Meeting Summary

Leveraging Electronic Health Records (EHR) Sourced Measures to Improve Care Communication and Coordination Option Year Web Meeting 5

The National Quality Forum (NQF) convened a multistakeholder Committee web meeting for the Leveraging Electronic Health Record (EHR) Sourced Measures to Improve Care Communication and Coordination Project on May 24, 2022.

Welcoming Remarks, Meeting Objectives, and Attendance

Chelsea Lynch, NQF Director, welcomed participants to the web meeting and reviewed housekeeping reminders. Ms. Lynch introduced the Committee Co-Chairs, Dr. Richard Antonelli and Dr. Gerri Lamb, who provided welcoming remarks. Ms. Lynch reviewed the project timeline, meeting agenda, and the following meeting objectives:

- Refine recommendations for approaches to using detailed EHR data to improve the measurement of care communication and care coordination by:
  - Prioritizing possible EHR-sourced measure concepts to improve care communication and care coordination
  - Identifying specific EHR data elements needed to measure care communication and care coordination

Debbie Olawuyi, NQF Analyst, conducted attendance for Committee members and Federal Liaisons. Ms. Lynch introduced the NQF project team and CMS staff before reviewing the meeting ground rules for conducting a respectful and insightful discussion.

Recap of Web Meeting 4

Ms. Lynch provided a brief overview of the fourth web meeting objectives, which included:

- Review current approaches to digital quality measurement
- Discuss how existing and future development of EHR-sourced measures can be leveraged to improve care communication and care coordination
- Identify measure topic areas from which measure concepts could be developed for EHR-based care communication and care coordination

Ms. Lynch provided an overview of the presentation from Kyle Cobb from the Office of the National Coordinator for Health Information Technology (ONC) and Joel Andress from the Centers for Medicare & Medicaid Services (CMS). They outlined CMS' and ONC's commitment to data standardization and ensuring that electronic data sets are harmonized across national standards. The key takeaways from the presentation included ONC using United States Core Data for Interoperability (USCDI) to standardize sets of health data classes and related data elements to create baseline data elements for EHR interoperability. ONC recently launched USCDI+ to facilitate the harmonization across use cases, including quality measurement. CMS is transitioning to digital quality measures and aims to enhance interoperability by using high-quality standardized data for measurement. Ms. Cobb and Dr. Andress highlighted the importance of national alignment on data standardization and the need to prioritize interoperability of digital data. Ms. Lynch highlighted that additional information can be found on the Electronic Clinical Quality Improvement (eCQI) Resource Center website for Digital Quality Measures.

During the breakout groups, the Committee developed recommendations for using detailed EHR data for care communication and care coordination quality measurement. The Committee discussed the differences between EHR-based and claims-based data for quality measurement, highlighting how EHR-based data can improve the measurement of care communication and care coordination. Breakout group 1 explored measure topic areas that are important to measure outcomes related to EHR-based care communication and care coordination. In contrast, breakout group 2 focused on EHR-based data that could improve the measurement of care communication and care coordination activities. The key takeaways from these robust discussions included that claims-based data and EHR-based data are both important for quality measurement. However, EHR-based data are preferred for quality measurement since they provide granular, qualitative information and can potentially address social risks. Measurement topic priorities identified by the Committee included capturing patient priorities and goals in care plans and closing the loop on referrals. These discussions were synthesized into recommendations to guide the use of EHR-sourced measures to improve care communication and care coordination in the Final Recommendations Reports.

Overview of Final Recommendations Reports

Ms. Lynch provided a brief overview of the Final Recommendations Reports and highlighted recommendations that were included in both reports. Ms. Lynch reminded the Committee that the two Final Recommendations Reports are being developed concurrently. She highlighted that one of the reports is a long, detailed, and technical report for EHR vendors, healthcare providers, and other quality measurement stakeholders. The intent of this report is to support the evolution of EHR-based care communication and care coordination and performance measurement to drive quality improvement and equitable health outcomes. The other report will be a short, non-technical, and visually appealing report which will be for change makers, legislative professionals, and other non-technical stakeholders. The intent is to educate a broad audience to highlight the importance of the topic and why these recommendations should move forward. She informed the Committee that both reports were sent to them on May 13 for their review and feedback.

Ms. Lynch transitioned to discussing the overview of the context for the recommendations. Ms. Lynch noted this context is based on previous web meeting discussions to facilitate development of practical recommendations for both the current and future states of EHR development. To execute this, the Committee considered interoperability where information can be shared easily between different systems to both facilitate care communication and care coordination as well as decrease the burden for patients and clinicians. The Committee also considered a broader view of EHR maturity to include the level of EHR functionalities to support care communication and care coordination including features such as interoperability, data standardization, and usability. Ms. Lynch emphasized that EHR maturity is on a continuum, ranging from simple to more advanced functionalities. The intent is to focus on achieving more advanced levels of EHR maturity within and across all healthcare settings to improve care communication and care coordination.

Ms. Lynch transitioned to discuss the recommendation to effectively facilitate care communication and care coordination with EHRs. She informed the Committee that the EHR maturity phases were used to organize these recommendations to allow stakeholders to both acts on the recommendations with their current EHR systems and plan for future advancements. The recommendations were classified into three themes: (1) collecting and sharing standardized data for care communication and care coordination, (2) optimizing usability by patients and caregivers, and (3) optimizing usability by clinicians. Ms. Lynch informed the Committee that NQF is requesting for any written feedback either using comments and/or tracked changes in the reports themselves or by sending summarized feedback via email by May 27.

Recommendations to Leverage EHR-Sourced Measures to Improve Care Communication and Care Coordination

Ms. Lynch provided a brief overview of the recommendations to leverage EHR-sourced measures to improve care communication and care coordination based on the web meeting four discussions. She noted that these recommendations build on the recommendations related to EHR functionalities needed for EHRs to effectively facilitate care communication and care coordination. As EHR functionalities continue to evolve and advance, the resulting EHR-based data can facilitate the measurement of care communication and care coordination. Ms. Lynch highlighted that using EHR-based data in quality measures will allow for the development of new measures and the revision of existing measures to capture additional, relevant information.

Ms. Lynch shared the recommendations are grouped into three themes. The first theme includes the high-priority recommendations that could be taken to advance the science of measure development for care communication and care coordination. One recommendation is to develop standardized EHR data elements for patient engagement regarding care communication and care coordination. Another recommendation is to improve the specificity of existing measures related to downstream care after an index visit. The third recommendation is to develop an EHR-based care plan measure since care plans are tools that could help multiple clinicians adhere to care plan goals and assess whether those specific goals are met. The final recommendation for this theme is to develop an EHR-sourced measure that identifies specific patient-oriented goals and whether those goals are being achieved.

The second theme includes identifying additional EHR data elements needed to measure care communication and care coordination. She highlighted that the intent is not to get to the granular detail of something like the Gravity Project, which identifies specific data elements for social determinants of health. Instead, these are higher-level data element categories such as care communication and care coordination activities like shared decision making and care planning, identifying goals of care, providing details for transitions in care across settings, and communicating between clinicians and patients. A component of this theme is developing standardized data elements that could be entered by patients, family members, and caregivers. The data categories include engagement with care communication and care coordination, participation in developing care plans, perceived correctness of clinical notes, and perceived equity of care or trust in clinicians.

The final theme is concepts that may be possible to measure. These include new measure concepts and the re-specification of existing measures to include EHR data. The measure concepts are categorized into three groups:

- Outcomes of poor communication and care coordination
    - Hospital readmissions within 30 days of discharge
    - Unexpected return ED visits within 72 hours of discharge with hospital admission
    - Frequency of duplicate, unnecessary testing

  - Frequency of follow-up care that was not completed within the recommended time frame
  - Frequency of specific medical errors related to care communication and care coordination
- Outcomes of effective communication and care coordination
  - Patient engagement with care coordination/clinician communication/care integration
  - Utilization of patient portals, the responsiveness of clinicians
  - Assessing whether care goals are met Improving outcomes related to SDOH
- Critical actions for effective communication and care coordination
  - Closing the loop: communication of critical test findings to the care team and patient
  - Appropriate handoff/communication performed between clinicians for high-risk transitions
  - Care plan creation, availability, and use
  - Interventions to address SDOH problems

Working Session: Purpose and Approach

Ms. Lynch outlined that the breakout sessions allow for a more in-depth discussion to refine the recommendations for approaches to using detailed EHR data to improve the measurement of care communication and care coordination. She noted that the Committee should consider the importance and feasibility of the measure concepts and identify additional EHR data elements entered by patients, family, and caregivers needed to measure care communication and care coordination. Lastly, there will be some time at the end of the breakout sessions for the Committee to provide feedback on the reports. Ms. Lynch emphasized that each group would have 50-60 minutes to brainstorm and discuss recommendations before reporting from the session and addressing any final points for discussion.

Breakout Group 1 Discussion

Prior to the discussion, Dr. Lamb ensured that all group members had access to the breakout group worksheet and briefly reviewed the breakout session discussion topics:

- Categorize the possible EHR-source measure concepts to improve care communication and care coordination based on importance and feasibility in the short, intermediate, and long term.
- Reviewing the topic areas (found in the worksheet) and examples of potential EHR data elements, what additional potential EHR data elements (new or existing) relate to those topic areas?
- Do the recommendations in the Final Recommendations Report resonate with you? Are any recommendations missing, or should they be clarified?
- Do you feel that the Shortened Final Recommendations Reports includes sufficient information regarding the recommendations, is accessible to its respective intended audience, and has an educational tone? If not, what suggestions do you have to improve the report?

Dr. Lamb introduced the first part of the discussion and asked Committee members to provide feedback on the 13 EHR-sourced measure concepts and categorize them based on importance (high/medium/low) and considering feasibility in the short/intermediate/long-term.

One Committee member started the discussion by sharing their selected concepts related to hospital readmissions, outcomes, and interventions to address SDOH, frequency of medical errors, and appropriate handoff/communication in high-risk transitions as these measure concepts contribute to adverse events and readmissions in outpatient settings, emphasizing that these measures are essential to the root of the problem. Another Committee member agreed with the selection of hospital readmissions and outcomes and interventions to address SDOH and also added effective communication between the patient and doctors. These concepts were selected as they are concepts indicating if a patient's needs and comorbidities are being met. In addition, having an effective flow of communication eliminates the presence of miscommunication between the patients and providers.

A couple of Committee members, representing the perspectives of patients and caregivers, shared that the concepts that resonated the most with them were the frequency of duplicate, unnecessary tests which have led them to non-compliance because of the resulting financial burden of these tests. Additionally, a Committee member emphasized that the highest priority should be on the importance of closing the loop and interventions to address SDOH problems due to the impact on quality of life. As an example, a Committee member shared they are participating in a Patient-Centered Outcomes Research Institute (PCORI) project related to financial and emotional burdens around transportation and the time it takes for patients to get a test done at a critical access hospital. They noted that these burdens to patients and caregivers result in financial hardship, emotional fatigue, and a tendency toward discontinuing treatment and labels of non-compliance.

Another member shared that SDOH measures include readmissions, frequency, and duplicate testing or testing not completed in the recommended timeframe. Care plans should consist of metrics on meeting care goals. Their rationale was to capture how care plans are often not communicated effectively to patients or caregivers, contributing to readmissions. They also raised how patients' needs and preferences are not usually addressed during the initial visit. Care plans can be complicated for patients to follow with these information gaps, affecting the patient's compliance with their care plan.

The Committee also discussed the impact of these concepts on clinician workflow, particularly closing the loop between the care team and patients, ensuring testing was completed within the recommended timeframe, and appropriate communication across different clinicians on the care team. Committee members agreed that measures should work collectively to meet care plan goals, further explaining that there is a broad understanding of the metrics of hospital readmission. They also emphasized that the prioritization of measures should be directed toward information that is not readily available. A Committee member shared that the patient portal has been utilized well in their practice and has investigated using it to measure patient involvement. She explained that while SDOH has been incorporated into the system, there is little information on the care/resources patients are receiving.

It was noted by the Committee that the concepts are related to either processes or outcomes. While outcomes, such as hospital readmissions within 30 days of discharge, are important, measuring processes needs more attention because when care pathways fail it negatively impacts outcomes. The Committee also discussed that the SDOH measure concepts should be prioritized and that considerations are needed for how to operationalize the resources to achieve their creation. Another concept highlighted by the Committee was the utilization of patient portals because it puts patients at the forefront of gaps in care that may present opportunities for new measures. One Committee member shared that those measures including unexpected return ED visits within 72 hours of discharge after hospital admission should not be prioritized because this data fails to add value to improve care.

The Committee then discussed the concepts' value, process, and sensitivity. It was suggested not to pursue metrics around duplicate testing and medical errors because these are multifactorial, so it would be difficult to evaluate trends for care communication or care coordination. The Committee highlighted how some of the measures are being captured in other federal programs such as the Merit-Based

Incentive Payment System (MIPS) and also noted the closing the loop measure is being considered for removal by the Measure Applications Partnership (MAP).

A Committee member representing clinical quality for insurance plans agreed that assessment of SDOH is critical. However, they shared their concern about the difficulty of collecting and evaluating this data due to the lack of standardized terminology which can be measured. A Committee member provided an example of measures in development for food insecurity focusing on screening, interventions, and reporting outcomes. There was a discussion that when assessing SDOH measures, it is essential to acknowledge the need for implementation time to identify outcomes. There was an agreement that even high priority measures need to be in practice for a minimum of three to five years before measuring outcomes.

Dr. Lamb introduced the second discussion topic and asked Committee members for their feedback on any additional EHR data elements from patients, families, and/or caregivers that should be added to the topic areas found in the worksheet. A Committee member mentioned that to initiate new measures, the healthcare system needs to move away from binary answers such as yes/no to groups of questions to allow a greater depth of the answers. There was agreement from the Committee that the component of data collection that is absent is how measures are limited to a binary response. Committee members highlighted that it could be as simple as asking patients initially about their needs toward understanding if the care goals are met. A Committee member shared that they found a short survey on health equity that captures perceptions of care from the patient's perspective. A Committee member mentioned that addressing the patient's needs should be addressed throughout treatment in real-time and not want to wait until the end of treatment. They highlighted that it is often measured through satisfaction scores, and the patient's needs are addressed as an afterthought after the scores are reported.

Dr. Lamb introduced the third discussion topic and asked Committee members for their feedback on the Final Recommendations Reports. There was a robust discussion on the lack of resources in the healthcare system and measure development. There is also a lack of resources to keep clinicians accountable for reporting accurate data and for clinicians to follow-up with patients and update care plans that address SDOH interventions. Committee members elaborated that the cost implications of implementing the recommendations should be addressed. Committee members shared their concerns about the accountability of stakeholders when this report is disseminated. There was some commentary for the shortened report to show a movement on SDOH. Another member added concerns about the digital inconsistencies across different health entities that do not have access to digital databases, including patients and clinicians. Lastly, there was a comment on SDOH forms being a part of different databases that no one is using, and there should be some simplification on the data collection for it to be used more often as a standard.

Breakout Group 2 Discussion

Dr. Antonelli began the discussion by introducing the first topic of prioritizing measure concepts, acknowledging that EHR-based data can provide more granular data compared to claims-based documentation. The ONC federal liaison shared that they will be working with the CMS federal liaison to provide feedback on the Final Recommendations Report to ensure alignment with current federal work. The ONC representative noted that USCDI Version 1 is required to be implemented in all EHRs participating in CMS reporting programs within the next six months. They also shared that USCDI Version 1 includes about 70 percent of the data elements needed and there is a roadmap to expand the data elements included, including elements related to patient engagement. In addition, the representative shared that there is a need for actionable recommendations for various electronic platform maturity levels as well as a need for incentives for adoption. The Committee noted the limited inclusion of data elements related to care plans and patient engagement in USCDI Version 1 and acknowledged that the work is evolving.

The discussion then transitioned to the concepts. A Committee member shared that not all concepts should be developed with the same purpose, noting some may be better for quality improvement while others could be developed for inclusion in payment and accountability programs. Another Committee member suggested prioritizing concepts relate to hospital readmissions, a return to the ED, lack of follow-up care, errors, closing the loop, and hand-offs as being high impact in the short-term.

The Committee also discussed that utilization measures address gaps in care and are different than accountability measures. The Committee also acknowledged that while measures such as readmissions and return to ED visits are likely associated with failures in care communication and care coordination, they are not always actionable. A Committee member suggested these measures be seen as “background” measures. In contrast, timeliness of follow-up, care plan creation, and SDOH measures could be more actionable.

The Committee also noted the need to focus on SDOH as a high-priority concept and noted these data elements should be prioritize for integration into the expansion of USCDI. One Committee member shared that the advantage of process measures is that since they can directly processes associated with care communication and care coordination while outcome measures are impacted by factors outside of care communication and care coordination. The Committee also measure feasibility as a priority due to the potential difficulty of collecting some data elements required for the measures.

The discussion then transitioned to prioritizing data elements for care communication and care coordination. Committee members discussed the challenges of patients’ lack of trust in the care system and the lack of modifiable data fields for questions or reports of errors in their medical records. Committee members acknowledged that patients may face duplicate or unnecessary tests or have very different perceptions about their care compared to their clinician which is not captured in their medical records. Members discussed that patients need to have their individualized needs, wants, and desires at the center of shared decisions which could result in greater trust in both providers and healthcare systems. The concept of shared decision-making seemed to resonate with several Committee members as a tool to encourage equity and active participation of patients toward their care goals.

The Committee acknowledged that standardizing the definition of the data elements can help with the consistency of the data being collected. Several Committee members described the vital importance of involving patients in reviewing their medical records and having the ability to amend or provide feedback to providers. However, they also acknowledged the difficulty patients could have in sharing negative or critical feedback with providers. Members cautioned that measures should not represent an ideal but instead be practical about what data can be collected. A Committee member commented that we should be careful not to presume readmissions are a failure of care communication or care coordination but instead consider the importance of SDOH in care plan creation and tracking. Committee members commented that USCDI and quality measure alignment to support patient-reported outcomes and feasibility should be prioritized, noting also that patient-reported data elements need to be defined.

One of the Committee members shared that Rush University Medical Center has a model for collecting this information but requires active involvement from patients and families to develop a patient-centered plan of care. Another member shared that addressing individual preferences was important even for minor concerns such as pain or fear of a blood draw in which providers can place a pain patch, hot pack, or coach to reduce fears if they are aware of the concern. In addition, a Committee member stated that perceptions of both the patient and clinician are vital to reducing errors, especially for patients that are unable to speak for themselves and could lead to emergency situations. An example from the Committee member was the use of a shared student school evaluation form in which notes are given to the family for review and signature before these reports are included in student transcripts. This may be a model for healthcare records in which patients can provide feedback, correction, and sign-off supporting a shared care plan. Several members discussed that different methods could be used to capture patient-level data such as screening tools, but this could increase the provider burden and create a burden for patients and their families. To counteract this burden, the Committee suggested having this be part of the workflow but including a space for the patients to sign off on the care plan itself and include a space for them to add their own notes. One Committee member shared preliminary work by Yale University on patient-reported outcomes found that burden associated with surveys can be decreased if it is incorporated into the delivery of care.

The Committee also discussed the importance of trust and equity as a high priority. A Committee member expressed concerns that patients will not share their mistrust in their provider for fear of retribution. In agreement, one Committee member shared that coming up with a question such as, “do you trust me”, may be difficult for patients to respond to so there is a need for some sensitivity on how we would approach patients for their feedback. Several Committee members commented that SDOH was critically important in care plan creation and tracking.

The Committee briefly shared their feedback about the Final Recommendations Reports. A Committee member noted the shorter report was technical and may be difficult for a layperson to understand. The Committee also emphasized the importance of shared decision making and including it within the reports. It was also noted that use cases for signatures and measure calculations can be recommended for incorporation into USCDI. Several Committee members shared they will provide feedback in writing.

Working Session: Breakout Group Report Outs

Ms. Lynch welcomed everyone back from the breakout sessions before asking Dr. Lamb and Dr. Antonelli to share critical recommendations from the breakout group discussions. First, Dr. Lamb shared the report out for Breakout Group 1, followed by Dr. Antonelli’s report out for Breakout Group 2.

Breakout Group 1 – Report Out

Dr. Lamb emphasized that breakout group 1 had a robust discussion on the approach leading to recommendations, including the principles and foundations. The group had a wide variety of perspectives, whether they were patients, clinicians, or health insurance policymakers, and provided detailed explanations as to why some recommendations were important over others. Some identified priority recommendations were related to SDOH, meeting care goals, duplicate testing, readmissions rates, and ED visits. The Committee kept in mind that the measures that should be prioritized are those that directly affect patients and caregivers, including health equity and disparities.

The group highlighted that some measures/concepts have already been established. The Committee encouraged that the development of these measures should be continued and be addressed in greater depth, such as the sensitivity and specificity as to why someone was readmitted. The members assessed process and outcome measures and emphasized that the process measures should be focused on understanding the outcome fully. An example was the emphasis on patient portals, care plans, and patient-identified data. The group acknowledged that the SDOH measures are essential but are unlikely to be ready for widespread use in the next three to five years. The group’s recommendation was to encourage a robust start to promote the momentum of the data elements and preparedness for SDOH measures to have a more significant impact. Dr. Lamb emphasized how the measures need to move away from being collected as checklist measures. The group emphasized that it is essential to capture data collection happened and assess the efforts to address identified issues and receive input from patients on the care they are receiving.

Dr. Lamb transitioned the discussion to feedback about the two Final Recommendations Reports. She highlighted that the group put a lot of emphasis on looking at resources necessary to do the work of measure development, whether it is capturing, documenting, or reporting the data. The group emphasized that this is important in the SDOH space, where it is challenging to implement due to cost. Another component was the accountability of stakeholders actively putting in the work to incorporate the recommendations. The group transitioned to discussing the equity and disparities that should be captured because it can be overlooked that digital access is not always readily available for seamless care communication and care coordination. The group highlighted that trust was an overarching theme during the breakout group discussion, identifying that there needs to be consistency across multiple entities, clear explanations provided to patients, and care plans should be simple but as impactful as a treatment plan.

Breakout Group 2 – Report Out

Dr. Antonelli shared that Breakout Group 2 had a robust discussion on recommendations on measure concepts and data points. He reviewed several themes that emerged from the breakout including the following: characteristics of measures including type and feasibility; the role of patients in sharing perceptions and needs and level of access and control of their medical record; and the need for shared decision making. He shared that utilization and process measures may be important to measure care communication and care coordination. He shared that they discussed the challenges of patients' lack of trust in the care system and the problem of duplicate or unnecessary tests. He also shared that patient perceptions about their care compared to their clinicians need to be captured in medical records. He reviewed the idea that patients need to have their individualized needs, wants, and desires at the center of shared decisions which could result in greater trust in both providers and healthcare systems. The concept of shared decision-making seemed to resonate with several Committee members as a tool to encourage equity and active participation of patients toward their care goals.

Dr. Antonelli then switched to prioritizing data elements for care communication and care coordination which centered on several themes: capturing patient-level data; integration of patient preferences in care plans; and the value of individual indicators including hospital readmission. Several Committee members described the vital importance of involving patients in reviewing their medical records and having the ability to amend or provide feedback to providers but also acknowledged the difficulty patients could have in sharing negative or critical feedback. One of the Committee members noted that hospital readmission is often used to measure care communication and care coordination but is too broad and not actionable. Several Committee members preferred other more tailored metrics to better represent care communication and care coordination and equity of care including the following: timeliness of follow-up; return visits to the Emergency Department; lack of follow-up care; error rates; closing the loop and hand-offs. Then he concluded with the need for alignment between CMS and ONC USCDI data elements and the need for a platform that could prospectively provide options for patient feedback and the ability to amend or adjust plans of care.

Member and Public Comment

Ms. Lynch opened the web meeting to allow for public comment. No public comments were offered.

Next Steps

Ms. Olawuyi reminded the Committee that any additional input on the Final Recommendations Reports should be received by the NQF staff no later than May 30. She highlighted that the Public Comment Period opens on July 1 and closes on July 22. She noted that if the Committee has any questions, comments, or concerns, share them via email to EHRCarecoordination@qualityforum.org. Ms. Olawuyi also noted that the next web meeting will be held on Tuesday, August 9 from 2-4 pm ET. Ms. Lynch, Dr. Lamb, and Dr. Antonelli offered final remarks and concluded the meeting.