe it is the intent of the Panel to identify necessary data elements and promote the development of those data elements where needed. Therefore, it would be helpful to explicitly articulate this intent in the report. In addition, we suggest that authoritative and accurate be two separate criteria and more detail be provided regarding the criterion auditable.</p>	<p>Action: describe each criterion.</p> <p>Action: describe possible actions for low-scoring data type - candidate for removal or for improving quality of data type.</p>
43	Nancy Nielsen, American Medical Association	<p>Also toward this point, it may be worthwhile to consider prioritizing measures based on those measures that can be reported on by EHRS today, as well as those critical for fast track resolutions of outstanding issues.</p> <p>Regarding scoring, we are unsure how the criteria, weighting, freq% and rel% are used in calculating the overall measure quality scores (see, for example, score for 30-day mortality in AMI and HF tables). Are the scores actually quantitative calculations or were they derived from consensus-based decisions based on available information? We also suggest the Panel clarify why some tables include inpatient and outpatient data elements when the related performance measure focuses on ambulatory care.</p> <p>Lastly, we have learned through work with the AMA-NCQA Collaborative and the EHRS vendor community that vendors are in various stages of adding the necessary data elements and functionalities to report NQF-endorsed measures. Staff at AMA will contact NQF to explore whether the Collaborative could be helpful in soliciting additional information from a broader EHRS vendor community regarding ratings of the data types against the data quality criteria.</p>	<p>Thank you for raising this important point. We will consider EHR availability as a method of staging implementation of use of an EHR-derived measures. This would be considered in future iterations of the HITEP.</p> <p>Action: clarify use of REL % calculation of overall measure quality score.</p> <p>Action: clarify that some "inpatient" measures require knowledge of outpatient events.</p>

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44	Nancy Nielsen, American Medical Association	<p>Recommendation 1: Use of problem list to identify patient conditions</p> <p>We fully support that the medical record (whether paper or electronic) is the gold standard and should be used as the data source to identify patients for performance measurement. We are concerned with the language included in the recommendation that limits identification of patient conditions in the EHRs strictly to the problem list. Because each EHRs may operationalize the concept of problem list differently, we would not wish to see the problem list as the only way to identify patients for whom measures are relevant but rather recommend that the language of the recommendation be broadened.</p> <p>Moreover, we recently worked with Dr. Jeffrey Linder at Brigham and Women's Hospital to evaluate the feasibility of utilizing an EHRs to report on the PCPI performance measures for outpatient pneumonia and learned that acute conditions are not typically entered on the problem list and, therefore, some exceptions should be noted.</p> <p>We appreciate the additional recommendation about the accessibility of the 'problem list' across care settings, but believe that this is a longer-term goal and somewhat out of scope of this report. There are issues of attribution of both clinical responsibility and delivery of care when using shared problem lists that need considerable discussion by multiple stakeholders before this broad recommendation can be made.</p>	<p>Although existing problem lists vary in their implementation and availability of data, the Panel acknowledges that the problem list requires further development, hence the recommendation.</p>
45	Nancy Nielsen, American Medical Association	<p>Recommendation 2: Data dictionary of different data types</p> <p>While agreeing with the need to produce such a dictionary, we are concerned that pre-existing standards for data types (such as those within HL7 standards for data transmission) are not mentioned in this recommendation. We believe that a recommendation calling for further work to align and harmonize HL7 data types, the HITSP interoperability specification, the data elements identified here, and those identified by the AMA-NCQA Collaborative XML schema would provide greater benefit. Alignment also will be needed with the Quality Reporting Data Architecture (QRDA) work that is currently making progress toward defining output requirements for quality reporting. It would also be useful to look at those data types defined by the Centers for Medicare &amp; Medicaid Services' Physician Quality Reporting Initiative EHRs pilot for 2008.</p> <p>The data types identified by the Panel, of necessity, only define those data elements that occur within the 84 measures that were examined. Considering first data elements that are needed to record patient care and then setting standards for the way in which those data elements are represented and made accessible in EHRs would be a better approach. Structured, coded data will then be available for many uses, including direct patient care, clinical decision support, quality measurement, billing, biosurveillance, public health, and research.</p>	<p>The output of the Panel, regarding standards related work, has been in identifying common data types, not their <i>representation</i>. The task of identifying existing taxonomies for the data type is in the purview of HITSP. Regarding alignment with existing efforts, proposed HITEP data types compliments the work of these efforts. For example, AMA-NCQA Collaborative identified representation of logic and not the individual data types required to include in the logic; QRDA is developing standard for representing patient-level data and does not specify data types, rather the structure for containing these data.</p>
46	Nancy Nielsen, American Medical Association	<p>Recommendation 3: Medication allergies and side effects should be distinct from each other and coded</p> <p>We support this recommendation and would recommend that it be expanded to promote the distinction between allergies, side effects, and contraindications. We believe that, for both quality improvement and performance measurement, these distinctions are critical.</p> <p>Recommendation 4: Development of standardized codes for summary impressions of diagnostic test results</p> <p>We agree broadly with this recommendation, but point out that where diagnostic test result data with numerical values are available, these data also should be transmitted with the date the test was performed and with the appropriate code to the ordering physician along with the summarized impression (eg, [date of test] LVEF [coded] = 35% [numerical value], severe LVSD [impression]; the impression might also be coded). There would be educational implications for radiologists, pathologists, and other physicians in ensuring that they understood the need to enter both kinds of data. However, EHRs vendors could assist physicians by producing standard pick lists for the test result and the clinical impression.</p>	<p>Allergies and side effects are specific to an interaction between a patient and a medication. This interaction is independent of other clinical information. Contraindications, on the other hand, are often non-specific, dependent on other clinical information (e.g. presence of other medication, presence of disease processes), and as a result change with time. This complex interaction inherent to a designation of "contraindicated" does not lend itself to a characteristic of an individual medication, and further thought is required to model this interaction. No changes to report.</p> <p>Action: clarify that dates are required for all data types. When available, quantitative results should accompany qualitative results of diagnostic studies.</p>

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47	Nancy Nielsen, American Medical Association	<p>Recommendation 7: NQF to evaluate the quality of data types in measures as a criterion in measure endorsement</p> <p>We concur that NQF should consider the quality of data types in measure specifications; however, as noted above, we suggest that NQF not prioritize measures for data capture within EHRS solely on the state of the technology today. Rather, if a measure and accompanying data elements meet other NQF criteria, NQF is in a strong position to motivate the development of needed codes, data elements, and functionality.</p> <p>Regarding measure exclusions, the AMA has and continues to work with practice sites and researchers to conduct sensitivity and specificity analyses and would welcome further discussion on this topic with NQF. We respectfully submit that perhaps it also is worthwhile to broaden the discussion of exclusions. We believe it is critically important in patient care for a physician to document the specific reason why a patient may not be receiving a recommended drug or procedure, including both clinical reasons and patient preferences, and it is important for a physician to periodically revisit that decision with the patient. Therefore, we believe we should encourage EHRS vendors to develop ways that physicians can easily capture such information at the time of decision-making and track this information over time.</p>	<p>Agree that importance of availability within an EHR should not limit NQF endorsement at this time. This work will hopefully continue to drive incorporation of needed data for performance measurement into EHRs. Sensitivity analyses suggest a small effect of EHR availability to the overall score. Future iterations of HITEP will consider the use of EHR availability to stage adoption. No changes to report.</p> <p>The issue of exclusions requires additional work. NQF would welcome the opportunity to work with the AMA and others to consider the best approaches for use of exclusions in EHRs that allow for reasonable workflow and appropriate transparency.</p> <p>Further discussion should surround the appropriate workflow and EHR functional requirements to efficiently capture these data and the specific relationship to individual measures. No changes to report.</p>
48	Nancy Nielsen, American Medical Association	<p>Request for Clarification and Recommendations for Further Refinement</p> <p>Line 19, 118: The statement that the majority of readily available electronic health information has been from administrative claims is inaccurate. There is extensive health information available in electronic form including laboratory, pharmacy and imaging data. However, these data are often not available in the electronic medical record maintained by a provider. The statement should be restated as the majority of health information readily available in electronic health records has been administrative data</p> <p>Line 59: The phrase standard languages, or code sets is unclear in this context. The term language, when speaking of software, tends to imply a programming language. The phrase standard languages should be replaced by terminology, which more accurately represents the concept of codified data.</p> <p>Line 67: The phrase vendors to develop software needed should be revised. CCHIT does not have a role in working with EHRS vendors to develop software. CCHIT simply develops functionality criteria that vendors then build. The phrase should be revised to say develop functionality criteria</p>	<p>Lab, pharmacy, and imaging data are often available to EHRs. The discrepancy lies in the fact that quality measurement has not typically been performed within the EHR that contains these clinical data. Therefore, to clarify this statement, it will be reworded to "The majority of electronic health information readily available for quality measurement has been administrative data."</p> <p>Action: change to "terminology."</p> <p>Action: change to "develop functionality criteria."</p>
49	Nancy Nielsen, American Medical Association	<p>Line 92: The sentence in line 92 ends with the phrase in these national efforts. It is unclear which national efforts are being referenced here. Clarify whether this sentence references the national effort to create a roadmap or the efforts described in the recommendations (lines 63-71).</p> <p>Line 206: These categories and types will be submitted to HITSP who will recommend standardized code sets.</p> <p>HITSP has recently issued an interoperability specification including data types (see also comments above on Recommendation 2).</p>	<p>Action: change to refer to "roadmap."</p> <p>These interoperability specifications were based on draft data types from this report. No changes to report.</p>

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50	Nancy Nielsen, American Medical Association	<p>Line 215: Table 2: The Data Categories Diagnostic Study and Laboratory could be combined into a single category Investigations; the Data Types, order and result are the same.</p> <p>We are concerned that there is no indication that each data type should also have an associated date and time component. Although this omission may be a function of the measures studied for this review, when integrating the performance measures into the system knowledge of the date of entry or occurrence is critical to ensure accurate data collection. This information is equally important when analyzing the data from an EHRS in order to determine if the parameters of the metrics have been achieved. Time is an important factor in many measures investigations/physical exams need to have a time period specified within which they should have been carried out; the order in which data elements occur is important in some measures and there are other examples. Procedure includes past history; this data type might actually be a data category, and include such data types as event (e.g. AMI), diagnosis (e.g. CAD), procedure (e.g. CABG) and all of these should have a date attached.</p> <p>Line 224: We would recommend saying initial assessment of the availability and quality of a given data type.</p> <p>As noted above, we suggest broad input from the EHRS vendor community and will contact NQF to offer assistance through the Collaborative.</p>	<p>As these 2 categories have fundamentally different data structures and data sources, the Panel agreed to keep them separate. No changes to report.</p> <p>Action: add specific language that all data types have an accompanying date/time attribute.</p> <p>Agreed that "past history" should, in theory, be included in the Procedure_outpt or Procedure_inpatient_start, with a date/time attribute in the past. However, from a workflow perspective and limitation of available data, "past history" was included as a separate data type. Further discussion is required to address this issue.</p> <p>Action: added "initial" language.</p> <p>NQF and HITEP welcome input from the EHRS vendor community and the Collaborative.</p>
51	Nancy Nielsen, American Medical Association	<p>Line 232: Define the attributes of a comprehensive EHR system. It is unclear whether a comprehensive EHRS would include any level of interoperability with other external systems (e.g., lab, imaging) or whether the phrase comprehensive refers only to functionality offered by the system itself.</p> <p>Line 239: The quality of a measure is a function of the quality of its individual data types.</p> <p>We suggest that the quality of a measure should be judged on many factors: the clinical significance of the aspect of care it addresses, whether it is based on evidence, whether it is well-constructed and specified. We do not believe that the quality of individual data types is a sole criterion.</p> <p>Line 253: The word accurately should be included in this sentence. It should read A measure can be calculated accurately only if</p> <p>Lines 309/10: This description of the Collaborative's work should be revised to say focuses on a standard approach of representing measures in a computable format for use by EHRS vendors.</p> <p>Line 311: CCHIT was felt to clearly impact EHRs as well as physicians.</p> <p>We are not sure to what this statement refers the sentence seems out of context.</p>	<p>Action: add definition of "comprehensive EHR."</p> <p>Action: rephrase to "The data quality of a measure is a function of the integrity of its individual data types."</p> <p>Measure calculation is or all-or-none proposition that requires all of the data in the measure specification. This does not comment on the accuracy of these data, rather only on the presence or absence of these data. No changes to report.</p> <p>Action: language re: Collaborative changed. See #117.</p>
52	Nancy Nielsen, American Medical Association	<p>Line 313: guidelines be written so that they are in EHRs.</p> <p>We would suggest that this be amended to say guidelines be written with enough precision to enable EHRS vendors to translate recommendations into clinical decision support rules and algorithms, and to enable measure developers to provide detailed measure specifications in agreed formats to EHRS vendors.</p> <p>Thank you for the opportunity to comment on this report.</p>	<p>Action: change language as suggested.</p>
53	Bernard Rosof, Physician Consortium for Performance Improvement	<p>The Physician Consortium for Performance Improvement (PCPI) is pleased to have the opportunity to comment on the National Quality Forum's (NQF) draft Health IT Expert Panel Report: Recommended Common Data Types and Prioritized Performance Measures for Electronic Healthcare Information Systems. We commend the attention and detail that the NQF has given to this topic and agree that it is imperative to maximize the benefits of electronic health record systems (EHRS) and ease their use for driving performance measures, which will assist in improving the quality of care delivered. In this letter, we discuss an overarching suggestion regarding data quality criteria and scoring, outline our comments on</p>	<p>General comment. No changes to report.</p>

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		some of the recommendations, and provide requests for clarification and recommendations for further refinement for the Panel's consideration.	
54	Bernard Rosof, Physician Consortium for Performance Improvement	<p>Overarching Suggestions Regarding Data Quality Criteria and Scoring</p> <p>The PCPI strongly supports the development of criteria to guide the prioritization of measures and related data elements in the context of EHRS. Because of the importance of such criteria, we recommend that the Panel further describe each criterion and consider carefully the implication or message of a low score for each of the criteria.</p> <p>For example, we suggest that the Panel specify that the criterion availability in EHRS not be a rate limiting factor. For example, there may be widespread agreement that a performance measure and related element (eg, ACEI/ARB for HF and ejection fraction) are priorities from a clinical perspective. Yet a data element for ejection fraction is not widely available today in EHRS and would therefore receive a low score on that criterion. If NQF does not place a high priority on this measure, as a result, we may lose the opportunity to advance and maximize EHRS for performance measurement and quality improvement. We believe it is the intent of the Panel to identify necessary data elements and promote the development of those data elements where needed. Therefore, it would be helpful to explicitly articulate this intent in the report. In addition, we suggest that authoritative and accurate be two separate criteria and more detail be provided regarding the criterion auditable.</p>	See #42. No changes to report.
55	Bernard Rosof, Physician Consortium for Performance Improvement	<p>Also toward this point, it may be worthwhile to consider prioritizing measures based on those measures that can be reported on by EHRS today, as well as those critical for fast track resolutions of outstanding issues.</p> <p>Regarding scoring, we are unsure of how the criteria, weighting, freq% and rel% are used in calculating the overall measure quality scores (see, for example, score for 30-day mortality in AMI and HF tables). Are the scores actually quantitative calculations or were they derived from consensus-based decisions based on available information? We also suggest the Panel clarify why some tables include inpatient and outpatient data elements when the related performance measure focuses on ambulatory care.</p>	See #43. No changes to report.
56	Bernard Rosof, Physician Consortium for Performance Improvement	<p>Recommendation 1: Use of problem list to identify patient conditions</p> <p>The PCPI fully supports that the medical record (whether paper or electronic) is the gold standard and should be used as the data source to identify patients for performance measurement. We are concerned with the language included in the recommendation that limits identification of patient conditions in the EHRS strictly to the problem list. Because each EHRS may operationalize the concept of problem list differently, we would not wish to see the problem list as the only way to identify patients for whom measures are relevant but rather recommend that the language of the recommendation be broadened.</p> <p>We appreciate the additional recommendation about the accessibility of the 'problem list' across care settings, but believe that this is a longer-term goal and somewhat out of scope of this report. There are issues of attribution of both clinical responsibility and delivery of care when using shared problem lists that need considerable discussion by multiple stakeholders before this broad recommendation can be made.</p>	See #44. No changes to report.
57	Bernard Rosof, Physician Consortium for Performance Improvement	<p>Recommendation 3: Medication allergies and side effects should be distinct from each other and coded</p> <p>We support this recommendation and would recommend that it be expanded to promote the distinction between allergies, side effects, and contraindications. During the development and implementation of the PCPI measures, we have found that each of these aspects are critical pieces of information, both for providing care that is high quality and promotes patient safety and for performance measurement purposes.</p>	See #46. No changes to report.

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58	Bernard Rosof, Physician Consortium for Performance Improvement	<p>Recommendation 7: NQF to evaluate the quality of data types in measures as a criterion in measure endorsement</p> <p>We concur that NQF should consider the quality of data types in measure specifications; however, as noted above, we suggest that NQF not prioritize measures for data capture within EHRs solely on the state of the technology today. Rather, if a measure and accompanying data elements meet other NQF criteria, NQF is in a strong position to motivate the development of needed codes, data elements, and functionality.</p> <p>As you may know, the PCPI Measure Implementation and Evaluation Advisory Committee defines the testing needed for each of the measure components including exclusions and the sensitivity and specificity analyses. We would welcome the opportunity to work with NQF on determining how to best approach this analysis.</p> <p>We respectfully submit that perhaps it also is worthwhile to broaden the discussion of exclusions. We believe it is critically important in patient care for a physician to document the specific reason why a patient may not be receiving a recommended drug or procedure, including both clinical reasons and patient preferences, and it is important for a physician to periodically revisit that decision with the patient. Therefore, we believe we should encourage EHR vendors to develop ways that physicians can easily capture such information at the time of decision-making and track this information over time.</p>	See #47. No changes to report.
59	Bernard Rosof, Physician Consortium for Performance Improvement	<p>Request for Clarification and Recommendations for Further Refinement</p> <p>Line 239: The quality of a measure is a function of the quality of its individual data types.</p> <p>We suggest that the quality of a measure should be judged on many factors: the clinical significance of the aspect of care it addresses, whether it is based on evidence, whether it is well-constructed and specified. We do not believe that the quality of individual data types is a sole criterion.</p> <p>Line 253: The word accurately should be included in this sentence. It should read A measure can be calculated accurately only if</p> <p>Line 313: guidelines be written so that they are in EHRs.</p> <p>We would suggest that this be amended to say guidelines be written with enough precision to enable EHR vendors to translate recommendations into clinical decision support rules and algorithms, and to enable measure developers to provide detailed measure specifications in agreed formats to EHR vendors.</p> <p>Thank you for the opportunity to comment on this report.</p>	See #51. No changes to report.
60	Deborah Willis-Fillinger, MD, HRSA Center for Quality	<p>General HRSA Comments</p> <p>HIT Focus on EHR and Tendency Toward Hospital Centric Language and Typology.</p> <p>Lines 14 to 16 Quality improvement leaders have long recognized that the widespread adoption of Health Information Technology (HIT) will automate and simplify these processes by providing electronic information.<sup>3, 4, 5.</sup></p> <p>Comment HRSA supports the recommendation to identify common language/codes and to support interoperability and communication among HIT users at all levels of the health system (primary, secondary and tertiary). To maximize patient quality outcomes, we wish to also emphasize the importance of enhanced data sharing capabilities among state and local level health care entities currently involved in patient care and population health management.</p> <p>Specific Recommendation * Line 86 to 87 and Table 5. Consider adding key recommendation that EHR vendors should develop functionality to automatically capture population level and chronic disease management program performance measures.</p>	<p>Population-level and chronic disease management are functions of patient-level data aggregation over multiple patients and multiple care settings/sessions, respectively.</p> <p>Functional requirements for data aggregation are beyond the scope of this project, however should be explored in future workflow analysis.</p>

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61	Deborah Willis-Fillinger, MD, HRSA Center for Quality	<p>HIT vs E HR Focus</p> <p>HRSA recommends that, if the goal is to improve health outcomes across a variety of health care settings, other HIT tools and functions also be considered when developing performance measure quality scores and recommendations to HITSP and CCHIT. This report will be used by vendors and others to create future applications that will influence how health care is practiced and patients are managed. We agree that the electronic health record (EHR) is a fundamental HIT tool for collecting high-quality electronic clinical information, (line 21), especially in hospitals and in the small percentage of ambulatory environments currently equipped with E HRs. There are also other HIT tools that are equally critical for attaining quality outcome improvements resulting from population health management, disease prevention screening, and health provider decision support. A broad variety of stakeholders benefit from these tools, including State Health Departments, State Medicaid/Medicare programs, Federally Qualified Health Centers, QIOs and other Federal Partners.</p> <p>Specific Recommendation Data Types made possible by other HIT tools such as dynamic multi-condition ambulatory patient registries, and state immunization registries used by local and state health system partners should be incorporated into the language and data typology (table 2) as well as the scoring matrix in Appendix C.</p>	While the data sources may vary, there are similarities in the data types across these sources. Table 2 comments primarily on the data types rather than their sources. The scoring matrix data sources are descriptive only and do not affect the data integrity scores. No changes to report.
62	Deborah Willis-Fillinger, MD, HRSA Center for Quality	<p>Outside the E HR Box</p> <p>When developing a scoring methodology for performance measures and recommendations to CCHIT and HITSP, it is important to consider data types that have not yet been considered for measurement in the pre HIT era and are currently not incorporated into most E HRs. Specifically, important quality concepts are rapidly emerging in the areas of medical homes (e.g. patient centered care, coordination across multiple settings/providers, bidirectional data exchange) and chronic disease management.</p> <p>At this time the NCQA has developed standards to assess whether practices are functioning as patient centered medical homes. HRSA recommends that the HIT data typology be revisited as medical home performance standards are developed.</p>	Out of scope for this phase; may be included in next phase. No changes to report..
63	Deborah Willis-Fillinger, MD, HRSA Center for Quality	<p>Outside the EHR Box Continued</p> <p>- Chronic disease management software programs for care coordination are a different type of HIT. To date few EHRs have incorporated functionalities that allow true population based analysis and management and other HIT has evolved to fill the need in the form of care coordination products and multi-condition registry systems with interoperability to enable data reports. For example, the Chronic Disease Management Program (CDMP) HIT product available from The Department of Defense (DOD) is able to interface with EHRs and has been made available to the public as an open source product. Another example of an HIT product capable of better population data analysis and management is the iCare product being used by Indian Health Service (IHS). This is another HIT product that is not an EHR but can work with the IHS EHR product to abstract the population-based information for population-based management of clinical conditions. There are also registry systems such as the Aristos Patient Electronic Care System (PECS) and i2i's Meditracks and others which have functionalities not typically found in most EHRs as most EHRs have been developed for the purpose of managing individual patient's and not to manage the entire population of active patients with any given condition.</p>	Out of scope for this phase; may be included in next phase. No changes to report.
64	Deborah Willis-Fillinger, MD, HRSA Center for Quality	<p>Outside the EHR Box Recommendation:</p> <p>Specific Recommendations</p> <ul style="list-style-type: none"> <li>* Data Types made possible by chronic disease management software programs for care coordination should be considered and incorporated into the language and data typology, as well as the scoring matrix.</li> <li>* Future data types corresponding to patient-centeredness, care coordination and bidirectional workflow should be revisited as evolving medical home quality standards are translated into practicable performance measures.</li> </ul>	Although new diagnoses may be used in future measures, the data type of diagnosis will not need to be changed. However, when a new type of data is required by a measure, the mechanism for adding and modifying data types needs to be defined in future work of HITEP. This set of common data types will approach a finite set. No changes to report.

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65	Deborah Willis-Fillinger, MD, HRSA Center for Quality	<p>Methodology</p> <p>General Comments</p> <p>The IOM priority areas appear broad based and appropriate for a variety of life cycles; however the Methodology used to select Tier One measures used in this report only targeted performance measures already approved by NQF. In setting the Priority Order for Measure Selection, the Panel further limited their field of consideration to AQA and HQA measures endorsed by NQF. This decision appears to result in measure discussions and data types that are hospital-centric and elderly focused. NQF has endorsed a larger scope of quality measures National Voluntary Consensus Standards for Ambulatory Care (12/07), which is more inclusive of Pediatric Issues.</p> <p>HRSA notes that NQF has ambulatory measures for children (e.g. pediatric immunizations) and self-management (e.g. management plan for people with asthma, hypertension plan of care) that aren't reflected in Appendix B; if used, these may serve to expand the data typology presented (table 2) and include more longitudinal care scenarios that occur in ambulatory settings such as communication for patient education, anticipatory guidance encounters, behavioral and other health risk assessments etc, and planned follow up visits ( not included in the current model).</p>	See #5. No changes to report.
66	Deborah Willis-Fillinger, MD, HRSA Center for Quality	<p>Consideration of Pediatric Populations</p> <p>In general, Pediatric health issues seem to be missing from the priority areas discussion, and selection of high priority measures (Appendix B). In some cases, measures have not yet been developed, in other cases, measures are currently endorsed by NQF but were not included in this project.</p> <p>One of the IOM priority areas is children with special health care needs. NQF has previously noted the importance of developing newborn screening measures. Every infant in this country (over 4 million) is screened at birth for a variety of congenital disorders. Newborn screening communication processes are of interest to both public health and health care delivery systems.</p> <p>Specific Recommendations:</p> <ul style="list-style-type: none"> <li>* HRSA recommends that the following NQF endorsed ambulatory care measures be added to the high priority list: Childhood Immunization Status (NCQA) and Diagnosis of ADHD (ICSI).</li> <li>* HRSA supports the inclusion of more measures for pediatrics which would enhance the generalizability of the proposed approach to all performance measures and it would allow identification of additional data elements and processes unique to high quality care for millions of children".</li> </ul>	See #5. No changes to report.
67	Deborah Willis-Fillinger, MD, HRSA Center for Quality	<p>Assessment of Disparities</p> <p>Specific Recommendations</p> <ul style="list-style-type: none"> <li>* Line 209-210. The Panel has identified three data types (not found in the measure set) that will be required to assess disparities. HRSA recommends that age, gender, SES and literacy level be considered as well.</li> <li>* Line 84 87 and Table 5. Consider adding key recommendation that EHR vendors should develop functionality to generate and automatically capture issuance of patient education and self-management materials with built in language and picture options to accommodate non-English speaking and functionally illiterate populations.</li> </ul>	<p>Age is included (as calculation from History_birth date). Sex was selected over gender. Literacy and SES should be considered. Action: add data types.</p> <p>Adding functional recommendations are beyond the scope of this report. Future work will be needed to identify functional requirements for the capture of quality data. No changes to report.</p>

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68	Deborah Willis-Fillinger, MD, HRSA Center for Quality	<p>Framework and Pareto Charts:</p> <p>In general, this is a good start to a comprehensive framework for data types and performance measures for Electronic Health Information Systems. The key recommendation (p. 4) to shift to the clinical problems from the billing code is a giant leap. This recommendation will help make a patient-centered health care system.</p> <p>Appendix D potentially is useful to decision makers in selecting quality measures because it assigns scores to the various measures. It is not apparent how the section identification of high and low yield common data types on pages 12 to 15 relates to the appendix D measures or to the next section titled quality domain organizational analysis.</p> <p>The Pareto analysis and its relevance to the measures is not self explanatory. Pareto Analysis charts could be more helpful by reinforcing the concepts of frequency and completeness. They could be renamed to highlight frequency and completeness and what the charts show. The discussion of exclusions is interesting, but a question remains how this relates to selection of measures.</p> <p>The Expert Panel addressed the very complex task of standardizing a means by which data can be collected and utilized primarily by the patient and clinician, as shown in Figure 3 on page 16. However, it is noted that all arrows in Figure 3 are pointed to the patient and clinician. This schematic suggests that the patient and clinician are only acted upon and have no organizational relationship or communications linkages with any of the quality measurement components.</p>	<p>See #42.</p> <p>Action: clarify connection of Pareto and recommendations.</p> <p>Action: replaced 10 tables of Appendix D with single combined table ranked by measure quality score (Y axis) and data type quality score (X axis).</p> <p>Action: Org chart removed – see #117.</p>
69	Deborah Willis-Fillinger, MD, HRSA Center for Quality	<p>The NQF Health IT Expert Panel (HITEP) Members</p> <p>Line 39 (Appendix A) were selected to ensure broad representation across quality measurement, health information technology, EHR vendors, health systems, and government organizations.</p> <p>Comment HRSA supports seasoned and articulate grantees with considerable experience in EHR implementation who are leaders in quality improvement, including IHI Health Disparities Collaboratives. These experts, familiar with HIT factors that support or confound data and patient management within and across ambulatory settings, and with national experience with multi-condition registries, chronic disease management and care coordination HIT might be of value to the NQF Expert Panel and are available to add the perspective of ambulatory care providers in resource constrained settings.</p>	No changes to report.
70	Ellen Schwalenstocker, NACHRI	<p>Several pediatric experts and organizations have been working together with regard to developing Health Information Technology in support of quality measurement, most notably through the HL7 Pediatric Data Standard SIG. The following comments were submitted by these individuals.</p> <ol style="list-style-type: none"> <li>1. The National Quality Forum is to be commended for undertaking this effort.</li> <li>2. If a semicircle is for numerator analysis, why is it not a semicircle for denominator?</li> <li>3. We agree with the recommendation for a coded, interdisciplinary clinical problem list that is accessible and used across care settings. This can be addressed by leveraging existing standards such as the Continuity of Care Document/Continuity of Care Record, which is a harmonized standard approved by the ANSI Health Information Technology Standards Panel (HITSP) and roadmapped for the Certification Commission on Health Information Technology's (CCHIT) 2008 testing criteria. It should also be recognized that, today, clinicians do not routinely use problem lists. It may be unrealistic and create analysis biases if performance measures are driven by fields in which the data are not realistically available. Also, even amongst clinicians that do maintain problem lists, a master problem list may not be as prevalent as a problem list specific to a specialty.</li> <li>4. In line 85, please clarify whether the intent is to measure whether patients receive the appropriate discharge instructions. Are there specific outcomes to which this measure is linked?</li> </ol>	<p>The whole circle represents the population for the measure, or the denominator (e.g. n=100). Therefore, a subset of denominator qualifies as the numerator (e.g. n=70). Hence, a semicircle was chosen to represent this subset of the whole denominator.</p> <p>Action: for clarity, shapes are changed to D=denominator, N=numerator, X=exclusion.</p> <p>The Panel agrees that moving to problem lists may require a change in culture. As problem lists are increasingly used for quality measurement and decision support, their further adoption will be led by these value-added features for clinicians. Depending on implementation, problem lists can be aggregated across care settings.</p> <p>See clarification in #16.</p>

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71	Ellen Schwalenstocker, NACHRI	<p>5. With regard to line 87, data types in and of themselves may not be sufficient if a description of their meaning/context is not included (for example, does a diagnosis field have a meaning if you don't have the right reference set/vocabulary, eg, ICD-9?)</p> <p>6. Rather than inpatient diagnosis/outpatient diagnosis, the measure should state the query criteria to be used, objective findings (age, physical finding), and assessments (eg, diagnosis of diabetes) as the denominator/inclusion criteria. The plan would refer to the action to be taken. The numerator is the evidence of plan execution (eg, medication or laboratory plus time). Exclusion criteria should specifically list other patient attributes (eg, pregnancy status). By this, looking at Table 4, is it useful to distinguish between medication (outpatient filled) vs medication order? Why isn't there an opt-out for every measure? Does this rely on a unified system between inpatient and outpatient? Looking at the Figure 1, could this be sorted by frequency?</p>	<p>Rec #7 focuses on the utilization of high integrity data types. In addition to that, future measure endorsement will require specifications according to HITSP taxonomy recommendations.</p> <p>The reason for differentiating between a medication fill versus order is taken from measure specifications. Some ask for every evidence of a fill, others for just the order.</p> <p>Opt-out is a data type -- it is indeed included in many measures, yet not all measures, at the discretion of the measure developer. For example, some developers opt to include only clinical criteria for exclusion rather the more generic "opt-out" criteria.</p> <p>Figure 1 is sorted by frequency. (Line 255)</p>
72	Ellen Schwalenstocker, NACHRI	<p>7. With regard to the recommendation that medication allergies and side effects should be distinguished from each other and entered using standardized codes, CCHIT is addressing this issue as follows:</p> <ol style="list-style-type: none"> <li>For 2008, the draft criteria require that an electronic health record (EHR) be able to specify the type of allergic or adverse reaction, in either free text or discrete data.</li> <li>For 2009, the criteria roadmap proposes to require that an EHR be able to specify the type of allergic or adverse reaction using discrete data.</li> <li>For 2010 and beyond, the criteria roadmap proposes to require that an EHR be able to specific the type of allergic or adverse reaction using standardized codes.</li> <li>This roadmap gives HITSP time to identify appropriate terminology standards for medication allergies and adverse reactions, and also gives EHR vendors time to incorporate those standards into their production systems.</li> <li>Consider existing work effort on Allergy standardization by Consolidated Health Informatics (attached) in defining ontologies and data structure related to allergy documentation.</li> </ol> <p>8. There is no mention in the report that recognized that most of the measures are for adults and therefore child health information technology would be adversely impacted by the lack of comparable guidance. The EHR vendors build what they are told by the market and regulators (such as CCHIT). If they are being told how or encouraged to include pediatric measures, they won't. On page 23, it would be helpful to denote which measures (if any) relate to pediatrics.</p>	<p>The prioritization exercise was part of the charge and done for the purpose of the HITEP work. The priority and goal setting work of the National Priorities Partners will form the basis for priority setting going forward.</p> <p>No pediatric measures were identified within the scope of this project. However, the data quality framework is applicable to all areas of clinical medicine. No changes to report.</p>
73	Ellen Schwalenstocker, NACHRI	<p>9. It is unfortunate that the committee did not come to a resolution regarding the priority measures.</p> <p>10. With regard to the recommendation that NQF evaluate the quality of data types used in measure specifications as a criterion in the endorsement of measures, we support this recommendation. We believe that this role should not be limited to NQF, but that all parties involved in the development of clinical guidance and quality measures should be aware of the need for health information systems to accurately and consistently implement clinical guidance and report on quality measures. The AAP has already taken steps to address this need through the establishment of the Partnership for Policy Implementation, which works with clinical content experts to ensure AAP guidance to clinicians is structured to be implementable at the point of care.</p>	<p>Action: Appendix D restructured to single table, now sorted by measure quality score of the 84 high-priority measures.</p> <p>The NQF encourages other stakeholders to be involved in the process of efficient translation of clinical content into implementable actions and measures.</p>

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74	Ellen Schwalenstocker, NACHRI	11. HITSP has just released the interoperability specification for the Quality Use case and this should become an important standard for reporting and querying measures. The goal is to be able to define queries to extract the measures from any EHR and to report and aggregate them. Health information exchange and regional health information organizations will add a cross-setting and cross-institutional dimension. Trial National Health Information Network implementations will use this specification. Also to be considered is the Quality Reporting Document Architecture (QRDA), a standard based on the HL7 Clinical Document Architecture, which is currently under development within HL7, supported by the Alliance for Pediatric Quality, and will help meet this need. The proposed QRDA supports use case requirements published by the Office of the National Coordinator for Health Information Technology and is consistent with requirements defined by the professional societies, quality organizations, and vendors. All indications are that QRDA is a critical component required to meet the data export requirements defined by the National Quality Forum (NQF) Health Information Technology Expert Panel (HITEP), The Collaborative for Performance Measure Integration with EHR Systems (The Collaborative), HITSP, and Integrating the Healthcare Enterprise (IHE).	See #45.
75	Ellen Schwalenstocker, NACHRI	11. (Cont'd) In fact, both HITSP and IHE quality work groups have reviewed the Phase I work on QRDA and have expressed a strong desire to adopt it as an integral part of their 2008 development. Phase I discussions indicate that QRDA supports and complements these efforts. Initial work on QRDA indicates that the standard can fit the interoperability requirements for the high-priority measures identified by HITEP. 12. CCHIT will eventually integrate quality reporting into EHR certification. A general purpose solution based on the HITSP spec (if it works) should be an efficient pathway to implementing quality measures. 13. Immunizations, Newborn Hearing, and Blood Spot Screening may become targets for American Health Information Community use cases that will address the ability of EHRs to provide quality measurement and reporting in these limited domains. The work on immunizations is expected to start in April 2008, with Newborn Screening in 2009. 14. States are getting more involved in interoperability of health information technology and quality measurement (for licensure requirements). A report is expected from the National Governors Association in February on using health information technology and health information exchange to improve quality.	General comment. No changes to report.
76	Ellen Schwalenstocker, NACHRI	15. Part of the reason why quality measurement specifications are not designed to leverage EHR systems is the availability of clinical data. Administrative datasets were the most commonly available source for assessing quality. With the emerging capability of EHRs to capture clinically-relevant quality information, measure developers must also have a paradigm shift in developing measures. Therefore, we endorse NQF's recommendation to encourage the use of high quality data elements for newly submitted measures. However, we should also point out that the measure developers must have the ability/capability to provide explicit logic and algorithm for the desired parameters of the specific quality measure (i.e., inclusion/exclusion criteria, measure set/category information, etc) so that the logic can be easily adopted by vendors and EHR system developers. The wheel-reinvention among the vendors usually occurs in the interpretation of the measure parameters and how the logic is embedded in the system's rules engine. Therefore, if there is a well-validated process for standardizing the translation of the measures to computer-speak (i.e., computable logic); then it would make the adoption of the quality functions more readily-acceptable by the vendors. Such an effort is currently being undertaken by the American Academy of Pediatrics through its Partnership for Policy Implementation.	Appreciate this important comment. This issue will be considered in future iterations of HITEP work and NQF related endorsement activities.
77	Ellen Schwalenstocker, NACHRI	16. If we envision a standardization of computable quality measurement reporting activity; then a need for an authoritative source/repository of the measures is an important consideration. This way, vendors can target their development (which consumes a lot of resources) based on the authoritative source (updates, clarification, etc) and not from multiple organizations (AQA, Joint Commission, etc). This also necessitates identifying each quality measure uniquely in order to enhance measure interoperability in health information exchange situations, as well as in managing the versioning and updates for the given set of measures.	Possibilities include centralized versus distributed databases. NQF is actively engaged with measure developers in these efforts. No changes to report.
78	Bernice Bennett, MPH, CHES, National Association of Public Hospitals and Health Systems	It is recommended that the standards for quality measurement include definitions of different patient populations in order to measure disparities, as well as other factors that could influence the measures and make them more useful for quality improvement activities. For race and ethnicity, please consider using the Office of Management and Budget (Census Bureau) list. In addition, efforts should be made to ensure that the selected terminology set can meet the need for identifying unique populations that are not typically captured in billing data, such as smokers and patients at the end of life. Also, other patients' unique characteristics, including socioeconomic status, language and learning level/preferences, need to have standardized definitions and be included in HITS. This standardized approach to capturing this information would provide a better opportunity for comparative and collaborative efforts to improve care.	The Panel agrees that it is important to capture these patient characteristics. Within the scope of this project, the panel identified history_behavioral (for smoking), history_care_classification (for end of life). SES data types are included as well. Future iterations of HITEP will consider these additional areas. See #67.
79	Bernice Bennett, MPH, CHES,	Consideration should be given to developing a process for discrete data elements to be entered manually to capture results from non-integrated systems. Many public health efforts are addressing services, such as immunizations and	Future work of HITEP will focus on workflow and functional requirements for EHRs to

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	National Association of Public Hospitals and Health Systems	cancer screening, which are given outside of their main site. HITS need to allow for this information to be entered for accurate reporting.	capture quality data across settings. No changes to report.
80	Bernice Bennett, MPH, CHES, National Association of Public Hospitals and Health Systems	Efforts should be devoted to standardizing the reporting requirements focusing on a format that supports the usability of the data for quality improvement efforts and consumer friendly public reporting. Most importantly, resources should be committed to support the continuous evaluation/ research, refinement of data standards, data collection/transmission and data reporting mechanisms to ensure validity, accuracy and comprehensiveness.	See #79.
81	David Muntz, Baylor Health Care System	On line 83, page 5, the value of data from dispensing pharmacies might be useful, but is highly unreliable. The goal of creating algorithms to determine medication usage by EHR vendors, in my opinion, is too risky to include in an EHR. The medication reconciliation process for both inpatient and outpatient admission processes would be a better place to focus. The individual collecting the data does and should be able to associate a level of reliability for that data. A reliability rating would have clinical and analytical implications and be more consistent with the framework you recommended.	See #33.
82	David Muntz, Baylor Health Care System	On line 210, page 9, the consideration of disparities associated with economics is not addressed. Geocoding based on zip code for home and business does have relevance as it relates to matters of access at a minimum. Both locations should be added as a basis for analysis. Such an analysis would help determine the efficacy of existing activities in both population management and facility placement.	Future iterations of HITEP will consider these additional areas.
83	David Muntz, Baylor Health Care System	On page 18, recommendations about what vendors should do are included. Vendors must meet CCHIT functional criteria to have their products certified as EHRs. Most of your recommendations are consistent with the framework which they have put in place. The challenge to those of us in the customer stakeholder group is the variability with which those capabilities are implemented. No means to test processes is recommended. To that list of certification requirements, I suggest that CCHIT or its designee develop or champion the development of a specific set of scenarios (inputs) that when processed through an EHR produce an expected set of outcome reports (outputs) to ensure the vendor products can support the framework you are recommending. It is the only way to ensure your framework is appropriately implemented and will validate comparability between and among providers, something that features based certification does not address.	Important consideration for future iterations of HITEP. No changes to report.
84	Bob Darin, MediQual services, Cardinal Health	Overall, we believe that the document is clearly presented and has valuable recommendations and priorities as it relates to the use of Electronic Health Records (EHRs) and quality measurement.	General comment. No changes to report.
85	Bob Darin, MediQual services, Cardinal Health	For vital signs, we would suggest including other vital signs (pulse, temperature, respirations) to blood pressure. (reference page 10, row 215, Table 2)	See #5. No changes to report.
86	Bob Darin, MediQual services, Cardinal Health	Altered mental status (measured by the Glasgow Coma Scale or a set of predefined definitions) should be included under physical exam (reference page 10, row 215, Table 2)	See #5. No changes to report.
87	Bob Darin, MediQual services, Cardinal Health	Recommendations could be expanded to include the ability automated feeds into the EHR, as well as the ability to extract information out of EHRs. This is a critical component to work flow and reducing redundancy (references: page 6, rows 120-130, discussion of efficiency and effectiveness of using HIT and page 17 row 326, Table 5)	Future work of HITEP. No changes to report.
88	Bob Darin, MediQual services, Cardinal Health	Additionally, we would recommend capturing drug administered route and dosage as well as duration. (references: page 25 Appendix C and page 17 row 326, Table 5)	See #5. No changes to report.
89	Bob Darin, MediQual services,	As the next priority areas are addressed, these recommendations could be applied (e.g., Surgical Care Improvement Project or infections).	General comment. No changes to report.

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	Cardinal Health		
90	Bob Darin, MediQual services, Cardinal Health	More broadly, we commend NQF for promoting the goals of standardization and development of common data types. We also believe that the continued pursuit of automated, standardized solutions to enable quality measure development and implementation is a critically important strategy. We would encourage NQF to continue to move in this direction, including the use of other electronic clinical data sets such as automated laboratory data. The growing body of evidence shows that using automated clinical data brings standardization, enhances the objectivity, reduces the burden of data collection and produces more accurate reporting.	General comment. No changes to report.
91	Carmela Coyle, American Hospital Association	The AHA commends the National Quality Forum (NQF) for taking a systematic approach to the collection of quality data. Creating a framework within which quality data standards can be effectively developed and maintained as quality measures evolve is an important step. This early work on standardization will result in a long-term reduction in quality reporting burdens.	General comment. No changes to report.
92	Carmela Coyle, American Hospital Association	The AHA agrees with the panel's concept of leveraging existing data from electronic health record (EHR) systems whenever possible, especially in those situations where no additional functionality must be added to an EHR system to create a discrete data element for quality measurement. This effort will lay the groundwork for realizing the additional benefits of data standardization. Standardizing the electronic format and transfer of quality data also could be viewed as a first step toward increasing standardization of broader clinical data. The lessons learned by first achieving standardization of quality data will provide a foundation for further work toward broad standardization. All of these efforts can advance patient safety, as well as the goal of promoting healthier communities.	General comment. No changes to report.
93	Carmela Coyle, American Hospital Association	As quality reporting becomes an embedded EHR function and quality measures continue to evolve, it is important to recognize the potential impact of software development cycles on both providers and vendors. A change in quality reporting requirements will require every hospital in the country to upgrade its EHR system. This could be burdensome, and could introduce risks to the continual functioning of EHR systems. Stakeholders engaged in quality reporting, as well as those involved in health information technology implementation, should remember that the burden to implement new measures, and the risks of unsuccessful implementation, become greater as more providers implement EHR systems. The growth of these systems will change workflow, health care delivery and even the way quality is measured. These should be positive changes, but there will be challenges to providers as they attempt to fully transition.	This is the exact reason for standardizing quality measuring in EHRs. When the process of measure specification input into the EHR and quality data output from the EHR are both standardized, the incremental cost of implementing a new or updated measure will be negligible.
94	Carmela Coyle, American Hospital Association	Finally, the AHA suggests that, as the NQF formalizes its framework, the language be clarified to more clearly articulate what is meant in the document by the word "quality." In the draft report, the panel uses the word in three distinctly different ways. First, the panel uses the term as an indicator of whether or not the care provided meets certain minimum standards. Second, the report discusses the "quality" of the data captured or reported. We suggest referring to this concept as "data integrity" or some similar term. Third, the NQF discusses the "qualities" of the data; we believe the terms "attributes" or "traits" might be more appropriate and less confusing.	Although it does require additional explanation, data <i>quality</i> best captures the intensions of HITEP. Will clarify wording to emphasize the relationship between quality measures and quality of data types. Additionally, removed all reference to "qualities of the data" in place of alternative wording.
95	Greg Pawlson, National Committee for Quality Assurance	A couple of suggestions for the overall approach of the document: 1. Given the newness of the field and the proliferation of concepts and acronyms, there is a need to have a glossary of terms- including "health information technology" and "electronic health record" to name a few basics.	Action: added specific definitions for EHR and HIT.
96	Greg Pawlson, National Committee for Quality Assurance	2. While it should primarily address, as it does, the use of EMR information for quality, it should also given some attention to the need to have a single set of criteria and conventions- and core data- for patient care, public health (as for example the NYC health department is planning) and research (rapid clinical learning, support and feedback to decision support etc), as well as quality.	We agree that data standards and core data are required for multiple aspects of health care, and often these requirements will overlap. The output of this report will serve as a contribution from the quality community to HITSP. Additional efforts are encouraged and are underway from additional domains of health care.
97	Greg Pawlson, National Committee for Quality Assurance	3. There could be more attention given to the very critical task of blending data from the EMR of a single practitioner or office with data from labs, pharmacies, and other sources of critical administrative and clinical data.	Data aggregation is a critical component of quality measurement, however beyond the scope of this project. Standards derived from the work of this report will make such aggregation more manageable. No changes to report.

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98	Greg Pawlson, National Committee for Quality Assurance	4. Again, while focus is on data elements, it seems like more attention could have been given to the need to restructure data entry and capture in EMR's- so that we move from EMR's that are merely electronic versions of paper records, to EMR's that capture the full range of data required for patient care, quality, research and public health,	See #27.
99	Greg Pawlson, National Committee for Quality Assurance	5. The report fails to give any note of established, and well structured data collection and reporting systems like HEDIS (with standardized formats, data collection rules etc)	See #3.
100	Greg Pawlson, National Committee for Quality Assurance	6. One of the most glaring failures of current quality measurement efforts is the lack of adequate data to examine appropriateness or to measure the quality of procedures. This was implicit in a number of the IOM recommended priority areas- and is even more critical as we move beyond the IOM scientific focus to the needs of our current health policy dilemma (cost concerns as trumping quality issues). While the goals of the panel were focused primarily on dealing with data elements required for current measures, some additional attention should be give to rapidly moving to include data elements necessary to address appropriateness and quality of procedures.	The current project was restricted to the AQA/HQA measure set but hope to include the data elements required to address appropriateness and quality of procedures in future iterations of HITEP. No changes to report.
101	Greg Pawlson, National Committee for Quality Assurance	Comments on specific recommendations 1. Clinical problem list: While the problem list is a good anchor, information on inclusions and exclusions should also be derived from the medication list (unless "problem list" is seen to be all inclusive –medications, allergies etc), lab results, allergy and side effect lists, and at least a consideration given to special data related to exclusions entered by clinicians related to patient factors or preferences (like refusal to have a screening test). It is also unclear how temporary problems or "rule outs" should be handled in this proposed scheme to avoid clogging problem lists with long resolved or trivial issues. Finally, there should be some at least inference as to what impact this may have on billing codes (perhaps billing codes should be driven only from problem list entries- even where there are temporary problems).	Agree that measure specifications will rely on more than the problem list. Identifying data types is a first step to providing data standards, which will allow more complex measure logic.  Regarding billing codes, there is need for continued discussion on interim solutions while measurements evolve from administrative to clinical data. No changes to report.
102	Greg Pawlson, National Committee for Quality Assurance	2. Simple data dictionary: agree- need to check with measure developers to see what has already been done	General comment. This data dictionary should focus on data types and not specific elements. For example, although there are 35 data types in these 84 measures, there are over 300 individual data elements. No changes to report.
103	Greg Pawlson, National Committee for Quality Assurance	3. Medication and Allergy: Good thought- but this would require a great deal of clinical education- since many clinicians DO NOT clearly understand the differences. Note also that any attempt by EMR vendors to develop functionality here (or with problem lists) should be done in collaboration with clinicians	General comment. No changes to report.
104	Greg Pawlson, National Committee for Quality Assurance	4. Summary impressions: Again a good idea- but again, this would again take a great deal of education of radiologists etc, to develop standardized nomenclatures of "summary impressions"	General comment. No changes to report.
105	Greg Pawlson, National Committee for Quality Assurance	5. Link to pharmacy: This is a critical linkage, not only for quality, but for patient management- it should be malpractice of both the physician and pharmacist, NOT to have this linkage	General comment. No changes to report.
106	Greg Pawlson, National Committee for Quality Assurance	6. Discharge data: ditto for hospital or other entity	General comment. No changes to report.

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107	Greg Pawlson, National Committee for Quality Assurance	7. Evaluate quality of data types: Agreed, but this report looks only at quality of data from EHR perspective- and not from paper chart review or use of methods like the HEDIS hybrid methodology. One also has to weigh the value of even a somewhat flawed measure with no data at all.	Intended to move field toward EHR integration rather than a comprehensive evaluation of existing non-EHR data. No changes to report.
108	Greg Pawlson, National Committee for Quality Assurance	Body of the report (keyed to line and excluding issues already addressed above) 187: It is unfortunate that data elements related to resource use/cost or appropriateness and overuse did not somehow get into the higher tiers	The restriction to the AQA/HQA measures limited ability to address resource use and appropriateness. Important consideration for future iterations of HITEP. No changes to report.
109	Greg Pawlson, National Committee for Quality Assurance	210: Strongly support the addition of data on ethnicity, language and payment source	General comment. No changes to report.
110	Greg Pawlson, National Committee for Quality Assurance	215: The list of data types for procedures seems limited- what about lists of alternative approaches, prior treatments or procedures etc.	Alternative approaches, prior procedures and prior treatments would still be considered procedures and treatments with similar representation standards, however in a different context. No changes to report.
111	Greg Pawlson, National Committee for Quality Assurance	222, Need to note in summary of report that the rating of information was from the standpoint of the EMR- NOT current admin data or paper chart review- there has already been a great deal of misinterpretation of the ratings of the panel.	Action: clarified language in report to reflect perspective of EHR
112	Greg Pawlson, National Committee for Quality Assurance	228: would patients be considered to be authoritative if they entered data on their preferences? Was any consideration given to patient entered data?	Patient-reported data, including symptoms, would be considered authoritative, but not completely "accurate" for example, since the full qualification of sxs typically need questions and probing by a health care professional. No changes to report.
113	Greg Pawlson, National Committee for Quality Assurance	238: Would add "and the quality of the actual data source or data used". Missing values for lab tests results, which might be considered very reliable, causes just as much if not more error than lack of "authoritative" data entry.	Action: add "and their respective sources" to line 239.
114	Greg Pawlson, National Committee for Quality Assurance	247 (table) some consideration should be given to some rating of the degree of certainty of the estimates of the criteria scores	Action: add language that criteria scores were generated from subjective consensus from the broad stakeholders in HITEP.
115	Greg Pawlson, National Committee for Quality Assurance	257: While frequency of data element is a useful metric- it doesn't reflect importance- for example, it may be that lab results, which are only used in a low frequency of current measures are really much more important than lab other less widely used (in current measures) element.	The importance of individual data types is dependent on the context of the quality measure and can not be determined as a function of the individual data type. No changes to report.
116	Greg Pawlson, National Committee for Quality Assurance	273: The issue of exclusions is a very critical issue that a more broad based body of IOM and/or NQF should address as soon as possible in relationship to the EMR environment. While there are studies going on (including the Cardio-HIT study led by the AMA-PCPI) it is not clear that the results of that or other studies will be done in time to incorporate the convention into EMR standards at least in the first iteration. In the meantime, there should be a flexible approach to standards in this area.	General comment. No changes to report.
117	Greg Pawlson, National Committee for Quality Assurance	315 The much more detailed diagram subsequently developed by a group led by Carolyn Clancy of AHRQ should be substituted for this one.	Deleted organizational diagrams, as has been updated by more recent works.

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	Assurance		
118	Greg Pawlson, National Committee for Quality Assurance	330: Clearly the work of this panel has only begun- there are many more questions and issues that need to be addressed by a group with broad representation. AHRQ and others, should be strongly urged to continue support for this panel.	General comment. No changes to report.