

eMeasure Learning Collaborative Planning Committee Conference Call June 18th, 2012

Members Present:

Ann Watt (The Joint Commission)	Sharon Hibay (QIP)	Ginny Meadows (McKesson)
Dave Stumpf (Northwestern University)	Karen Nielsen (Siemens)	Dana Alexander (GE)
Michael Mirro (Ft Wayne Cardiology/ACC)	Zahid Butt (Medisolv)	

Federal Liaisons Present:

Kevin Larsen (ONC)
Julie Spatik (ONC)

Members Not Present:

John Maese (Geriatric Private Practice),	Jason Colquitt (Greenway)	Amit Popat (EPIC)
Christopher Snyder (Peninsula Regional)	Kendra Hanley (AMA- PCPI)	Liz Johnson (Tenet)
Ted Palen (Kaiser Permanente)	Greg Pawlson (BCBSA)	Aldo Tinoco (NCQA),
Dwight Brown (Mayo)	Jacob Reider (ONC)	Jesse James (ONC)
Greg Sharpe		

NQF Staff Present:

Floyd Eisenberg, Rosemary Kennedy, Danielle Sims, Heidi Bossley

Summary:

The June 18, 2012 eMeasure Collaborative Planning Committee call began with a review of the minutes of the June 4 call. A quick review of the June 14, 2012 eMeasure webcast highlighted the value of having measure developers indicate their direction in transitioning to eMeasures. The majority of the call addressed options for the August 10, 2012 face-to-face meeting. Two major themes were discussed:

1. The first theme primarily addressed how EHRs and local users can improve workflow to manage capture and use of required data. Initiated by comments from Kevin Larsen (ONC), the group addressed how measure developers can work with vendors and users of EHR products to standardize the sequencing of the workflow within the measure consistent with best practice clinical process. The result would be workflow “implementation guides” to accompany their measures. The collaboration will help measure developers more clearly define the expectations for implementing their measures and to limit data requirements to those that can be managed with real-world workflows.

2. The second theme addresses the feasibility of measure concepts as they are selected for measures. That issue was the driver for the QDM Style Guide, now out for public comment, identifying QDM categories, states (contexts) and attributes that should be achievable in current EHRs, and those that will do not fit existing workflows in most EHRs. The proposal was to have the Collaborative assign numerical values to specific data elements so that a measure developer could receive a score suggesting the work effort required to implement the measure.

The Planning Committee agreed that both themes have significant merit but the logistics of a single day meeting will limit the discussion for August 10 to one of the two. The Planning Committee focused on the first theme --- that of addressing culture, workflow and data management based on real-world examples from existing measures. The April 26, 2012 findings identified the same basic themes --- governance (management of the culture), creation of a learning health system (managing the workflow to improve data management and learn from prior actions) and content (managing the data). The second theme (enhanced Style Guide and a scoring mechanism, perhaps within the Measure Authoring Tool) may be best managed with a large, diverse and participatory audience. Such participation may be better managed using online discussion groups for collaboration as a potential subsequent activity for the eMeasure Learning Collaborative.

The cross-cutting measure concept examples still need to be determined, but two examples are an inpatient pneumonia measure and the inpatient venous thromboembolism (VTE) measure. With these measures, issues regarding medication management, condition identification or negation (either presumptive / admission diagnoses or 'confirmed' conditions as a result of diagnostic imaging), and prior adverse reactions (including allergies) can be discussed along with proposed recommendations.

The proposal presented prior to the Planning Committee call is modified is to address the culture, workflow and data management best practices and recommendations with respect to four primary information flows as used in EHRs to support measurement. The August 10, 2012 flow can include 4 breakout groups, each addressing a different measure and determining recommendations for each of the four target areas. Alternatively, the flow can include one breakout group per target area, allowing each breakout group to address the specific recommendations for its target; all breakout groups will be given the same 2 or 3 measures. [Note: These targets were addressed in the HIT Policy Committee Methodologic Issues Tiger Team Summary (October 28, 2010).¹]

¹ 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).

- 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 0.8.²

Medication Adherence Definition	
Numerator	Denominator
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>	1. New users: Number of days from the first prescription to the end of the measurement period.
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 in 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>	2. Continued users: Number of days from the beginning to the end of the measurement period. <i>** Multiply by 100. Cannot exceed 100%.</i>

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. Best practices in medication list maintenance 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

² 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>.

- Coordinating data from disparate IT systems that are not well integrated even within the same organization
 - 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
- Identification of Conditions (using the Problem List or other means)
 - Best practices in managing conditions using problem lists or other means 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
 - Guidance is required to identify a working, or *presumptive* diagnosis at the time the patient is first seen 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
- 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 (by target issue or by measure(s)). 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:

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

Next Steps

The Planning Committee members agreed to provide some recommendations for organizations that exhibit best practices in managing medication lists, problem / condition lists, allergy/adverse event lists and essential data elements. As suggested, a combined discussion by a vendor and a clinical site will add benefit for the description of the best practice. Preferably, the best practice could be submitted in writing to the attendees as pre-reading with a short presentation during the meeting.

The next call of the eMeasure Learning Collaborative will occur on Monday, July 9, 2012 from 2:00-3:00 pm ET:

Conference Call #: **888-450-5996**, Passcode: **974715**