

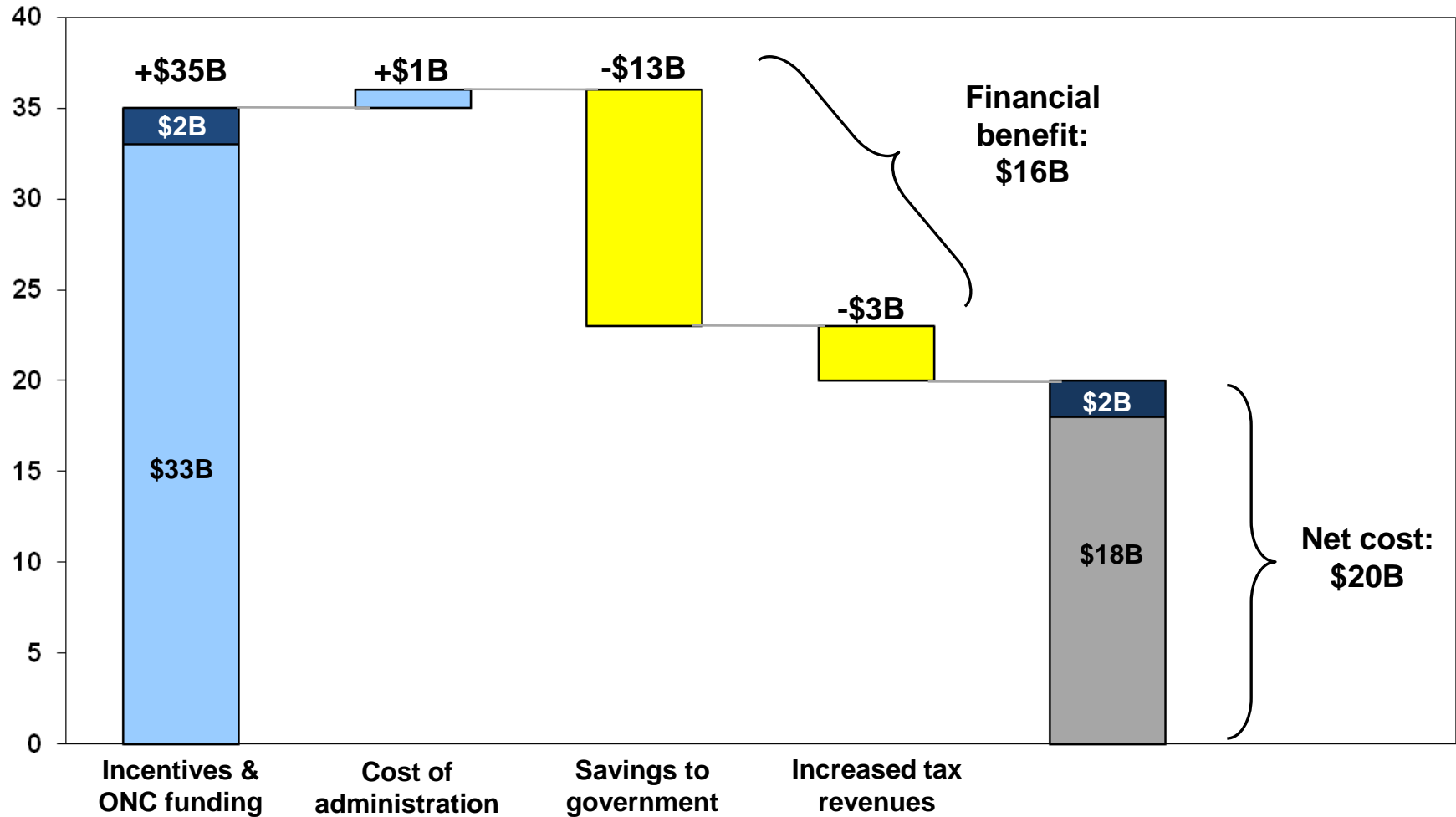
# **NCVHS HEARINGS**

## **Measuring Meaningful Use**

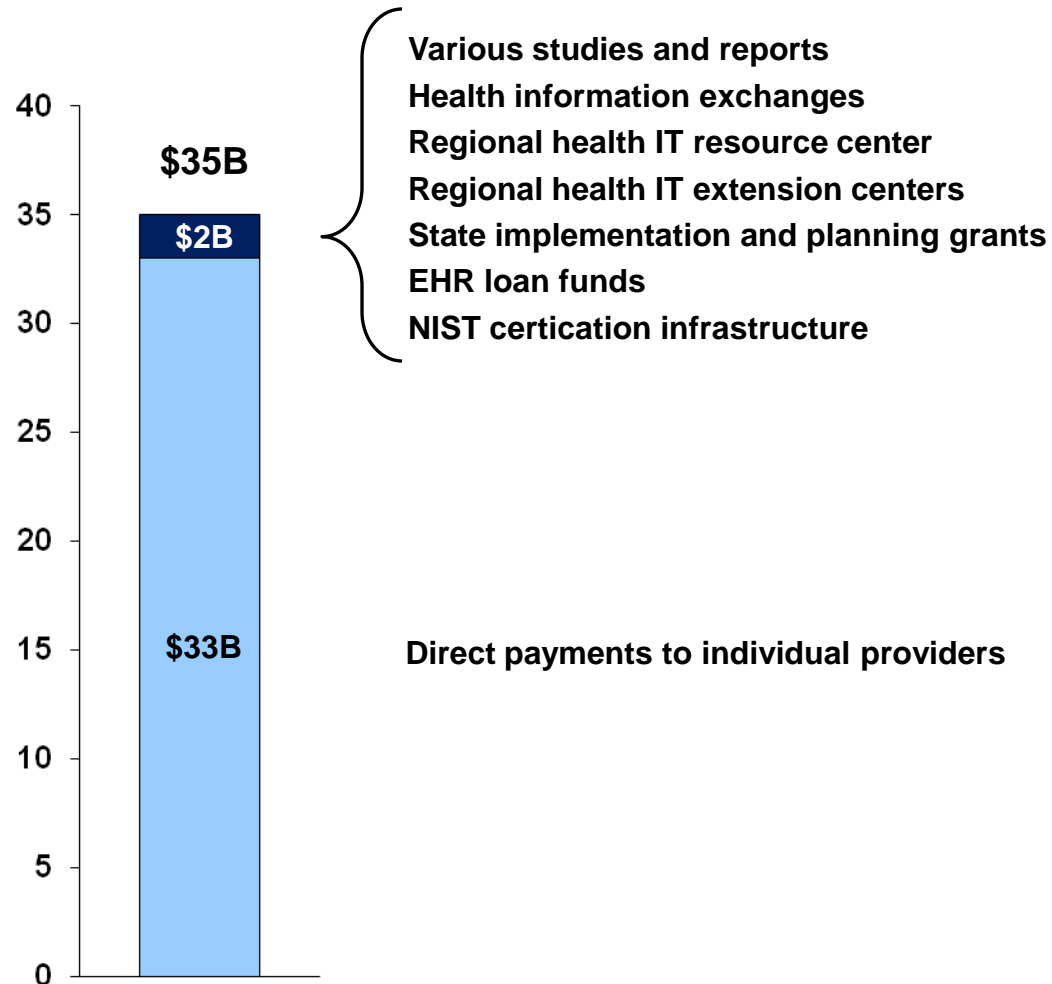
**April 29, 2009**



# THE GOVERNMENT HAS HIGH EXPECTATIONS FOR MEDICARE AND MEDICAID INCENTIVES

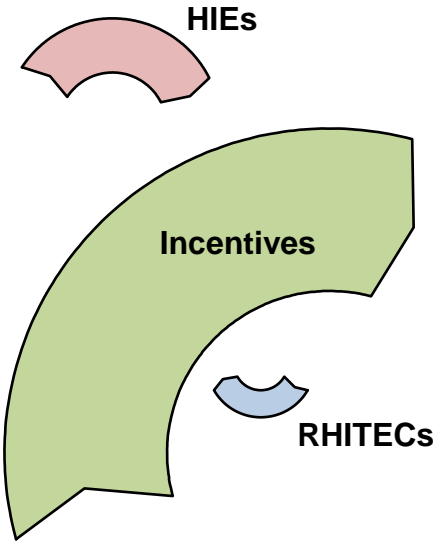


# YET, TOO LITTLE IS BEING INVESTED ON THE INFRASTRUCTURE NEEDED TO MEET THOSE EXPECTATIONS

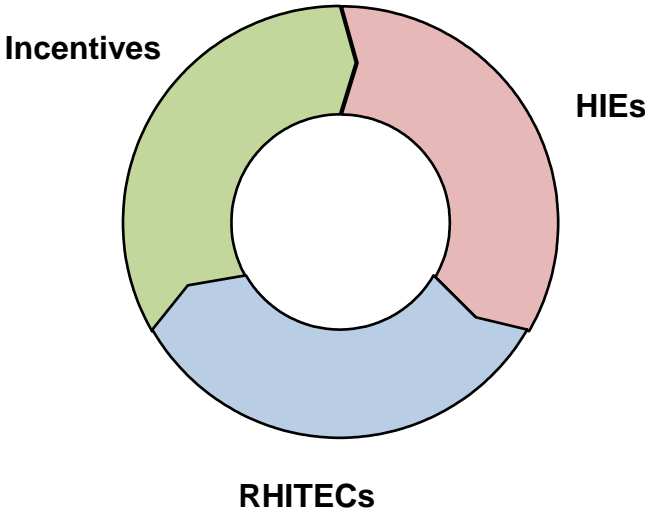


# MEANINGFUL USE DOESN'T HAPPEN, IT GETS DONE

*Current approach funds the pieces, but doesn't connect them*



*RHITECs and HIEs will be the key getting to a higher level of meaningful use at a lower cost, but only if they are tied to the incentives*



# HOW TO MEASURE DEPENDS ON WHAT IT IS WE NEED TO MEASURE

Assume that meaningful use will have the following core elements:

- **Interoperability**
  - eRX
  - ~~Electronic lab/rad results and order entry~~
  - ~~Clinical summary document exchange~~
- ~~Quality data reporting~~

The depth of “meaningful use” will depend on the success of RHITECs and HIEs – unless some fundamental aspects of the program are changed, we will likely have to live with a shallow definition of meaningful use

What is the best way to measure these use elements?

Want to make sure that the cost of monitoring and enforcement doesn’t exceed the benefits of higher compliance

# MAeHC ARCHITECTURE AND DATA FLOWS

**MAeHC-level:  
Analysis**

**MAeHC-level:  
QDC**

**Community-level:  
HIE**

**Provider-level:  
EHR**

Outcomes  
analysis

Benchmarking

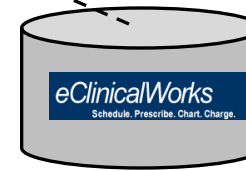
Negotiated reporting  
to plans  
• P4P



Brockton



Newburyport



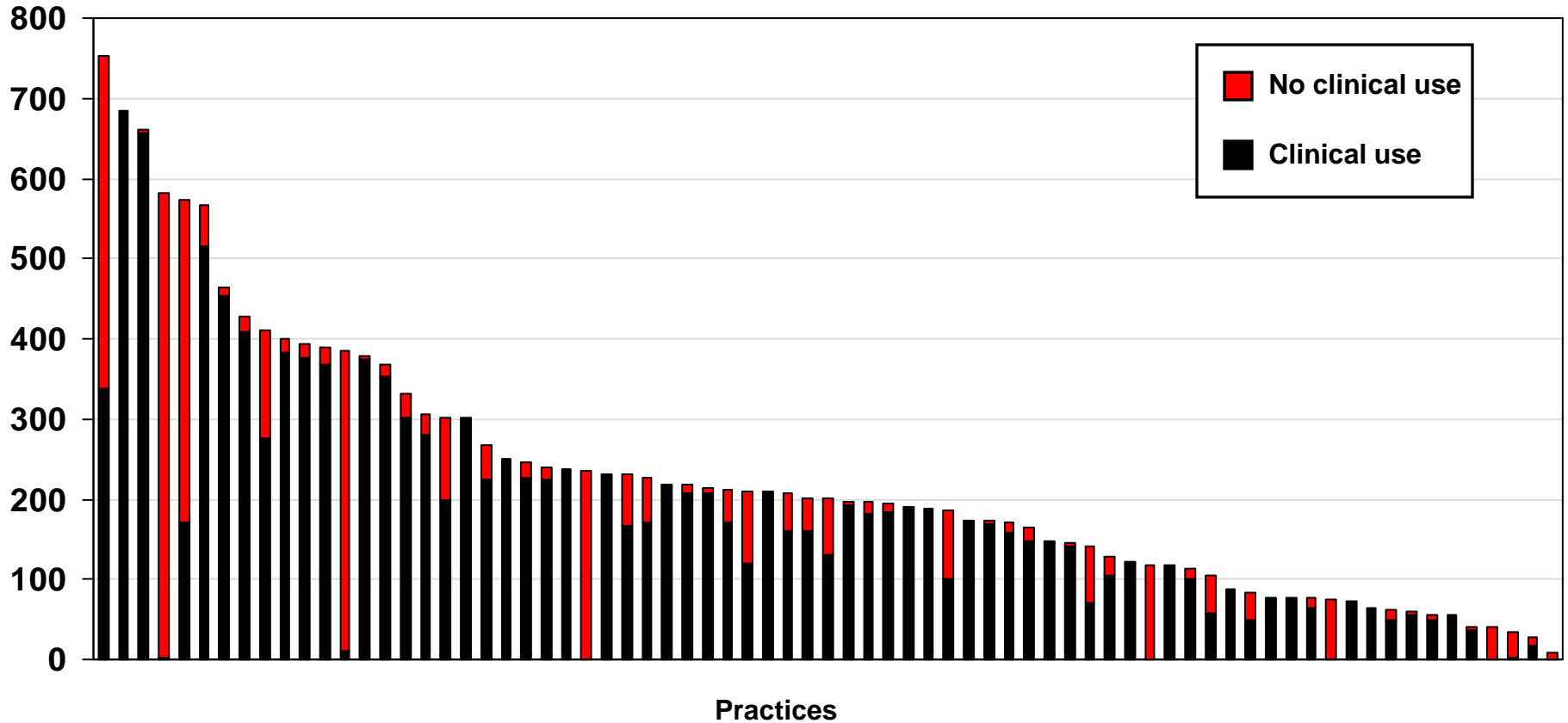
North Adams



# CLINICAL USE OF THE EHR

## Average Encounters Recorded – January 2007

# actual office visits

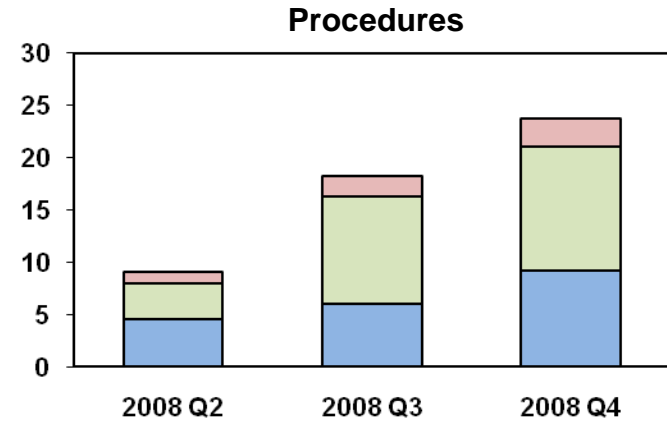
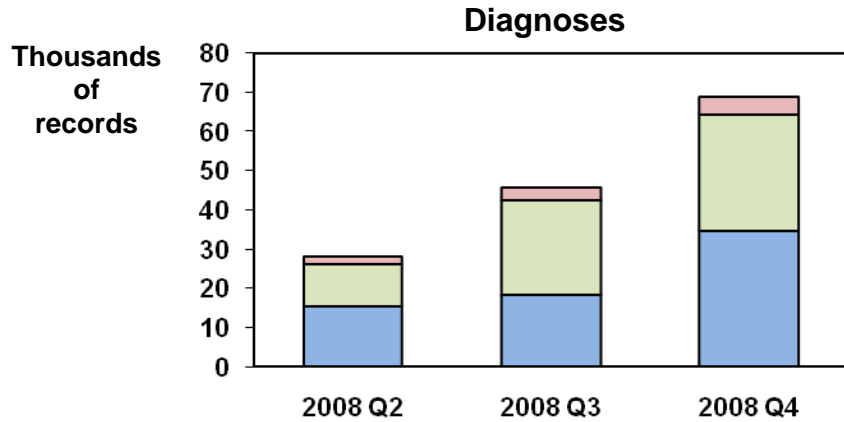
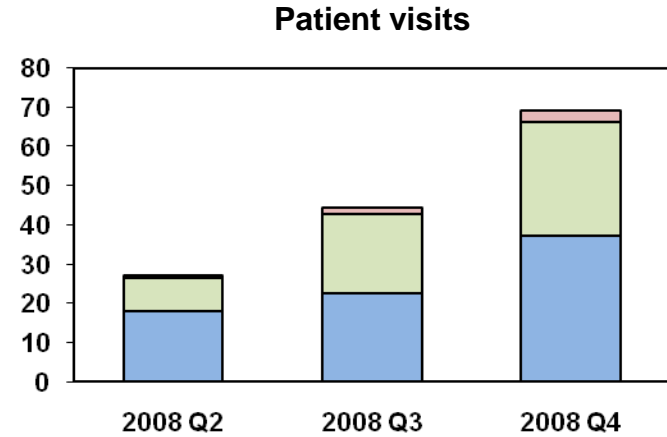
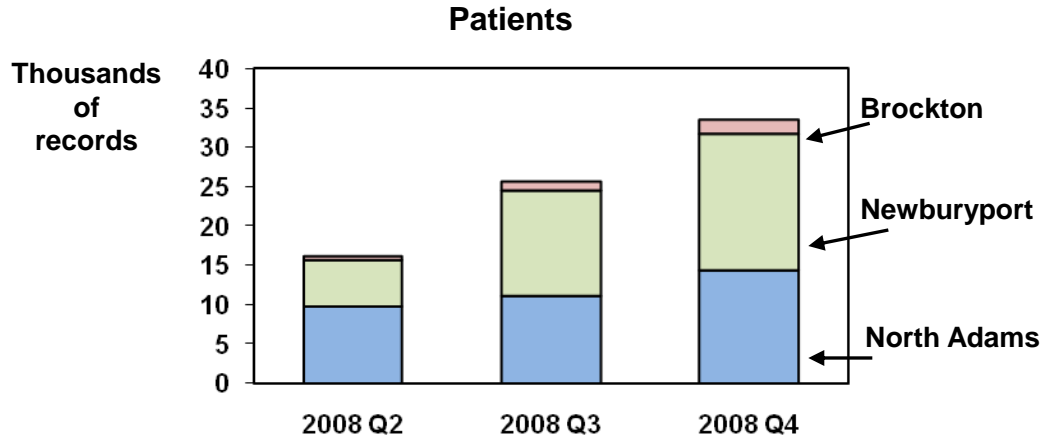


# BREAKOUT OF CLINICAL USE MEASUREMENT

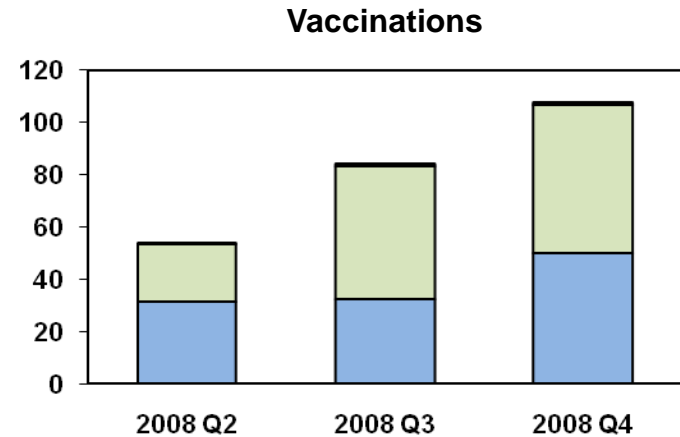
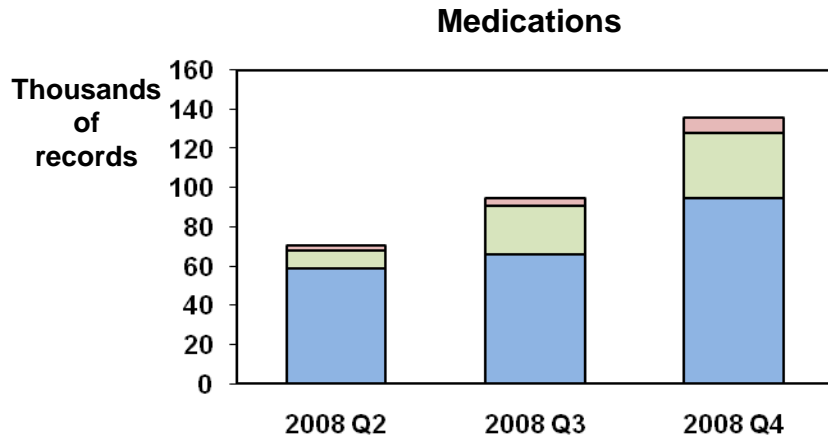
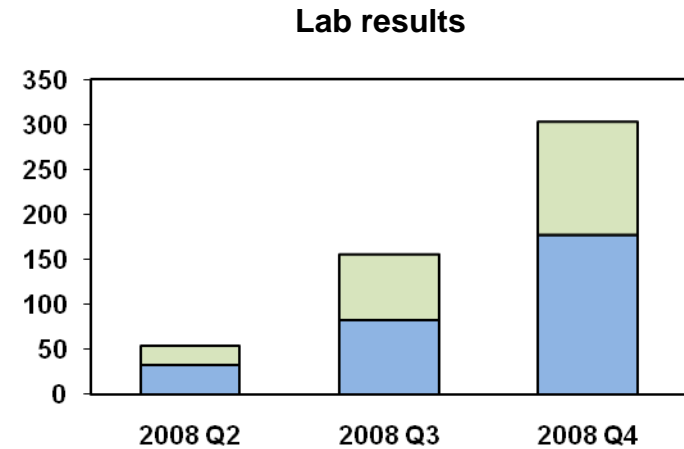
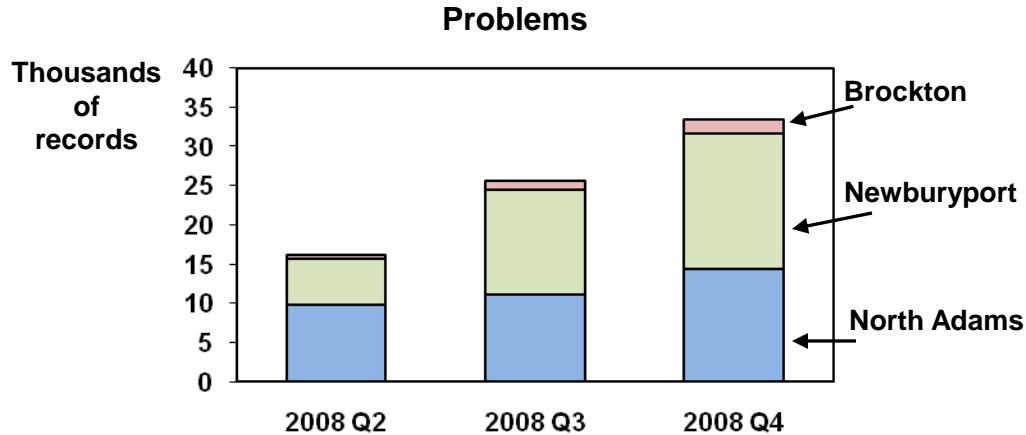
Community	Brockton
PracticeName	(All)
Quarter	(Multiple Items)

	Specialty Groups	
Data	Primary Care	Specialty Care
Clinical Enc	90.7%	82.6%
Follow-up	82.8%	76.2%
HPI	68.5%	41.1%
Allergies	34.4%	23.3%
Vitals	65.0%	22.5%
Current Meds	42.3%	50.2%
Medical Hx	45.9%	33.1%
Social Hx	23.3%	21.7%
Family Hx	19.5%	11.7%
Surgical Hx	14.2%	16.3%
ROS	22.7%	17.6%
Rx	41.6%	15.2%
Phys Exam	11.8%	14.4%
Exam	68.0%	32.7%
Total Office Encounters	204,079	213,134

# MAEHC QDC DATA COUNTS (I)



# MAEHC QDC DATA COUNTS (II)



# THERE IS A RANGE OF MEASUREMENT APPROACHES TO CHOOSE FROM

## Attestation & Audit

- Physician self-attestation to Medicare/Medicaid
- Would require creation of monitoring process and infrastructure
- Periodic audits could leverage QIO infrastructure and processes

## Surveys

- Routine surveys of use of all incentive recipients
- Would require creation of monitoring process and infrastructure
- Could leverage current CDC and NACS survey infrastructure

## Third-party reporting

- Physician-level reporting from aggregator organizations
- National labs, Surescripts-RxHub
- Include hospital labs/imaging centers?

## Claims-based reporting

- Claims-based process measure coding
- Leverages existing PQRI g-code process and infrastructure

## EHR activity measurement

- EHR-based reporting usage reporting

## HIE activity measurement

- HIE-based activity monitoring and reporting
- Content monitoring and reporting by certified quality data centers and public health entities

A shallow definition of meaningful use does not require robust measurement

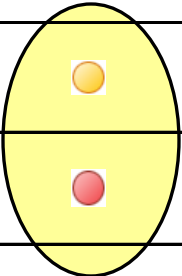
# CRITERIA OF EVALUATION FOR MEASUREMENT METHODS



<b>Provider burden</b>	Requires most amount of work outside of clinical workflow	↔	Requires least amount of work outside of clinical workflow
<b>Sensitivity</b>	High rate of false positives	↔	High rate of true positives
<b>Specificity</b>	High rate of false negatives	↔	High rate of true negatives
<b>Precision</b>	High measurement error	↔	Low measurement error
<b>Management burden</b>	High cost of administration or direct oversight	↔	Low cost of administration or direct oversight
<b>Temporal availability</b>	Requires infrastructure build	↔	Infrastructure currently available
<b>Geographic availability</b>	Selectively available	↔	Uniformly available

# COMPARISON OF MEASUREMENT METHODS

	Attestation & Audit	Surveys	Third-party reporting	Claims-based reporting	EHR activity measurement	HIE activity measurement
Provider burden	●	●	●	●	●	●
Sensitivity	●	●	●	●	●	●
Specificity	●	●	●	●	●	●
Precision	●	●	●	●	●	●
Management burden	●	●	●	●	●	●
Current availability	●	●	●	●	●	●
Geographic availability	●	●	●	●	●	●

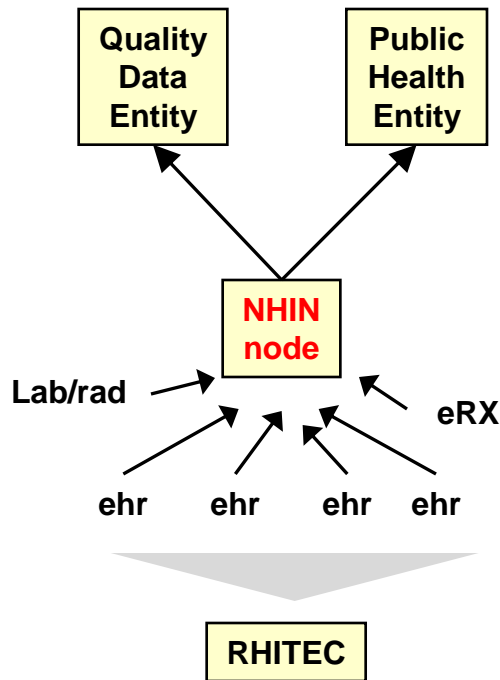
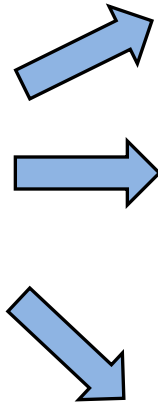


**Focus of ONC discretionary spending should be here!!**

# MEASUREMENT RESPONSIBILITY PUSHED TO ADOPTION, INTER-OPERABILITY, AND DATA AGGREGATION ENTITIES



HHS contracts with regional and functional entities to facilitate, monitor, and enforce meaningful use



Monitoring and enforcing initial adoption and ongoing HIE activity obviates the need to monitor EHR-level activity

Aggregate and report clinical and public health measures according to national core set



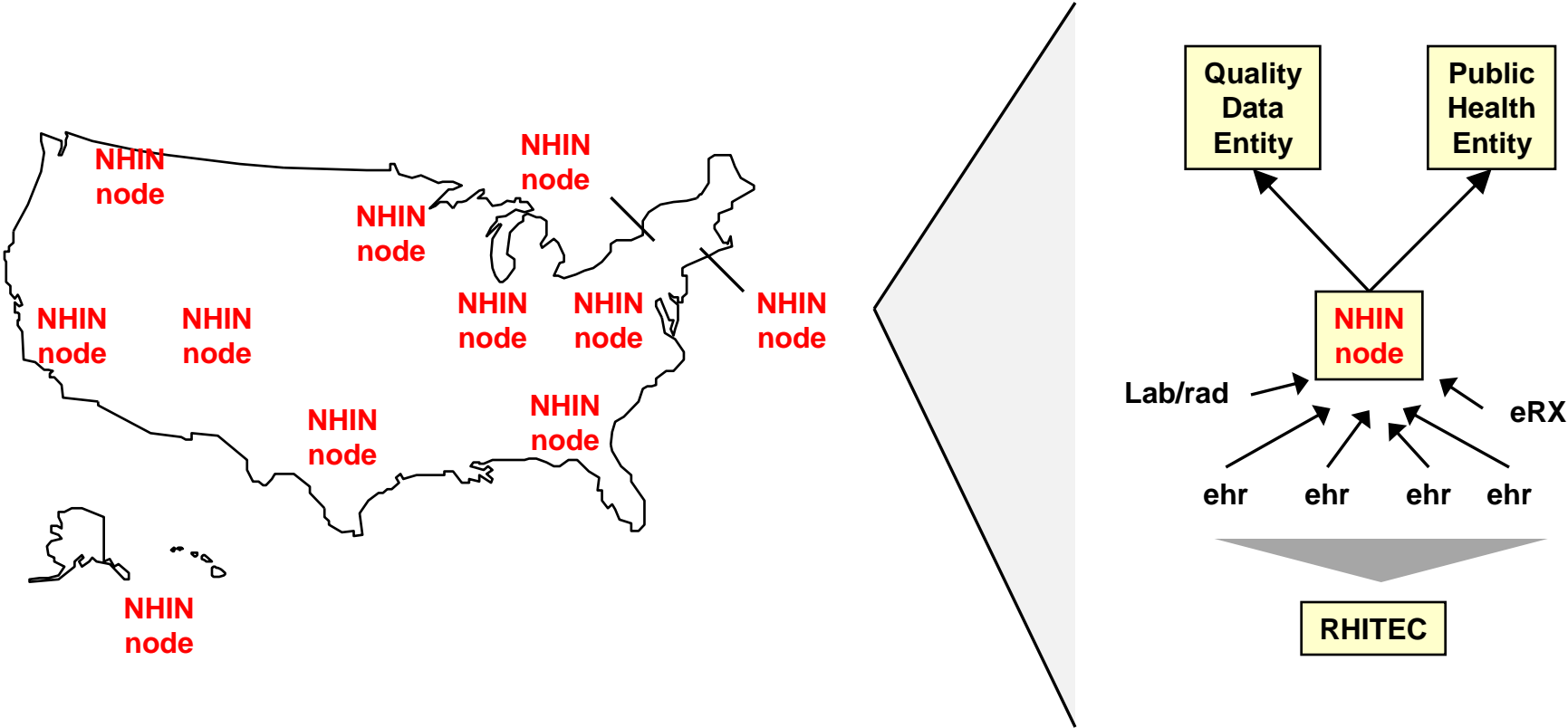
Facilitate, monitor, and enforce data exchange according to HITSP-approved exchange standards; report physician-level use of HIE exchange



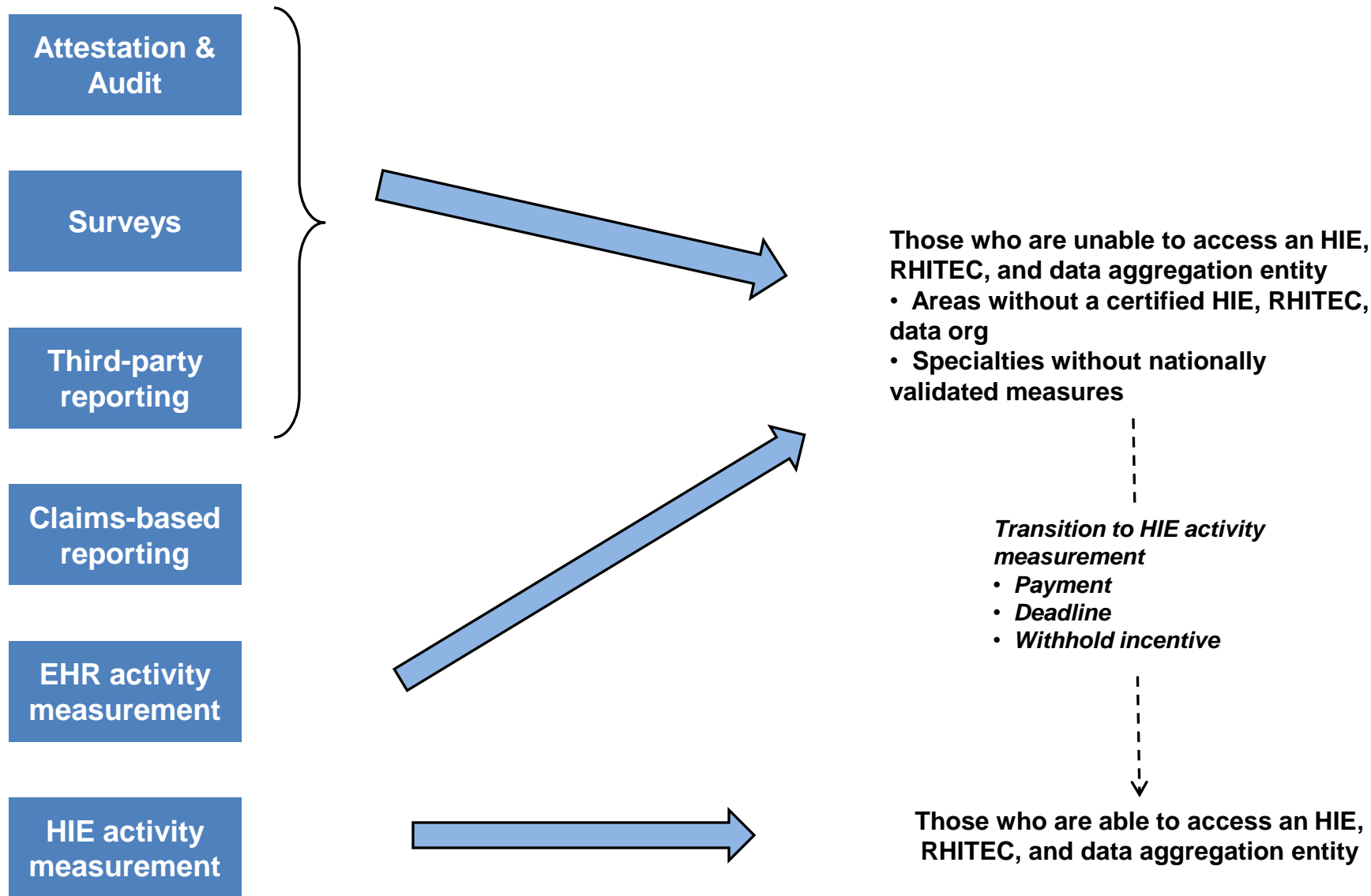
Execute EHR and HIE adoption according to meaningful use requirements



# NHIN NODES EVENTUALLY BECOME THE BASIS FOR DEMONSTRATING MEANINGFUL USE



# MIXED MEASUREMENT MODEL WILL BE REQUIRED WHILE THE INFRASTRUCTURE GETS ESTABLISHED



# CONCLUDING THOUGHTS ON MEASURING MEANINGFUL USE

## Monitoring works best when it's invisible

- **Create an infrastructure to reduce the cost and improve the effectiveness of meaningful use**
- **Directly measure activities and results that flow from clinical workflows**
- **Measure at a point of aggregation that couldn't have been achieved without effective use of an EHR**
  - **If providers are exchanging data over standards-based HIEs, and submitting quality and public health data to certified entities.....they're meaningfully using their EHRs**

## To that end

- **Push measurement accountability down to the HIEs, RHITECs, and quality & public health data aggregation organizations**
- **Invest every single discretionary dime on HIEs, quality data aggregation infrastructure, and on RHITECs**
- **Require that some portion of physician incentives be directed to RHITECs, HIEs, and quality data aggregation organizations**
- **Require that meaningful use elements related to inter-operability be transacted through certified HIEs and data aggregation/measurement organizations**



[www.maehc.org](http://www.maehc.org)

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