

eMeasure Learning Collaborative Proposal for August 10th, 2012 In-Person Public Meeting

During the June 4, 2012 call, the Planning Committee recommended review of data feasibility for data required to measure outcomes using real-world examples. One example provided by the Planning Committee was the identification of patients with congestive heart failure (CHF). Many organizations search for all patients receiving furosemide (brand name: LasixTM) and narrow the list with manual review efforts. Cardiac ejection fraction (EF) could be more useful to define the population of patients with CHF but the EF results may not be present (either a diagnostic study was not performed or it was performed external to the organization and results are not available, or the results exist only in unstructured text, PDF or other image format). By identifying a few such real-world examples, the Collaborative could identify a small set of data elements for which standardization (data capture and definition) could significantly enhance measurement for care coordination and efficiency.

The Planning Committee suggested the QDM Style Guide (published for comment June 15, 2012) could be the framework to guide the work of the Collaborative in defining such essential data elements. From an operational standpoint, the Planning Committee noted the pressure for organizations to extract information in a timely manner for multiple requesters, noting that the practice of Cardiology has five registries with slightly different definitions for each. The Planning Committee further suggested that data feasibility should be based on clinical need rather than regulatory requirements. Requirements to manage the process from a clinical standpoint also include harmonization and consistency of value sets across all clinical uses of the same information – to create a linking strategy across information rather than testing each value set as it applies to an individual measure or rule.

The cross-cutting measure concept examples still need to be determined.

Next Steps

NQF reviewed the concepts with Kevin Larsen (ONC) and reviewed the Efficiency Measure Concept project with RAND. Based on discussions with Kevin Larsen, a different approach to the August 10 may be preferred by using specific, known measure issues as the examples.

The current proposal to be reviewed by the eMeasure Learning Collaborative Planning Committee is to address four primary targets for use of the EHR to support measurement. These targets were addressed in the HIT Policy Committee Methodologic Issues Tiger Team Summary (October 28, 2010).

- Medication List
 - Reconciliation best practices
 - Coordination with dispensing information / adherence
 - Inclusion of patient generated information

In 2010, NQF published a Medication Management report that defined medication adherence assuming data from pharmacy claims (dispensing). Adherence was defined as a “medication possession ratio” of greater than or equal to 0.8.¹

Medication Adherence Definition	
Numerator	Denominator
<p>1. New users: For patients with no prescriptions in the 180 days prior to the measurement period, sum of: Days’ supply of all medications from the first prescription until the end of the measurement period. <i>Remove the days’ supply that extends past the end of the measurement period.</i></p> <p>2. Continuous users: For patients with one or more prescriptions in the 180 days prior to the measurement period, sum of: Days’ supply of all medications from the first prescription until the end of the measurement period. <i>Remove the days’ supply that extends past the end of the measurement period and add the days’ supply from the previous period that applies to the current period.</i></p>	<p>1. New users: Number of days from the first prescription to the end of the measurement period.</p> <p>2. Continued users: Number of days from the beginning to the end of the measurement period.</p> <p><i>Multiply by 100. Cannot exceed 100%.</i></p>

To address adherence from data in the EHR Medication List requires consideration of new elements, some of which may be present in the EHR today and some may not. Maintenance of the Medication List will be required to manage measures consistently.

- Allergy / Adverse reaction List
 - Best practices in automating collection and reporting of patient-level adverse events within clinical workflow. Methodology Tiger Team identified numerous barriers to adverse event reporting including:
 - Standardization of data capture and coding for medication-related adverse events
 - The ability to link event reporting to specific drugs (based on the nature and timing of the reporting)
 - Integration into the clinician’s workflow with attention to the time required to accurately complete and submit the adverse event report
 - Protection for the privacy of patients and clinicians
 - Coordinating data from disparate IT systems that are not well integrated even within the same organization

¹ NQF. National Voluntary Consensus Standards for Medication Management: A Consensus Report. 2010. Available at: <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=25837>.

- Sophisticated computer algorithms that analyze data and identify adverse events are not very high-tuned to detect events
- If adverse events can be detected using electronic systems, the level of harm from the events is not well documented
- Recommendations of the Tiger Team:
 - Identify standard codes for each of allergy, adverse events and intolerance
 - Evaluate standards for ability to manage time of onset, type of reaction
 - Certify EHRs for ability to capture and report based on established standards, and to support clinical workflow
 - Develop meaningful use criteria to encourage use of certified products as expected within clinical workflow
 - Require allergy and adverse event reconciliation
 - Develop measures of appropriate alerting and inappropriate alerting for EHRs
 - Encourage research regarding the level of harm associated with specific categories of events
- Problem List
 - Best practices in managing problem lists across different settings and providers over time with consistent maintenance of the Problem List. [Include date of onset (not only date documented), management of problems to determine when each becomes inactive or re-activates, or when each is resolved.]
 - Clinicians should consider the problem list as a quality measurement reporting tool
 - Conventions are needed for how to deal with problems that have resolved and been deleted from problem list
 - Rules need to be established rules for consistent use of problem list and past medical history
 - Guidance is required for proper use of problem list for reporting of new conditions
 - Recommendations of the Tiger Team:
 - Establish certification for EHR use and reconciliation of Problem Lists
 - Review standards to determine if standards for problem attributes are sufficiently comprehensive
 - Establish certification requirements that enable problem lists as interactive tools to support clinical workflow and encourage clinician usage
 - Use a measure that requires care based on the working diagnosis at the time the patient is first seen. Identifying the working, or *presumptive* diagnoses to effectively trigger EHR-generated clinical decision support during the care process.
- Essential Elusive Results
 - Identify best practices and potential new solutions to manage results that have proven problematic to manage and have high impact on clinical care
 - Ejection fraction
 - Gestational age
- Other issues identified by the referenced Methodologic Issues Tiger Team include patient reported outcomes and the need for a value set registry. Patient reported outcomes will be addressed by a separate NQF project currently in progress

(http://www.qualityforum.org/Projects/n-r/Patient-Reported_Outcomes/Patient-Reported_Outcomes.aspx). HHS is also addressing resolution of the value set registry requirements based on recommendations of the HIT Standards Committee Clinical Quality Workgroup Essential Components Tiger Team presented May 24, 2012 (http://healthit.hhs.gov/portal/server.pt/document/957865/052412_cqwg_ec_tt_recommendations_pdf).

- August 10, 2012 Deliverables
 - The deliverables from the day are best practices, gaps and recommendations for each
 - The proposal is to break into 4 groups (Problem List, Allergy List, Medication List, and Essential Results). Each group is proposed to have 1 or 2 best practice vignettes about how the group-specific EHR component is used in a valuable manner to support measures and clinical decision support. Then each group is to review components from 1 ambulatory and 1 inpatient measure to illustrate requirements for their EHR component. Examples:
 - To implement an inpatient measure evaluating the antibiotic choices for the first 3 days of treatment requires identification during the first 3 days all patients with a presumptive active diagnosis of pneumonia. Is the Problem List capable of providing such information and what are considerations to be sure it is populated with presumptive diagnoses (and that the diagnoses are 'deactivated')?
 - To implement a measure defining heart failure by a cardiac ejection fraction of <40, what is the best method to capture and present that information?
 - To implement a measure that uses significant medication intolerance as a reason for exclusion or exception, how would an EHR be expected to capture and store that information?

In these scenarios the attendees should address:

- Business (organizational governance issues)
- Functional (data governance and enhancing performance by 'learning' from performance – improve the workflow of data capture and enhance clinical decision support)
- Content (sources for relevant information, best practice work-around efforts to capture essential information and recommendations to fill the gaps requiring work-around processes).