Collaborative for Performance Measure Integration with EHR Systems
Work Group A Recommendations to full Collaborative

Overarching Recommendations

The Collaborative proposes the following toward achieving the integration of clinical performance measures within EHRS. Some recommendations are earmarked for measures developers, EHRS vendors and physicians; however, continued collaboration across the groups is needed so that functionality to calculate and report on performance measures can be uniformly accomplished across EHRS and across physician practices. Achieving the overarching recommendations also will require collaboration and coordination among groups outside the Collaborative. Because of the importance of all stakeholders' roles, coordinating recommendations with these interests also will be critical to success.

- Consensus must be reached among all stakeholders on one set of performance measures. These measures should be implemented consistently in all public and private reporting programs. When this happens, the gains achievable with other recommendations will have a greater impact on integrating quality measurement into EHRs and the ability of EHR-equipped practices to participate in quality measurement programs.

- One set of performance measure definitions should be implemented consistently so that a national standard vocabulary will be in place for all of the necessary data elements: medications, allergies to medications, laboratory test orders and results, diagnoses, encounter types.

- In circumstances where there is an absence of consensus about a particular medical code set, intensive effort should be directed toward reaching national consensus. These circumstances include, for example, situations in which two (or more) different code sets that could be used to implement a performance measure are applicable and situations where consensus on a nationally agreed-upon code set has not yet been reached (eg, use of NDC codes in the absence of a more flexible, directly relevant, and robust code set). While these circumstances are being further debated, measure developers, EHR vendors and physician practices are in a position of having to create temporary workarounds, which will confound interoperability efforts after consensus is eventually reached.

- National consensus needs to be reached about how measure specifications consistently specify attribution of a given performance measure to a given principal coordinating physician (PCP) or other provider and for specifying the patient population that is being measured.

- Incentives are needed to encourage physician practices to participate in quality measurement programs, since extra effort is required to accomplish necessary documentation and reporting.

Recommendations to Measure Developers

- Feasibility of data capture, the reliability of data elements required to calculate performance measures, and the impact of data collection on physician practices need to be carefully weighed during quality program definition and measure development. To determine the appropriate balance, measure developers should solicit public input from EHR vendors, eg, through EHRVA, and physicians. Measure developers should collaborate with EHR vendors to field test measures for feasibility of implementation. Testing needs to occur in multiple practice sites.

- Specifications for measures and for data extraction and reporting procedures must be unambiguous—both to EHR vendors and to physician practices. Including measure specifications in the public comment process recommended above will help ensure that specifications are uniformly and clearly communicated to EHR vendors and to physician practices. Include vendors and clinical informaticists in the performance measure design process.

- Exclusions in measure definitions and specifications indicate valid medical, patient and system reasons why a measure may not apply to a given patient. Exclusions are intended as a means of providing physicians with reminders so that previously documented information is available at the point of care. Some exclusions may be time insensitive, such as an allergy. Other exclusions are time sensitive, such as gastrointestinal bleeding in relation to antiplatelet therapy. Exclusions are included in the numerator when calculating “reporting” rates and are removed from the denominator when calculating “performance” rates. However, in both situations, the number of each type of exclusion should be reported, as the rates of exclusions provide valuable information upon which action may be needed. To the greatest extent possible, time insensitive exclusions should be derived from data already captured as part of routine EHR documentation (eg, diagnosis, allergies). Time sensitive exclusions should be linked to the decision point since they need to be revisited. Measure developers and vendors should reach agreement on workable solutions for identifying, codifying and easily documenting the reasons for denominator exclusions.

- Vendors and physician practices need a long lead time to incorporate new measures and changes in measure specifications. Therefore, changes in quality reporting programs must be infrequent and detailed specifications should be made available a year to 18 months in advance to notify vendors of changes necessary for updating EHR vendor products.

- EHRs are best equipped to export data in their original code set (eg ICD-9, SNOMED CT®, CPT®) and in the format such data are typically represented. It is recommended that the code sets and formats used by EHR vendors be nationally accepted standards. Quality reporting programs requesting data should be able to accept data exported in the original code set (and, preferably, that original code set is a “standard”) rather than requiring translation and remapping on the EHR side. Until there are nationally recognized standards for all measure data, there is likely to be an interim set of specifications where multiple ways of expressing a data value will be allowed.

Recommendations to EHR Vendors

- Provide the ability to link a PCP responsible for care to a particular problem on the patient's problem list or to a diagnosis code and to link a particular problem to a non-PCP when the PCP is not the responsible party for purposes of quality measurement.

- Provide a consolidated view – eg, through providing performance measure templates – of all rule-based recommendations for a patient that includes current status, next due date, and documented exclusions as one option for the user to view a patient's care management status.

- Minimize the need for practice sites to add data elements necessary for calculating and reporting on performance measures, especially for exclusions, by providing necessary libraries of data elements and specifications required to participate in quality reporting programs.

- Do not require documentation of time insensitive exclusions that are captured elsewhere in the EHR, eg allergies, to document the same exclusion for quality measurement purposes, but rather direct rule-based logic to review data already collected. EHR vendors and measure developers should work together on ways to capture time sensitive exclusions, which are important for patient care.

- Incorporate data capture for quality measurement into the normal workflow of visit documentation, rather than in a separate tab or module, and provide flexibility for when and how alerts are triggered and addressed.

- Collaborate with measure developers to field test implementation of new measures and to identify required software changes. Feedback will be useful to the measure developer to determine if data specifications need to be amended and to the EHR vendor if software alterations need to occur to optimize feasibility of data collection.

- In the library of EHR-provided pre-programmed reports, include the typical ones needed for national quality measurement programs, both to identify patients with gaps in care and to analyze performance for quality improvement or for voluntary reporting to quality improvement programs, payers, CMS, medical boards, and others.

- Design data export capabilities for quality measurement at the level of "one click required."

Recommendations to Physician Practices

The following recommendations for physician practices are not one-time events – these are ongoing initiatives for quality improvement and increased EHR adoption.

- Become expert in the capabilities of your EHR to capture data for quality measurement and to aid you in delivering recommended care. Options include training, ensuring that you are using the latest version of software, attending user groups to share experiences, and joining vendor-associated quality programs.

- Proactively work on policies, procedures, and EHR set-up to maximize the likelihood that patients' problem lists, diagnosis codes and medication lists are always up-to-date. This will not only benefit quality measurement, but also clinical care delivery.

- Reflect teamwork when redesigning visit workflow so that the whole care team is involved in documenting an encounter based on their appropriate roles and so that each patient's care management status is available to physicians and others in real-time and as appropriate.

- Be an active contributor in forums where your EHR vendor takes solicitations for enhancements that would make it easier for your practice to participate in quality measurement programs.