NATIONAL QUALITY FORUM
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Meeting Summary

Leveraging Electronic Health Records (EHR) Sourced Measures to Improve Care Communication and Coordination Option Year Web Meeting 6

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 August 9, 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:

- Review and discuss public comments, Committee feedback, and related modifications to the:
    - Final Recommendations Report
    - Shortened Final Recommendations Report
- Review future steps and conclude the project

Udara Perera, NQF Senior Manager, conducted attendance for Committee members and Federal Liaisons. Ms. Perera introduced the NQF project team and Centers for Medicare & Medicaid Services (CMS) staff before reviewing the meeting ground rules for conducting a respectful and insightful discussion.

Overview of Final Recommendations Reports

Ms. Lynch provided a brief overview of the remaining timeline for the development of the Final Recommendations Reports. She shared that during this meeting, there will be a discussion of public comments, Committee feedback, and potential modifications to the reports. The NQF team will subsequently make the final updates to the reports and share the drafts with CMS before the final versions of the reports are submitted to CMS on September 14, followed by the reports being posted on the NQF website on September 19.

Ms. Lynch reminded the Committee of the difference between the two Final Recommendations Reports. She highlighted that the Final Recommendations Report 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 Shortened Final Recommendations Report is a short, non-technical, and visually appealing report which will be for changemakers, 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 the content in both reports is the same but presented slightly differently.

Discussion of Public Comments, Committee Feedback, and Potential Modifications

Ms. Lynch transitioned to discussing public comments, Committee feedback, and potential modifications needed to finalize the recommendations reports. She noted that both reports were posted for a 21-day review and public commenting period on July 1. Five prompts were used to elicit feedback from the public:

- The Shortened Final Recommendations Report is intended to convey the Committee's recommendations to an audience of change-makers, policy and legislative professionals, and healthcare executives. Please provide any general feedback on this report.
- The Final Recommendations Report is intended to convey the Committee's recommendations to measure developers, EHR vendors, and other technical stakeholders. Please provide any general feedback on this report.
- Please provide any comments or general feedback on the recommendations related to effectively facilitating care communication and care coordination with EHRs.
- Please provide any general feedback on the recommendations related to leveraging EHR-sourced measures to improve care communication and care coordination.
- Please provide any comments or general feedback on the additional considerations for advancing EHR-sourced measurement.

Ms. Lynch shared that 15 public comments from five individuals, two of whom identified affiliated organizations, were received. She noted that the public comments received had been grouped into themes. She mentioned that a commentor had expressed the importance of patient portals in patient communication and suggested that additional language be added to highlight this more. There were also a couple of comments about the lack of data sharing requirements with health insurance providers which are an important stakeholder for improving healthcare quality and equity. In addition, there were comments related to the importance of having incentives to advance the recommendations. Ms. Lynch noted that another commentor had suggested additional emphasis for data capture from non-EHR digital devices and for standardizing patient-reported outcomes and functional status measures. Additionally, a couple of commentors had shared some other initiatives relevant to this work: Centers for Disease Control and Prevention's (CDC) Adapting Clinical Guidelines for the Digital Age and Office of the National Coordinator for Health Information Technology's (ONC) Trusted Exchange Framework and Common Agreement.

The first discussion question that was shared is: what considerations, if any, does the Committee want to include regarding the lack of data sharing requirements for health insurance providers in interoperability incentives? A Committee member noted that when the promoting interoperability rule came out, the intent with CMS was for the patient to have control over their personal health information and allow them to filter out what information they would like to share with insurance companies and providers. The Committee member shared that providers are unable to share a patient's full medical chart without the patient providing permission to do so. While sharing this information could aid in identifying care gaps and social determinants of health, there could be public backlash for sharing information that patients may not want shared such as a medication list or psychiatric issues. The Committee member continued that insurance companies could share information with a third-party application that the patient then has control over. Another Committee member mentioned that insurance providers should have this information on a need-to-know basis for purposes such as billing and prior authorizations, as opposed to having access to everything. A Committee member provided a chat comment that patient information can be de-identified so that data can be shared. Another Committee member highlighted in the chat that it is also important to acknowledge that insurers have programs that are intended to improve outcomes and without enough data or information these programs cannot achieve their goals. A Committee member noted that there is a need to look at the roles of different stakeholders and determine what information is appropriate for them and what guidelines need to be followed. The member shared no concerns about identifying insurance providers as critical stakeholders. Another Committee member agreed that interoperability of the data is important and stated that it is necessary to keep patients and family at the center, highlighting that the patient still has control over their data. A Committee member noted that multiple stakeholders are relevant to equitable outcomes for care communication and care coordination and defining those roles should be part of the agreement for giving access to ensure all stakeholders receive the data that they need. The member noted that the data must flow in multiple directions if it is a system that is designed to improve equitable patient and family centered outcomes. Multiple Committee members expressed their agreement.

The second discussion question that was shared is: what considerations, if any, does the Committee want to include regarding incentives to advance the recommendations? Two Committee members shared that providing incentives to each entity and providing directives as to what is needed to reduce the burden on those who are required to collect and submit this information is crucial. It was noted that an entity should be considered a stakeholder if they are leveraging the EHR. A Committee member highlighted that incentives are important and that since this work entails working with many different stakeholders, the incentives will need to be unique to each type of stakeholder. The member highlighted that there are different incentives currently in place already and their effectiveness should be evaluated when developing other incentives that will be driving the healthcare system in the future. Another Committee member noted that we want to be able to enhance the healthcare system so that the functions of care communication and care coordination become more electronic which will align with increasing emphasis on EHR-sourced performance measures. The member noted the data entry burden on clinicians and healthcare practices related to quality measures that align with a pay for performance or pay for reporting contracts will be reduced over time. This will allow clinicians to focus more on providing care, rather than inputting data. A Committee member shared that incentives do not have to equate to money, as there can be incentives that are not monetarily driven. In the chat, a Committee member shared non-monetary incentive examples of less burden, quality of life, convenience, and pajama time. Another Committee member noted that historically, incentives have focused on the customers who purchase EHRs, so it is important to look at the lessons learned from meaningful use. What was driven with meaningful use was a transactional view of healthcare (i.e., individual transactions between a provider and a patient), and now there can be a focus on the consumer, which is the healthcare provider purchasing technology. It is possible to create incentives for purchasing technology where the communication, collaboration capabilities are not ancillary or satellite. The Committee member continued that we can also do things from a regulation perspective for health Information technology (IT) vendors that prohibit information blocking and make interoperability critical. The Committee members agreed that the patient is the center of their care, so the focus needs to be on what is best for the patient and their caregivers to participate in effective care coordination.

The third discussion question is what considerations the Committee wants to include regarding two initiatives shared by the public commentors. Ms. Lynch shared that the first initiative is CDC’s Adapting Clinical Guidelines for the Digital Age, which is an integrated process to develop and implement narrative and computable guidance using Fast Healthcare Interoperability Resources (FHIR) to improve how clinical guidance is used in practice and can be disseminated through Clinical Decision Support systems. The other initiative is ONC's Trusted Exchange Framework and Common Agreement which establishes a universal floor for interoperability nationwide by creating the infrastructure model and governing approach for users in different networks to share basic clinical information. A Committee member noted that these are prudent initiatives and suggested sharing the Committee's recommendations with these groups. Another Committee member shared that the recommendations should be aligned with other initiatives that are already in existence with ONC and any other organization. Another Committee member highlighted that it is important to note how this work expands thinking about clinical guidelines and noted that a consistent feedback loop is useful to have in the Final Recommendations Report. A Committee member also noted that care should be given to research initiatives and clinical guidelines before they are placed in the Recommendations Reports. Another Committee member shared that adopting clinical guidelines may be out of scope.

The fourth discussion question that was shared is: what additional public comments should the Committee discuss, and should any additional detail be included in the draft proposed responses? The Committee did not have any additional comments to share.

Ms. Lynch announced that the discussion would transition to themes from feedback received from the Committee. She shared that six Committee members had provided feedback on these versions of the reports. The feedback included needing to highlight the opportunity and urgency for improving care communication and care coordination more explicitly as well as presenting the recommendations in both reports consistently. It was also recommended to clarify the differences between the second and third recommendations in the Shortened Final Recommendations Report as they seem redundant with how they are currently presented. There were also recommendations to strengthen the language around the importance of patient trust as a barrier and shared decision making. Ms. Lynch opened the discussion by asking about the Committee's overall reactions to the reports and asked for any general feedback that the Committee members wanted to share. A Committee member expressed that the reports seemed to be on the right track.

Ms. Lynch continued to note that because the audience of the Shortened Final Recommendations Report is less technical, simplified definitions for care communication and care coordination were used: *care coordination denotes organizing patient care activities and information to meet patient and family needs and preferences for healthcare and related services. And care communication is the transfer of information for care, a critical component of care coordination.* The longer definitions developed in the first year of the project and included in the Final Recommendations Report are: care coordination is *the deliberate synchronization of activities and information to improve health outcomes to ensure patient and family needs and preferences for health care and community services are met over the course of their treatment and care.* Care communication is *the transfer of information related to patient care.* Ms. Lynch asked whether the Committee thinks these simplified definitions adequately represent care communication and care coordination or whether the longer definitions be used instead?

A Committee member shared that they are fine with the definition of care coordination, but her recommendation on care communication is to have a more active word than" transfer", as it seems very passive. They suggested replacing it with a word such as "exchange" because there is a dialogue that happens with care communication and care coordination. A Committee member agreed with this change. Another Committee member stated that the shorter definitions do not convey what care communication and care coordination are and felt that even though the report is shortened there is no need to shorten the definitions. Other Committee members noted their agreement.

Ms. Lynch continued to share the categorization of the recommendations, particularly for the Shortened Final Recommendations Report. Currently the 3 recommendation categories are:

1. Optimize EHR functionalities for care communication and care coordination
2. Advance EHR data elements related to care communication and care coordination
3. Leverage EHR data to fill care communication and care coordination measure gaps

She shared that the first question for this section is whether the recommendation categories should be presented consistently in both reports? Multiple Committee members expressed that the recommendations should be presented consistently in both reports. Ms. Lynch asked whether the titles of the categories effectively portray the intent of the recommendations? Examples of potential updated categories were presented to the Committee.

Original Recommendation Category	**Potential Updated Recommendation Category**
Optimize EHR functionalities for care communication and care coordination	Optimize EHR functionalities necessary to improve care coordination and care communication
Advance EHR data elements related to care communication and care coordination	Expand the set of EHR data elements available to measure core care coordination and care communication processes and outcomes
Leverage EHR data to fill care communication and care coordination measurement gaps	Leverage the potential of EHR-sourced data to fill high priority care communication and care coordination measurement gaps by developing new EHR-sourced measures and improving current measures

Ms. Lynch also asked the Committee how to better differentiate between recommendation two and three. A Committee member shared the first recommendation is related to the technological infrastructure and the second has to do with the approach to data, data modeling, and defining the data. Once both are in place, the third recommendation relates to the use and application of technology and data infrastructure. Another Committee member commented that the third updated recommendation is verbose, and several Committee members agreed. A Committee member suggested the removal of the word “core” in the second updated recommendation because it is still in unicorn territory, as core care communication and care coordination activities have yet to be agreed upon.

Ms. Lynch then transitioned to the next discussion. She shared that in the reports, three top priorities areas for advancing the use of EHR data for quality measurement were highlighted based on previous discussions:

- Develop an EHR-sourced measure that identifies specific patient-oriented goals and whether they are being achieved.
- Develop an EHR-based social determinants of health measure.
- Improve the specificity of existing measures related to downstream care after an index visit.

Ms. Lynch asked whether these are the correct priorities to highlight. A Committee member shared that patient-oriented goals, social determinants, and equity are priorities, but it is important not to forget that additional advanced care coordination and care communication measurement and process measures are not where they need to be. A Committee member shared that from a practical point of view, they are unsure of how the first priority will be achieved, and shared concern over whether it is “busywork”. Another Committee member noted that patient-oriented goals should be centered around the patient and the onus of success should not fall on the primary care provider (PCP), as the success of the patient belongs to the patient, their family, their PCP, and all the other stakeholders that are involved in their treatment. Another Committee member highlighted that it is important to look at other areas for improvements because it is always going to be difficult to engage with some patients, but clinicians should still try to ask patients what their goals are and try to align with them. The Committee member continued to state that it is important to include goals in the EHR and align their care with the goals and it is important to measure what the patient themselves is identifying as their goals for care, not just what the clinician wants. Another Committee member cautioned that it is better to ask a patient what is important to them to get better feedback about what the patient-oriented goals are. A Committee member shared that the Committee had talked about whether social determinants of health are considered and whether they are captured, but the second bullet does not clarify the kind of measure that is being recommended or identified as a priority.

Ms. Lynch thanked the Committee for a great discussion and shared that the Committee should feel free to email the NQF team with any feedback and ensured that this would be captured.

Discussion of Future Steps

Ms. Lynch called upon Ms. Kim Rawlings of CMS to provide context about how this work fits into the rest of CMS' vision and goals. Ms. Rawlings thanked the Committee for all their hard work in developing these recommendations and shared that she wanted to provide more context on the next steps for this work as well as share what CMS has been doing related to care communication and care coordination. The CMS National Quality Strategy Goals debuted at the CMS Quality Conference in April. Of the eight goals in the National Quality Strategy, Ms. Rawlings highlighted two goals that align with this work: accelerating the digital transition and embedding quality across the care journey. The transition to digital measurement is the key pillar of the National Quality Strategy and CMS is working towards accelerating that transition to digital data on multiple fronts from the data standardization from United States Core Data for Interoperability (USCDI) to implementing using FHIR. Another National Quality Strategy goal is embedding quality across the care journey which is embedding a commitment to seamless care coordination. Ms. Rawlings continued that whether we are talking about whole person care, seamless care coordinated services, or person-centered care, all of those have the foundation of care coordination at the forefront. She concluded that CMS shares the enthusiasm for this topic and emphasized that the recommendations dovetail nicely with the National Quality Strategy.

Ms. Lynch then asked Drs. Lamb and Antonelli to lead the discussion of future steps for this work. A Committee member mentioned that it is important to ensure that the reports are shared with all the different organizations and medical societies to ensure that we receive adequate feedback and frame it appropriately so that the message sticks. Dr. Antonelli asked for additional clarification on how this may be done. The Committee member shared that a possibility is to send the reports to specific departments to receive feedback, rather than just the organization in general and to have specific asks such as giving a statement about it or requesting a meeting to receive feedback. A Committee member noted that all Committee members should disseminate the reports to all of their social media networks and NQF should include the reports in email update blasts with organizations such as the Institute for Healthcare Improvement (IHI). Another Committee member asked whether there is a way for NQF to receive feedback on how many people the report gets sent out to and how many look at it. Ms. Lynch shared that before the end of September, NQF will be sending a publicity kit to Committee members to help disseminate this information and would be happy to hear about organizations that Committee members think this information should be sent to. A Committee member shared that healthcare informatics groups would be an important stakeholder to share the reports with and noted the American Informatics Association or the Healthcare Information and Management Systems Society (HIMSS) as places where vendors go. Dr. Antonelli noted that organizations that specialize in social work, behavioral health clinics, and housing and food stability organizations should all be included as well.

Member and Public Comment

Ms. Lynch opened the web meeting to allow for public comment. A comment was offered from a member of the public via chat: "Accelerate the formal generation and evidence assessment of the impact, effectiveness, safety, and risk of bias of care communication and coordination Application Programming Interfaces (APIs) across the entire digital health spectrum. These assessments should occur at both the individual patient and population levels and rely on formal standard and scientifically sound evaluation methods. These assessments should also include the ability to detect and monitor adverse and near-miss event rates related to both human and machine errors that most often occur through EHR and other digital health device usage." Ms. Lynch thanked the individual for their comment and no additional public comments were offered.

Next Steps

Ms. Perera thanked the Committee for their contributions and dedication during both the Base Year and Option Year of the project. She also reminded the Committee members to review their credentials and notify the project team of any updates that need to be made by August 12. She highlighted that both Final Recommendations Reports will be posted on the project web page on September 19. Ms. Perera noted that if the Committee has any questions, comments, or concerns, share them via email to EHRCarecoordination@qualityforum.org. Ms. Lynch, Dr. Lamb, and Dr. Antonelli offered final remarks, expressed their gratitude to the Committee, and concluded the meeting.