Meeting Summary

Leveraging Electronic Health Records (EHR) Sourced Measures to Improve Care Communication and Coordination Committee Web Meeting #4

The National Quality Forum (NQF) convened a multistakeholder Committee for the Leveraging Electronic Health Record (EHR) Sourced Measures to Improve Care Communication and Coordination Project on August 17, 2021.

Agenda Topics for Discussion

- Welcoming Remarks, Introductions, and Meeting Objectives
- Overview of the *Environmental Scan Report* Timeline
- Review and Discuss Public Comments and Committee Feedback
- NQF Member and Public Comment
- Next Steps

Welcome, Introductions, and Review of Web Meeting Objectives

Chelsea Lynch, NQF Director, opened the web meeting with welcome remarks and housekeeping reminders. She thanked the Committee for their attendance and acknowledged the Centers for Medicare & Medicaid (CMS) as the funder of the work. Gerri Lamb and Richard Antonelli, Committee Co-chairs, offered additional welcoming remarks and highlighted the importance of the project. Chelsea Lynch proceeded to provide an overview of the meeting agenda and introduce the NQF project staff. Victoria Freire, NQF Analyst, called roll and reminded Committee members to disclose any potential conflict of interests not previously mentioned. Victoria Freire then invited Federal Liaisons on the call to announce their presence as well.

Chelsea Lynch explained that the meeting objectives were to review and discuss the public comments and Committee feedback received on the *Environmental Scan Report*, the Literature Review, and the Measure Scan and identify any related updates to those documents. In her review of ground rules, Chelsea Lynch encouraged open discussion and participation by the Committee by reminding everyone that there is no rank in the room.

Overview of the Draft Environmental Scan Report Timeline

Beth Flashner, NQF Manager, reminded the Committee of the Base Year timeline. The project's overall goal is to identify best practices to leverage EHR sourced measures to improve care communication and coordination quality measurement in an all-payer, cross-setting, fully electronic manner. She said that the focus of the first year has been to identify the topic's current state and resulted in the development of two reports: the *Environmental Scan Report*, a high-level, non-technical, educational document designed to raise awareness about using EHRs to measure and improve care communication and care coordination, and a more extensive Literature Review that includes more details and technical information on the findings and a list of existing quality measures (Measure Scan).

The timeline shared highlighted that the Committee previously met three times and that the reports were informed and updated based on discussions from those meetings. In addition, Committee members reviewed and provided written feedback on the reports in March, May, and July. Beth emphasized that this is the last opportunity for the Committee to provide input into updates and revisions to the reports. The final reports will be posted on the NQF website on September 24, 2021.

Before proceeding with the review and discussion on public comments and Committee feedback received, Chelsea Lynch gave a brief update regarding the project's Option Year. She informed the Committee that CMS recently notified NQF of their intent to exercise the Option Year but that this the notification was not a guarantee that Option Year would proceed. Additionally, the details of the Option Year may change, but it is currently expected to last for 12 months and include four to six Committee meetings. If exercised, the purpose of the Option Year is for the development of recommendations which will be published in both a shorter educational piece and a more extensive technical report. The current Base Year of the project will end on September 24, and, if exercised, the Option Year would start sometime after that date. NQF will provide additional updates to the Committee regarding the Option Year as they become available.

Review and Discuss Public Comments and Committee Feedback

Chelsea Lynch then provided an overview of the public comments and Committee feedback received on the *Environmental Scan Report*, Literature Review, and Measure Scan. She explained that NQF held a public comment period between July 12 and August 2. NQF advertised the public comment period though multiple channels including emails to distribution lists of NQF members and other healthcare stakeholders who have expressed interest in relevant topic areas, notifications in two CMS electronic publications, multiple social media posts on LinkedIn and Twitter, and tailored emails to two NQF committees with overlapping topic areas. In addition, NQF offered Committee members an overlapping feedback period. While NQF offered five prompts for the public to respond to, nine of the ten comments were submitted to the prompt, "What general comments do you have on the report?" The tenth comment was submitted to the prompt, "What additional advantages or challenges of measuring care communication and coordination in EHRs that should be included in the Literature Review?" In addition to the ten public comments, five Committee members provided written feedback on the documents. Copies of the public comments were included in the meeting materials sent to Committee members. The meeting slides included themes derived from the public comments and Committee feedback.

Overall, the public comments were positive, but highlighted topics in the report that can be strengthen. The public comment themes included adding additional information on team-based care, the role and impact care coordination has on the cost of care, why new care communication and coordination measures are needed, and expanding on patient portal alternatives since information technology (IT) is not always feasible or accessible to all patients. Feedback received from the Committee overlapped with some of the public comments and included adding emphasis on the need for the better care coordination measures, the role of interprofessional team-based care, and acknowledging the importance of connections with non-healthcare-related community services such as schools, housing, and food access, as well as equity issues. The overview was followed by an engaging Committee discussion on the themes of the public comments and Committee feedback facilitated by Richard Antonelli and Gerri Lamb.

Gerri Lamb started the discussion by thanking the Committee for their hard work over the course of the project and emphasized that this is the last chance to provide input into the details of the reports. She explained the purpose of the discussion is to go into detail on the public comments and Committee feedback in order to provide priority changes and additions to the reports to the NQF team. She encouraged all Committee members to participate and to openly express if they agree or disagree with the comments and provide any additional insights about what additions and changes the NQF team should make the reports. She said the conversation would start with general feedback and be followed by a detailed structured discussion of each major theme. She shared that Richard Antonelli would lead the discussion on the public comment themes and she would lead the discussion on the Committee feedback themes. No Committee members shared general comments about the reports and Gerri Lamb handed the meeting to Richard Antonelli.

Team-Based Care

The Committee proceeded to discuss the public comment theme of team-based care. They agreed with the public commentors that wrote that multidisciplinary teams are important in healthcare and more information on the topic should be included in the reports. Several issues and details around team-based care where identified. The first is that the makeup of the team should be driven by the needs and goals of the patient and family. Teams can include both health professionals (physicians, mid-level providers, nurses, social workers, physical therapists, etc.) as well as members outside of healthcare that help meet the needs of the patient, and can include, but are not limited to, the family, paid or non-paid in-home caregivers, transportation providers, food access, housing, education, lifestyle coaching, nutritionists, and alternative therapists such as massage. The list of team members with contact information should be captured in the EHR to facilitate communication and care coordination across the team. Team members and organizations need ways to receive and share appropriate information and the patient/family should have some input into who is in the team and has access to different types of information. Only when the team is fully defined with contact information, can members of the team be kept informed, be able to consult with each other as needed, and be held accountable though quality metrics.

Technical and operational issues related to how well EHRs can facilitate team-based care were also identified. Technical issues included that there are differences in EHR designs and capabilities which effect the ability or inability to capture all team members, including listing some health professionals (e.g., nurses) who work in a different health systems/networks and non-healthcare community providers and members of community services. Additionally, operational issues related to team identification include capturing updates as teams change over time and identifying the process and responsibility to make the updates to the care team roster in the EHR. Frequently the roster is only updated when the patient is interacting with a provider at particular time (e.g., during a hospital stay). Home healthcare providers and paraprofessionals that assist patients with activities of daily living often implement care plans but are not often involved in the EHR and therefore may not have up to date information or the ability to add information that they have regarding the patient. While some EHRs, such as Epic, have capability to add a variety of team members, it is challenging to add team members in other EHRs. Overall, EHRs are weak in connecting non-healthcare community providers and services. The connection to community providers and services can be partially remedied by add-ins from IT used by community-based organizations. However, the use of these systems vary by community and health system.

Another issue identified was the interoperability and data access challenges when healthcare team members are associated with different health systems or independent organizations that each have their own EHR. This can lead to barriers to having easy access to all relevant health records. When health providers are in different systems, it often means someone must take the lead to actively and manually communicate with members of the team though phone or email, and this process tends to be done on a case-by-case basis.

Overall, it is important for healthcare systems to really think about the broader network of individuals involved in patient care and assess how they can be brought into the communication and care coordination process. In addition, if more that the data within the EHRs can be standardized, the easier it will be to use the EHR to improve the care communication process. The Committee highlighted that improving the standardization and processes related to care communication will require a lot of resources, so most healthcare systems are likely not going to be able to do it at this point. They also highlighted those new ways to organize care teams and networks beyond traditional healthcare providers is needed. Interoperability is the goal, but the United States healthcare systems are not yet there.

Cost and Value Related to Care Coordination

Another public comment suggested the addition of information about value and costs related to care coordination be added to the reports. Committee members asked from which perspective(s), such as patient, insurance/payers, and health systems, should the cost and value of healthcare and care coordination be considered, as each perspective may have different ideas about what aspects are important when calculating and reporting on the cost and value of healthcare services. Overall, the Committee agreed that tracking costs is important, but strict dollars amounts and levels of utilization, do not capture all value or cost for everyone. For example, patient functional outcomes, such as increased days in school for youth and the ability to sustain jobs for adults, are often not included in the value and health care costs but can be very important to the patient or family. Some Committee members mentioned that measures of costs and value could include patient-reported satisfaction or experience and how well they felt the care team addressed their needs. Another Committee member stated that tracking spending data related to care communication and care coordination has the potential to lead to improved care communication and care coordination since positive findings could improve upfront funding. However, if higher costs are found, or these activities appears to lead to greater utilization, the outcome of tracking costs could be reduced funding or lack of access to care coordination services.

Committee members also shared their lived and professional experiences to highlight several issues related to the costs and values of outcomes related to the sharing or not sharing patient medical records across providers. In one example, a Committee member recounted the difficulty in getting providers, including major health systems, to send medical records to another provider. In the example, she requested that medical records be sent from five different providers to another organization for a family member enrolling in a clinical trial for a complex healthcare condition. A few days before the pending first appointment with the study team, the Committee member checked and found out none of the five organizations had forwarded the records to the study center. This means that she had to follow up with all five organizations, a time-consuming process. The receipt of the medical records was critical for the baseline study appointment, and if not provided, would lead to a number of repeat invasive and painful activities including labs, imaging, and other tests. This example can be true of any patient transferring between providers, especially when multiple tests are needed for diagnostics and treatment planning. In addition to the cost of these otherwise unnecessary tests, the lack of communication also increases the time spent by the patient and the family in attempting to coordination care, impacts quality of life issues with pain and psychological effects of repeated invasive tests, increases resource use of healthcare provider time and equipment, and may result in delays in moving forward with the care planning and treatment. Therefore, managed care coordination is important especially around transitions of care.

When it comes to performance measures about the sharing of medical records, another Committee member pointed out that when the patient/family spends time to request and follow up on requests for medical records, the care process will reflect well on the receiving healthcare organization, but the time the patient or the family member will not be captured. Additionally, there are equity issues as not all patients and families have the ability, time, or knowledge to repeatedly request and follow up to ensure the records are sent on time. This leads to question if performance measures can capture the missed opportunity when records are not shared.

One Committee member also shared in her professional experience many primary care physicians, community health centers, and practices in Accountable Care Organizations (ACO) around the nation have a difficult time getting hospitals to share data related to hospital stays, including notification of discharges. This can be due to not all areas of the country having shared EHRs participating in health information exchanges (HIEs), or the hospitals require the practices to pay large fees to connect to the EHR to access data. The Committee member stated that when primary care practices receive good admission, discharge, and transfer information from hospitals in a timely manner, they can decrease the cost by doing transitional care management. However, when the information is not shared, community physicians are unable to follow up in a timely manner (or at all), leading to avoidable readmissions as the data shows that, on average, one readmission is prevented for every seven transitional visits in the community. Therefore, access to the hospital discharge data is crucial to patient outcomes and overall costs, yet many hospitals still are not sharing the data with community physicians.

Lastly, the Committee discussed the burden to providers on reporting quality data. On average, ACOs are spending at least two and a half hours per physician per week to complete quality reporting. Documentation for reporting requirements has led to provider burnout. Therefore, it was recommended that the administrative burden be considered as a component of the cost of care. One possible solution identified for future implementation to help with the cost of care, improve care coordination, and reduce provider administrative burdens, would be if the healthcare community identified a standardized data set of data elements needed to accompany all care transitions and also have that data be democratized (shared freely across relevant providers and patients).

Equity

Although the reports have strong sections on social determinants of health (SDOH), both the public comments and Committee feedback suggested that issues related to equity should be more explicitly discussed. Committee members defined a variety of equity issues that can be strengthened in the report including: 1) provider access to EHRs, 2) issues related to high-speed internet infrastructure and patient access to technology, and 3) issues related to collection of race, ethnicity, disability, and language data. In addition to equity issues directly related to EHRs, patient groups should be consulted to determine what their needs are and what the actual equity issues are that need to be solved.

Provider Access to EHRs: While most healthcare providers now use EHRs, there is considerable variation in the quality and robustness of the systems in use. Some providers use very basic EHRs that similar to being a Word document while others have comprehensive systems that include a wide variety of features. The lack of robust EHRs leads to differences in the ability to collect and share patient records and report on performance metrics. This means that if the use of EHR-sourced measures increase it is possible to also increase existing inequities.

High-Speed Internet Access: The Committee highlighted that there is a digital divide in the United States, especially in rural areas. A major component of the digital divide is access to high-speed internet and mobile phones. The lack of access is a barrier for both providers and patients. One Committee member noted that even when a well-resourced academic medical center purchases medical practices, or smaller facilities, in rural areas, they cannot always implement the EHR, video telehealth, or electronic communications, due to the lack of high-speed internet and phone services. In addition, patients in these areas may not have access to high-speed internet which can affect their access to services and use of patient portals. Even in areas with high-speed internet and mobile phone infrastructure, socioeconomic factors can limit patient access to computers, home internet service, or robust smart phones or mobile devices, leading to disparities in access to health care information or telehealth visits. Lastly, some patients are not particularly computer literate and will not know how to use electronic data and communication tools.

Demographic Data Collection: The collection of patient demographic data of race, ethnicity, language, and disability status vary across healthcare providers. Reasons for variation include providers are not typically reimbursed for the collection of this information, the data can be seen as sensitive and therefore some providers choose not to ask for it, and some providers are unsure about where to store the data if they do collect it. Members of the Committee shared that this type of demographic data could be useful in a variety of ways and recommended that the data be included in the EHR with the fields build so that the data can be pulled in combination with other data. A Committee member provided the example of a practice being able to run a query on a dataset to see how many and which Spanish speaking patients need the COVID vaccine to assist them in conducting targeted outreach to encourage those patients to get vaccinated.

Community Service Connections to EHRs

The Committee broaden the discussion on the public comment recommending EHR access for schools and special education staff for youth that have specific health needs to be addressed or that may need to occur during the school day, to include linkages to all types of community services used by patients of all ages. The Committee clearly agreed that communication and coordination with non-medical community services are critical for many patients. They highlighted the importance of acknowledging that care coordination partners should be based on the patient’s needs and ensure the information goes beyond just transitions of care. Providers of community services and alternative therapists are often missed when the team is defined and usually do not have access to the EHR. In general, as a team moves further into the community and away from health care organizations, the barriers to communication and coordinate care increase.

In summary, there is harmonization between the notions developed in the discussion of the multi-disciplinary team identified by the patient, family, caregiver unit can include community resources. Additionally, there should be a holistic approach to care coordination including the creation of a plan of care and having everyone knowing and having access to the data required for effective coordination.

Existing Care Coordination Measures

Rich Antonelli then turned the discussion to existing quality measures for care coordination. The draft report currently includes example measures related to readmissions and care plans. Based on the public comments, he asked the Committee to reflect on exciting measures and where current gaps exist. He asked if the Committee thought readmissions were worthy care coordination measures and how well exiting measures met the mark for measuring care coordination.

The Committee expressed mixed reactions to the use of readmission rates as exemplar care coordination measures. Some Committee members had reservations while others found the use of utilization measures to be understandable, as readmissions rates can be influenced by care communication and coordination. However, they acknowledged readmissions are a downstream effect and a variety of elements can lead to readmissions. Members of the Committee acknowledged that additional measures are needed, but identifying those measures was difficult. One Committee member recommended that measures related to the provider component of the quadruple aim (e.g., measuring provider experience such as if providers have what they need, when they need it, in order to do the best job for patients and families) could be paired with patient experience scores to measure care coordination. The discussion on measures concluded with there being clear gaps in performance measures related to care coordination and that is a major reason for this project.

Committee Feedback

Patient Portals

Gerri Lamb opened the section on Committee feedback by asking the Committee their thoughts on the strengths and weaknesses of patient portals. Specifically, she asked if patients generally have access to portals, if patients with access are comfortable using them, and which issues related to portals exist to balance the benefits.

Overall, the Committee concluded that the quality and functionality of patient portals varies. Many portals were put in place to meet Meaningful Use requirements. In general, there is limited but growing use of patient portals when they are available. For some patients, the family will use the portal even when the patient is unable to use the portal themselves. As with the discussion on equity issues related to EHRs, the digital divide also exists related to portals as some patients are unable to use the portals, especially due to a lack of high-speed internet either due to costs or lack of infrastructure in rural areas. Additionally, portals are only as useful and robust as the healthcare facility make them. Many patients appreciate the easy access to test results, imaging reports, and asynchronous communications when their healthcare provider has and uses the feature. The Committee recommended that the healthcare community consider how to measure the impact and use of patient portals.

Care Plans

The Committee discussion then transitioned to care planning. The Committee identified that patients often have separate care plans developed by each provider. They recommended that additional work be performed on the usefulness of developing of single or overall care plan that can be shared across a patient's care team. Members of the Committee noted that most care plans are not used across different settings and the current default after a hospital transition is the discharge summary. A Committee member shared that they look for specific information after a patient hospital visit and questioned how often care plans are actually used in patient care. The Comprehensive MDS (Minimum Data Set) care plan used in skilled nursing facilities was provided as an example of a strong care plan.

Gerri Lamb then summarized the key points raised during the meeting. These included that Committee discussion resulted in recommendations for the NQF staff to revise the report to emphasize the interdisciplinary care teams that are defined by the needs of the patient and may include both healthcare and non-healthcare professionals, the importance to define and list the members of the care team, and the need for the patient to have say in who can view their EHR records. The discussion of cost and value of care communication and care coordination should include the patient perspective as well as the perspectives of healthcare providers and payers. Additionally, the provider aspect of the quadruple aim should be considered by including provider satisfaction and if providers have the resources need to best serve their patients and families. A variety of equity issues were also discussed related to EHR features, high-speed internet access, and patients and families having variable access and ability to use patient portals and electronic communications. It was also acknowledged that the healthcare community should continue to work on standardizing data in the EHRs as well as the policies and processes to share the data.

Member and Public Comment

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

Next Steps

Victoria Freire thanked the Committee for their active participation during the Base Year and noted that the *Environmental Scan Report* and Literature Review will be posted to the NQF website on September 24, 2021. Chelsea Lynch, Gerri Lamb, and Richard Antonelli offered final remarks and concluded the call.