Quality Council

May 6th, 2015

Meeting Agenda

Item	Allotted Time
1. Introductions/Call to order	5 min
2. Meaningful use measure – ACO-11 (Dr. Tikoo)	30 min
3. HIT Council Update	20 min
4. Readmission measures	20 min
5. Claims vs. EHR as a data source	30 min
6. Minutes	5 min
7. Public Comment	10 min

Meaningful Use Measures

Connecticut's EHR Incentive Program
May 6, 2015

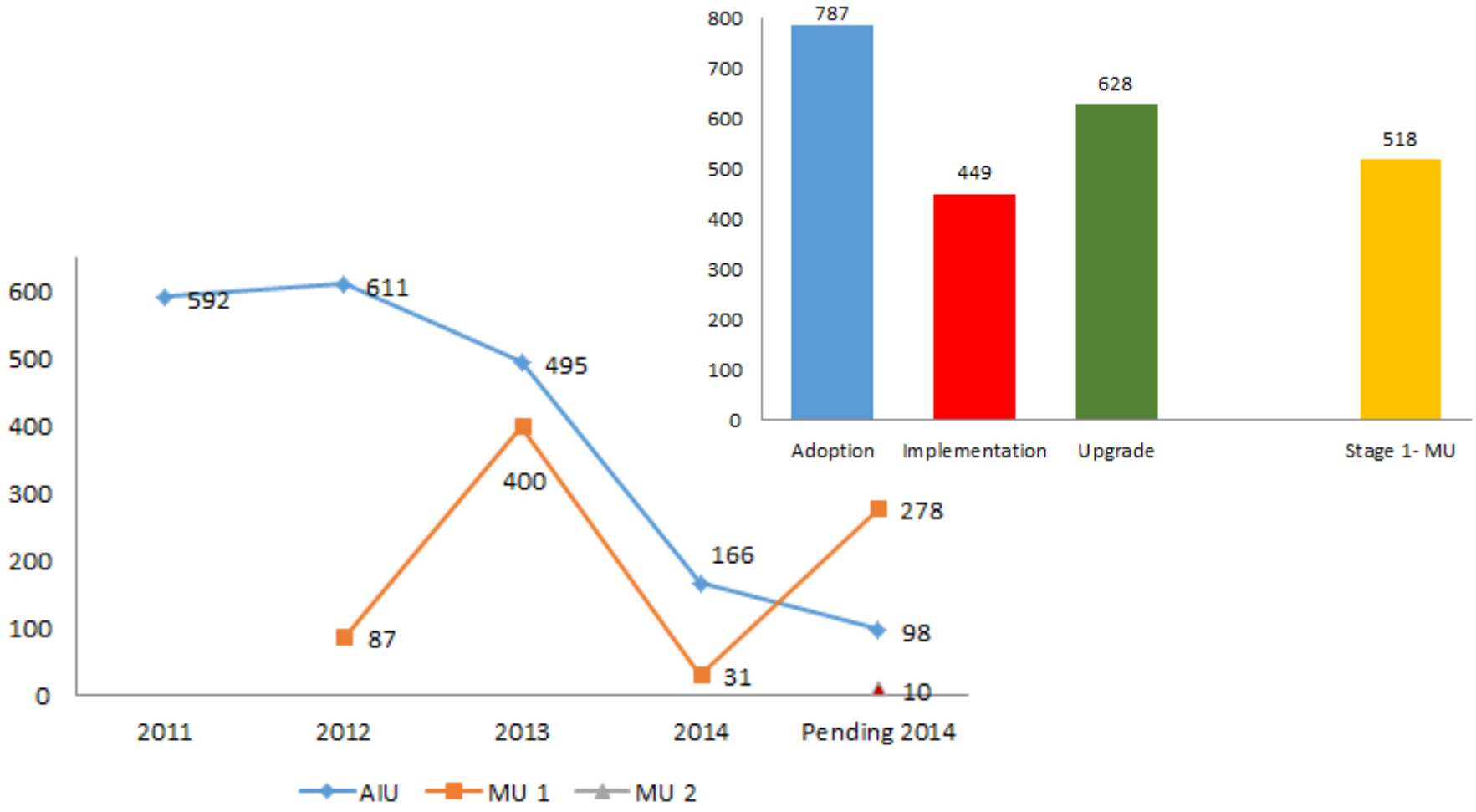
Minakshi Tikoo, PhD, MBI, MS, MSc
Director, Business Intelligence & Shared Analytics
HHS HIT Coordinator
DSS

EHR Incentive Programs (1/11-2/15)

State/Territory	Program Type	Unique EPs	Unique Hospitals
Connecticut	Medicaid	1,826	1
3.597 million	Medicare	3,955	1
	Medicaid/Medicare		27
		5,781	**29**
Massachusetts	Medicaid	5,609	2
6.745 million	Medicare	10,306	4
	Medicaid/Medicare		59
		15,915	**65**
Rhode Island	Medicaid	448	
1.055 million	Medicare	876	1
	Medicaid/Medicare		12
		1,324	**13**

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/February2015_UniqueCountofProvidersbyStates.pdf

Eligible Professionals Participating in the EHR Incentive Program (4/9/2015)



Dashboard

CORE AND MENU MEASURES REPORT

MAPIR Extract Date: 4/9/2015

EHR Phase: Meaningful Use-1

Percentage of Core and Menu Measures by Eligible Providers — **No. Eligible Professionals: 516**

Core	Description	Exclude	Data Qual	Comp/Met	Threshold%	Min%	Max%	Mean %	Std Dev%
1	Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.	67	0	449	30.00%	34.21%	100.00%	88.66%	12.43%
2	Implement drug-drug and drug-allergy interaction checks.	0	0	516					
3	Maintain an up-to-date problem list of current and active diagnoses.	0	0	516	80.00%	80.07%	100.00%	97.52%	4.40%
4	Generate and transmit permissible prescriptions electronically (eRx).	81	6	429	40.00%	40.43%	100.00%	89.25%	12.19%
5	Maintain active medication list.	0	0	516	80.00%	80.56%	100.00%	96.19%	4.06%
6	Maintain active medication allergy list.	0	0	516	80.00%	80.85%	100.00%	96.64%	4.24%
7	Record all of the following demographics: (A) Preferred language; (B) Gender; (C) Race; (D) Ethnicity; (E) Date of birth	0	0	516	50.00%	50.77%	100.00%	93.40%	9.55%
8	Record and chart changes in the following vital signs: (A) Height; (B) Weight; (C) Blood pressure; (D) Calculate and display body mass index (BMI); (E) Plot and display growth charts for children 2-20 years, including BMI	18	0	496	50.00%	47.45%	100.00%	89.04%	12.08%
9	Record smoking status for patients 13 years old or older.	4	0	512	50.00%	0.00%	100.00%	88.78%	13.40%
10	Report ambulatory clinical quality measures to CMS.	0	429	87					
11	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.	0	0	516					
12	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request.	350	0	133	50.00%	0.00%	100.00%	94.09%	12.41%
13	Provide clinical summaries for patients for each office visit.	1	0	515	50.00%	0.00%	100.00%	81.18%	16.53%
14	Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.	0	429	87					
15	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	0	0	516					

Percentage of Core and Menu Measures by Eligible Providers — **No. Eligible Professionals: 516**

Dashboard

Percentage of Core and Menu Measures by Eligible Providers									No. Eligible Professionals: 516
Menu	Description	Exclude	Data Qual	Comp/Met	Threshold%	Min%	Max%	Mean %	Std Dev%
1	Implement drug formulary checks.	14	122	380					
2	Incorporate clinical lab test results into EHR as structured data.	8	114	394	40.00%	0.00%	100.00%	88.12%	16.52%
3	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.	0	107	409					
4	Send reminders to patients per patient preference for preventive/follow-up care.	18	392	106	20.00%	15.51%	100.00%	81.43%	23.84%
5	Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP.	17	378	121	10.00%	0.08%	100.00%	82.10%	24.19%
6	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	0	176	340	10.00%	0.00%	100.00%	60.08%	27.98%
7	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconcilation.	22	241	253	50.00%	50.36%	100.00%	86.48%	14.29%
8	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.	23	376	117	50.00%	64.71%	100.00%	91.57%	9.81%
9	Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.	416	49	8					
10	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.	86	427	2					

Dashboard

Core and Alternate Core CQMs

NQF	Measure	CQM Type
0013	Hypertension: Blood Pressure Measurement	Core
0028	Preventive Care and Screening Measure Pair: a) Tobacco Use Assessment; b) Tobacco Cessation Intervention	Core
0421	Adult Weight Screening and Follow-Up	Core
0024	Weight Assessment and Counseling for Children and Adolescents	Alternate Core
0038	Childhood Immunization Status	Alternate Core
0041	Preventive Care and Screening : Influenza Immunization for Patients >= 50 Years Old	Alternate Core

N = 456 Eligible Professionals

Eligible Providers Completing Individual CQMs

NQF	Measure	EPs	Percent
Core			
0028	Preventive Care and Screening Measure Pair: a) Tobacco Use Assessment; b) Tobacco Cessation Intervention	367	80.5%
0421	Adult Weight Screening and Follow-Up	321	70.4%
0013	Hypertension: Blood Pressure Measurement	197	43.2%
Alternate Core			
0024	Weight Assessment and Counseling for Children and Adolescents	223	48.9%
0038	Childhood Immunization Status	140	30.7%
0041	Preventive Care and Screening : Influenza Immunization for Patients >= 50 Years Old	63	13.8%
Additional			
0036	Use of Appropriate Medications for Asthma	112	24.6%
0002	Appropriate Testing for Children with Pharyngitis	108	23.7%
0061	Diabetes: Blood Pressure Management	107	23.5%
0027	Smoking and Tobacco Use Cessation, Medical Assistance	91	20%
0059	Diabetes: HbA1c Poor Control	86	18.9%
0031	Breast Cancer Screening	82	18%
0032	Cervical Cancer Screening	79	17.3%
0018	Controlling High Blood Pressure	77	16.9%
0033	Chlamydia Screening for Women	71	15.6%

ACO Measure 11

ACO #11 -- Percent of Primary Care Physicians Who Successfully Qualify for an EHR Program Incentive Payment

Measure description - Percentage of Accountable Care Organization (ACO) primary care physicians (PCPs) who successfully qualify for either a Medicare or Medicaid Electronic Health Record (EHR) Incentive Program incentive payment.

- ***What does this measure tell us?***
- ***What do you want to use it for?***

HIT Council Overview and Update re: Proof of Solution review

Membership

Commissioner Roderick Bremby (Chair)	Commissioner	Department of Social Services
Dr. Thomas Agresta	Associate Professor and Director of Medical Informatics	UConn Health Center
Dr. Anne Camp	Director, Diabetes & Diabetes Prevention Program	Fair Haven Community Health Center
Dr. Patricia Checko	Public Health Practice and Policy Consultant	
Dr. Anthony Dias	Vice President, Data Services	Connecticut Hospital Association
Ed Fisher	VP & Chief Technology Officer	Yale New Haven Health System
Dr. Michael Hunt	CMO/CMIO	St. Vincent's Health Partners
Ludwig Johnson	CIO	Middlesex Health System
Vanessa Kapral	Information Technology Manager	Department of Public Health
Matthew Katz	EVP/CEO	Connecticut State Medical Society
Dr. Alan Kaye	Vice President	Radiological Society of Connecticut
Michael Michaud	Chief of Staff to the DMHAS Deputy Commissioner	Department of Mental Health and Addiction Services
Mike Miller	Client Relationship Executive	Optum Solutions
Mark Raymond (co-chair)	Chief Information Officer	Bureau of Enterprise Systems Technology
Philip Renda	HCCN Network Director/CIO	Community Health Center Association of Connecticut
Dr. Craig Summers		Community Medical Group IPA
Sheryl Turney	Staff VP HlthCore APCD	Healthcare Inc., a wholly owned subsidiary of Anthem, Inc.
Joshua Wojcik	Policy Director	Office of the State Comptroller
Moh Zaman	Vice President, Analytic	Hartford Healthcare

HIT Council Goal: Documented in the charter

Purpose

- Develop recommendations for the Healthcare Innovation Steering Committee with respect to HIT requirements and technology components by SIM participants (e.g. hospitals, physicians, state agencies, consumers) to achieve the goals of the SIM proposal. Specific recommendations and deliverables (outcomes) include:
  - Solution set of scalable and adaptable health information technologies,
  - High-level diagram of the technologies and data interactions
  - HIT implementation approach and roadmap for SIM participants

Goals

- **Access:** Ensure HIT supports health care service access and delivery, as well as data aggregation method for analysis and quality improvement
- **Connectivity and Exchange:** Achieve integration across and within health care delivery systems and physician practices based on national standards for content and information exchange, and transmit data to the SIM participants.
- **Quality:** Support SIM Quality Initiatives that are quantitative and qualitative enabled by HIT. Provide ongoing monitoring of the data reporting and technology supporting the quality initiatives.

Draft Charter Scope

Scope: the range and boundaries of the responsibilities of the HIT Council

In Scope

- Review of the current and proposed technologies cited in the SIM grant to understand capabilities and uses for Test Model
- Work collaboratively and actively support two way communications with the other SIM workgroups and councils to develop the HIT design.
- High level schema of HIT solution
- SIM HIT solution implementation approach and roadmap
- Recommendations for technologies to support the SIM initiatives
- Participation with the SIM HIT Steering Committee and other SIM work groups and councils.

Out of Scope

- Personal Health Record technology and Patient Portal (from original grant proposal)
- Development of policies and procedures tied to the above technologies

Draft Charter

Roles and Responsibilities

1. Develops and recommends SIM HIT Council charter
2. Establishes ad hoc task forces to investigate specific technical, functional and integration topics
3. Discusses options and makes a recommendation using majority consensus. If necessary, the council will follow a majority voting process, assuming a quorum (one co-chair and at least 50 percent of the members are present)
4. Members communicate SIM HIT Council progress back to constituents and bring forward their ideas and issues
5. Works collaboratively with the other SIM groups to collect and share information needed to provide an aligned HIT solution
6. Monitors progress and financials, and makes adjustments to stay within the timeline- pre and post SIM HIT solution implementation
7. Recommends SIM HIT solutions to the HISC
8. Comes to the meetings prepared by reviewing the materials in advance
9. Issues, questions and concerns that cannot be resolved by the HIT Council as a group (versus individual members) are escalated to the HISC.
10. Has an Executive team that includes the co-chairs and one member from each of the three main stakeholder groups: payer, provider and consumer advocate. The executive team provides input into the agenda and brings to the co-chairs issues voiced by other members.

Draft Charter

Guiding Principles:

- Advocate for HIT solutions that are scalable and meet existing standards that are available and feasible
- Comply with SIM's conflict of interest protocol, currently in draft status
- HIT is a tool to support or supplement care delivery and the collection of necessary data but is not, nor should be the end goal
- Be the advocate for the role you are representing

Work Groups:
To be determined by the SIM HIT Council, as needed

Meeting Frequency:
Meets every three weeks and as needed to meet the scope deliverables.

Meeting Preparation and Staffing

- The chair or designee and the facilitator are responsible for overseeing preparation of the materials for the meetings.
- Meeting agendas will be sent at least 72 hours in advance of the meeting. Every effort will be made to send out meeting materials in advance. Draft minutes will be taken and posted within five days of the meeting. Final minutes will be posted after adoption.

HIT Council Goal: Documented in the charter

Develop recommendations for the Healthcare Innovation Steering Committee with respect to HIT use by SIM participants (e.g. hospitals, practices, state agencies, consumers) to achieve the goals of the SIM initiatives. Specific recommendations and deliverables (outcomes) include:

- Review selected (owned) technologies
- Recommend solution set of technologies for unanswered questions
- Outline high-level diagram of the technology and interactions, and identify dependencies
- Develop implementation approach and roadmap
- Integrate HIT timeline with SIM Initiatives

Draft Charter

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Note: changes in bold

Proposed Performance Measurement Solution in Model Test Grant

Zato Edge Server Technology

Edge Server Education and Q & A Session

State MU Reporting for Provider Groups is Evolving

1. Processes modeled on federal MU reporting have not delivered consistent, complete, comparable data efficiently from disparate EHRs and other data silos

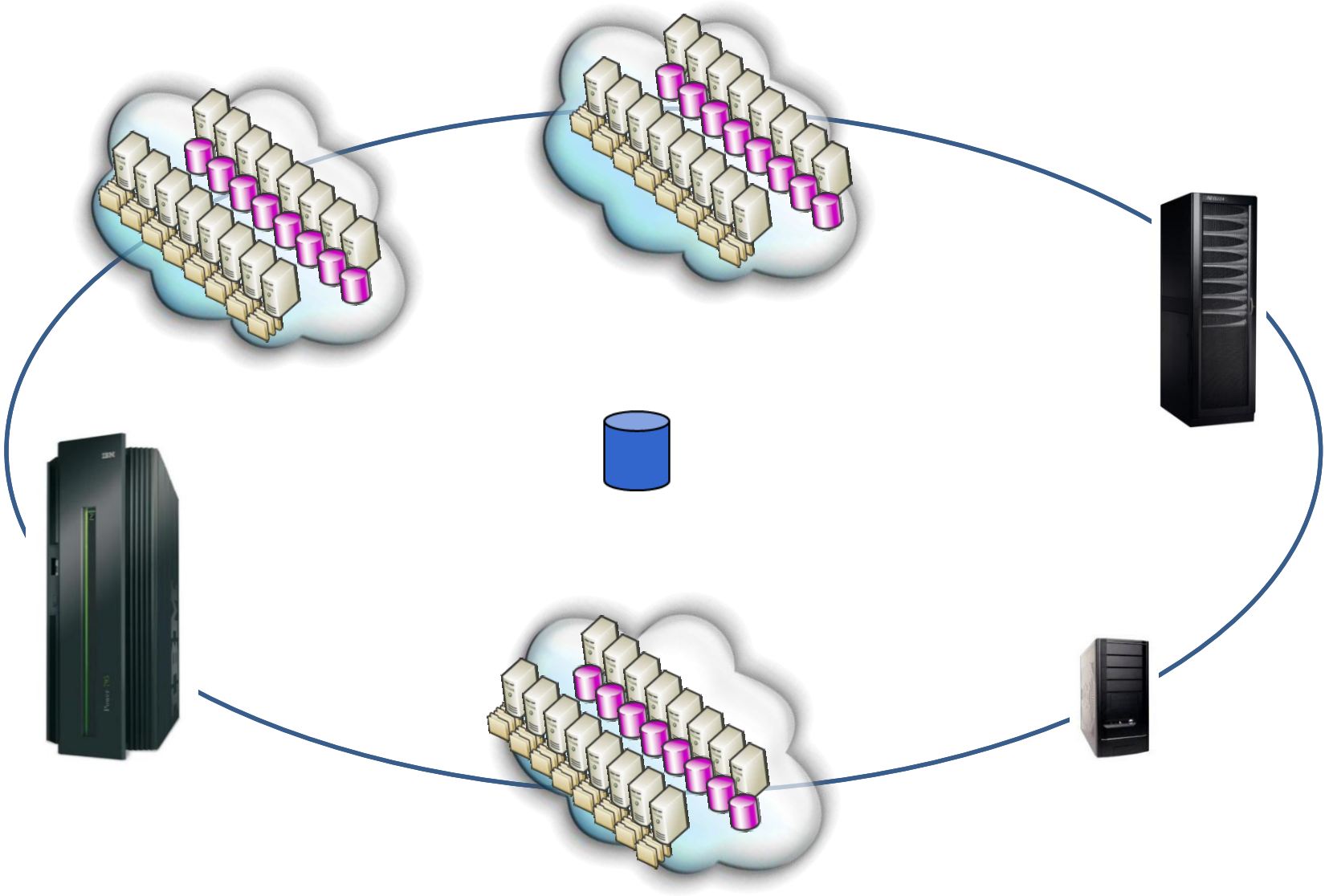
2. Open Source reporting models are a useful and affordable resource

3. Federal data reporting model is shifting to support a changing payment model

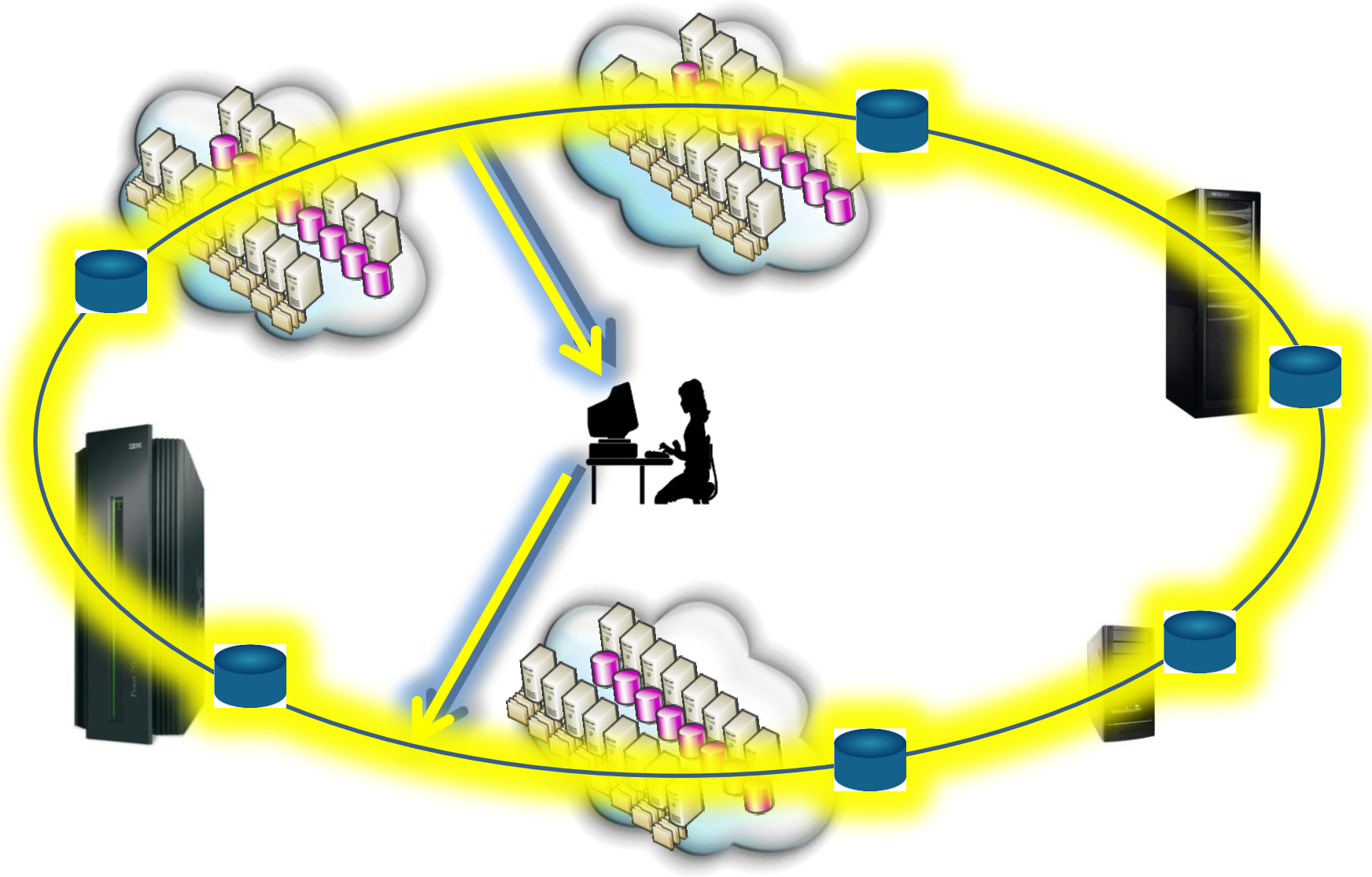
4. Interoperability software provides the fidelity back to the EHRs and data silos to :

    a) Enable efficient, affordable verification and auditing of submitted data
    b) Incentivize Providers for reporting more useful data
    c) Correlate reporting criteria need with payments, outcomes, and costs
    d) Incentivize enabled improvements in quality of care and cost effectiveness

A Data Warehouse or Data Lake Requires Copying and Aggregation of Diverse Healthcare Application Data for Centralized Processing

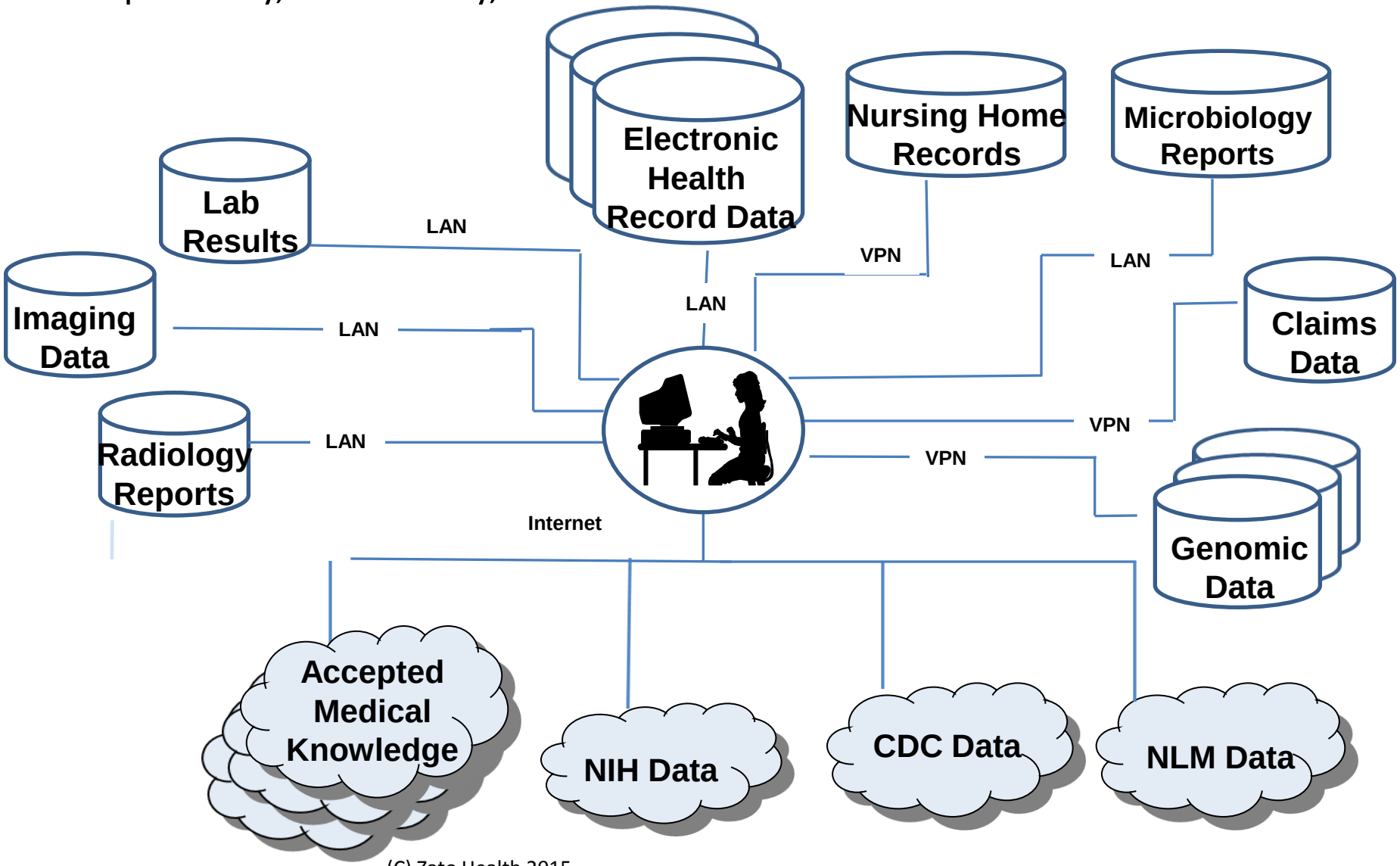


Cooperative ‘Edge Processing’ Spans a Navigable Network of Data Repositories (‘Virtual Data Lake’) without Data Centralization



Edge Server Education and Q & A Session

Spanning Data Centers and Organizations Simultaneously for Interoperability, Productivity, and Global Views



Performance Measurement Design Group

HIT Council's Response to QC's "Proof of Solution" Memorandum

- Form a quality measurement design group made up of volunteers from the Council
- Develop the group's charge
  - Develop functional specification and options to address the request
  - Identify data and data format needs, output reporting and analysis requirements
  - Identify options, narrow source options in terms of data and technology
  - Document questions for vendors, Quality Council, HIT Council

HIT Performance Measure and Reporting Design Group

The Design Group was formed to analyze the requirements for and solutions options for the Quality Measure production. Three meetings have been held and another schedules for the second week in May. The following is a brief synopsis of the progress.

Meeting Date	Discussion Topics	Outcomes/ Follow up
March 12th	• DG objectives • QC Inter-council memorandum Jan 2016	• List of questions to clarify the memo request requirements
April 8th	• Discussion of a staged approach • Review of Zato (IT vendor) provided material on product • Identify gaps and additional data	• List of Zato specific questions developed and sent to the vendor via Dr. Tikoo
April 23rd	• Discuss 2016 SIM requirements – what can be done by Jan 2016 • Discussion on how the vendors addressed the requirements	• Follow up questions to APCD, Zato and the Quality Council • Investigate what other SIM sites are doing
May (TBD)	• Review all responses to questions • Discussion of Stage 1 and Stage 2 options	• Prepare materials for the HIT Council to review and discuss

HIT Performance Measure and Reporting Design Group - Mtg #2 and #3

Preliminary findings from the vendor demonstrations. Note: Outstanding materials and answers follow up questions not included in all cases

	Zato	APCD
Capabilities	• Leading edge tool with ability to be configured to read any data source and provide performance measure processing and reporting	• List of questions to clarify the memo request requirements
Fit with SIM	• Innovative and has the potential to meet our requirements without creating a central repository of identifiable data	• Can handle some of the measures and reporting. • Can standardize Medicare to match commercial data
Timeframe	• TBD - outstanding question • Not January 2016	• Data available by end of 2015. Operational by October 2016
Challenges	• Not been used in healthcare • Requires resources from providers to set up and support • Need to specify our requirements • Potential issues with data normalization and patient consent	• Cannot meet the clinical value measures (e.g., A1C>9) without significant claims coding procedures • Legislative changes needed for use of identifiable data

HIT Performance Measurement Design Group #3

Central to selecting the best HIT solution(s) is understanding the data, processing and reporting needs for SIM. The following questions were asked of the Quality Council to help the HIT Design Group define IT requirements.

1. A staged approach is a viable option for SIM HIT at this time. When will the measure sets for Phase I be final? It would be optimal if there is someone on the design group who understands the data tools being used at both the SIM PMO as well as the practices side.

   Response: Level 3 culling of provisional measure set completed by July. Final set will depend on HIT Council's feasibility assessment. Public comment may also be solicited.

2. Please provide the minimum acceptable data, processing and reporting for Stage 1?

   Response: TBD.

HIT Performance Measurement Design Group #3

Central to selecting the best HIT solution(s) is understanding the data, processing and reporting needs for SIM. The following questions will help the HIT Design Group define IT requirements.

3. Who are we asking to submit the data for year 1? What is the year 1 attributable population?

   <u>Response</u>: As of January 2016, we would ask that all Advanced Networks provide the data necessary for reporting on all measures, whether or not all of those measures are included in each of their contracts. As of July 2016, FQHCS participating in the MQISSP would also be asked to provide necessary data.

   Measures would be computed separately for each Advanced Network and limited to patients attributed for the purpose of shared savings. At this time, payers have not agreed to panel wide (payer agnostic) measure production, so measures would need to be calculated separately for each payers attributed population with any given Advanced Network. Payers will need to provide a list of attributed patients.

HIT Performance Measurement Design Group #3

Central to selecting the best HIT solution(s) is understanding the data, processing and reporting needs for SIM. The following questions will help the HIT Design Group define IT requirements.

4. When will the ACOs that are participating in SIM be finalized?

   Response : *We currently have a list of all known Advanced Networks that we believe are participating in a Shared Savings Program with one or more commercial payers in 2015. We likely will not know of all 2016 participants until January 2017. We do not anticipate more than a few new participants.*

5. Are DURSAs part of the ACO SIM sign-up?

   Response: Yes. Once the requirements are finalized, the PMO intends to prepare and execute DURSAs with all of Connecticut's Advanced Networks.

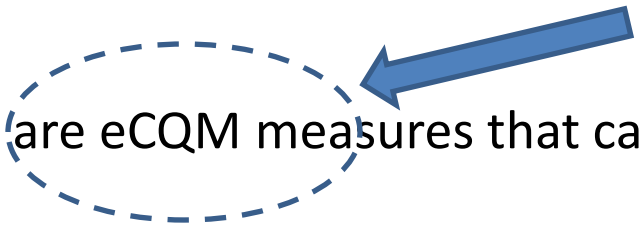
Draft "Proof of Solution" memo

1. Review "Stage 1" draft requirements
2. Consider issues that have emerged since the document was drafted
3. Review what we have learned from other states at the National Governor's Association SIM Meeting in April 2015 and through individual state contacts

Quality Measure Production Narrative - DRAFT

The Council request for the first stage of this initiative is the production of measures of provider performance that can be used by all payers as the basis for shared savings distribution. At a minimum this requires measurement of the provider's performance (advanced network or FQHC) for all patients attributed to that provider by each payer, in aggregate and stratified by race/ethnicity.

Assumes that:



- all measures are eCQM measures that can be produced by any ONC certified EHR
- providers are responsible for developing their own analytic methods to inform continuous quality improvement, and
- all measures and any associated data are de-identified from point of extraction

Stage 1 - End User Requirements

- End users for stage 1 will include:
  - PMO – generates the aggregated reports and posts appropriate information to inform a consumer view of provider quality
  - Payer – reliable and valid performance data for use by all payers in value-based payment scorecard and shared savings distribution
  - Provider – performance information for use in monitoring progress over time and informing areas for focused improvement

Stage 1 - End User Requirements

- Payers will not require patient level detail, there will need to be a robust audit process whereby an auditor is provided access to patient level data in order to certify the accuracy/validity of the reported measures

- Payers will require identifiable data so that they can audit directly and so that they limit the measure to specific accounts/contracts…e.g., fully insured, individual self-funded accounts, exchange products

Stage 1 - Current Issues

- Initially, it appeared that providers could calculate measures that are eCQM type measures using their ONC certified EHR
- Zato edge server would index to the EHR and extract the calculated eCQM measure of provider performance
- Advantages would be that no patient level data would be extracted and we would avoid the complexities of indexing directly to EHR source data.
- Preliminarily, it appears that this solution has some limitations or vulnerabilities

Stage 1 - Current Issues

- As previously noted, payers identified additional requirements that would not be addressed by this provider computed eCQM approach
  - It would not allow providers the ability to appeal and verify measure performance - (in theory, not an issue given that providers are producing and self-reporting the measure)
  - Payer ability to audit at the client level to verify measure validity
  - Payer ability to segregate performance by account/self-funded employers to satisfy employers' ability to evaluate performance for their employees

Stage 1 - Current Issues

- Various experts identified additional issues including:
  - eCQM programming within the EHR would have to be custom modified by each provider to produce eCQMs broken down in accordance with our requirements; also would no longer be certified measure
  - eCQMs can be gamed; provider can potentially modify parameters to nudge performance over a performance threshold
  - eCQM calculations are limited to data in resident EHR; does not show activity in other health systems (current Medicare approach has similar limitation)
  - eCQM option does not appear to be scalable to bi-directional analytics; thus the invest in Stage 1 does not get us closer to stage 2

Stage 1 - Current Issues

- Zato edge server solution could potentially address all of these issues
- However, additional testing needs to be done to assess the viabiilty of this technology solution
- Moreover, substantially more time will be required to
  - Define requirement
  - demonstrate at pilot sites,
  - and implement a statewide solution:

We are not alone…

- Other states have encountered similar issues
- Delaware is standing up only claims based measures in year 1
- Vermont is simply extending the Medicare SSP EHR measure collection solution to commercial and Medicaid because:
  - Many practices still use paper based charts or have EHRs that do not provide access to specified data
  - VT plans to produce measures in the future through their health information exchange, however, implementation of the health information exchange is years off

Vermont solution

- Commercial and Medicaid each draw a random sample of patients for chart review
- ACOs pull data from charts in order to compute the numerator of the measure
- De-identified data is provided to a SIM contracted vendor (Lewin), who computes performance and provides the calculated performance to the commercial and Medicaid payers
- They are doing this only for Medicare SSP self-reported (EHR) measures and selected new measures (e.g., immunization rates and child/adolescent weight assessment, counseling and follow-up

Whatever we do…we had better take the long view. There are no easy solutions.

Next Steps

Meeting Date	Discussion Topics	Outcomes/ Follow up
May (TBD)	• Reconvene PMDG with QC liaisons • Review all responses to questions • Discussion of Stage 1 and Stage 2 options	• Prepare materials for the HIT Council to review and discuss

Readmission Measures

Under Review - Readmission

Domain: care coordination/patient safety		NQF	Steward
ACO-8	Risk standardized all condition readmission	1789 (adapted)	CMS
	Plan All-cause Readmissions	1768	NCQA

Under Review - Readmission

	CMS readmission NQF 1789	NCQA readmission NQF 1768
Pros	Medicare SSP aligned Risk standardization can apply to commercial and Medicaid	Harmonized with CMS measure on index admission and planned exclusions Includes BH admissions National benchmark data *Appears* to be the standard adopted in other SIM states
Cons	Excludes BH admissions No national benchmark	No risk adjustment for Medicaid Excludes births

Under Review – Readmission - Options

- NCQA (1768)
  - Use for commercial, no readmission measure for Medicaid scorecard for payment purposes
  - CT /other SIM states steward risk standardization for Medicaid
- CMS (1789)
  - CT stewards addition of BH component to CMS measure

Claims vs. EHR as data source for measures

Provisional Measure Set

- Based on Level I/II review, measures have been recommended for provisional measure set
- Does not include readmission, admission, ED use or other measures under review
- Final review and culling will be based on expanded stakeholder input and examination of base rate information and improvement opportunity
- Final review will also consider HIT Council examination of feasibility, especially as it pertains to EHR based measures

Provisional Measure Set – Source of Data

Principles that guided this preliminary recommended data source

1. **Claims** as the data source for those measures for which:

   a) Claims data feasible to obtain and provides a reasonably complete/valid measure of performance

   b) Claims data is already the sole source of data for Medicare, Medicaid or commercial plan production of the measure

   c) Codes are currently in widespread use for claims submission

Provisional Measure Set – Source of Data

2. **EHR** as the data source for those measures for which:

   a) Measure is a hybrid measure that requires medical record or EHR chart abstraction

   b) Medicare has engineered the production of the measure using EHR source data

   c) Measure is an electronic Clinical Quality Measure (eCQM) and thus programmed into ONC certified EHRs

3. **Survey** as a data source for those measures for which:

   a) Survey is the most efficient and valid means to gather data

   b) Survey is the source of data for Medicare and commercial plans

   c) Survey methodology available

Provisional Measure Set – Care Experience

Prevention Measure	Proposed Data Source
PCMH CAHPS	Survey

Provisional Measure Set - Prevention

Prevention Measure	Proposed Data Source	eCQM	Medicare ACO Measure
Breast cancer screening	Claims		PREV-5 (ACO-20)
Cervical cancer screening	Claims	eCQM	
Chlamydia screening in women	Claims	eCQM	
Colorectal cancer screening	EHR	eCQM	PREV-6 (ACO-19)
Preventive care and screening: influenza immunization	EHR	eCQM	PREV-7 (ACO-14)
Preventive care and screening: body mass index screening and follow-up	EHR	eCQM	PREV-9 (ACO-16)
Weight assessment and counseling for nutrition and physical activity for children/adolescents	EHR	eCQM	

Provisional Measure Set - Prevention

Prevention Measure	Proposed Data Source	eCQM	Medicare ACO Measure
Developmental screening in the first three years of life	Claims		Pediatric Prevention Composite
Well-child visits in the first 15 months of life	EHR		Pediatric Prevention Composite
Well-child visits in the third, fourth, fifth and sixth years of life	EHR		Pediatric Prevention Composite
Adolescent well-care visits	EHR		Pediatric Prevention Composite
Pediatric behavioral health screening	Claims		
Preventive care and screening: tobacco use: screening and cessation intervention	EHR	eCQM	PREV-10 (ACO-17)
Preventive care and screening: screening for high blood pressure and follow-up documented	EHR		PREV-11 (ACO-21)

Provisional Measure Set - Prevention

Prevention Measure	NQF	eCQM	Medicare ACO Measure
Preventive care and screening: screening for clinical depression and follow-up plan	EHR	eCQM	PREV-12 (ACO-18)
Prenatal care & Postpartum care	EHR		
Frequency of ongoing prenatal care	EHR		
Maternal depression screening	Claims	eCQM	
Annual dental visit	Claims		

Provisional Measure Set – Acute & Chronic care

Measure	Proposed Data Source	eCQM	Medicare ACO Measure
Medication management for people with asthma	Claims		
Disease modifying anti-rheumatic drug therapy for rheumatoid arthritis	Claims		
DM: Hemoglobin A1c Poor Control (>9%)	EHR	eCQM	DM All or nothing Composite: ACO-27
DM: Diabetes eye exam	Claims	eCQM	DM All or nothing Composite: ACO-41
DM: Diabetes foot exam	Claims		
DM: Diabetes: medical attention for nephropathy	Claims	eCQM	

Provisional Measure Set – Acute & Chronic care

Measure	Proposed Data Source	eCQM	Medicare ACO Measure
HTN: Controlling high blood pressure	EHR	eCQM	HTN-2 (ACO-28)
CHF: beta-blocker therapy for left ventricular systolic dysfunction	Claims	eCQM	HF-6 (ACO-31)
COPD: Use of spirometry testing in the assessment and diagnosis of COPD	Claims		
CAD: Persistence of Beta blocker therapy after a heart attack	Claims		
CAD: Medication adherence	Claims		
Use of imaging studies for low back pain	Claims	eCQM	
Avoidance of antibiotic treatment in adults with acute bronchitis	Claims		
Appropriate treatment for children with upper respiratory infection	Claims	eCQM?	

Provisional Measure Set

Behavioral Health Measures	Proposed Data Source	eCQM	Medicare ACO Measure
Follow-up care for children prescribed ADHD medication	Claims	eCQM	
Depression Remission at 12 Twelve Months	EHR	eCQM	
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	EHR	eCQM	
Preventive Care and Screening: Unhealthy Alcohol Use – Screening	EHR		

Obstetrics Measure	Proposed Data Source	eCQM	Medicare ACO Measure
Elective Delivery	Claims		

Next Steps