Identifying Other Data Sources to Measure Interoperability

11. Should ONC select measures from a single data source for consistency, or should ONC leverage a variety of data sources? If the latter, would a combination of measures from CMS EHR Incentive Programs and national survey data of hospitals and physicians be appropriate?

Given the complexity of interoperability and the lack of definitive data measuring interoperability, it would seem that having multiple data sources would be a benefit. These measures from multiple data sources could be accumulated into a dashboard to give a picture of the level of interoperability and the trend over time.

Yes, a combination of measures from CMS EHR incentive programs and national survey data of hospitals and physicians would be appropriate. However, as strongly emphasized previously, measures selected should be focused on continuity of care and care coordination, with the goal of avoiding unnecessary administrative burden. The national survey data gathered and displayed, to provide context to results observed, should include multiple data sources rather than strictly NEHRS and NAMCS survey data. It is imperative that physician and provider perspectives present within other national surveys are incorporated as well, to obtain a 360-degree view of front-line user perceptions about the ability of current functionality in technology to meet interoperability needs and goals.

12. Are there Medicare claims based measures that have the potential to add unique information that is not available from the combination of the CMS EHR Incentive Programs data and survey data?

ONC could leverage the Medicare claims data similar to how Docgraph (www.docgraph.com) has used the subset of data made publicly available. ONC could use the claims to identify networks of physicians and hospitals that are caring for the same Medicare beneficiaries. These graphs of health care providers could then be levered to either identify entities for focus groups or additional surveys around interoperability or filter existing data to understand the level of interoperability within these networks. For example, ONC could identify networks that have a high number of common patients and networks that have a low number of common patients. These could allow ONC to see how interoperability is progressing in these two scenarios. One would assume that the network with a high number of common patients would have incentives in place to invest in infrastructure to drive interoperability, whereas the networks with a low number of common patients would be a better representation of the general, wide-scale level of interoperability. This data could also help ONC identify specific instances of transitions of care where follow-up survey or other data could be gathered to measure the level of interoperability in those transitions.

13. If ONC seeks to limit the number of measures selected, which are the highest priority measures to include?

The ability to narrow the focus of interoperability measures to those of most immediate importance is appreciated. If interoperability measures are prioritized, while continuity of care is important, this is already occurring. Care coordination, however, is an area that clinicians struggle with, especially when required to coordinate care efficiently with clinicians outside of their own practice or within the larger community. The AAFP recommends that measuring actual progress toward interoperability across disparate systems and across clinicians for the purpose of care coordination should receive highest prioritization among measures. Again, administrative burden must be avoided to allow clinicians to focus their time on coordinating care rather than measuring the level of progress toward interoperability in care coordination.